Please visit us on the Web at bcbsnc.com for providers.
Today’s agenda

- Blue Options 1-2-3℠
- Blue Options HRA℠ (Pay Provider)
- Blue Medicare HMO℠ and Blue Medicare PPO℠
- Chiropractic copay change
- Medication updates
- Inter-Plan Programs updates (BlueCard®)
- Diagnostic imaging management program
- e Solutions
Blue Options 1-2-3<sup>SM</sup> is a new PPO plan that utilizes the same Blue Options<sup>SM</sup> network that our existing PPO plans use today.

Blue Options 1-2-3<sup>SM</sup> promotes members’ enrollment with primary care physicians and encourages preventive health screenings and regular physical exams.

Blue Options 1-2-3<sup>SM</sup> provides an affordable option for groups to offer to their employees because it gives employers the ability to design the benefits (deductible and coinsurance options) to meet their employees’ needs.
Starting in January you may begin seeing this new member identification card presented by patients at your practice who are enrolled in Blue Options 1-2-3℠.
Blue Options 1-2-3\textsuperscript{SM} – Starting January 1, 2008

1. Preventive and primary care
   - Copay
   - Lowest out-of-pocket

2. Inpatient hospital care
   - Coinsurance (following deductible)
   - Mid-level out-of-pocket

3. Outpatient care or specialist care
   - Coinsurance (following deductible)
   - Highest out-of-pocket
Blue Options HRA<sup>SM</sup>
Pay Provider

January 1
2008
Beginning January 1, 2008 “Large Group” employer groups offering their employees a Blue Options HRA\textsuperscript{SM} plan will have an option to elect “Pay Provider.”

The “Pay Provider” option will give providers the ability to file claims directly to BCBSNC for direct reimbursement by BCBSNC, instead of collecting payment from the member.
Blue Medicare HMO<sup>SM</sup>
and
Blue Medicare PPO<sup>SM</sup>

January 1
2008
Effective January 1, 2008, PARTNERS Medicare Choice membership and PARTNERS Medicare Options membership will be enrolled in new co-branded Blue Medicare products:

- Blue Medicare HMO<sup>SM</sup>
- Blue Medicare PPO<sup>SM</sup>

Blue Medicare HMO and PPO plans are being offered by PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS).

PARTNERS is a Blue Cross and Blue Shield of North Carolina (BCBSNC) company.
Blue Medicare HMO and PPO plans – Starting January 1, 2008

Sample card image – front

Alpha-prefixes that are unique to Blue Medicare members

Prefixes for Blue Medicare plans always end in the letter J

Blue Medicare plan type and PPO or HMO status

Highlighted area lets you know that the Blue Medicare member’s health plan is offered by PARTNERS National Health Plans of North Carolina, Inc.
Blue Medicare HMO and PPO plans – Starting January 1, 2008

- Unique alpha-prefixes identify a Blue Medicare plan type – even when you do not have the member’s identification card in hand:
  - YPWJ – Blue Medicare HMO
  - YPFJ – Blue Medicare PPO
  - YPJ – Blue Medicare HMO for Reynolds American Inc. retirees

- Blue Medicare alpha-prefixes are unique to Blue Medicare members and always end with the letter J.
PARTNERS claims mailing address – if not filing electronically

The cards display PARTNERS claims mailing address and telephone service lines.
Reminder: For fastest claims processing always file electronically!
Blue Medicare HMO and PPO plans
– Starting January 1, 2008

**Blue Medicare Rx™**

**Blue Medicare Supplement™**

Products offered by BCBSNC

Products offered by PARTNERS as a BCBSNC company

**Blue Medicare HMO™**
Offered by PARTNERS National Health Plans of North Carolina, Inc.

**Blue Medicare PPO™**
Offered by PARTNERS National Health Plans of North Carolina, Inc.

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BlueCross BlueShield of North Carolina
As part of the benefit design for Blue Medicare HMO and PPO plans, members will not be required to obtain a referral from a primary care physician in advance of receiving care from a participating specialist or when obtaining home durable medical equipment.

Prior plan approval guidelines and pre-certification/certification requirements apply.

- Referrals from primary care physicians in advance of receiving care from a specialist or when obtaining home durable medical equipment remains a requirement for Blue Medicare HMO members after January 1, 2008 (RAI, Reynolds American Incorporated).
Blue Medicare ID cards are readily recognizable but remember that the cards include both BCBSNC and PARTNERS information. Therefore it’s important to review the cards carefully and take note of the Blue Medicare alpha-prefixes and PARTNERS health plan information.
Chiropractic copay change

January 1
2008
Chiropractic copay change  
– Starting January 1, 2008

- Beginning January 1, 2008, or upon a group's renewal date, chiropractic services will be subject to a specialist copayment.

- Background:
  - Prior to 2005, BCBSNC paid chiropractors at the specialist copay (for products that had copays).
  - In 2005, SB 622 passed stating that: “If chiropractic services are paid under a copayment, that copayment must be set no higher than the primary care physician copayment…”
  - BCBSNC started paying chiropractors at the primary care physician copay.
  - October 1, 2007, SB 622 was repealed.
Chiropractic copay change
– Starting January 1, 2008

- Exceptions:
  - For members enrolled in State Health Plan PPO plans the specialist copayment began being applied October 1, 2007.
  - The chiropractic copay change does not impact ASO (administrative services only) products, as groups can customize their chiropractic copay amounts.
Medication updates
As of January 1, 2008, BCBSNC is removing the prior authorization (PA) requirement for anorexiants (obesity) drugs Xenical and Meridia.

These weight loss agents do have some long-term safety and efficacy data available and will continue to be covered on tier 3 of the formulary.

During this past summer there was a release of a half-strength OTC version of Xenical called Alli.

- But only the prescription medications Xenical and Meridia are covered under the pharmacy benefit.
Our new Medication Dedication℠ program is designed to help members with chronic conditions improve their overall health and reduce their out-of-pocket prescription drug expenses.

The program focuses on four chronic conditions:
- Congestive heart failure (CHF)
- High blood pressure
- Diabetes
- High cholesterol

The program waives the copayment for specific generic drugs and moves more expensive brand-name drugs to the second lowest copayment tier.
Inter-Plan Programs Updates (BlueCard®)
Effective January 1, 2008, BCBS Plans are placing coordination of benefit (COB) questionnaires on their individual Web sites.

The COB questionnaire will instruct members to complete and submit the form to their home-plan.

The questionnaires will be available to providers from home-plan Web sites to give to members believed to have COB.

BCBS Plans will accept the COB questionnaire received from their members and update membership files within five business days of receipt.
Effective January 1, 2008, all Blue Plans will crossover Medicare claims for services covered under Medigap and Medicare Supplemental products.

This will result in automatic claims submission of Medicare claims to the Blue secondary payer, and reduce or eliminate the need for the provider’s office or billing service to submit an additional claim to the secondary carrier.

Additionally, with all Blue Plans participating in this process, Medicare claims will crossover in the same manner nationwide.
Medicare primary / Blue Plan secondary claims – BlueCard®

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting a claim, it is essential that you enter the correct Blue Plan name as the secondary carrier.
- Be certain to include the alpha-prefix as part of the member’s identification number. The member’s ID will include the alpha-prefix in the first three positions. The alpha-prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.
When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to BCBSNC.

- If the remittance indicates that the claim was not crossed over, submit the claim to BCBSNC with the Medicare remittance advice.

- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim (COBA, coordination of benefits agreement).

- For claim status inquiries, contact BCBSNC.
Medicare primary / Blue Plan secondary claims – BlueCard®

- The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary.
- This process may take up to 14 business days.
- This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice.
- As a result, it may take an additional 14 to 30 business days for you to receive payment from the Blue Plan.
Diagnostic imaging management program
Prior plan approval is required for high-tech diagnostic imaging services when performed in a physician's office, the outpatient department of a hospital, or a freestanding imaging center:

- CT/CTA scans
- MRI/MRA scans
- Nuclear cardiology studies
- PET scans

American Imaging Management (AIM) administers the diagnostic imaging program.
Ordering physicians must contact AIM to obtain prior authorization before scheduling an imaging exam for outpatient diagnostic, non-emergency services.

Servicing providers (hospitals and freestanding imaging centers) should confirm that prior authorization was issued prior to performing the service.

- Only ordering physicians can obtain prior plan approval. Hospitals and freestanding imaging centers that perform the imaging services cannot obtain prior plan approval.
Included services

- Outpatient diagnostic imaging services:
  - CT, CTA
  - Nuclear Cardiology (e.g. SPECT scans)
  - PET scans
  - Magnetic Resonance Imaging (MRI/MRA/MRS)

Locations

- Included places of service:
  - Freestanding imaging centers
  - Hospital outpatient
  - In-office use of physician-owned equipment

- Not included places of service:
  - Inpatient
  - Emergency room
  - Ambulatory surgical center
  - Urgent care center
Diagnostic Imaging Prior Plan Approval Code List – 4th Quarter 2007

This list is subject to change once per quarter. Changes will be posted to the BCBSNC website at www.bcbsnc.com by the 10th day of January, April, July, and October.

NOTE: Unlisted and Miscellaneous health service codes should only be used if a specific code has not been established by the American Medical Association.

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<tr>
<th>Computerized Tomography (CT)</th>
<th>CPT</th>
<th>Service Description</th>
<th>Date Ineffective</th>
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<td>CT abdomen; w/o contrast</td>
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<tr>
<td>Abdomen</td>
<td>74160</td>
<td>CT abdomen; w/ contrast</td>
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<td>Abdomen</td>
<td>74170</td>
<td>CT abdomen; w/ contrast followed by contrast</td>
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<td>CT thorax; w/o contrast</td>
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<td>71260</td>
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<td>Chest</td>
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Diagnostic imaging management program
– High level program participation

- Members included:
  - Blue Advantage
  - Blue Care
  - Blue Options
  - Blue Options FC
  - Blue Options HRA
  - Blue Options HSA
  - State Health Plan PPO
  - Food Lion
  - BCBSNC employee group

- Members not included
  - Blue HMO (R.J. Reynolds)
  - Classic Blue
  - Federal Employee Program
  - Medicare Supplement
  - Medicare Options
  - NC Health Choice
  - State Health Plan Indemnity (CMM)
  - Blue Card members
Diagnostic imaging procedures

The following services may require prior plan approval when received on a non-emergency outpatient basis, such as in a doctor’s office, the outpatient department of a hospital or at a freestanding imaging center (for dates of service on or after February 1, 2017):

- CT/CTA scans
- MRI/MRA scans
- PET scans
- Nuclear cardiology studies

Some employer groups are not participating in the diagnostic imaging program. Prior plan approval will therefore not be required for these services. Diagnostic imaging services are required for your patient, enter the search button. The Group number can be found on the identification card.

- Group No: <123456>
- Effective Date: <01/01/2007>
- Rx BIN: <123456>
- Rx PCN: <123456>
- Rx Group: <ABCDEF>
- Issuer: <123456>

This group number query is not required. It is an optional tool for you to use in determining program participation. The group number is not covered or administered by Blue Cross and Blue Shield of North Carolina (BCBS). If you are uncertain about your member's participation, proceed with requesting an authorization. If you do not have the member’s group number, you can use the Health Eligibility Link in Blue.e to obtain it.
Request prior plan approval for diagnostic imaging procedures:

- Online: ProviderPortal℠ using Blue e℠
- By fax: Prior plan approval fax request form
- By phone: American Imaging Management

**1–866–455–8414**
Monday – Friday, 8 a.m. – 5 p.m., Eastern Time
Diagnostic imaging resources on the Web:

- More information – Get answers to your questions about this program by reviewing the frequently asked questions.
- Medical policy information – Review guidelines governing the use of diagnostic imaging procedures by reviewing our medical policies.
- Training materials: @ bcbsnc.com/providers/imaging.faces
  - Program overview
  - Ordering Provider Quick Reference Guide
  - Servicing Provider Quick Reference Guide
  - AIM Provider Portal Quick Reference Guide
  - Troubleshooting Guide for Common Set–up Issues
  - Provider Training Presentation on BCBSNC’s Diagnostic Imaging Program (with Audio Feature)
e Solutions
Key points for consideration
- Administrative costs for paper claims are far more than electronic claims
- Additional capability for tracking and trending can be obtained through electronic filing
- Multiple opportunities exist for electronic filing

Next steps for action
- Assess operational “points of pain”
- Talk to practice leadership about operational goals
- Visit www.bcbsnc.com/providers/edi
- Review information on Blue eSM, RealMed, or direct batch filing
- Contact your local e Solutions Consultant for assistance
Key points for consideration

- Free Online application for claims entry, membership and claims status inquiry
- Provides information for all local lines of business as well as out of state Blue Cross plans
- Provides coverage information for NC Medicaid
- Allows self service options

Next steps for action

- Visit www.bcbsnc.com/producers/edi
- Download and execute contract online
- Contact your local e Solutions Consultant for training
EOP/NOP Access via Blue e<sup>SM</sup>

- **Key points for consideration**
  - PDFs (Exact representation of paper NOP/EOP)
  - All Lines of BCBSNC Business
  - Available for 365 Days for Blue Products

- **Next steps for action**
  - Anticipate BCBSNC paperless (2009)
  - Adopt in Work Processes
  - Additional Enhancements in Spring 2008
Secondary/corrected claims

- **Key points for consideration**
  - Secondary and corrected claims can be filed to BCBSNC electronically in the HIPAA 837 format

- **Next steps for action**
  - Refer to BCBSNC Companion Guide for HIPAA 837 claims at [www.bcbsnc.com](http://www.bcbsnc.com) for specific data and filing information
Key points for consideration

- Compliance date of 5/23/07 extended through contingency period until 5/23/08
- Providers must obtain an NPI and tell BCBSNC what PPN the NPI maps to
- Testing for NPI/PPN mapping can be accomplished through dual submission
- Providers are encouraged to move to NPI use only as soon as possible before 5/23/08

Next steps for action

- Register to obtain appropriate NPIs for your practice
- Register them with BCBSNC
- Test mapping through dual use submission
More things than we have time to talk about

- HIPAA 270/276
- RealMed
- HealthTrio
Your questions?

Thank you!

http://www.bcbsnc.com/providers/