Inter-Plan Programs (BlueCard®) now using new processing system

Blue Cross and Blue Shield Inter-Plan Programs (BlueCard®) strives to make improvements and increase efficiencies to better service our customers. That’s why we’re pleased to announce that our Host Migration Project was successfully completed in November 2008. This project was critical to improving service by transitioning the BlueCard host claims processing from our Legacy claims processing system to Blue Cross and Blue Shield of North Carolina’s (BCBSNC) newer Power-MHS claims processing system. The initiative was a large-scale undertaking and was performed in a phased approach that began in August 2008. By November, we began processing and pricing BlueCard host claims using only the Power-MHS system. Using the Power-MHS system, we are now able to:

- Improve data and financial claims accuracy through the use of a single claims processing system
- Increase claims processing speed through automation that replaced manual processes

It’s an exciting time for Inter-Plan Programs, as many enhancements have been included with the November completion of Host Migration, including expanding the BlueSquared® systems application. This application provides functionality to support the exchange of: informational messages, tracking misrouted claims, claim status inquiries, medical records, pre-existing information and miscellaneous attachments for Inter-Plan Program (BlueCard) claims. Host migration, along with the enhancements of BlueSquared, have been designed and implemented to improve provider satisfaction by increasing speed and accuracy of claims processing, while significantly decreasing wait times and duplicate requests previously experienced.

To find out more about Inter-Plan Programs, turn to page 4 of this publication.
Changes for BCBSNC Medicare Supplement and Medicare High Option Programs:
Effective January 1, 2009

This year, the BCBSNC Medicare supplement got a new name: Blue Medicare Supplement™. We added “Blue” to the name, so members will be better recognized as having health care coverage administered by Blue Cross and Blue Shield of North Carolina (BCBSNC). Along with this name change, we also issued new member ID cards in mid-December of last year to members enrolled in Blue Medicare Supplement and Medicare High Option programs.

The new member ID cards are plastic, making the cards more durable and less likely to fade or tear. Members who were enrolled before December 31, 2008 maintained YPZW prefixes as part of their member ID; new members enrolled after January 1, 2009 received a prefix of YPZJ.

Along with the name change and new cards for members, there are additional changes that affect how claims will be processed for Blue Medicare Supplement and Medicare High Option member services:

- BCBSNC previously processed (Blue) Medicare Supplement and Medicare High Option plans using our Legacy claims adjudication system. Effective January 1, 2009, we began processing claims for services provided to Blue Medicare Supplement and Blue Medicare High Option members (services provided on or after 01/01/09) using the AMISYS* claims processing system. It’s important to note that moving the claims processing platform from Legacy to AMISYS will not change a member’s benefits.

- Professional services submitted on Blue e™, 837P or CMS-1500 paper claim forms and Institutional services filed on Blue e, 837I or UB-04 paper claim forms were previously processed on the Legacy claims system and priced according to amounts and coding edits contained within the Legacy system. After claims processing transitioned to the AMISYS claims processing system, claims for most services provided to Blue Medicare Supplement and Medicare High Option members are reimbursed based on Medicare allowances for services. Blue Medicare Supplement 835 Remittances, though created from the AMISYS claims processing system, is included in the BCBSNC mailbox as a separate transmission. Blue Medicare Supplement 835’s are produced semi-weekly with payments on Wednesday and Friday.

As part of the transition process for (Blue) Medicare Supplement and Medicare High Option claims processing to AMISYS, there will be a temporary interruption for providers receiving EFT (electronic funds transfer). For dates of services January 1, 2009 and after, providers will receive paper-check remittances for claims payments for services provided to Blue Medicare Supplement and Medicare High Option members. Receipt of paper-check payments will be temporary, and we anticipate EFT to be restored by May 2009.

There is no change in the electronic connectivity for Blue Medicare PPO™ and Blue Medicare HMO™ plans. For questions about changes to the (Blue) Medicare Supplement and Medicare High Option programs, as well as questions about any of the products with Blue Medicare in the name, please contact your regional Network Management representative.

For questions regarding access to any electronic data through Blue e, please contact your regional Electronic Solutions consultant.

*AMISYS is the claims processing system already utilized for processing claims for Blue Medicare HMO and Blue Medicare PPO members enrolled in the Medicare products offered by PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS), a subsidiary of Blue Cross and Blue Shield of North Carolina (BCBSNC). PARTNERS is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans. BCBSNC and PARTNERS are independent licensees of the Blue Cross and Blue Shield Association.
How are medical-necessity decisions made?

BCBSNC wants to make sure all providers are aware of the criteria and guidelines that we use to make medical-necessity decisions. BCBSNC uses two sets of criteria: the Milliman Care Guidelines and the BCBSNC corporate medical policy. Most of our licensed nurses use Milliman Care Guidelines to authorize coverage for inpatient services and for length-of-stay extensions. They also use the Milliman Care Guidelines for home care and rehabilitation services. Our corporate medical policy applies more to services that require prior plan approval. Practitioners can obtain a copy of a specific Milliman Care Guideline or a BCBSNC medical policy by calling our Medical Resource Management department at 1-800-672-7897, ext. 57078.

Our medical policies are also available through our Web site at bcbsnc.com via the “I’m a provider” portal. If a nurse cannot approve a service, a BCBSNC medical director, who is licensed in North Carolina, will review the case and may approve or deny coverage based on Milliman Care Guidelines or BCBSNC medical policy, along with clinical judgment. Only a medical director can deny coverage for a service based on medical necessity. We encourage you to take part in a peer-to-peer consultation regarding a case before or after a determination; a discussion between physicians can help clarify a situation and affect the determination. A BCBSNC medical director is always available during regular business hours and can be reached by calling us at 1-800-672-7897, ext. 51019.

Protecting your patients’ health care needs

Did you know there are standards in place that protect health-care consumers? The National Committee for Quality Assurance (NCQA), a not-for-profit organization that accredits BCBSNC, has developed standards that do just that. NCQA and BCBSNC want you to know that:

- Any decisions made about coverage for care or service are based on your patient’s benefit plan, BCBSNC medical policy and information from the doctor about the patient’s medical condition.

- BCBSNC doctors and nurses who review you or your patient’s requests for service or coverage are not rewarded for denying or limiting coverage.

At BCBSNC, we’re committed to making appropriate coverage decisions about our members’ health care that meet the terms of their health benefit plan while meeting their medical needs.
Inter-Plan Programs: Updates and reminders

COB form available

As part of the BCBSNC Inter-Plan Programs’ on-going efforts to streamline claims processing and reduce the number of denials related to COB (Coordination of Benefits), we’ve joined other Blue Plans to offer a COB questionnaire for BlueCard members to complete via bcbsnc.com.

Blue Plans have placed the questionnaires on local Web sites, where they can be accessed, printed and presented to members believed to have COB needs. When you see a Blue Cross and/or Blue Shield BlueCard member and are aware that they might have other health insurance coverage, please provide them with a copy of the questionnaire during their visit. Ask them to complete the form and send it to their Blue Plan, the Blue Plan through which they are covered, as soon as possible after leaving your office. (The mailing address for the member’s plan can be found on the back of their member ID card, or by calling the customer service number also listed on the back of the card.)

Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays.

You can download and print a copy of the COB questionnaire by accessing the Links section on Blue e or on our Web site located at bcbsnc.com/content/providers/coordination-of-benefits.htm.

Medicare Advantage PPO Network Sharing

What is it?

Blue Cross and Blue Shield (BCBS) Medicare Advantage PPO network-sharing became available January 1, 2009 in the CMS-approved MA PPO local service areas of the following Blue Cross and/or Blue Shield Plans: HealthNow (Blue Cross and Blue Shield of Western New York and Blue Shield of Northeastern New York), Blue Cross and Blue Shield of South Carolina, and Blue Cross and Blue Shield of Tennessee.

This network sharing will allow MA PPO members from these Blue Plans to obtain in-network benefits when traveling or living in the service areas of the other two plans, as long as the member sees one of those plans’ contracted MA PPO providers.

What does the BCBS MA PPO Network Sharing mean to providers in North Carolina?

There is no change from your current practice. You should continue to verify eligibility and bill for services as you currently do for any out-of-area (Blue) Medicare Advantage member that you agree to treat. Benefits will be based on the Medicare allowed amount for covered services and be paid under the member’s out-of-network benefits, unless for urgent or emergency care. When a BCBSNC-participating provider submits an MA claim, any eligible payment will be sent by BCBSNC.

How do I recognize an out-of-area member from one of the plans participating in the BCBS MA PPO network sharing?

The “MA” in the suitcase indicates a member who is covered under the MA PPO network sharing program. Remember, this only affects providers of those plans in the MA PPO network sharing program in 2009: HealthNow, Blue Cross and Blue Shield of South Carolina, and Blue Cross and Blue Shield of Tennessee.

Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and Blue Shield member ID.

Do I have to provide services to these Medicare Advantage PPO network sharing members or other Blue Medicare Advantage members from out of area?

You may see these and other Blue Medicare Advantage members, but you are not required to provide services since BCBSNC is not contracted with CMS for the Medicare Advantage Program. Should you decide to provide services to any Blue Medicare Advantage out-of-area members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits.

For urgent or emergency care, you will be reimbursed at the member’s in-network benefit level.

If you choose to provide services to a Blue Private-Fee-for-Service (PFFS) member (as a “deemed” provider), you will be reimbursed for covered services at the Medicare allowed amount as outlined in the Plan’s PFFS Terms and Conditions.

Important:

Please note that providers participating with PARTNERS National Health Plans of North Carolina. (PARTNERS), who are already servicing MA members enrolled in the Blue Medicare HMO and Blue Medicare PPO plans are required to provide services to BlueCard eligible Medicare Advantage members seeking care within North Carolina.

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Inter-Plan Programs: Updates and reminders
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If I provided services, how do I verify benefits and eligibility?

Call BlueCard Eligibility at 1-800-676-BLUE (2583) and provide the member’s alpha prefix located on the ID card. You may also submit electronic eligibility requests for Blue members using Blue e. If you experience any difficulty obtaining eligibility information, please record the alpha prefix and report it to BCBSNC Inter-Plan Programs.

Where do I submit the claim?

Submit the member’s claim under your current billing practices to BCBSNC. Do not bill Medicare directly for any services rendered to a MA member. BCBSNC will send you an Explanation of Payment or payment advice.

What can I expect for reimbursement?

Benefits will be based on the Medicare allowed amount for providing covered services to any Blue Medicare Advantage out-of-area members. Once you submit the MA claim, BCBSNC will send you the eligible payment. These services will be paid under the member’s out-of-network benefits unless services were for urgent or emergency care.

What is the member cost-sharing level?

Any MA PPO members from out-of-area will pay the out-of-network cost-sharing amount. You may collect the copayment amounts from the member at the time of service.

May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, copayment, coinsurance and non-covered services).

Under certain circumstances when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in this situation.

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be balanced billed for any deductibles, coinsurance and/or copayments.

Billing reminder

Just like other claims filed to BCBSNC, BlueCard claims should never be split-billed or filed in partial increments:

- Claims should be filed utilizing valid CPT and/or HCPCS codes
- Claims are reviewed to determine eligibility for payment
- If services are considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, they are not eligible for separate reimbursement

BlueCard PPA and Radiology Management Services reminder

BlueCard members from non-North Carolina Blue Cross and/or Blue Shield plans may not be included in the BCBSNC radiology management program administered through American Imaging Management (AIM). However, it’s important to always verify a member’s eligibility and prior authorization requirements, as a member may be enrolled in a benefit coverage plan that includes authorization prior to receiving certain radiological services.

To verify:
- Call the number on the member’s identification card
- Call 1-800-676-Blue
- Access Blue e

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Blue coverage for members from Jamaica terminated
December 31, 2008

Effective December 31, 2008, Blue health insurance coverage for international Blue members from Jamaica was terminated. These members carried ID cards with alpha prefix JAM.

Sample Member ID Card

Please note the following:

- You should no longer accept ID cards with alpha prefix JAM for services after December 31, 2008. Claims for services rendered after this date will not be reimbursed through the BlueCard program.

- For services rendered prior to December 31, 2008, submit all claims to BCBSNC by May 1, 2009.

- Original claims and adjustments submitted after May 1, 2009, for services provided prior to January 1, 2009, will not be reimbursed through BlueCard.

Remember, to ensure eligibility and benefits, always verify patient coverage prior to rendering services by using Blue e, or by calling 1-800-676-BLUE.

If you have any questions, please contact your regional Network Management representative.

Electronic health ID cards

Some Blue Cross and/or Blue Shield plans around the country have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process for its members. Since any of these members might travel to North Carolina and be your patients, here are some tips related to their member ID cards:

- Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider’s system.

- A Blue Cross and/or Blue Shield electronic health ID card has a magnetic strip on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.

- Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth and plan ID.

- The plan ID data element identifies the health plan that issued the ID card. Plan IDs will help providers facilitate health transactions among various payors in the market place.

- Providers will need a track-3 card reader in order for the data on track 3 of the magnetic strip to be read (the majority of card readers in provider offices only read tracks 1 and 2 of the magnetic strip; tracks 1 and 2 are proprietary to the financial industry).

Sample image of an electronic health ID card:

Automatic crossover for all Medicare claims

All Medicare crossover claims are being automatically submitted to the secondary payor. After your claim has been filed to Medicare, there’s no need for you to file a second claim to BCBSNC. (Automatic crossover applies to both local BCBSNC claims and IPP BlueCard claims.)

All Blue Plans crossover Medicare claims for services covered under Medigap and Medicare Supplemental products, resulting in automatic claims submission of Medicare claims to the Blue secondary payor, and a reduction or elimination of the need for the provider’s office or billing service to submit an additional claim to

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the secondary carrier. Additionally, with all Blue Plans participating in this process, Medicare claims will crossover in the same manner nationwide. Whether the secondary payor is BCBSNC or another Blue’s Plan, you only need to file the claim once and the claim will be automatically routed for secondary processing.

This Medicare crossover process applies to all provider types, including: hospitals and facilities, professional providers, ancillary providers, federally qualified health centers, rural health clinics and comprehensive outpatient rehabilitation facilities. Federally qualified health centers, rural health clinics and comprehensive outpatient rehabilitation facilities can now bill Medicare using a UB-04 claim form without submitting a second CMS-1500 claim form to BCBSNC.

How do I submit Medicare primary / Blue Plan secondary claims?

For members with Medicare primary coverage and BCBSNC or another Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier. There is no need to submit a second claim to BCBSNC or another Blue Plan.

When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. Be sure to distinguish if the Plan is BCBSNC or a different Blue Plan. Check the member’s ID card for additional verification.

Be certain to include the alpha prefix as part of the member identification number. The members’ ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and crucial in 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 BCBSNC or another 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 information.

When should I expect to receive payment?

The claims you submit to the Medicare intermediary will be crossed over to BCBSNC or the out-of-state 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 release the claim to BCBSNC or the out-of-state Blue Plan for processing at about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14–30 business days for you to receive payment from BCBSNC or the out-of-state Blue Plan.

What should I do if I have not received a response to my initial claim submission?

If you submitted the claim to the Medicare intermediary/carry and have not received a response to your initial claim submission, do not automatically submit another claim. Rather, you should:

- Review the automated resubmission cycle on your claim system
- Wait 30 days
- Check claims status before resubmitting

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and can create confusion for the member.

Questions?

Answers to questions about claims that have crossed over can be found by accessing Blue e or by calling the Provider Blue Line at 1-800-214-4844 (for BlueCard claims call 1-800-487-5522). If you have general questions about the automatic crossover process, please contact your regional Network Management representative.
We feel that it is important for you to be aware of the member rights and responsibilities that we share with our members each year. The following information outlines our expectations regarding how our members should interact not only with us, their health insurer, but also with you, their provider of health care services, and in turn, how we should interact with them.

**As a BCBSNC member, you have the right to:**

- Receive information about your coverage and your rights and responsibilities as a member.
- Receive, upon request, facts about your plan, including a list of doctors and health care services covered.
- Receive polite service and respect from BCBSNC.
- Receive polite service and respect from the doctors who are part of the BCBSNC networks.
- Receive the reasons why BCBSNC denied a request for treatment or health care service, and the rules used to reach those results.
- Receive, upon request, details on the rules used by BCBSNC to decide whether a procedure, treatment, site, equipment, drug or device needs prior approval.
- Receive, upon request, a copy of BCBSNC’s list of covered prescription drugs. You can also request updates about when a drug may become covered.
- Receive clear and correct facts to help you make your own health care choices.
- Play an active part in your health care and discuss treatment options with your doctor without regard to cost or benefit coverage.
- Participate with practitioners in making decisions about your health care.
- Candid discussions about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
- Expect that BCBSNC will take measures to keep your health information private and protect your health care records.
- Voice complaints and expect a fair and quick appeals process for addressing any concerns you may have with BCBSNC.
- Make recommendations regarding BCBSNC’s member rights and responsibilities policies.

- Receive information about BCBSNC, its services, its practitioners and providers and members’ rights and responsibilities.
- Be treated with respect and recognition of your dignity and right to privacy.

**As a BCBSNC member, you should:**

- Present your BCBSNC ID card each time you receive a service.
- Read your BCBSNC benefit booklet and all other BCBSNC member materials.
- Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear.
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide BCBSNC and your doctors with complete information about your illness, accident or health care issues, which may be needed in order to provide care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor’s office at least 24-hours notice.
- Play an active part in your health care.
- Be polite to network doctors, their staff and BCBSNC staff.
- Tell your place of work and BCBSNC if you have any other group coverage.
- Tell your place of work about new children under your care or other family changes as soon as you can.
- Protect your BCBSNC ID card from improper use.
- Comply with the rules outlined in your member benefit guide.
When to send medical records

Only send medical records when requested by BCBSNC. Please do not include medical records when submitting claims to BCBSNC, unless you have received a letter from BCBSNC requesting that medical records be supplied.

We will send you a medical record request form when medical records are needed from your health care business. This form will document what required information is needed; this form must be returned with the records requested. This medical request form is critical to getting your medical records routed to the correct area to review.

Not submitting your medical records with the medical record request form contributes to the delay or possible loss of the medical record.

Do not submit medical records based on your NOP/EOP. When we send an NOP/EOP stating that medical records are needed, this is a message intended to advise that medical records are needed from a provider somewhere, however not necessarily a provider with your health care business.

What’s missing could delay claims

One of the biggest delays to claims processing is missing information. Below we’ve identified some of the most common pieces of frequently omitted claims information that can result in claims processing and payment delays:

- Missing or invalid NPI (national provider identifiers [for individual and/or group])
- Missing, invalid or incomplete member ID (always include the complete member ID including applicable alpha prefixes and numeric suffixes as they appear on the member’s current ID card)
- Missing or invalid place-of-service code (filing one-digit code instead of a two-digit code)
- Missing patient’s date of birth
- Missing onset date of symptoms
- Missing or incomplete specific diagnosis
- Missing primary payer's EOB if BCBSNC is secondary
- Missing admission and discharge dates for inpatient claims

Omitting any of the above information may also contribute to a request for review of a already processed claim being delayed. Please review this information and ensure that your claims and any requests for review are complete and accurate before submitting them to BCBSNC.

Filing with unlisted codes

Per CPT/HCPCS coding guidelines, all unlisted codes require the submission of pertinent records, such as the operative report, detailed description of the service in question, etc. to support the use of the unlisted code. This supporting information is required in order for us to make coverage and pricing determinations. By submitting it with the claim, you prevent any payment delay that will result if we have to request medical records.

For unlisted drugs, such as codes J3490, J3590, J9999, we require the NDC number, the name and dosage of the drug provided. If there is a valid CPT or HCPCS code, then do not submit the unlisted code.

For unlisted DME codes E1399 and K0108 remember to include the description of the DME item, and the manufacturer's invoice.

Vision discount program

As a benefit to our eligible members, we offer a vision discount program. Participating vision providers offer BCBSNC eligible members a 30-percent discount on prescription lenses and frames and non-disposable contact lenses. Participating vision providers offer a 15-percent discount for disposable contact lenses. Additional options may be offered at the provider's discretion.
New generics

Generic equivalents for the following drug products have recently become available. These generic products are available at the lowest copayment level, Tier 1, on the BCBSNC commercial and Medicare Part D formularies.

Remember to tell your patients that the FDA requires generic drugs to have the same quality, strength, purity and stability as their brand-name counterparts. Save money for your patients and prescribe generic drug products when appropriate.

<table>
<thead>
<tr>
<th>Tier 1 - New generics (Lowest copayment amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand-name</td>
</tr>
<tr>
<td>Ceftin® oral suspension</td>
</tr>
<tr>
<td>Sonata®</td>
</tr>
<tr>
<td>Requip®</td>
</tr>
<tr>
<td>Paxil CR®</td>
</tr>
<tr>
<td>Wellbutrin XL® 150 mg</td>
</tr>
<tr>
<td>Risperdal®</td>
</tr>
<tr>
<td>Razadyne®</td>
</tr>
<tr>
<td>Lamictal® tablet</td>
</tr>
<tr>
<td>Depakote®</td>
</tr>
<tr>
<td>Inspra®</td>
</tr>
<tr>
<td>Sular®²</td>
</tr>
<tr>
<td>Precose®</td>
</tr>
<tr>
<td>Activella® 1-0.5 mg</td>
</tr>
<tr>
<td>Yasmin®</td>
</tr>
<tr>
<td>Marinol®</td>
</tr>
<tr>
<td>Prilosec® 40 mg</td>
</tr>
<tr>
<td>Dovonex® solution</td>
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<tr>
<td>Olux® foam</td>
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</tbody>
</table>

¹For most groups, a benefit limit applies.
²There are no generic equivalents for the new strengths of Sular (8.5, 17, 25.5, 34 mg).

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New generics
(Continued from page 10)

Commercial drug formulary update

BCBSNC and its Pharmacy & Therapeutics (P&T) Committee have reviewed the following new drug products and made the following decisions regarding their formulary tier (copayment) placement on the BCBSNC commercial formulary.

<table>
<thead>
<tr>
<th>Tier 2 – Preferred brands (second-lowest copayment amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand-name</td>
</tr>
<tr>
<td>Intelence™</td>
</tr>
<tr>
<td>Comtan®</td>
</tr>
<tr>
<td>Simcor®</td>
</tr>
<tr>
<td>Fenoglide®</td>
</tr>
<tr>
<td>Bystolic®</td>
</tr>
<tr>
<td>Tekturna®</td>
</tr>
<tr>
<td>Tekturna® HCT</td>
</tr>
<tr>
<td>Arimidex®</td>
</tr>
<tr>
<td>Aromasin®</td>
</tr>
<tr>
<td>Femara®</td>
</tr>
<tr>
<td>Renvela®</td>
</tr>
</tbody>
</table>

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## Tier 3 – Brands (second-highest copayment amount)

<table>
<thead>
<tr>
<th>Brand-name</th>
<th>Generic</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luvox CR®</td>
<td>Fluvoxamine maleate sustained-release</td>
<td>SSRI Antidepressants</td>
</tr>
<tr>
<td>Pristiq®</td>
<td>Desvenlafaxine extended-release</td>
<td>Miscellaneous Antidepressants</td>
</tr>
<tr>
<td>Treximet®1</td>
<td>Sumatriptan succinate / Naproxen sodium1</td>
<td>Headache Therapy</td>
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<tr>
<td>Voltaren® gel</td>
<td>Diclofenac sodium 1% gel</td>
<td>NSAIDs</td>
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<tr>
<td>Flector®</td>
<td>Diclofenac epolamine patch</td>
<td>NSAIDs</td>
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<tr>
<td>Lamisil® granules2</td>
<td>Terbinaine oral granules2</td>
<td>Antifungal Agents</td>
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<tr>
<td>Veregen®</td>
<td>Sinecatechins ointment</td>
<td>Miscellaneous Dermatologicals</td>
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<tr>
<td>Atralin™</td>
<td>Tretinoin 0.05% gel</td>
<td>Acne Therapy</td>
</tr>
<tr>
<td>Evamist®</td>
<td>Estradiol topical spray</td>
<td>Estrogens</td>
</tr>
<tr>
<td>Combigan®</td>
<td>Brimonidine tartrate 0.2% / Timolol maleate 0.5% ophthalmic drops</td>
<td>Glaucoma Drugs</td>
</tr>
<tr>
<td>Iquix®</td>
<td>Levofoxacin 1.5% ophthalmic suspension</td>
<td>Ophthalmic Antibiotics</td>
</tr>
<tr>
<td>Allegra® ODT</td>
<td>Fexofenadine rapid dissolve tablet</td>
<td>Antihistamines</td>
</tr>
<tr>
<td>Omnaris®</td>
<td>Ciclesonide nasal spray</td>
<td>Intranasal Steroids</td>
</tr>
<tr>
<td>Patanase®</td>
<td>Olopatadine nasal spray</td>
<td>Miscellaneous Agents</td>
</tr>
<tr>
<td>Sanctura XR™</td>
<td>Trospium chloride extended-release</td>
<td>Anticholinergics &amp; Antispasmodics</td>
</tr>
<tr>
<td>Calomist®</td>
<td>Cyanocobalamin nasal spray</td>
<td>Vitamins &amp; Hematinics</td>
</tr>
</tbody>
</table>

1 Quantity limitations may apply.  
2 Prior approval may apply.  

Luvox CR® is a registered trademark of Solvay Pharmaceuticals, Inc. Pristiq® is a registered trademark of Wyeth Pharmaceuticals Inc. Treximet® is a registered trademark of GlaxoSmithKline. Voltaren®, Lamisil® are registered trademarks of Novartis Pharmaceuticals Corp. Flector® is a registered trademark of Alpharma Inc. Veregen® is a registered trademark of MediGene AG. Atralin™ is a registered trademark of Coria Laboratories, Ltd. Evamist® is a registered trademark of Ther-Rx Corp. Combigan®, Sanctura XR™ are registered trademarks of Allergan, Inc. Iquix® is a registered trademark of Daiichi-Sankyo Co. Ltd. Allegra® is a registered trademark of Sanofi-Aventis U.S., LLC. Omnaris® is a registered trademark of Nycomed GmbH. Patanase® is a registered trademark of Alacon, Inc. Calomist® is a registered trademark of Fleming Pharmaceuticals.

## Tier 4 – Specialty Drugs (coinsurance amount)

<table>
<thead>
<tr>
<th>Brand-name</th>
<th>Generic</th>
<th>Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cimzia®1</td>
<td>Certolizumab pegol injection1</td>
<td>Miscellaneous Gastrointestinal Agents</td>
</tr>
<tr>
<td>Relistor®</td>
<td>Methylaltrexone bromide injection</td>
<td>Miscellaneous Gastrointestinal Agents</td>
</tr>
<tr>
<td>Arcalyst™</td>
<td>Rilonacept injection</td>
<td>Interleukins</td>
</tr>
<tr>
<td>Kuvan®</td>
<td>Sapropterin tablet</td>
<td>Miscellaneous Agents</td>
</tr>
</tbody>
</table>

1 Prior Approval may apply.  

Cimzia® is a registered trademark of UCB, Inc. Relistor® is a registered trademark of Wyeth Pharmaceuticals, Inc. Arcalyst™ is a registered trademark of Regeneron Pharmaceuticals, Inc. Kuvan® is a registered trademark of BioMarion Pharmaceuticals, Inc.
Written certification required for certain PPIs

Effective October 1, 2008, BCBSNC changed the administrative process for nonpreferred proton pump inhibitors (PPIs) listed below. These nonpreferred PPIs are considered restricted-access drugs that require an initial, written physician certification prior to being covered by our prescription drug benefit.

If you feel that a nonpreferred PPI is necessary in the care of your BCBSNC-covered patient, you will need to certify in writing to BCBSNC that the member has previously used a preferred PPI and that such drug was ineffective in treating the condition or likely to be detrimental to the member’s health. You can download the certification form on the Provider page of our Web site at bcbsnc.com, and fax it to us.

Members who are currently prescribed one of the nonpreferred PPIs will be notified about this new requirement in early September. Please note that as of October 1, 2008, if a member attempts to fill a prescription for a nonpreferred PPI, the claim will be rejected at the pharmacy if we have not received the required written certification. As a result of the claim rejection, the member may purchase an over-the-counter version such as Prilosec® OTC, or may contact you to discuss other treatment options that would be appropriate for his or her condition.

This certification requirement will apply to members enrolled in all BCBSNC commercial lines of business. It does not apply to the State Health Plan, the Federal Employee Program or our Medicare products. However, as these plans may have different utilization requirements for these drugs, we encourage you to check their respective benefits for details.

If you have questions or need more information about the certification process, please contact your regional BCBSNC Network Management representative.

1 Only the proton pump inhibitors listed are subject to the certification requirement.

Nexium®, Zegerid® are registered trademarks of Astra-Zeneca Pharmaceuticals. Prevacid® is a registered trademark of Takeda Pharmaceuticals North America, Inc. Protonix® is a registered trademark of Wyeth Pharmaceuticals Inc. AcipHex® is a registered trademark of Ortho-McNeil-Janssen Pharmaceuticals, Inc.

Prilosec® is a registered trademark of Astra-Zeneca Pharmaceuticals.

<table>
<thead>
<tr>
<th>Preferred Proton Pump Inhibitors</th>
<th>Nonpreferred Proton Pump Inhibitors1 (Physician Certification Required as of October 1, 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omeprazole (generic Prilosec)</td>
<td>Zegerid®</td>
</tr>
<tr>
<td>Pantoprazole (generic Protonix)</td>
<td>Prevacid®</td>
</tr>
<tr>
<td>Nexium*</td>
<td>Protonix® (40mg suspension only)</td>
</tr>
<tr>
<td></td>
<td>Lansoprazole powder for compounds AcipHex*</td>
</tr>
</tbody>
</table>
Changes to self-administered drug list effective January 1, 2009

In accordance with BCBSNC policy, medications are reviewed on a periodic basis to determine if certain medications can be safely administered by a member. As a result of our most recent review, 39 additional drugs were added to the list of self-administered medications. The reclassification of the below listed specific medications, as self-administered, became effective January 1, 2009:

**Injectables:**
- Antagon™
- Apokyn®
- Bravelle®
- Chorionic Gonadotropin
- Cetrotide®
- Cimzia®
- Follistim® AQ
- Fuzeon®
- Ganirelix
- Gonal®
- Menopur®
- Novarel®
- Ovidrel®
- Pregnyl®
- Reprotnex®
- Somatuline®
- Zorbtive®
- Rebetol®
- Revlimid®
- Ribasphere®
- Ribavirin®
- Sensipar®
- Sprycel®
- Sutent®
- Tarceva®
- Temodar®
- Thalomid®
- Tykerb®
- Xeloda® 150mg
- Xeloda® 500mg

**Oral:**
- Copegus®
- Exjade®
- Gleevec®
- Kuvan®
- Nexavar®
- Orfadin®
- Rebetol®
- Revlimid®
- Ribavirin®
- Sensipar®
- Sprycel®
- Sutent®
- Tarceva®
- Temodar®
- Thalomid®
- Tykerb®
- Xeloda® 150mg
- Xeloda® 500mg

The current list of specialty pharmacy drugs is available at [bcbsnc.com](http://bcbsnc.com) (please see the "Injectable Drug Network; Availability" link in the "I'm a provider" section). The list includes the next quarterly update (January 1st, April 1st, July 1st, October 1st). Please contact your local Network Management office to obtain fee schedule amounts for specialty pharmacy drugs.

**New pharmacy prior authorization programs for the State Health Plan for Teachers and State Employees**

Beginning November 1, 2008 the State Health Plan for Teachers and State Employees (SHP) implemented pharmacy prior authorization programs for new users of the following specialty drugs:

- For psoriasis – Amevive® and Raptiva®
- For multiple sclerosis – Betaseron®, Rebi®®, Copaxone®, Avonex®, and Tysabri®
- Immunomodulators –Thalomid® and Revlimid®

Also beginning November 1, 2008, a step therapy program was implemented for new users of Effexor XR® and Pristiq®. Members will be required to try generic antidepressants before approval of Effexor XR or Pristiq is granted.

Members who were currently using any of these medications as of November 1, 2008, are not subject to the above-listed prior-authorization requirements.

Detailed program information is located at the SHP Web site, on the pharmacy prior authorization page: [shpnc.org/pa-policies.html](http://shpnc.org/pa-policies.html).

Providers may request a review by calling Medco® toll-free at 1-800-417-1764, 8 a.m.–9 p.m. EST, Monday–Friday.

Amevive® is a registered trademark of Astellas Pharma U.S., Inc. Raptiva® is a registered trademark of Genentech USA, Inc. Betaseron® is a registered trademark of Bayer HealthCare Pharmaceuticals Inc. Rebi® is a registered trademark of EMD Serono, Inc. Copaxone® is a registered trademark of Teva Pharmaceutical Industries Ltd. Avonex®, Tysabri® are registered trademarks of Biogen Idec. Thalomid®, Revlimid® are registered trademarks of Celgene Corp. Effexor XR® and Pristiq® are registered trademarks of Wyeth Pharmaceuticals Inc. Medco® is a registered trademark of Medco Health Solutions, Inc.
Electronic Solutions:
Updates and reminders

New availability for electronic funds transfer

Coming in Spring 2009, BCBSNC-participating providers will have a new option to sign-up for electronic funds transfer (EFT) on-line with Blue e. This new sign-up alternative makes it easier for providers to receive the fastest receipt of eligible payments for their BCBSNC claim submissions. Once we have received and processed a claim, EFT payment is sent directly to the bank account of your designation. Payments are sent through an automated clearinghouse and typically take up to two days to post, which is a much faster process than a conventional check cycle, then mailing to your bank to process and deposit. BCBSNC offers EFT free of charge* and set-up can usually be completed in just one business week. To sign up for EFT using Blue e, providers should watch the Blue e home page, where we’ll post a link and additional instructions once the new EFT provider sign-up is fully functional.

*BCBSNC makes available EFT without charge to providers; however, providers are encouraged to verify with their financial institution if processing fees apply.

Going paperless: Provider payment detail

As part of BCBSNC’s continuing efforts to become a greener company for North Carolina, we’re changing the standard delivery method for provider payment details by discontinuing use of paper remittance in the second quarter, 2009. Forms of paper remittance scheduled for discontinuance include:

- Explanations of Payment (EOP)
- Notices of Payment (NOP)
- EFT Paper Voided Checks & Payment Summary Pages (EFT information for providers enrolled for electronic funds transfer)

The transition should be easy. Providers and vendors with Blue e access are already viewing the online version of the paper remittances using the Blue e Remittance Inquiry transaction — we’ll just no longer be mailing the duplicate paper copies. Additionally, providers enrolled for EFT will now be able to view their payment images, including copies of voided checks and payment summary pages, from the convenience of their computer screens using Blue e.

With electronic remittances, providers and vendors can:

- View electronic remittances 24 hours a day, seven days a week
- Quickly search electronic remittances for specific information
- Store and retrieve electronic remittances online, without off-site archiving
- Securely receive electronic remittances that are delivered directly without intermediary handling
- Conserve – electronic remittances are not only more cost efficient, they are also sound for the environment
- Handle coordination of benefits (COB) efficiently; electronic remittances are replacing paper by Medicare and other large payors as the new standard

Only providers enrolled in Blue e can receive electronic remittances.

Providers are encouraged to sign up today! Enrollment is easy; just visit Electronic Solutions online at bcbsonc.com/providers/edi/bluee and complete the Blue e Interactive Network Agreement. For questions about Blue e enrollment, call Blue e Customer Support at 1-888-333-8594. For help with EFT enrollment, call Provider Customer Support at 1-919-765-2293.

Providers already enrolled with Blue e having questions about the new paperless EOPs and NOPs are asked to contact their regional Network Management representative for assistance.

Easier billing navigation

The Blue e billing section has changed. Error and Claim Listings are now under the hyperlink for either UB04 or CMS 1500. You only have to select your provider number once to complete a whole series of tasks. Now, you can retrieve or modify a claim entered up to 5 p.m. on the same day, or enter a new claim, all under the same transaction link. This change provides easier navigation and less clutter of the transaction hyperlinks on the home page.

Help and Electronic User Guides

Blue e Help was redesigned to provide an integrated Help System that allows you to view all help topics from within any transaction. For example, if you are in Health Eligibility but want to know how something will work in Claim Status, you can click “View all help” (continued on page 16)
Electronic Solutions: Updates and reminders
(continued from page 15)

in the left-side navigation bar of the Help window to find a topic. The redesigned Help System also includes illustrations and replaces the old Blue e Manual.

The new Help System includes all external transactions within the application. Please note that you may see Help topics for transactions to which you do not have access, depending on your level of access.

Electronic User Guides have been developed for Blue e transactions. The guides are available on the right-hand side of the Home Page under Training Tools. Just click on the appropriate guide and view a simulation to learn how to execute a Blue e transaction like Health Eligibility, FEP/Out of State Eligibility, Claim Status, Claim Entry, Remittance Inquiry, etc. The Electronic User Guides are great tools for initial or refresher training.

837 Denial Listing for BCBSNC and Medicare claims

The HIPAA Claim (837) Denial Listing transaction is used to search for 837 institutional and professional claims that have failed processing because of business edits or HIPAA Implementation Guide edits. Searches can be made for claims submitted to BCBSNC or for claims received from Medicare for secondary or tertiary payment. Using the 837 Claim Denial Listing, you can identify claim errors, correct them on your management system, and resubmit them for adjudication. Medicare claims may also be corrected and directly submitted to BCBSNC as the secondary or tertiary payor.

Two 837 Claim Denial Listing selection pages exist: one for claims denied by BCBSNC and one for claims from Medicare that failed HIPAA Implementation Guide edits. Both selection pages provide essentially the same function; they display a list of report dates indicating failed claims within the previous 14 calendar days. A hyperlink allows you to access all failed claims associated with a specific report date. Please note that a report date appears only if a claim(s) was denied on that date.

Blue e health eligibility: Benefit accumulators

Blue e health eligibility now includes benefit period accumulators for North Carolina members. Eligibility responses are available from three tabs at the top of the page, listed as:

1. Member Information Tab: High-level coverage and demographic information
2. Coordination of Benefits Tab: Lists other insurers on file for the member
3. Benefit Information Tab: Detailed benefits that now include benefit aggregates for chiropractic, physical therapy, speech therapy and vision services, etc

This greater level of benefit detail enables providers to obtain the information online versus obtaining the information by telephone from BCBSNC Customer Services.

Manage your own Blue e account

BCBSNC offers a simplified transaction to allow providers to manage their own Blue e account. The transaction allows providers to designate one or more individuals to create new user IDs, delete user IDs when there are staff changes, and reset passwords as needed. All updates occur real-time without the need to call or send requests to BCBSNC. The transaction is very user friendly in that all functions are presented in one display screen (see screen example below). BCBSNC encourages providers to adopt this new functionality. Please contact your e-Solutions field consultant for access and training.

Corrected claims

Blue e now offers the ability to transmit corrected claims utilizing the CMS 1500 transaction. Complete the “Provider Number” field and select the “ADD” button. Visit Blue e for more details.
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HIPAA transactions that simplify

HIPAA 270/271

Did you know that you can submit eligibility inquiries utilizing HIPAA batch transactions much in the same way you transmit claims? The HIPAA batch transaction 270/271 allows you to send a batch of eligibility inquiries (the 270) and receive in return the 271 responses, eliminating one at a time inquiries and phone calls, saving you time and administrative expense.

HIPAA 276/277

You can also submit claim status inquiries utilizing the HIPAA batch transaction 276/277 much in the same way you transmit claims. The HIPAA batch transaction 276/277 allows you to send a batch of claim status inquiries (the 276) and receive in return the 277 responses, eliminating one at a time inquiries and phone calls saving you time and administrative expense.

If you are interested in adding these HIPAA transactions to your batch capabilities, please visit bcbsonc.com/providers/edi/contacts.cfm or contact your local e-Solutions field staff for assistance.

- Will Farrish-Charlotte (704) 561-2751
- Jason Bradshaw-Greensboro (336) 316-5346
- John Hodges-Greenville (252) 931-7223
- Ashley Teeters-Hickory (828) 431-3142
- Anil Samuel-Raleigh (919) 765-4658
- Ann Marie Lorenz-Wilmington (910) 509-0605

Reminder: State Health Plan no longer maintains indemnity membership

As mentioned in the Summer 2008 edition of Blue Link, the State Health Indemnity Plan was officially terminated effective July 1, 2008. The closure of the Indemnity Plan came as a result of 2007 legislation that afforded to the State’s Indemnity members the same choice of benefits and broad network access that members already enrolled in NC SmartChoice PPO plans receive. All State Health Plan membership is now PPO membership. You should always ask for the patient’s most recent ID card and be sure to update your records, replacing the patient's previous State Health Indemnity information with their new NC SmartChoice PPO plan information. Providers can submit Indemnity Plan claims, if not sending electronically, (for dates of service prior to July 1, 2008) for up to 18 months, to:

NC Teachers and State Employees Indemnity Plan
P.O. Box 30025
Durham, NC 27702

Please note that this address should not be used for claims with dates of service after June 30, 2008. Indemnity Plan members and providers still have access to Indemnity Plan Customer Service for questions about services provided prior to July 1, 2008. That telephone number remains the same: 1-800-422-4658.

Facts about NC Health Choice

With the termination of the State Health Indemnity Plan, we have received a lot of calls about NC Health Choice. Here are a few facts:

- NC Health Choice (NCHC) is a fee-for-service program providing free or low-cost health insurance for children and teens up to their 19th birthday. The benefits covered by NCHC are the same as the benefits that were covered by the State Health Indemnity Plan. Vision, dental, and hearing services are also covered and follow the same guidelines as Medicaid. The reimbursement is also based on the Medicaid rates.

- Providers should submit claims to BCBSNC for processing.

- Members received new ID cards effective January 1, 2009. Please be sure to request a copy of the newest card.

For more information, visit the North Carolina Division of Medical Assistance (DMA) Web site at dhhs.state.nc.us/dma/prov.
More improvements to our phone system

Based on feedback from Providers like you, we have been making changes to our automated phone system, which were introduced this past fall.

Streamlined interaction within the system

We recognize that many of you communicate with us using our automated phone system and our customer service representatives on a frequent basis. Therefore, you were already familiar with the specific questions we asked in order to accurately service your call. Since September of last year, you may have noticed that the questions we asked became significantly shorter, and that you could rapidly navigate the system. This was done to assist you in quickly getting eligibility and benefits information through self-service or from a representative. Of course, if you experienced difficulties within the system, you could (and will) still be able to receive instructions to help get you back on track. Additionally, you will always have access to a representative to further assist you.

Tips for getting the most out of our automated system

Your call will go faster if you have your NPI number and relevant patient records available. Here’s the information you may be asked for, depending on the reason for your call:

- Your NPI number
- Each patient’s subscriber number (including alpha prefix)
- Each patient’s date of birth
- The relevant claim date(s) of service

And remember, these are some things you can do to help make the call go more smoothly:

- Use a standard telephone handset (rather than a speakerphone or cell phone)
- Speak in your normal voice (speaking louder or more slowly than normal will actually make it more difficult for our system to understand you)
- If possible, try to place your calls in a quiet area where there is not a lot of background noise
- When the system asks for the letters at the beginning of the patient's Subscriber Number, please provide all of the letters, including the W, if there is one

Finally, remember that many of your customer service needs – including eligibility and claim status inquiries, claims filings, admission and treatment notifications, and remittance information – can be found by using Blue e, our online provider system. Contact your e-Solutions field consultant or visit bcbsnc.com/providers to find out more.

Appeals process reminders

Level I

BCBSNC implemented a new provider appeals process in August 2008. This process replaced the post-service Provider Courtesy Review with a Level I Provider Appeal for billing disputes, medical necessity denials, and denials for no preauthorization for an inpatient stay. The new process allows providers to appeal without gaining consent from the member. Pre-service Provider Courtesy Reviews, currently handled by the Member Health Partnership Operations department, will remain the same.

Level II

Since November 21, 2008, physicians, physician groups and physician organizations have been able to file a Level II Post-Service Provider Appeal for medical necessity or billing disputes. Level II Provider Appeals are conducted by an Independent Review Organization, and there is a filing fee associated with these requests for appeal.

The BCBSNC Billing Dispute Resolution Process is available to resolve disputes over the application of coding and payment rules and methodologies to specific patients. Physicians, physician groups and physician organizations must submit a written request for Level II Post-Service billing dispute Provider Appeal within ninety (90) calendar days of the date of the Level I Post-Service Provider Appeal denial letter. Physicians, physician groups and physician organizations must exhaust BCBSNC's Level I Post-Service Provider Appeal process before submitting a review of a Level II Post-Service Provider Appeal. Physicians, physician groups and physician organizations are deemed to have exhausted BCBSNC's Level I Post-Service Provider Appeal process if BCBSNC does not communicate a decision within thirty (30) calendar days of BCBSNC's receipt of all documentation reasonably needed to make a determination the Level I Post-Service Provider Appeal.

For additional information and instructions for filing a Level I Provider Appeal and/or a Level II Post-Service Provider Appeal and filing fee matrix, please visit the BCBSNC provider Web site at bcbsnc.com/content/providers/appeals/index.htm.
Updates to medical policies available online

BCBSNC Medical Policies consist of medical guidelines, including diagnostic imaging management policies, payment guidelines and evidence-based guidelines. Medical guidelines are based on constantly changing medical sciences. Therefore, policies are periodically updated and reviewed. The updates to medical policies are available online at bcbsnc.com/providers/medical-policy/updates.

Provider warehouse requisition no longer available

Due to a reduction in the forms offerings, BCBSNC eliminated the Provider Warehouse Requisition (B117 Form) in 2007. If your office is currently utilizing the form, please note that the form is no longer accepted by Moore Wallace, and all copies in circulation should be destroyed. In addition, we ask provider offices not to contact Moore Wallace directly, as they will instruct you to contact BCBSNC. Questions regarding the availability of supplies for health care providers should be directed to your regional Network Management representative. As a reminder, forms are available for copying from the Blue Book Provider Manual, available on the BCBSNC Web site at bcbsnc.com/providers.

Nerve conduction studies billing reminder

BCBSNC wants to ensure that your practice is rendering nerve conduction studies in accordance with current BCBSNC medical policy guidelines. If your health care business performs nerve conduction studies, please review your practices for the following requirements that must be met:

- Standard nerve conduction studies must be billed with standard CPT codes (for example 95900, 95903, 95904, etc.). Any non-standard nerve conduction studies must be billed with the appropriate code (for example HCPCS S3905).
- Testing must be done by a physician trained in electro-diagnostic studies.

- All medical necessity components of the corporate medical policy must be met for the services to be considered medically necessary.
- If you are currently using the service of an outside vendor to conduct the testing, BCBSNC would not expect to receive a global claim from your office.

The corporate medical policy on nerve conduction studies may be viewed at bcbsnc.com/assets/services/public/pdfs/medicalpolicy/automated_nerve_conduction_tests.pdf.

Providers with questions should contact their regional Network Management representative for assistance.

CPAP and BiPAP rentals prior to purchase

BCBSNC wants to remind you that CPAP and BiPAP equipment will be rented with rental fees applied to purchase price for a trial period of three months to document patient compliance, patient tolerance, and clinical benefits prior to purchase.

Payment for CPAP and BiPAP include payments for the provision of all necessary accessories, such as mask, tubing or cannula. Separate charges for replacement of masks, tubing, cannula or respiratory equipment maintenance services are not covered since they are included in the rental payment for CPAP.

Additional information regarding BCBSNC guidelines for purchasing DME equipment can be found at bcbsnc.com/services/medical-policy/.
BCBSNC partners with North Carolina providers to provide the best quality health care to our members. As we strive to uphold to this commitment, we sometimes find it necessary to remind network providers of policies for caring for our members. Recently, BCBSNC experienced an increase in calls from members stating they are being charged by network providers in advance of receiving bariatric surgery services. Therefore, we would like to remind in-network providers about their obligations for our members:

- Charging/billing members for any type of prepayment in advance of rendered services, such as an administration fee or medical service deposit or any type of prepayment in advance of rendering services is prohibited by your contractual agreement.

- Charging/billing members for educational seminars required in order to obtain other billable services is also prohibited by contractual agreement.

- Charging/billing members for your time required to obtain prior authorization of services is prohibited by contractual agreement.

- Billing for any additional amounts beyond the agreed upon fee schedule is considered a breach of contract.

- Practices are responsible for submission of claims, for any covered services, on the member's behalf.

- BCBSNC members cannot be required to be evaluated by other out-of-network providers if in-network providers are available to render the required services (for example, for psychological evaluations as part of pre-bariatric surgery evaluations). When the need arises for a BCBSNC member to receive other professional services, outside of the scope of your license, BCBSNC expects you will refer the Member locally within the Provider Network, when reasonably possible and consistent with good medical care. If you are aware of a non-participating provider who would benefit the BCBSNC network, please share this information with your local Network Management Representative who will be glad to contact this provider directly.

BCBSNC corporate medical policy, “Surgery for Morbid Obesity,” is available on our Web site at bcbsnc.com/services/medical-policy/pdf/surgery_for_morbid_obesity.pdf. We encourage you to visit this site to ensure your practice is adhering to the policy guidelines and if you have any questions, please feel free to contact your regional Network Management Representative.
Gastric band adjustments

Typically BCBSNC approves gastric band adjustments (code S2083 [adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline]) whenever a lap band has been approved for a member. Because of this, we want to make providers who perform lap band services aware of an internal process implemented November 4, 2008.

When a provider requests, on a member's behalf, coverage for the lap band procedure, and the member has coverage for the procedure that has been authorized by BCBSNC, a BCBSNC nurse will also place an authorization into our systems for the adjustment code S2083. The authorization will be approved for 12 units for the remaining time of the benefit year. However, please note that once a member’s benefit year is complete, a new request for authorization of adjustment code S2083 will need to be requested by the provider performing the lap band adjustment services. If approved, BCBSNC will normally extend the authorization for another benefit year time span with a unit of 12.
How can you access health coaching?

Health coaches work with physicians to facilitate the most medically appropriate, cost-effective quality care for our members. Health coaches are available to discuss the health care management process and the authorization of services for your patients. You can contact a health coach by the following methods:

- You can obtain certification, request discharge services, and get information regarding a request by calling 1-800-672-7897 Monday–Friday, 8 a.m. – 5 p.m., EST. When calling after hours:
  - For discharge services, leave a detailed message at extension 51910 for response on the next business day.
  - For all other requests, leave a detailed message at the identified prompt for response on the next business day.
- If you are contacting health coaching to request prior plan approval, you may make a request by fax or use our online request form, both available on the BCBSNC Web site at bcbsnc.com/providers/ppa/services.cfm.

When faxing a request, please use one of the following numbers, 24 hours a day, 7 days a week:

- State PPO: 1-866-225-5258
- Region 1 – Asheville/Charlotte: 1-800-459-1410
- Region 2 – Raleigh/Chapel Hill/Greenville: 1-800-571-7942 (includes out-of-state requests)
- Region 3 – Durham/Greensboro/Winston Salem/Wilmington: 1-800-672-6587
- Pharmacy: 1-800-795-9403
- Discharge Services: 1-800-228-0838

Health care management functions can be accessed via the Provider Blue Line at 1-800-214-4844, and information may also be obtained via Blue e, our free Web-based tool available to participating providers.
Member ID card redesign

We would like to remind our readers that BCBSNC has redesigned our member ID card as part of an overall Blue Cross and Blue Shield Association effort to standardize ID cards for all Blue members nationwide. The Association wants to ensure that the benefit information on the cards is consistent, easy to find and understand.

Additionally, a North Carolina Senate bill, effective January 1, 2009, required that all insurers list certain copayments on ID cards, as well as either the effective date of coverage or the issue date of the card.

What has changed?

The main change is that the ID card will now be a more wallet-friendly, two-sided card instead of a four-sided card. As a result:

Benefits displayed on the ID card will reflect the NCDOI-required copayment information and benefit information most commonly used at the time of service by providers and members.

Benefits displayed will reflect the member’s responsibility (e.g., $0 or 20% coinsurance) rather than BCBSNC’s responsibility (e.g., 100% or 80%).

If a member also has BCBSNC dental coverage, the Dental Blue® or Dental Blue for Individuals™ logo will appear on the front of the ID card.

Benefit information for routine vision, chiropractic care and mental health/substance abuse will no longer appear on the ID card.

Helpful phone numbers and Web site addresses will be grouped together logically on the back of the ID card and will now have easy-to-understand descriptions.

What will not change?

Benefits will not change. The new member cards simply reflect a new look and the new requirements for information. As always, providers should verify a member’s benefit information using Blue e or by calling the Provider Line at 1-800-214-4844, as the ID card is not a substitute.

for benefits information. In addition, since providers have told us that they value having the members names listed on the ID card for all dependents covered, as well as copayment amounts and helpful phone numbers, those items will continue to be noted on the new ID cards.

When will the ID cards be printed?

ID cards for our group business and under-65 individual business that are printed on or after September 15, 2008 reflect the new design and card stock. This includes all new enrollees, requests for additional ID cards and group maintenance changes. Everyone will receive a new ID card at the time of their renewal.
Diagnostic imaging management claims process change for facilities

As of December 1, 2008, a new process was implemented for Diagnostic Imaging Management (DIM) outpatient claims from facility providers. Previously, facility claims were being processed at the line-item level if they were not given a DIM claim type but were assigned a prior authorization (PA) claim type due to a lack of an authorization (if containing a line-item for a DIM[s]) service. Under the revised process, outpatient DIM claims processed on or after December 1, 2008 will be compared with the DIM PPA list to see if any CPT on the claim requires PPA; if so, the DIM claim type will be assigned to that claim line, rather than to the entire claim and the DIM CPT code line will be denied.

Facilities providing outpatient DIM services should be aware that:

- DIM services on outpatient facility claims with no authorization will be denied; other lines on the claim will be processed independently.
- When determining whether or not the service line requires authorization, the CPT code on the UB-04 claim will be used.
- Facility claims with DIM services that paid in the past with no authorization (due to the use of revenue code tables) will have the DIM services denied.
- Facilities will see the denied DIM service line listed separately on their EOP with the “Failure to obtain PPA” message.