THE Blue BOOK℠

Blue Medicare HMO℠ and Blue Medicare PPO℠ Supplemental Guide

Provider e-Manual

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BlueCross BlueShield of North Carolina

The Blue Book℠
Provider e-Manual

Blue Medicare HMO℠ and Blue Medicare PPO℠
Supplemental Guide

Edition: April 2010

Blue Cross and Blue Shield of North Carolina "BCBSNC" is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans.

Note: In the event of any inconsistency between information contained in this manual and the agreement(s) between you and Blue Cross and Blue Shield of North Carolina, "BCBSNC," the terms of such agreement(s) shall govern. Also, please note that BCBSNC may provide available information concerning an individual's status, eligibility for benefits, and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, presentation of Blue Medicare HMO℠ and/or Blue Medicare PPO℠ identification cards in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. Member's actual Blue Medicare eligibility and benefits should always be verified in advance of providing services.

To view pdf documents, you will need Adobe Acrobat Reader. If you do not have it already, a link is provided for you at ***http://www.bcbsnc.com/providers/bluelinks/*** or you can access the Web site for Adobe directly at ***www.adobe.com/products/acrobat/readstep2.html***.

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Introduction

1.1 About this manual

We are pleased to provide you with a new and comprehensive **Blue** Book℠ Provider Manual – Blue Medicare HMO℠ and Blue Medicare PPO℠ Supplemental Guide, for providers participating in the Blue Cross and Blue Shield of North Carolina, "BCBSNC" provider network. This manual has been designed to make sure that you and your office staff have the information necessary to effectively understand and administer Blue Medicare HMO℠ and Blue Medicare PPO℠ member health care benefit plans.

Blue Cross and Blue Shield of North Carolina "BCBSNC" is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans.

BCBSNC's goal is that all BCBSNC members are provided quality health care, including preventive care, by an ample, accessible network of participating providers. We want to work with all participating BCBSNC providers and their staffs to reach that goal. Each HMO member electing Blue Medicare coverage must choose a primary care physician who is responsible for coordinating his/her care. PPO members are strongly encouraged to chose a primary care physician. BCBSNC strives to offer our members the advantages of a primary care physician and access to a broad panel of qualified specialists, hospitals, ambulatory care facilities and non-physician providers.

BCBSNC offers several resources for providers and their staff. Our Network Management staff is responsible for providing ongoing support to participating providers' office staff and is available at any time to answer questions and/or direct inquiries to other BCBSNC departments. Our health care services staff of experienced nurses work with physician offices on a regular basis for precertification, case management, utilization review and quality improvement issues. BCBSNC customer services representatives are available for general billing, claims or benefit questions.

The provider line **1-888-296-9790** provides another resource to help you and your staff to obtain information that is important in managing your Blue Medicare HMO℠ and Blue Medicare PPO℠ patient population. Additional provider information is available on the BCBSNC Web site's provider section. HealthTrio Connect is an electronic format that is available to providers to access information such as claims status and verify member benefits (the BCBSNC system ***Blue e***℠ may not be accessed for these purposes).

Also, our medical director or an associate medical director is available if BCBSNC physicians have medical or procedural questions. Our goal is to be responsive to our participating physicians as they serve Blue Medicare HMO℠ and Blue Medicare PPO℠ members in their practices. We believe that your participation in BCBSNC provider network is integral to our success. Our commitment is to work with our providers to continually improve our medical care delivery system.

We would like to highlight several items that may be of importance to you and the chapters in which to find them:

- Phone numbers for contacting BCBSNC
  Chapter 2
- Health benefit plans and sample identification cards
  Chapter 4
- Prior authorization requirements
  Chapter 10 (Including prior authorization list)

As referenced in your participation agreement, this provider manual supplemental guide is intended to supplement the agreement between you and BCBSNC. Nothing contained in this provider manual supplemental guide is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the participation agreement. If there is an inconsistency between the information contained in this manual and the participation agreement, the terms of the participation agreement shall govern. If there is an inconsistency between the participation agreement and the member certificate, the member certificate shall govern.

All codes and information are current as of the manual proofing date but could change based on new publications and policy changes. Changes will be communicated through but not limited to the mail, provider newsletter, and the Web site ***bcbsnc.com***.

Web site resource

Please note that we will periodically update this manual. The most current version will be available in the "providers" section of the BCBSNC Web site at ***http://www.bcbsnc.com/providers/***.

This manual contains information providers need to administer BCBSNC Blue Medicare HMO℠ and Blue Medicare PPO℠ plans efficiently with regard to claims and customer service issues.

If you experience any difficulty accessing or opening The **Blue** Book℠ from our Web site, please contact your local Network Management field office (field office contact information is available in chapter two of this manual). Additionally, if you cannot access the Web site please contact your local Network Management field office to receive a copy of the manual in another format.

1.2 Provider Manual Blue Medicare HMO℠ and Blue Medicare PPO℠ Supplemental Guide online

The **Blue** Book℠ Provider Manual Blue Medicare HMO℠ and Blue Medicare PPO℠ Supplemental Guide is maintained on the BCBSNC Web site for providers at ***http://www.bcbsnc.com/providers/***. The manual is available to providers for download to their desktop computers for easy and efficient access. The process to view is easy, just click on The **Blue** Book℠ Provider Manual – Blue Medicare HMO℠ and Blue Medicare PPO℠ Supplemental Guide hyperlink and select the option to open, it's that easy. If you want to save a copy of the manual to your computer's desktop, open the manual for viewing following the same instructions, and after you have opened the manual to view, just select "file" from your computers tool bar, and select the option to "save a copy," then decide where you want to keep your updated edition of the provider manual supplemental guide on your computer, and click on the tab to save.

Important: Please note that providers are reminded that this manual supplemental guide will be periodically updated, and to receive accurate and up to date information from the most current version, providers are encouraged to always access the provider manual in the "providers" section of the BCBSNC Web site at ***http://www.bcbsnc.com/providers/***.

1.3 Feedback

This manual is your main source of information on how to administer BCBSNC Blue Medicare HMO℠ and Blue Medicare PPO℠ plans. If you cannot find the specific information that you need within the manual, please utilize the following resources:

- Your health care businesses provider agreement with BCBSNC
- The BCBSNC Web site ***bcbsnc.com***
- BCBSNC provider blue line at **1-888-296-9790**
- The online provider newsletters, also located on the BCBSNC Web site ***bcbsnc.com***.
- Your Network Management service team as listed in chapter two, Contacting BCBSNC and general administration
- HIPAA companion guide located on the Web site at ***bcbsnc.com***
- BCBSNC formulary information on the Web site at ***bcbsnc.com***

Chapter 2

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Contacting BCBSNC and general administration

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2.1 Provider line – 1-888-296-9790

The provider line is available to assist providers with the following information:

- Route inquiries to the appropriate representative only when it is necessary to speak with a representative.
- Identify claims status (limit 5 members per call)
- Identify claims status for each claim when providers file multiple claims for the same patient for the same date of service.
- Provide additional detail for claims payment-coinsurance amounts, check numbers and check dates.
- Provide eligibility information and benefit information including effective and termination dates of coverage, and deductibles met for current and prior year.
- Provide current and future primary care physician assignment name and telephone number.
- Identify multiple members with the same date of birth to make sure the information is provided for the correct patient.
- Provide Network Management telephone numbers.
- Provide BCBSNC address information.
- Prior plan approval status – approved / denied / currently in review / unable to locate request.
- Provide referral status

Before calling the provider line, have the following information available:

- Patient's identification number
- Patient's date of birth (mm/dd/yyyy)
- Date of service (mm/dd/yyyy)
- Amount of charge ($0.00)

2.2 Written provider claim inquiry

One alternative to the provider line for claims status information is the provider claim inquiry form (see chapter 25, Forms). Providers may make copies of the form from this manual and send to the address below. Use of this form will allow:

- Reconsideration of a paid or denied claim for professional services that were billed on a CMS-1500 Claim Form or other similar forms
- Request for review of an incorrectly paid claim for professional services that were billed on a CMS-1500 Claim Form or other similar forms
- Request for information regarding denial of services not included in member's health benefit plan
- Requests for status of filed claims
- Refund of overpayments

The completed provider claim inquiry should be mailed to:
Blue Cross and Blue Shield of North Carolina
PO Box 17268
Winston-Salem, NC 27116-7268
or the form may be faxed to **1-336-659-2962**

2.3 On-line availability

For questions regarding	
HealthTrio Connect Provider directory information Provider newsletters HIPAA companion Provider education information	***bcbsnc.com***
Formulary	***bcbsnc.com***

2.4 BCBSNC central office telephone numbers and fax numbers

Services	Phone	Fax
General information/customer service	**1-800-942-5695** **1-336-760-4822**	**1-336-659-2963**
Provider information line	**1-888-296-9790** **1-336-774-5400**	**1-336-659-2963**
Customer service	**1-888-310-4110**	**1-336-659-2963**
Disease management	**1-877-672-7647**	**1-336-794-1546**
Claims	**1-888-296-9790** **1-336-774-5400**	**1-336-659-2962**
Referrals	**1-888-296-9790** **1-336-774-5400**	**1-336-659-2944**
Authorizations	**1-888-296-9790** **1-336-774-5400**	**1-888-296-9790**
Health services (utilization review/precertification)	**1-888-296-9790** **1-336-774-5400**	**1-336-794-1556**
Discharge planning/concurrent review	**1-888-296-9790** **1-336-774-5400**	**1-888-794-1555**
Case management	**1-888-296-9790** **1-336-774-5400**	**1-336-659-2945**

2.5 Mailing addresses for BCBSNC Blue Medicare HMO℠ and Blue Medicare PPO℠

Main mailing address	FedEx, UPS and 4th class
Blue Cross and Blue Shield of North Carolina **PO Box 17509** **Winston-Salem, NC 27116-7509**	**Blue Cross and Blue Shield from North Carolina** **5660 University Parkway** **Winston-Salem, NC 27105-1312**

Claims for Blue Medicare members should be submitted electronically (or by paper when necessary) to Blue Cross and Blue Shield of North Carolina. Claims sent in error for Blue Medicare HMO℠ and Blue Medicare PPO℠ members (filed electronically or by mail) will be returned to the submitting provider, which will result in delayed payments.

2.6 BCBSNC Network Management – local offices

The BCBSNC Network Management department is responsible for developing and supporting relationships with physicians and other practitioners, acute care hospitals, specialty hospitals, ambulatory surgical facilities and ancillary providers. Network Management staff are dedicated to serve as a liaison between you and BCBSNC, and are available to assist your organization.

Please contact your local Network Management field office for contract issues, fee information and educational needs. Network Management field offices are located across the state and are assigned territories; each of the Network Management field offices supports its provider community by specific geographical region. To find the Network Management office that serves your area, please refer to the following charts.

Western region – includes Asheville, Charlotte, Hickory and areas west

Office	Phone	Address
Charlotte	**1-800-754-8185** **1-704-676-0501**	**BCBSNC Network Management** **P.O. Box 35209** **Charlotte, NC 28235**

Triad region – includes Greensboro, High Point, Winston-Salem and surrounding areas

Office	Phone/Fax	Address
Greensboro	**1-888-298-7567** **1-336-316-0259 (fax)**	**BCBSNC Network Management** **The Kinston Building** **2303 West Meadowview Road** **Greensboro, NC 27407**

Eastern region – includes Fayetteville, Greenville, Raleigh, Wilmington and surrounding areas

Office	Phone/Fax	Address
Durham	**1-800-777-1643** **1-919-765-7109**	**BCBSNC Network Management** **PO Box 2291** **Durham, NC 27702-2291**

Network Management staff is available to assist you Monday through Friday, 8 a.m. - 5 p.m. EST.

2.7 Changes to your office and/or billing information

Contact your local Network Management by phone, mail or fax to request changes to office and/or billing information (e.g., physical address, telephone number, etc.) by sending a written request signed by the physician or office/billing manager to the address or fax number above. Changes may include the following:

- Name and address of where checks should be sent
- Name changes, mergers or consolidations
- Group affiliation
- Physical address
- Federal tax identification number (attach W9 form)
- National Provider Identifier "NPI"

The following table summarizes which Network Management regional office to call based on the location of your practice:

County	Office
Alamance	Greensboro
Alexander	Hickory
Alleghany	Greensboro
Anson	Charlotte
Ashe	Greensboro
Avery	Hickory
Beaufort	Greenville
Bertie	Greenville
Bladen	Wilmington
Brunswick	Wilmington
Buncombe	Hickory
Burke	Hickory
Cabarrus	Charlotte
Caldwell	Hickory
Camden	Greenville
Carteret	Wilmington
Caswell	Greensboro
Catawba	Hickory
Chatham	Raleigh
Cherokee	Hickory
Chowan	Greenville
Clay	Hickory
Cleveland	Charlotte
Columbus	Wilmington
Craven	Wilmington
Cumberland	Wilmington
Currituck	Greenville
Dare	Greenville
Davidson	Greensboro
Davie	Greensboro
Duplin	Wilmington
Durham	Raleigh
Edgecombe	Wilmington
Forsyth	Greensboro

County	Office
Franklin	Raleigh
Gaston	Charlotte
Gates	Greenville
Graham	Hickory
Granville	Raleigh
Greene	Wilmington
Guilford	Greensboro
Halifax	Raleigh
Harnett	Raleigh
Haywood	Hickory
Henderson	Hickory
Hertford	Greenville
Hoke	Greensboro
Hyde	Greenville
Iredell	Greensboro
Jackson	Hickory
Johnston	Raleigh
Jones	Wilmington
Lee	Raleigh
Lenoir	Wilmington
Lincoln	Charlotte
Macon	Hickory
Madison	Hickory
Martin	Greenville
McDowell	Hickory
Mecklenburg	Charlotte
Mitchell	Hickory
Montgomery	Greensboro
Moore	Greensboro
Nash	Wilmington
New Hanover	Wilmington
Northampton	Greenville
Onslow	Wilmington
Orange	Raleigh

County	Office
Pamlico	Greenville
Pasquotank	Greenville
Pender	Wilmington
Perquimans	Greenville
Person	Raleigh
Pitt	Wilmington
Polk	Hickory
Randolph	Greensboro
Richmond	Greensboro
Robeson	Wilmington
Rockingham	Greensboro
Rowan	Charlotte
Rutherford	Charlotte
Sampson	Wilmington
Scotland	Greensboro
Stanly	Charlotte
Stokes	Greensboro
Surry	Greensboro
Swain	Hickory
Transylvania	Hickory
Tyrrell	Greenville
Union	Charlotte
Vance	Raleigh
Wake	Raleigh
Warren	Raleigh
Washington	Greenville
Watauga	Hickory
Wayne	Wilmington
Wilkes	Greensboro
Wilson	Wilmington
Yadkin	Greensboro
Yancey	Hickory

Chapter 3

The Blue Book℠
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Administrative policies and procedures

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BlueCross BlueShield of North Carolina

Blue Medicare HMO℠ and Blue Medicare PPO℠ are offered by Blue Cross and Blue Shield of North Carolina, an HMO with a Medicare contract. BCBSNC does not discriminate based on color, religion, national origin, age, race, gender, disability, handicap, sexual orientation, genetic information, source of payment or health status as defined by CMS. All qualified Medicare beneficiaries may apply. Members must be entitled to Medicare Part A, enrolled in Medicare Part B and reside in the CMS approved service area. Some limitations and restrictions may apply.

3.1 Participating provider responsibilities

3.1.1 Basic principles

BCBSNC participating providers are responsible for providing quality health care to our members according to the standards of care of the community, the medical profession and the various professional organizations and certifying boards. BCBSNC has certain policies and guidelines and frequently makes decisions regarding coverage of services; however, these are not intended to be treatment decisions and do not obviate or supersede the responsibility of the physician to provide quality care, acting in the patient's best interest, in each individual case.

All providers who agree to participate as BCBSNC providers accept responsibility for the provision of appropriate medical care according to BCBSNC policies and guidelines, and in keeping with the standards of care described in the previous paragraph of this section.

BCBSNC primary care physicians

BCBSNC primary care physicians are responsible for providing or arranging for all appropriate medical services for BCBSNC members. BCBSNC relies on primary care physicians to decide when specialist care is necessary or when other services such as medical equipment are indicated.

Typically, the following provider types that specialize in primary medicine may serve as a PCP: family practitioner, internist, gerontologist, general practitioner, and pediatrician (for those under 18 years of age). In some cases a specialist, such as an OB/GYN or an oncologist, may serve as a PCP.

BCBSNC specialists

BCBSNC specialists are expected to render high quality care appropriate to the needs of BCBSNC members requiring specialized treatment.

Dual eligibility

If provider meets BCBSNC credentialing standards for both a primary care physician and a specialist physician with respect to BCBSNC members, the provider may elect to designate him or her as both a primary care physician and a specialist physician as approved by BCBSNC. Contact your local Network Management field office for details.

3.1.2 Criteria for selection and listing as a specialist or subspecialist

In order to be selected and listed in BCBSNC provider directory as a medical specialist or subspecialist (excluding general practice), one (1) of the following criteria must be met:

1. The applicant must be board-certified by a certifying board of the American Medical Association and/or the American Board of Medical Specialties.
2. The applicant must be board-qualified for a specialty or subspecialty as defined by the appropriate certifying board for a period of not more than three (3) years following completion of training, unless otherwise defined by the board.
3. The applicant must be board-qualified and within a three (3) year period following completion of board qualification.

   or

4. The applicant presents special documentation justifying listing as a specialist.

3.1.3 Primary care physician-patient relationship

The primary care physician-patient relationship for BCBSNC members begins at the time the member selects the physician to be his or her primary care physician and coverage for medical services becomes effective. From that time on, unless the relationship is terminated, the physician is responsible for providing necessary medical care, including emergency care. This includes a member who is new to a practice, even if the patient has not made previous contact with that office.

Individual requirements for obtaining medical records, initial physicals and/or other initial contacts with the physician's office may be instituted by a physician but do not alter the responsibility for providing services when the need arises.

If a physician chooses to terminate a physician-patient relationship, either for cause or change in the physician's availability, BCBSNC must receive 60 days notice. The member must be given thirty (30) days written notice by BCBSNC in order to select another primary care physician. During the thirty (30) day period following receipt of the notice by the member from BCBSNC, the physician remains responsible for emergency and/or urgent care for the member. A copy of the termination notice must be sent to BCBSNC Network Management department.

Practice limitations

Provider agrees to give BCBSNC thirty (30) days prior written notice regarding the limitations or closing of its practice, or the practice of any participating physician, to BCBSNC members.

Availability and coverage

Participating physicians, primary care and specialist, should be available to their patients when needed. When the physician's office is closed, the members should have a clear and readily available access pathway for needed care. Usually this will be through an answering service.

Coverage for members in the event of the physician's absence should be arranged with a BCBSNC participating physician if possible. If coverage is arranged with a non-participating physician, the participating physician is responsible for insuring that the covering physician agrees to provide services to BCBSNC members according to BCBSNC policies, accept BCBSNC compensation according to BCBSNC fee schedule, and bill only BCBSNC for covered services (i.e., patients to be billed only for appropriate copayments or coinsurance).

3.1.4 Reimbursement and billing

What the provider can collect

Participating providers agree to bill only BCBSNC for all covered services for BCBSNC members, collecting only appropriate copayments or coinsurance from the member. BCBSNC members are directly obligated only for the copayment/coinsurance amounts indicated on their member card (and in their certificate of coverage or evidence of coverage), payment for non-covered services and payment for services after the expiration date of the member's coverage. The provider should not collect any deposits and does not have any other recourse against a BCBSNC member for covered services.

In the event that the participating provider provides services which are not covered by the Plan, he or she will, prior to the provision of such non-covered services, inform the patient (1) of the services to be provided, (2) that the Plan will not pay for the services and (3) that the patient will be financially liable for the services. BCBSNC shall make the relevant terms and conditions of each Plan reasonably available to participating providers. The participating provider may bill a participant directly for medically necessary non-covered services.

Submission of claims

Claims should be submitted using CMS-1500 Claim Form or other similar forms; or UB-04 form. To file electronic claims submission, please refer to chapter 14.1, General filing requirements, for information on how to get set up to file electronically.

The provider is responsible for proper submission of claims for compensation of services rendered. The guidelines in the current AMA CPT and HCPCS code books and ICD-9-CM must be used for coding. Selection of the procedure and evaluation and management codes should be appropriate for the specific service rendered as is documented in the patient's medical record.

3.1.5 Self-pay for privacy

If a member pays the total cost of medical services and requests that a provider keep the information confidential, the provider must abide by the member's wishes and not submit a claim to BCBSNC for the specific services covered by the member. In accordance with section 13405, "Restrictions on Certain Disclosures and Sales of Health Information," of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 "ARRA" and any accompanying regulations, you may bill, charge, seek compensation or remuneration or collection from the member for services or supplies that you provided to a member if the member requests that you not disclose personal health information to us, and provided the member has paid out-of-pocket in full for such services or supplies. Unless otherwise permitted by law or regulation, the amount that you charge the member for services or supplies in accordance with section 13405 of ARRA may not exceed the allowed amount for such service or supply.

Additionally, you are not permitted to (i) submit claims related to, or (ii) bill, charge, seek compensation or remuneration or reimbursement or collection from us for services or supplies that you have provided to a member in accordance with section 13405 of ARRA.

3.1.6 Utilization management

BCBSNC utilization management charter and annual work plan are reviewed and approved by a Physician Advisory Group comprised of participating physicians, the associate medical director, the director of health care services operations and BCBSNC staff. The policy relative to a specific procedure or pre-certification requirement may be obtained by contacting BCBSNC health services department.

All of BCBSNC providers participate in BCBSNC utilization management process by providing appropriate medical care and complying with BCBSNC administrative guidelines and required provider activities. These include:

1. Prior approval requirements for admissions (chapter 10) and certain procedures (chapter 11)
2. Prior approval requirements for durable medical equipment and certain pharmaceuticals (chapters 10 and 15)
3. Participation in BCBSNC case management program when necessary (chapter 9)
4. Requirements for providers to supply adequate information to permit concurrent review for hospital patients and for patients receiving home care.

3.1.7 Quality improvement

BCBSNC relies on its participating physicians to deliver medical care of high quality. BCBSNC is required to document and demonstrate that medical care provided for our members is of acceptable quality.

BCBSNC quality improvement program monitors potential quality of care events, patient complaints about quality of care, and assesses performance in certain areas periodically.

When necessary, a complaint or potential quality problem is presented to the credentialing committee. The decision of BCBSNC associate medical director or credentialing committee may be any of the following:

1. No action is necessary.
2. The single event may or may not indicate a problem; the item is filed in the provider's file for reference and to detect trends, if present.
3. The medical care provided is below standard and remedial action is indicated. Institution of the sanction process, however, is not warranted.
4. The medical care provided is below standard and warrants instituting the sanction process.

The provider involved would be notified of decisions 3 or 4; however, notification is not considered necessary for 1 or 2.

All items reviewed are placed in the provider's file and made available to the credentials committee at the time of recredentialing.

3.1.8 Use of physician extenders and assistants

BCBSNC understands and encourages the use of physician assistants, nurse practitioners and other nursing and specially trained personnel. The physician remains responsible for all care provided and the outcome of that care and submits claims for services rendered under the physician's name and provider number. The physician and the extender are expected to comply with all applicable statutes and regulations as appropriate for the practice site.

3.1.9 Advance directives

On December 1, 1991, the requirements for advance directives in the Omnibus Budget Reconciliation Act of 1990 "OBRA 1990" took effect. As of that date Medicare and Medicaid certified hospitals and other health care providers (such as prepaid health plans [HMOs]) must provide all adult members with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to exclude advance directives.

Blue Cross and Blue Shield of North Carolina recognizes the difficulty of making decisions about the medical care of a loved one. The decision to administer treatment of extraordinary means is an issue with no easy answers, an issue which will elicit a variety of responses from different people. Thinking about these issues is difficult; however, a member may wish to set out in advance what sort of treatment he or she would like to receive under serious medical conditions. It may be that a member will become seriously ill or injured and unable to make these decisions for themselves.

Considering and discussing his/her views on life-sustaining treatment when they are not under pressure or strain may make the process somewhat less difficult. The member may then wish to draft an advance directive, which instructs his/her physician regarding the types of treatment they want or do not want under special, serious medical conditions. Alternatively, they may wish to designate health care power of attorney to an individual who will make health care decisions should they become unable to do so.

The Blue Medicare HMO℠ and Blue Medicare PPO℠ certificates of coverage informs members of their right to make health care decisions and to execute advance directives. We urge members to become informed about advance directives and then discuss any questions or concerns they have about these directives with their primary care physician. Discussion of advance directives should be noted in the member's medical record. Additionally, BCBSNC participating physicians are required to keep a copy of an advance directive a member has written in his/her medical record.

3.2 Special procedures to assess and treat enrollees with complex and serious medical conditions

As a managed care organization with a contract with CMS, BCBSNC is required by the balanced budget act to ensure identification of individuals with complex and serious medical conditions, assessment of those conditions, identification of medical procedures to address and/or monitor the conditions and development of plans appropriate to those conditions. To meet this CMS requirement, BCBSNC sends out an initial health risk assessment questionnaire to new members at the time of enrollment asking members to complete the questionnaire. The members mail the completed survey to BCBSNC. The information in the survey is entered into a database. If the sum of the results equal or are greater than a designated score, the member is flagged as potentially at risk for having, or developing a complex and serious medical condition. The primary care physician "PCP" and a designated care manager are sent a copy of the risk assessment results. The member receives a letter indicating a care manager will contact him or her for an additional assessment.

Members identified as potentially at risk for having or developing a complex and serious medical condition will be further screened/assessed by their PCP and/or care manager to determine if they have a complex and serious medical condition. The PCP must develop a treatment plan including an adequate number of visits to a contracting specialist to accommodate the treatment plan. Based on the results of the detailed assessment, the care manager, in cooperation with the PCP or managing physician identifies and documents problems, provides interventions and coordinates services that supports the member's needs and the physician's treatment plan. This function is carried out by BCBSNC care management staff or designated vendor.

3.3 Requirements for agreements with contracting and sub-contracting entities

The current provider contracts outline provisions which must be agreed to in order to provide services to BCBSNC members. These provisions include timeframes regarding record retention for inspection purposes and other key rules a provider must realize when dealing with a government-sponsored program. Please refer to your contract for details.

3.4 Requirements for provider credentialing and provider rights

BCBSNC follows a documented process governing contracting and credentialing, does not discriminate against any classes of health care professionals, and has policies and procedures which govern the denial, suspension and termination of provider contracts. This includes requirements that providers meet original Medicare requirements for participation, when applicable. Qualified providers must have a Medicare provider number for participation. For more information, refer to chapter 20, Credentialing.

3.5 Defines payments to contractors and sub-contractors as "federal funds," subject to applicable laws

Since BCBSNC payments for Medicare services for Blue Medicare HMO℠ and Blue Medicare PPO℠ members are considered "federal funds," providers are reminded to meet all laws applicable to entities that accept federal funds. These laws relate to anti-discrimination, rehabilitation act, as well as civil rights issues to name a few. Please refer to your contract for details.

3.6 Confidentiality and accuracy of medical records or other health and enrollment information (including disclosure to enrollees and other authorized parties)

Providers are reminded that member identifiable data should not be released to entities other than BCBSNC or BCBSNC authorized representatives without the consent of the member, except as required by law. Further, providers are advised that members have a right to access their own medical records subject to reasonable guidelines developed by providers.

3.7 Risk adjustment data validation program

The Balance Budget Amendment "BBA" of 1997 mandates that CMS payments to Medicare Advantage "MA" organizations are based on the health status of each beneficiary. The new payment methodology uses risk adjustment, which is sometimes called case-mix adjustment, that incorporates diagnoses from hospital inpatient, hospital outpatient and physician services into adjusted capitated payments made to MA organizations.

Since the passage of the BBA, CMS has been moving from a demographic based payment system to a risk adjusted payment system. MA organizations will be fully risk adjusted beginning in 2007. That means that 100 percent of the MA's capitation for each member will be based on his or her relative health status.

Once the new payment methodology is fully implemented, ensuring complete and accurate data will be paramount to BCBSNC ability to maintain a competitive presence in the Medicare Advantage program.

The BBA mandates that MA plans collect and submit beneficiary level ICD-9 CM data to CMS. This data is used to determine the health status of each beneficiary. The capitation for each beneficiary is then adjusted to reflect the dollars needed to care for a beneficiary in a subsequent payment period. CMS performs data validation to verify that the diagnosis codes submitted by the Medicare Advantage organization are supported by the medical record documentation for an enrollee. Data discrepancies may affect risk-adjusted payment. The data validation process begins with the beneficiary records supplied by the physician to the MA organization. It is incumbent on physicians and their office staff to ensure that the documentation is complete and accurate in response to the validation request by the MA organization. MA organizations must attest to the completeness and accuracy of the data submitted for risk adjustment.

BCBSNC is initiating a new program by which to validate this data. The program may require on-site medical record review. In some cases, the validation can be handled via mail using questionnaires. Risk adjustment does not require a change in the way that claims are filed or reported. Any medical record request made for risk adjusted payment validation is allowed under HIPAA regulations.

3.8 Health Insurance Portability and Accountability Act (HIPAA) privacy regulation fact sheet

The collection of risk adjustment data and request for medical records to validate payment made to Medicare Advantage "MA" organizations does not violate the privacy provisions of HIPAA. Therefore, a patient authorized release of information is not required to submit risk adjustment data or to respond to a medical request from CMS for data validation. Specific sections of the HIPAA privacy regulation are referenced below:

General Reference:

45 code of federal regulations "CFR" Part 164, standards for privacy of individually identifiable health information, final rule

Web Link:
http://www.hhs.gov/ocr/combinedregtext.pdf

CFR References:

45 CFR part 164, subpart E, section 164.501 – definitions

45 CFR part 164, subpart E, section 164.502 – uses and disclosures of protected health information: general rules

45 CFR part 164, subpart E, section 164.506 – uses and disclosures to carry out treatment, payment or health care operations

3.9 Notification required upon discharge determination

The Centers for Medicare & Medicaid Services "CMS" requires a specific notice, called NODMAR, be given to Medicare beneficiaries when they are being discharged from the hospital only when (1) the beneficiary does not agree with the hospital discharge decision or (2) the Medicare Advantage "MA" organization (or the hospital that has been delegated the responsibility) is not discharging the individual, but no longer intends to continue coverage of the inpatient stay. Before the NODMAR can be issued, however, the physician who is responsible for the patient's inpatient hospital care must concur with the decision to discharge the patient.

The NODMAR is designed to inform the Medicare beneficiary that their inpatient stay is ending specifying the reason why inpatient hospital care is no longer needed, the prospective effective date of the Medicare beneficiary's financial liability for continued inpatient care and the Medicare beneficiary's appeal rights.

BCBSNC contracting hospitals are responsible for issuing the NODMAR for the Plan. Each NODMAR is to be signed by the Medicare beneficiary to acknowledge receipt of the notice. Contracting hospitals should fax a copy of the signed NODMAR notice to BCBSNC to **1-336-794-1555**. Medicare will not allow Plans or providers to hold members financially liable for any approved hospital admission until a discharge notice has been received.

Please note: Hospitals and facilities that do not facilitate the delivery of this notice may be prevented from billing the member for any continuation of service or from receiving payment from the health plan.

3.10 New enrollee rights/ new provider responsibilities in the Medicare Advantage program

Enrollees of Medicare Advantage "MA" plans have the right to an expedited review by a Quality Improvement Organization "QIO" when they disagree with their MA plan's decision that Medicare coverage of their services from a Skilled Nursing Facility "SNF," Home Health Agency "HHA" or Comprehensive Outpatient Rehabilitation facility "CORF" should end. This right is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

What is "Grijalva"?

"Grijalva" is Grijalva vs. Shalala, a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services was denied, reduced or terminated. Following extended legal negotiations – and significant changes to appeals procedures that resolved many issues – CMS reached a settlement agreement with plaintiffs and published a proposed rule based on that agreement in January 2001, and the final rule in April 2003.

Regulations

SNFs, HHAs and CORFs must provide an advance notice of Medicare coverage termination to MA enrollees no later than two (2) days before coverage of their services will end. If the enrollee does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO and the enrollee's MA plan must furnish a detailed notice explaining why services are no longer necessary or covered. The Medical Review of North Carolina is the QIO for the state of North Carolina. The review process generally will be completed within less than forty-eight (48) hours of the enrollee's request for a review.

The SNF, HHA and CORF notification and appeal requirements distribute responsibilities under the new procedures among four (4) parties:

1) The Medicare Advantage organization generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, Medicare Advantage organizations may choose to delegate

these responsibilities to their contracting providers.) BCBSNC policy requires the provider to issue the Notice of Medicare Non-Coverage "NOMNC" with the required timeline when services are scheduled to terminate or when the Plan determines a discharge date.

2) The provider is responsible for delivering the NOMNC to all enrollees no later than two (2) days before their covered services end.
3) The patient/Medicare Advantage enrollee (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.
4) The QIO is responsible for immediately contacting the Medicare Advantage organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.

These new notice and appeal procedures went into effect on January 1, 2004. You should be aware that the Medicare law (section 1869[b][1][F] of the Social Security Act) established a parallel right to an expedited review for "fee-for-service" Medicare beneficiaries. CMS implemented the procedure 7-1-2005 for these beneficiaries.

For additional information on the fast track appeals process review the following Web sites:

- ***http://www.cms.hhs.gov/healthplans/appeals***
- ***http://www.cms.hhs.gov/medicare/bni/***
- ***http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005***

3.11 What do the SNF, HHA and CORF notification requirements mean for providers?

Notice of Medicare Non-Coverage "NOMNC"

The NOMNC (formerly referred to as the important medicare message of non-coverage) is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS has developed a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider.

The NOMNC essentially includes only two (2) variable fields (i.e., patient name and last day of coverage) that the provider will have to fill in.

When to deliver the NOMNC

Based on the MA organization's determination of when services should end, the provider is responsible for delivering the NOMNC no later than two (2) days before the end of coverage. If services are expected to be fewer than two (2) days, the NOMNC should be delivered upon admission. If there is more than a two (2) day span between services (i.e., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. CMS encourages providers to work with MA organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to deliver the NOMNC

The provider must carry out "valid delivery" of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

Expedited review process

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform the MA organization and the provider of the request for a review and the MA organization is responsible for providing the QIO and enrollee with a detailed explanation of why coverage is ending. The MA organization may need to present additional information needed for the QIO to make a decision. Providers should cooperate with MA organization requests for assistance in getting needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

Importance of timing/need for flexibility

Although the regulations and accompanying CMS instructions do not require action by any of the four (4) responsible parties until two (2) days before the planned termination of covered services, CMS emphasizes that

whenever possible, it's in everyone's best interest for an MA organization and its providers to work together to make sure that the advance termination notice is given to enrollees as early as possible. Delivery of the NOMNC by the provider as soon as it knows when the MA organization will terminate coverage will allow the patient more time to determine if they wish to appeal. The sooner a patient contacts the QIO to ask for a review, the more time the QIO has to decide the case, meaning that a provider or MA organization may have more time to provide required information.

CMS understands that challenges presented by this new process and has tried to develop a process that can accommodate the practical realities associated with these appeals. With respect to weekends, for example, many QIOs are closed on weekends (except for purposes of receiving expedited review requests), as are the administrative offices of MA organizations and providers. Thus, to the extent possible, providers should try to deliver termination notices early enough in the week to minimize the possibility of extended liability for weekend services for either MA enrollees or MA organizations, depending on the QIO's decision.

Similarly, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance and, thus, facilitate a faster and more simple discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible.

CMS recognizes that these new requirements will be a challenge – at least at first – and that there may be unforeseen complications that will need to be resolved as the process evolves. CMS intends to work together with all involved parties to identify problems, publicize best practices and implement needed changes.

3.12 More information

Further information on this process, including the NOMNC and related instructions can be found on the CMS Web site at ***www.cms.hhs.gov/healthplans/appeals***. (Also, see regulations at 42 CFR 422.624, 422.626 and 489.27 and chapter 13 of the MA manual at this same Web site).

3.13 Requirements to provide health services in a culturally competent manner

Providers are reminded to provide services in a manner that meets the member's needs. Medicare beneficiaries may have disabilities, language or hearing impairments or other special needs. BCBSNC has established TTY/TDD lines and other systems to assist members in getting the benefits to which they are entitled. Please contact our BCBSNC customer service staff if you are presented with an issue that requires special assistance so that we can assist in connecting the member with community services if such services are not available within the Plan.

Additionally, in North Carolina, providers can locate an interpreter to assist in communicating with Spanish-speaking patients through the Carolina Association of Translators and Interpreters "CATI". CATI is an association of working translators and interpreters in North Carolina and South Carolina and is a chapter of the American Translators Association. CATI provides contact information of translators and interpreters within North Carolina at ***www.catiweb.org/index.htm***.

3.14 Member input in provider treatment plan

Members have the right to participate with providers in making decisions about their health care. This includes the choice of receiving no treatment. BCBSNC policy is to require providers to include members and their input in the planning and implementation of their care or, when the member is unable to fully participate in all treatment decisions related to their health care, have an appropriate representative participate in the development of treatment plan for said member, be they parent, guardian, family members or other conservator. This includes educating patients regarding their unique health care needs, sharing the findings of history and physical examinations, and discussing with members the clinical treatment options medically available, the risks associated with treatment options or a recommended course of treatment. BCBSNC and provider recognize that the member has the right to choose the final course of action, if any, without regard to plan coverage.

A choice of treatment must not be made without prior consultation with the member as member acceptance and understanding will facilitate successful care outcomes. However, a recommendation by a participating provider for non-covered services does not mean that the services are covered, but as an option may be pursued by member at the member's expense.

3.15 Termination of providers

In the case of terminations by BCBSNC or the provider, BCBSNC must notify affected members thirty (30) days before the termination is effective. Thus, we request that providers adhere to termination notice requirements in provider contracts so that members can receive timely notice of network changes.

3.16 Waiver of liability

Original Medicare's waiver of liability provision, which stipulates that the provider must notify the patient if services could be denied as medically unnecessary, does not apply to BCBSNC members. Under original Medicare, if the waiver of liability is signed by the patient, then the patient is liable for charges. With Blue Medicare HMO℠ and Blue Medicare PPO℠, a waiver of liability is valid only if it clearly and specifically identifies the non-covered service to be provided and is dated and signed by the member for the specific date of service. General waivers of liability are not valid and are not effective to make the member liable for the cost of non-covered services.

3.17 Reminder about opt-out provider status

BCBSNC cannot use federal funds to pay for services by providers that opt out of the original Medicare program and enter into private contracts with Medicare beneficiaries. If you are contemplating this payment approach, please notify BCBSNC in advance of sending your termination notice.

3.18 Utilization management affirmative action statement

Blue Cross and Blue Shield of North Carolina, and it's associated delegates require practitioners, providers and staff who make utilization management-related decisions to make those decisions solely based on appropriateness of care and service and existence of coverage.

BCBSNC does not compensate or provide any other incentives to any practitioner or other individual conducting utilization management review to encourage denials. The Plan makes clear to all staff who make utilization management decisions that no compensation or incentives are in any way meant to encourage decisions which would result in barriers to care, services or under-utilization of services.

3.19 Hold harmless policy

The member will not be held financially responsible for the cost of covered services except for any applicable copayment, coinsurance, or deductible if ALL of the following are true:

- The member has followed the guidelines of the Plan.
- The PCP or participating specialist fails to obtain pre-certification with Blue Medicare HMO℠ and Blue Medicare PPO℠ healthcare services department for those covered services which require pre-certification.
- The non-pre-certified covered services have already been rendered.

The participating provider will be advised that they must write-off the cost of the non-certified services and hold the member financially harmless according to contract provisions.

Ancillary services provided in conjunction with non-precertified services are also not payable by the Plan unless the ancillary provider is a non-participating provider.

This policy will also apply when the Plan is the secondary payer of claims.

Members will be held responsible for non-certified services when:

- Blue Medicare HMO℠ or Blue Medicare PPO℠ is able to intervene to redirect/inform a member prior to services being rendered that coverage has been denied; and

- There is evidence that the member clearly understood that the services were not approved for coverage, i.e., the member signed a waiver agreeing to be responsible for payment.

3.19.1 CMS-required provisions regarding the protection of members eligible for both Medicare and Medicaid (dual eligibles)

Federal legislation has made changes to the Medicare program. Current network provider agreements; in the section entitled "Hold harmless policy" incorporates certain CMS-required provisions regarding the protection of members. Changes to CMS's requirements that became effective January 1, 2010 resulted in our obligation to amend our contracts to incorporate specific hold harmless provisions as they relate to members that are dually eligible for both Medicare and Medicaid. The amendment is as follows:

The section entitled "hold harmless policy" is hereby amended to include the following:

- Members eligible for Medicaid. Providers agree that members eligible for both Medicare and Medicaid (dual eligibles) will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Provider agrees to accept the MA plan payment as payment in full or bill the appropriate state Medicaid agency for such amounts.

Chapter 4

The Blue Book℠
Provider e-Manual

Blue Medicare HMO℠ and Blue Medicare PPO℠ service area, ID cards, and provider verification of membership

Your plan for better health.℠1 | bcbsnc.com

BlueCross BlueShield of North Carolina

4.1 Service area for Blue Medicare HMO℠ and Blue Medicare PPO℠

Blue Medicare is available to individuals eligible for Medicare Part A and enrolled in Medicare Part B. The only exceptions to eligibility are people with end-stage renal disease.

Blue Medicare HMO℠ is a Medicare Advantage plan that includes health care benefits with or without prescription drug coverage in one plan.

Blue Medicare PPO℠ is a preferred provider organization plan that offers health care benefits and prescription coverage in one plan.

Blue Medicare HMO℠ and Blue Medicare PPO℠ plans are offered by Blue Cross and Blue Shield of North Carolina "BCBSNC".

Blue Medicare is available in select counties across North Carolina within the service area approved by the Centers for Medicare & Medicaid Services "CMS." Medicare beneficiaries must live in the following Blue Medicare service areas in order to enroll:

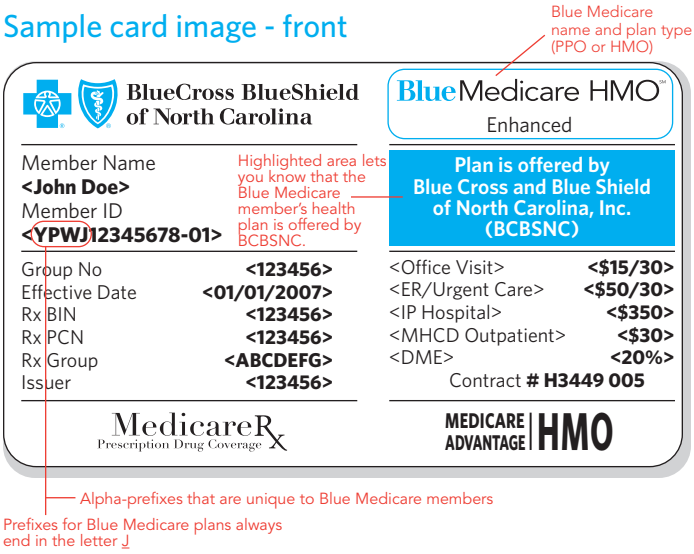
Alamance	Forsyth	Northampton
Alexander	Franklin	Onslow
Alleghany	Gaston	Orange
Ashe	Gates	Pender
Avery	Granville	Perquimans
Beaufort	Greene	Person
Bertie	Guilford	Pitt
Bladen	Halifax	Polk
Brunswick	Harnett	Randolph
Cabarrus	Hoke	Richmond
Caldwell	Haywood	Robeson
Carteret	Henderson	Rockingham
Caswell	Hertford	Rowan
Catawba	Hoke	Sampson
Chatham	Hyde	Stanly
Chowan	Iredell	Stokes
Columbus	Johnston	Surry
Cumberland	Lee	Tyrrell
Davidson	Lincoln	Wake
Davie	Martin	Warren
Duplin	Mecklenburg	Watauga
Durham	Nash	Wilkes
Edgecombe	New Hanover	Yadkin

As the service area expands we will provide updates, available on the Web at ***https://www.bcbsnc.com/providers/blue-medicare-providers/***.

4.2 Blue Medicare identification cards

Blue Medicare HMO℠ and Blue Medicare PPO℠ members have identification cards with a "blue" look. These cards have the Blue Cross and Blue Shield recognizable symbols. When arranging health care and/or submitting claims for services provided to Blue Medicare HMO℠ and Blue Medicare PPO℠ members contact BCBSNC at our Winston-Salem location instead of our Durham offices. It's easy to distinguish if a claim or question should be directed to BCBSNC at or Winston-Salem location with a quick look at a Blue Medicare member's identification card. Please see the sample card image below:

Sample card image - front



One quick glance at the front of the card and you can easily recognize a member as having Blue Medicare, a BCBSNC health care coverage plan. The upper right hand corner of the card displays that it's for a Blue Medicare plan and which plan type a member has enrolled. Just below you'll find an area shaded in blue that highlights the plan as offered by BCBSNC. Look to the card's left and you'll see that a Blue Medicare member's ID includes an alpha-prefix. Blue Medicare alpha-prefixes are unique to Blue Medicare members and always end with the letter J.

The following are unique alpha-prefixes that can help you to 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℠

It's easy to distinguish between Blue Medicare HMO℠ members and Blue Medicare PPO℠ members, just look at the alpha-prefix at the beginning of the member's Blue Medicare identification code. The alpha prefix YPWJ lets you know that the member's coverage type is an HMO plan, and if you see YPFJ, you'll know that the coverage type is PPO.

Sample card image - back

BCBSNC provider service line and Blue Medicare contact information

BlueCross BlueShield of North Carolina

www.bcbsnc.com/member/medicare

Medicare charge limitations may apply.

North Carolina Hospitals or physicians file claims to:
PO BOX 17509
Winston-Salem, NC 27116

Hospitals or physicians outside of North Carolina, file your claims to your local BlueCross and/or BlueShield Plan

Members: See 2008 Member Information Booklet for covered services

Customer Service:	**1-888-310-4110**
TDD/TTY:	**1-888-451-9957**
Provider Line:	**1-888-296-9790**
Mental Health/SA:	**1-800-266-6167**

Members send correspondence to:

Blue Medicare HMO℠
PO BOX 17509
Winston-Salem, NC 27116

BCBSNC is an independent licensee of the Blue Cross and Blue Shield Association.

BCBSNC claims mailing address

The back of a Blue Medicare member's identification card provides further information about arranging health care services and claim submission with BCBSNC. The cards display BCBSNC claims mailing address and telephone service lines.

4.3 Member identification card for Blue Medicare HMO℠

All Blue Medicare HMO℠ members will receive a member ID card when they are enrolled. Patients should be asked to present their Blue Medicare HMO℠ ID card at the time of their visit. You will find it helpful to make a copy of both sides of the member ID card when it is presented by the member. Members should present this card to receive services and not their traditional Medicare card.

Sample card image - front

Blue Medicare name and plan type (PPO or HMO)

BlueCross BlueShield of North Carolina

BlueMedicare HMO℠
Standard

Member Name
<John Doe>
Member ID
<YPWJ12345678-01>

Highlighted area lets you know that the Blue Medicare member's health plan is offered by BCBSNC.

Plan is offered by Blue Cross and Blue Shield of North Carolina, Inc. (BCBSNC)

Group No	**<123456>**
Effective Date	**<01/01/2007>**
Rx BIN	**<123456>**
Rx PCN	**<123456>**
Rx Group	**<ABCDEFG>**
Issuer	**<123456>**

<Office Visit>	**<$15/30>**
<ER/Urgent Care>	**<$50/30>**
<IP Hospital>	**<$350>**
<MHCD Outpatient>	**<$30>**
<DME>	**<20%>**

Contract **# H3449 013**

MedicareRx Prescription Drug Coverage

MEDICARE ADVANTAGE HMO

Alpha-prefixes that are unique to Blue Medicare members

Prefixes for Blue Medicare plans always end in the letter J

Sample card image - back

BCBSNC provider service line and Blue Medicare contact information

BlueCross BlueShield of North Carolina

www.bcbsnc.com/member/medicare

Medicare charge limitations may apply.

North Carolina Hospitals or physicians file claims to:
PO BOX 17509
Winston-Salem, NC 27116

Hospitals or physicians outside of North Carolina, file your claims to your local BlueCross and/or BlueShield Plan

Members: See 2008 Member Information Booklet for covered services

Customer Service:	**1-888-310-4110**
TDD/TTY:	**1-888-451-9957**
Provider Line:	**1-888-296-9790**
Mental Health/SA:	**1-800-266-6167**

Members send correspondence to:

Blue Medicare HMO℠
PO BOX 17509
Winston-Salem, NC 27116

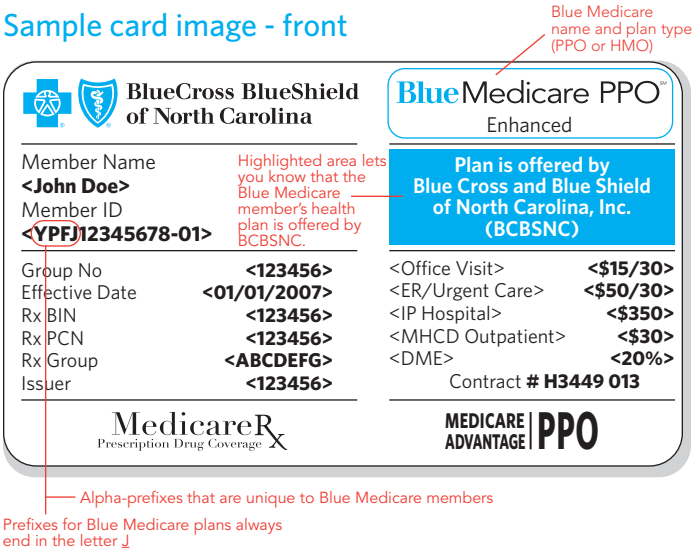
BCBSNC is an independent licensee of the Blue Cross and Blue Shield Association.

BCBSNC claims mailing address

4.4 Member identification card for Blue Medicare PPO℠

All Blue Medicare PPO℠ members will receive a member ID card when they are enrolled. Patients should be asked to present their Blue Medicare PPO℠ ID card at the time of their visit. You will find it helpful to make a copy of both sides of the member ID card when it is presented by the member. Members should present this card to receive services and not their traditional Medicare card.

Sample card image - front



4.5 Verification of membership

Possession of a Blue Medicare member ID card does not guarantee eligibility for benefits coverage or payment. Providers should verify eligibility with BCBSNC in advance of providing services.

Except in an emergency medical condition, providers are required prior to rendering any services to BCBSNC members, to request and examine the member's

BCBSNC Blue Medicare identification card. If a person representing himself or herself as a Blue Medicare member lacks a Blue Medicare HMO℠ or Blue Medicare PPO℠ membership card, the provider shall contact BCBSNC by telephone for verification before denying such person provider services as a BCBSNC member. In an emergency medical condition the provider will follow these procedures as soon as practical. In the event member is determined to be ineligible for coverage due to retroactive enrollment activity and/or incorrect information submitted to BCBSNC by employer group, BCBSNC will not be responsible for payment for services rendered and provider may seek compensation from member.

Please refer to the provider formulary or visit the BCBSNC Web site at ***bcbsnc.com/member/medicare/formulary/***.

4.6 Summary of benefits for Blue Medicare HMO℠ January 1, 2009 – December 31, 2010

Summary of benefits offered for Blue Medicare HMO℠ members, this is not a guarantee of benefits coverage. Always verify member eligibility and benefits prior to providing services.

Benefit	Enhanced plan	Medical-only plan	Standard plan
Additional monthly premium[1, 3]	$80.90	$0	$0
Provider choice	In-network benefits only Must use a network provider	In-network benefits only Must use a network provider	In-network benefits only Must use a network provider
Primary care physician office visits	$15 copayment for in-network visits only	$5 copayment for in-network visits only	$25 copayment for in-network visits only
Inpatient hospital benefits	$550 copayment for each Medicare-covered stay	$350 copayment for each Medicare-covered stay	$975 copayment for each Medicare-covered stay
Medicare prescription drug benefit[2]	Includes our enhanced drug benefit No deductible Generics covered in coverage gap	None	Includes our standard drug benefit No deductible No coverage in the coverage gap
Features	Includes our most robust medical benefits Prescription drug coverage offered	Includes our most robust medical benefits	Basic medical and standard prescription drug coverage

1 As a member of one of the Blue Medicare HMO℠ or Blue Medicare PPO℠, you must continue to pay the Medicare B premium in addition to your plan premium.

2 Formulary applies. Refer to the *Guide to Medicare Prescription Drug Coverage* for details on the enhanced and standard packages.

3 Except for emergency or urgent care, you may pay more for out-of-network provider services.

Benefits, premium and/or copayment/coinsurance may change on January 1, 2011. The benefit information provided herein is a brief summary, but not a comprehensive description of available benefits. A member's complete benefits should always be verified in advance of providing service.

4.7 Summary of benefits for Blue Medicare PPO℠ January 1, 2009 – December 31, 2010

Summary of benefits offered for Blue Medicare PPO℠ members, this is not a guarantee of benefits coverage. Always verify member eligibility and benefits prior to providing services.

Benefit	Enhanced plan	Enhanced Freedom plan
Additional monthly premium[1, 4]	$97.60	$147.50
Provider choice	In- and out-of-network benefits Choice of any network physician for less cost Choice of an out-of-network physician for higher cost	Choice of any network or out-of-network physician at generally the same cost
Primary care physician office visits	$20 copayment for in-network visits Pay 20% coinsurance for out-of-network visits	$20 copayment for in-network visits Pay $40 for out-of-network visits[3]
Inpatient hospital benefits	$700 copayment for each in-network Medicare-covered hospital stay 20% of the cost for each out-of-network hospital stay	$700 copayment for each in-network Medicare-covered hospital stay $700 copayment for each out-of-network hospital stay
Medicare prescription drug benefit[2]	Includes our enhanced drug benefit No deductible Generics covered in coverage gap	Freedom to visit out-of-network providers at generally the same benefit level as in-network providers
Features	Freedom to visit out-of-network providers	Freedom to visit out-of-network providers at generally the same benefit level as in-network providers

1 As a member of one of the Blue Medicare HMO℠ or Blue Medicare PPO℠, you must continue to pay the Medicare B premium in addition to your plan premium.

2 Formulary applies. Refer to the *Guide to Medicare Prescription Drug Coverage* for details on the enhanced and standard packages.

3 Except for emergency or urgent care, you may pay more for out-of-network provider services.

4 If you decide to switch to premium withhold or move from premium withhold to direct bill, it could take up to three months for the change to take effect, and you will be responsible for premiums during that time.

Benefits, premium and/or copayment/coinsurance may change on January 1, 2011. The benefit information provided herein is a brief summary, but not a comprehensive description of available benefits. A member's complete benefits should always be verified in advance of providing service.

4.8 Medicare Advantage PPO℠ network sharing for out-of-state Blue Cross and/or Blue Shield members

As of January 1, 2010, all Blue Medicare Advantage PPO Plans, including the BCBSNC offered Blue Medicare PPO℠ plan, began participation in reciprocal network sharing. This network sharing allows all Blue Cross and/or Blue Shield MA PPO members from another state to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan, as long as the member sees a contracted MA PPO provider.

This means that as a provider participating in the Blue Medicare PPO℠ plan you can see MA PPO members from out-of-state Blue Plans; Blue Cross and/or Blue Shield Plans other than Blue Cross and Blue Shield of North Carolina "BCBSNC" and these members are eligible to receive their same in-network level of benefits, just like when receiving care from their Blue Plan's in-network providers at home.

MA PPO network sharing extends the same access of care to MA PPO out-of-state Blue Plan members when receiving care in North Carolina that's available to Blue Medicare PPO℠ members, and claims for services will be reimbursed in accordance with your Blue Medicare PPO℠ negotiated rate with Blue Cross and Blue Shield of North Carolina "BCBSNC."

Providers who are not participating in the Blue Medicare PPO℠ plan are not eligible to see MA PPO out-of-state Blue Plan members as "in-network." Non-participating providers will receive the Medicare allowed amount for covered services except for urgent or emergency care. Urgent or emergency care will be reimbursed at the member's in-network benefit level. All other services will be reimbursed at the member's out-of-network benefit (when out-of-network benefits are available) for non-participating providers.

Providers participating with Blue Cross and Blue Shield of North Carolina "BCBSNC", who are already servicing MA members enrolled in the Blue Medicare PPO℠ plan are required to provide services to out-of-area Blue Plan eligible Medicare Advantage PPO members seeking care within North Carolina. The same contractual arrangements apply to MA PPO out-of-area Blue Plan members as with our local Blue Medicare PPO℠ members.

Exception note: If your practice is currently full (or becomes full) and is closed to all new Medicare Advantage PPO members, you are not required to provide services for MA PPO out-of-area Blue Plan members.

4.8.1 How to recognize members from out-of-state Blue Plans participating in MA PPO network sharing

The "MA" in the suitcase logo on a member's identification card tells you that that the card belongs to a member who is eligible as part of the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member identification cards.

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MEDICARE ADVANTAGE

Providers are reminded that a person's possession of an identification card is not a guarantee of their enrollment, benefits or eligibility in a MA PPO Blue Plan. A member's identification, enrollment, benefits and eligibility should always be verified in advance of providing services except when verification is delayed because of urgent or emergency situations.

Verification is easy!

Verifying benefits and eligibility for MA PPO out-of-state Blue Plan members is easy! Just call BlueCard® Eligibility at **1-800-676-BLUE**℠ (**2583**) and provide the member's alpha prefix information that is located on their Blue Plan issued membership ID card. Blue Medicare PPO℠ providers who also participate with BCBSNC have the added convenience to submit electronic eligibility requests for out-of-state Blue Plan members using ***Blue e***℠.

4.8.2 Claims administration for out-of-area MA PPO Blue Plan members

Network sharing for MA PPO out-of-state Blue Plan members makes claims filing simple. After providing services to eligible members, submit claims to BCBSNC.

Submit electronic claims to BCBSNC under your current BCBSNC billing practices or enroll for electronic claims filing with BCBSNC at our Durham-based claims address. Contact BCBSNC to set up electronic billing by first visiting the electronic solutions page of the BCBSNC Web site located at: ***http://www.bcbsnc.com/content/providers/edi/index.htm.***

If still filing claims using paper claim forms, send claims for MA PPO out-of-state Blue Plan members to BCBSNC at:

BCBSNC
P.O. Box 35
Durham, NC 27702

Important!

Claims for services provided to MA PPO out-of-state Blue Plan members should be sent to BCBSNC. Medicare should not be billed directly.

Claims payment for services provided to MA PPO out-of-state Blue Plan members will be based on your contracted Blue Medicare PPO℠ rate. Once you submit a MA PPO claim to BCBSNC, the claim will be forwarded to the member's Blue Plan for benefits processing. BCBSNC will work with the member's out-of-state Blue Plan to determine eligible benefits and then send the payment directly to you.

MA PPO out-of-state Blue Plan members who see Blue Medicare PPO℠ participating providers will pay in-network cost sharing (in-network; copayments, coinsurance and deductibles). Providers may collect any applicable co-payment amounts from the member at the time of service. Additionally, providers may collect from members any deductible and/or coinsurance amounts as reflected on the payment remittance for a processed claim (members may not be balance billed for any additional amounts). If you have questions about a processed MA PPO out-of-area Blue Plan member's claim call BCBSNC BlueCard® customer service for assistance at **1-800-487-5522**.

If you have any questions regarding the MA PPO network sharing program for out-of-area Blue Plan members, please contact your local Network Management representative.

4.8.3 Medicare Advantage PPO network sharing provider claim appeals

Network Provider Claim Appeals:

If you participate in the Blue Medicare PPO℠ plan offered by BCBSNC, you will be able to see Blue Plan Medicare Advantage PPO℠ members from out-of- state Blue Plans. Claims for services provided to out-of- state Blue Plan members will be reimbursed in accordance with your Medicare Provider Agreement with BCBSNC. If a participating provider disagrees with claim processing for services provided to an out-of state Blue Plan member, the provider may submit a Network Provider Claim Appeal for one of the following reasons:

- Payer allowance/pricing
- Incorrect payment/coding rules applied
- Benefit determinations made by the Home Plan

The Network Provider Claim Appeal must be submitted in writing within 90 days of claim adjudication and may be mailed to:

Blue Medicare PPO℠
Attention: IPP Provider Appeals
PO Box 17509
Winston-Salem, NC 27116-7509

Eligible Network Provider Appeals concerning out-of-state Blue Plan members will be completed by the Plan within 30 days of the Plan's receipt of all information.

Non-Network Provider Claim Appeals:

Providers who do not participate in the Blue Medicare PPO℠ plan offered by BCBSNC are not eligible to see Blue MA PPO out-of-state members as "in-network." Such "out-of-network" providers will receive the Medicare-allowed amount for covered services, except for urgent or emergency care. Urgent or emergency care will be reimbursed at the member's in-network benefit level. All other services will be reimbursed at the member's out-of-network benefit level (when out-of-network benefits are available) for non-participating providers.

If a provider disagrees with claim processing for services provided to an out-of state Blue Plan member, the provider may submit a Non-Network Provider Claim Appeal for one of the following reasons:

- Medical policy/medical necessity (e.g. cosmetic and investigational)
- Adverse organization determinations made by the Home Plan

The Non-Network Provider Claim Appeal may be submitted to the out-of-state member's Blue Plan or to the following address:

Blue Medicare PPO℠
Attention: IPP Provider Appeals
PO Box 17509
Winston-Salem, NC 27116-7509

Chapter 5

The Blue Book℠
Provider e-Manual

Participating physician responsibilities

Your plan for better health.℠ | bcbsnc.com

BlueCross BlueShield of North Carolina

5.1 Participating physician responsibilities

BCBSNC primary care physicians "PCPs" are responsible for providing or arranging for all appropriate medical services for BCBSNC members, including preventive care, and the coordination of overall care management for the patient. Members enrolled in both the Blue Medicare HMO℠ and Blue Medicare PPO℠ plans may be referred for care outside of their primary care physician's office without a "referral" being written by the primary care physician. However, members enrolled in the Blue Medicare HMO℠ plan do require advanced authorization from BCBSNC if being referred to an out-of-network (non-BCBSNC HMO) provider or facility. The following specialists may serve as PCP's in certain situations:

- Family practice/general practice doctors provide care for infants, children, adolescents and adults in the areas of community medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery.
- Internists (internal medicine) provide service for treatment of diseases in adults. Normally, they do not deliver babies, treat children or perform surgery.
- Geriatric doctors provide care for older adults.

BCBSNC specialists are expected to render high quality care appropriate to the needs of BCBSNC members requiring specialized treatment.

5.2 Mental health and substance abuse

Members do not need a referral to access mental health and substance abuse services. Members should call our designated mental health substance abuse administrator Magellan Health Services at **1-800-266-6167** to speak with a case manager.

5.3 Advance directives

(Please also refer to chapter 3, Administrative Policies and Procedures)

Medicare and Medicaid certified hospitals and other health care providers (such as prepaid health plans [HMOs]) must provide all adult members with written information about their rights under state law to make health care decisions, including the right to exclude advance directives. The physician providing care for adult BCBSNC members will inquire about each adult member's intention to complete these directive documents and note in the member's medical record whether he/she has executed an advance directive. Such notations will be reviewed at the time of the recredentialing medical record review.

5.4 Physician case management services

Physician case management services including, but not limited to, team conferences, telephone calls for medical management and/or consultation, prescriptions and prescription refills for BCBCSNC patients. Compensation for such services is subject to BCBSNC fee schedules and policies, however, BCBSNC fee schedule at this time allows no compensation for services billed separately by CPT or HCPCS case management codes. BCBSNC considers such services part of overall case management and compensation is included in other payments to our providers.

BCBSNC patients must not be billed directly for case management services.

5.5 Benefit overview

The following preventive care coverage policies represent maximum coverage frequencies for BCBSNC members. They are included in this manual to allow providers to notify members in advance when tests will not be covered. Coding references are also included to assist the provider in filing preventive care claims. Please refer to the practice guidelines on periodic health assessment for adults and the pediatric health maintenance guidelines for proper frequencies for preventive health procedures.

Adult maximum frequency benefit schedule for routine testing

Age	Sex	Frequency of physical exam office visit	Lab	Procedures	Immunizations
Under 40 (18-39)	M	V70.0 3 years	Chemistries 80048, 80050 or 80053 CBC (85013, 85014, 85018, 85021, 85025, 85027) Lipid profile (80061) Urinalysis (81002) Varicella titer (86787)	1 baseline TB skin test (86580) then every 5 years after 1954 – 90705 Varicella (90716) if neg titer	Adult Td every 10 years – 90703 or 90718 Rubeola once for adults born
	F	3 years V70.0	Same plus Rubella titer xl (86762)	Same plus 1 baseline mammogram 35-39	Same plus 1 Rubella (90706) if neg titer
		Yearly V72.3 1 pelvic/pap breast exam	Hematocrit 85013 – 84014 or Hemoglobin 85018 or CBC 85021 Urinalysis 81002		
40 through 49	M	V70.0 2 years	Chemistries 80048, 80050, 80053 CBC (85013, 85014, 85018, 85021-85025, 85027) Lipid profile (80061) Urinalysis (81002) PSA (84153) Stool occult blood (82270) Varicella titer (86787)	1 aseline EKG xl (93000) 2 TB skin test every 2 years	Adult Td every 10 years – 90703 or 909718 Varicella (90716) if neg titer

Continued on the following page.

Adult maximum frequency benefit schedule for routine testing

Age	Sex	Frequency of physical exam office visit	Lab	Procedures	Immunizations
40 through 49	F	2 years V70.0	Same excluding PSA plus Rubella titer xl (86762) if not previously done	Same plus 1 mammogram yearly	Same plus Rubella (90706) if neg titer
		Yearly V72.3 1 pelvic/pap breast exam	Hematocrit 85013 – 84014 or Hemoglobin 85018 or CBC 85021 Urinalysis 81002	Same plus 1 baseline mammogram 35-39	Same plus 1 Rubella (90706) if neg titer
50 through 64	M	1 year	Chemistries 80048, 80050 or 80053 CBC (85013, 85014, 85018, 85021-85025, 85027) Lipid profile (80061) Urinalysis (81002) Stool occult blood (82270) PSA (84153) Varicella titer (86787)	1 skin test every 2 years 2 baseline sigmoidoscopy then every 3 years (45300 or 45330) 3 baseline EKG if not previously done Colonoscopy (45378 or G0121) every 10 years or within 4 years of sigmoidoscopy	Adult Td every 10 years Varicella (90716) if neg titer
	F	1 year	Same excluding PSA Rubella titer xl (50-55) if not previously done	Same plus yearly pelvic/pap Breast exam Yearly mammogram	Same Rubella (90706) 50-55 if neg titer
65+	M	1 year	Chemistries 80048, 80050 or 80053 CBC (85013, 85014, 85018, 85021-85025, 85027) Lipid profile (80061) Urinalysis (81002) Stool occult blood (82270) PSA (84153) Varicella titer (86787)	1 TB skin test every 2 years 2 sigmoidoscopy then every 3 years (45300 or 45330) 3 baseline EKG if not previously done Colonoscopy (45378 or G0121) every 10 years or within 4 years of sigmoidoscopy	Adult Td every 10 years Influenza yearly after 65 (90657- 90660) Pneumovax once age 65 & older (90732) and the one booster after 5 years Varicella (90716) if neg titer

Continued on the following page.

Adult maximum frequency benefit schedule for routine testing					
Age	Sex	Frequency of physical exam office visit	Lab	Procedures	Immunizations
65+	F	1 year	Same excluding PSA	Same plus yearly pelvic/pap Breast exam Yearly mammogram	Same

This table summarizes the maximum frequencies at which various preventive services will be covered by BCBSNC for members eighteen (18) years old and above. The necessity for increased frequency of exams or testing indicated by family history of disease or current clinical symptoms will be determined by the member's primary care physician. The guidelines in the table relate to preventive care of the healthy adult only.

If healthy adults request more frequent visits or testing, it should be done at their expense. They should be made aware of this policy before the services are delivered.

5.6 Physician availability

BCBSNC Primary Care Physicians "PCPs"*
BCBSNC PCPs are available twenty-four (24) hours a day, seven (7) days a week. If a physician is not available, another BCBSNC contracted doctor will be available to provide access to care.

BCBSNC OB/GYNs*
BCBSNC gives women the advantage of having a PCP plus an OB/GYN. Women may see any BCBSNC contracted OB/GYN without a referral from the PCP.

BCBSNC Vision Care Specialists*
No referral is required to access participating optometry or ophthalmology providers for vision care.

BCBSNC Physician Specialists*
Specialists servicing BCBSNC members are available twenty-four (24) hours a day, seven (7) days a week.

* Please see your certificate of coverage for more details, or call BCBSNC customer service at **1-888-310-4110**, Monday-Friday, 8:00 a.m. until 8:00 p.m. TTY/TDD **1-888-451-9957**.

Practice guidelines

6.1 Guidelines: clinical practice, preventive health and network quality

Clinical practice and preventive care guidelines help clarify care expectations and, when possible, are developed based on evidence of successful practice protocols and treatment patterns. Clinical practice guidelines are intended to be used as a basis to evaluate the care that could be reasonably expected under optimal circumstances. Preventive care guidelines provide screening, testing and service recommendations based upon national standards.

Network quality is assessed in conjunction with the re-credentialing process.

The following components of the network quality program are reviewed in:

- Access to care standards
- Facility standards
- Managed care medical record standards

Clinical Practice and Preventive Care Guidelines

6.2 Practice guidelines

BCBSNC practice guidelines are designed to improve the health of a group or population of BCBSNC members. In the case of clinical guidelines, these members share a common condition or illness for which there is/are medically approved and clinically accepted interventions that can lead to improved health for those members. Preventive health guidelines address the periodic health assessment of members, categorized by age groups. Both sets of guidelines are developed by a group of participating providers who demonstrate clinical expertise in the treatment of the illnesses or conditions covered by the guideline. At least two (2) providers are involved in the review of the guideline. Nationally recognized standards are adopted as clinical guidelines which provide links to full text versions of each guideline. All guidelines are reviewed and approved by:

- BCBSNC medical director
- BCBSNC Physician Advisory Group "PAG"
- BCBSNC Quality Improvement Committee "QIC"

The intent of practice guidelines is to set forth BCBSNC expectations and/or outcome goals in certain important areas of health care. The guideline should not be interpreted as standards of care.

The guidelines are not the same as covered benefits under traditional Medicare. BCBSNC member's benefits often cover more services than the minimum specified in the guidelines. If examinations or diagnostic tests are requested more frequently than as indicated in the guidelines for healthy members, the physician's office should verify coverage with BCBSNC customer services department.

The following example is used to illustrate our use of practice guidelines:

- The practice guideline for routine screening mammography for a healthy, asymptomatic, female member between the ages of forty (40) and fifty (50) years, with a normal physical examination is every two (2) years. BCBSNC will cover routine screening mammography annually, however, in this age group; giving the physician the latitude to request more frequent examinations if he/she chooses. Mammography is always covered when there are medical indications, such as breast nodules or the need to follow high-risk patients.
- If BCBSNC audits a primary care practice as part of our quality improvement program, we would expect to find a routine screening mammography recorded on all BCBSNC female members between the ages of forty (40) and fifty (50) at least every two (2) years.

Current practice guidelines are included in this chapter of the manual. New guidelines will be distributed as they become available. These guidelines are reviewed every two (2) years for compliance with Plan benefit coverage.

6.3 The initial medical evaluation of adults

Blue Medicare HMO℠ and Blue Medicare PPO℠ members should have a complete evaluation appropriate for their age and gender soon after enrollment. The following guidelines contain the data expected on all healthy adults who have been enrolled as a Blue Medicare HMO℠ and Blue Medicare PPO℠ member for one year or seen in a primary care provider's office on three occasions. If the complete evaluation is absent due to patient factors, counseling efforts should be documented.

These guidelines are based on the American Academy of Family Physicians Summary of Recommendations for Clinical Preventive Services "RCPS." These recommendations are provided to assist providers making clinical decisions regarding the care of their patients. As such, providers should not substitute for the individual judgment brought to each clinical situation by the patient's primary care provider. Providers are encouraged to review the needs of individual patients and community populations they serve to determine which specific population recommendations need to be implemented systematically in their practices.

The RCPS contains recommendations for screening and counseling only. These recommendations do not necessarily apply to patients who have signs and/or symptoms relating to a particular condition.

The RCPS (revision 6.3, March 2007) is available on the Web at ***http://www.aafp.org/exam/***.

Finally, recommendations are not presented specifically relating to women who are pregnant. Specific guidelines for prenatal care are addressed in a separate guideline. the periodic health assessment guidelines are provided to further clarify care expectations in the initial medical evaluation.

These guidelines are subject to the limitations of the member's preventive care benefits.

6.4 Periodic health assessment

Preventive care guidelines help clarify care expectations, and when possible, are developed based on evidence of successful practice protocols and treatment patterns. Preventive care guidelines provide screening, testing and service recommendations based on national standards. Periodic health assessment addresses age specific recommendations and includes guidelines for immunization.

Sources for preventive care guidelines

Advisory Committee on Immunization Practices ***http://www.cdc.gov/nip/acip***

American Academy of Family Physicians ***http://www.aafp.org***

American Academy of Pediatric Dentistry ***http://www.aapd.org***

American Cancer Society ***http://www.cancer.org***

American Medical Association ***http://www.ama-assn.org***

Centers for Disease Control ***http://www.cdc.gov***

National Center for Education in Maternal and Child Health ***http://www.ncemch.org***

National Osteoporosis Foundation Physician's Guide to Prevention and Treatment of Osteoporosis ***http://www.nof.org***

National Kidney Foundation ***http://www.kidney.org***

North Carolina Department of Health and Human Services ***http://www.dhhs.state.nc.us***

North Carolina General Statutes (for mandated screenings: 58-3-174; 58-50-155; 58-51-57; 58-65-92; 58-67-76; 135-40.5(e); 58-3-179; 58-3-260; 130A-125; 58-3-270; 58-51-58; 58-65-93; 58-67-77)

U.S. Preventive Services Task Force ***http://odphp.osophs.dhhs.gov/pubs/guidecps/***

(Guide to Clinical Preventive Services, *Report of the U.S. Preventive Services Task Force*, 3rd ed.: Periodic Updates, 2000-2006)

These guidelines are subject to the limitations of the member's preventive care benefits.

6.4.1 Periodic health assessment for newborns/infants to 24 months

Blue Medicare HMO℠ and Blue Medicare PPO℠ members should have period health assessments to: (1) detect illness at the earliest stage possible, (2) measure recognized risk factors; (3) facilitate implementation of preventive measures. The following schedule is the recommended preventive health guidelines for Blue Medicare HMO℠ and Blue Medicare PPO℠ members who are newborn/infants to 24 months of age.

Preventive care for newborns and infants (0-24 months)

Detection intervention

- Eight office visits during first 12 months for routine health assessment.
- Three office visits during months 13-24 for routine health assessment.

First week

Service		Schedule
All infants:	Ocular prophylaxis	No later than one hour after birth: Erythromycin 0.5% ophthalmic ointment, tetracycline 1% ophthalmic ointment, or 1% silver nitrate solution should be applied topically to the eyes of all newborns
	Vitamin K	At time of delivery
	Hearing	Before discharge from nursery; those not tested at birth should be screened before age 3 months

Routine visit

Service		Schedule
All infants:	History, physical exam (including length and weight), and vision assessment	Eight visits during first 12 months; three visits during months 13-24
	Length, weight and head circumference	Every visit
	Developmental/behavioral assessment	Every visit
	Anticipatory guidance for parent (including diet, injury prevention, dental health, effects of passive smoking, sleep positioning counseling	Every visit
	Fluoride supplement[1], if appropriate	Daily for children between 6 months to 16 years of age
High risk groups:	Tuberculin skin test (PPD)[3]	At 12 months of age for children at high risk
	Lead screening[4]	Conduct a risk assessment and screen for elevated lead levels by measuring blood lead at least once at age 12 months for children at high risk. Seek guidance from local health department.

Continued on the following page.

Footnotes:

1 AAPD recommends the supplementation of a child's diet with fluoride when fluoridation in drinking water is suboptimal. Fluoride supplements should be considered for all children drinking fluoride deficient (<0.6ppm F) water.

2 For babies who are pre-term, low birth weight, low income, migrant, or on principal diet of whole milk.

3 Risk factors include those with household members with disease, recent immigrants from countries where disease is common, migrant families and residents of homeless shelters.

4 Risk factors include living in or frequently visiting an older home (built before 1905), having close contact with a person who has an elevated lead level, living near lead industry or heavy traffic, living with someone whose job or hobby involves lead exposure.

These guidelines are subject to the limitations of the member's preventive care benefits.

6.4.2 Periodic health assessment for children and adolescents, 2-18 years old

Blue Medicare HMO℠ and Blue Medicare PPO℠ members should have period health assessments to: (1) detect illness at the earliest stage possible, (2) measure recognized risk factors; (3) facilitate implementation of preventive measures. The following schedule is the recommended preventive health guidelines for Blue Medicare HMO℠ and Blue Medicare PPO℠ members who are 2-18 years of age.

Preventive care for children and adolescents (2-18 years old)

Detection intervention

- Office visit annually between ages 2-18 years for routine periodic health assessment.

Routine visit

Service		Schedule
All children/ adolescents:	History and physical exam	Every 12 months
	Height and weight	At each visit for routine health exam
	Obesity screening	BMI at every visit
	Tobacco screening and counseling	Every visit
	Blood pressure	Sphygmomanometry should be performed at each visit beginning at age 3, in accordance with the recommended technique for children, and hypertension should only be diagnosed on the basis of readings at each of three separate visits
	Hearing	Before age 3 years for high risk children, if not tested earlier
	Behavioral/developmental assessment	Every visit
	Anticipatory guidance[1]	Every visit
	Fluoride supplement, if appropriate[2]	Daily for children between 6 months to 16 years of age
	Counseling on calcium intake	Every visit for all girls 11 years of age and over
	Vision screen for amblyopia, strabismus[3], and defects in visual acuity (beginning at age 3)	Recommended for all children once before entering school, preferably between ages 3 and 4 years. Vision screening generally provided by school system ages 7-12.
	Scoliosis screen	During complete physical exams for patients age 13-18 years
	Eating disorders screen	Every visit for patients age 13-18 years
	Hgb/hct	Every 12 months for menstruating adolescent females

Continued on the following page.

Routine visit		
Service		**Schedule**
	Hernia/testicular cancer screen	Every visit for male patients age 13-18 years
	HIV screening	Routine screening in health care settings; adolescents with known risk factors should be screened every 12 months[4]
High risk groups:	Tuberculin skin test (PPD)[5]	As recommended by provider
	Lead screening[6]	Conduct a risk assessment and screen for elevated lead levels by measuring blood lead among high risk children. Seek guidance from local health department.
	Cholesterol	One time at age 6 or older when positive family history for early cardiovascular disease or hyperlipidemia; otherwise one test between ages 13 and 18 years
	Chlamydia screening	Every 12 months for female patients who are/have been sexually active or are 18 and older

Footnotes:

1 For patients to age 12 years, this includes diet, injury and violence prevention, dental health, and effects of passive smoking. For patients age 13-18 years, anticipatory guidance should include diet and exercise, injury prevention, sexual practices and substance abuse. For patients with family history of skin cancer; large number of moles; or fair skin, eyes or hair, guidance should also include skin protection from UV light.

2 AAPD recommends the supplementation of a child's diet with fluoride when fluoridation in drinking water is suboptimal. Fluoride supplements should be considered for all children drinking fluoride deficient (<0.6ppm F) water.

3 Clinicians should be alert for signs of ocular misalignment. Stereoacuity testing may be more effective than visual acuity testing in detecting these conditions.

4 Routine, voluntary HIV screening for all persons 13-64 in health care settings, not based on risk. Repeat HIV screening of persons with known risk at least annually. Opt-out HIV screening with the opportunity to ask questions and the option to decline. Include HIV consent with general consent for care; separate signed informed consent not recommended. Prevention counseling in conjunction with HIV screening in health care settings is not required.

5 Risk factors include those with household members with disease, recent immigrants from countries where disease is common, migrant families and residents of homeless shelters.

6 Risk factors include living in or frequently visiting an older home (built before 1905), having close contact with a person who has an elevated lead level, living near lead industry or heavy traffic, living with someone whose job or hobby involves lead exposure.

These guidelines are subject to the limitations of the member's preventive care benefits.

6.4.3 Periodic health assessment for adults, 19-64 years old

Blue Medicare HMO℠ and Blue Medicare PPO℠ members should have period health assessments to: (1) detect illness at the earliest stage possible, (2) measure recognized risk factors; (3) detect lifestyle factors that may have deleterious effects; (4) receive appropriate counseling and preventive measures. The following schedule is the recommended preventive health guidelines for Blue Medicare HMO℠ and Blue Medicare PPO℠ members who are 19 to 64 years of age.

Preventive care for adults (19-64 years old)

Detection intervention

- Office visit every 12 to 36 months which includes assessment, routine testing and education.

Routine visit

Service		Schedule
All adults	History and physical exam	Every 12 to 36 months as recommended by your physician until age 40, and then every 12 months
	Height and weight	Every visit
	Obesity screening and counseling	BMI and abdominal girth at every visit
	Tobacco screening, counseling	Every visit
	Blood pressure	Every 12 to 36 months
	Diet and exercise counseling	Every 12 to 36 months
	Alcohol and substance abuse screening and counseling	Every 12 to 36 months
	Sexual practices counseling	Every 12 to 36 months
	Chlamydia screening	Every 12 months for women who are/have been sexually active, ages 19-25 years
	Eye exam	Every 12 to 36 months until age 40, and then every 12 months
	Folic acid supplement counseling	Every 12 months for women of reproductive age
	Lipid disorders screening[1]	Every five years, if normal
	Depression screening	Initial visit, then every 12 to 36 months and as suggested by symptoms[2]

Continued on the following page.

Routine visit		
Service		**Schedule**
	Colorectal cancer screening	One of the following screening tests is recommended for age 50 and older[3] • Fecal occult blood testing every 12 months • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy • Screening colonoscopy (or screening barium enema as an alternative) every 24 months (for **high risk** individuals)
	Calcium intake counseling	Every 12 to 36 months for women
	Osteoporosis prevention counseling	Very visit for peri- and post-menopausal women
	Mammography counseling	Every visit, women age 40 and over
	Mammogram	Women who have not had bilateral mastectomy: One baseline screening for any woman 35-39 years of age One screening every 12 months for women age 40 and older
	Clinical breast exam, teaching breast self exam	As recommended by provider
	Papanicolaou smear	Every 12 months for women who have a cervix (less frequent testing may be appropriate, if recommended by provider)
	HIV screening	Routine screening in health care settings; adults with known risk factors should be screened every 12 months[4]
High risk groups:	Diabetes screening	For patients with hypertension or hyperlipidemia
	Prostate cancer counseling[5]	And screening using PSA and/or DRE as recommended by provider for men considered at risk for prostate cancer
	Tuberculin skin test (PPD)[6]	Every 12 to 36 months
	Bone mineral density screening	Initial assessment and subsequent follow up for perimenopausal and postmenopausal women at risk for osteoporosis
	Testing for sexually transmitted disease[7]	As recommended by provider
	Electrocardiogram "ECG"[8]	As recommended by provider
	Aspirin counseling[8]	As recommended by provider

Continued on the following page.

Routine visit	
Service	**Schedule**
Chronic kidney disease screening for those at increased risk[9]	As recommended by provider
Ovarian cancer screening[10]	Screening using transvaginal ultrasound and rectovaginal pelvic exam for women 25 years and over who are at risk for ovarian cancer

Footnotes:

1 Recommended for men 35 and older and women 45 and older. Younger adults with other risk factors for coronary disease. Screening for lipid disorders to include measurement of lipid profile (total cholesterol low-density lipoprotein cholesterol, high-density lipoprotein cholesterol and triglycerides).

2 Symptoms to note include either those suggestive of a mood disorder or frequency of somatic complaints (more than 5 visits in the past year with problems in more than one organ system).

3 Begin screening earlier for higher risk adults, including those with a first-degree relative diagnosed with cholorectal cancer before age 60.

4 Routine, voluntary HIV screening for all persons 13-64 in health care settings, not based on risk. Repeat HIV screening of persons with known risk at least annually. Opt-out HIV screening with the opportunity to ask questions and the option to decline. Include HIV consent with general consent for care; separate signed informed consent not recommended. Prevention counseling in conjunction with HIV screening in health care settings is not required.

5 Risk factors include: family history of prostate cancer, age (risk increases beginning at ages 55-60), being of African-American descent, consuming a high-fat diet, having had a vasectomy.

6 Risk factors include those with household members with disease, recent immigrants from countries where disease is common, migrant families and residents of homeless shelters.

7 Risk factors include history of prior STD, new or multiple sex partners, inconsistent use of barrier contraceptives, use of injection drugs. STD tests may include HIV, syphillis, and gonorrhea.

8 Recommended for patients with two or more of the following risk factors: family history of heart disease, smoking, high cholesterol, diabetes, or hypertension.

9 Individuals with diabetes, hypertension, autoimmune diseases, systemic infections, exposure to drugs or procedures associates with acute decline in kidney function, recovery from acute kidney failure, age greater than 60 years, family history of kidney disease, reduced kidney mass (includes kidney donors and transplant recipients) are considered at increased risk for chronic kidney disease.

10 At risk for ovarian cancer means either (a) having a family history with at least one first-degree, relative with ovarian cancer; and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or (b) testing positive for a hereditary ovarian cancer syndrome.

These guidelines are subject to the limitations of the member's preventive care benefits.

6.4.4 Periodic health assessment for adults, 65 years and older

Blue Medicare HMO℠ and Blue Medicare PPO℠ members should have period health assessments to: (1) detect illness at the earliest stage possible, (2) measure recognized risk factors; (3) detect lifestyle factors that may have deleterious effects; (4) receive appropriate counseling and preventive measures. The following schedule is the recommended preventive health guidelines for Blue Medicare HMO℠ and Blue Medicare PPO℠ members who are 65 years old and older.

Preventive care for older adults (65 years and older)

Detection intervention

- Office visit every 12 months which includes assessment, routine testing and education.

Routine visit

Service		Schedule
All adults	History and physical exam	Every visit
	Obesity screening and counseling	BMI and abdominal girth at every visit
	Tobacco screening and counseling	Every visit
	Blood pressure	Every visit
	Diet and exercise counseling	Every visit
	Alcohol and substance abuse counseling	Every visit
	Sexual practices counseling	Every visit
	Lipid disorders screening[1]	As recommended by provider
	Vision screen and hearing test	Every 12 months, as recommended by provider. Periodically question patients about hearing, counsel about hearing aid devices, and make referrals for abnormalities
	Depression screening	Initial visit, then every 12 to 36 months and as suggested by symptoms[2]
	Colorectal cancer screening	One of the following screening tests is recommended: • Fecal occult blood testing every 12 months • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy • Screening colonoscopy (or screening barium enema as an alternative) every 24 months (for **high risk** individuals)

Continued on the following page.

Routine visit		
Service		**Schedule**
	Calcium intake counseling	Every visit for women
	Osteoporosis prevention counseling	Every 12 months for post-menopausal women
	Bone mineral density screening	As recommended by provider
	Clinical breast exam	As recommended by provider
	Mammogram	Every 12 months for women who have not had a bilateral mastectomy
High risk groups:	Diabetes screening	For patients with hypertension or hyperlipidemia
	Prostate cancer counseling[3]	And screening using PSA and/or DRE as recommended by provider for men considered at risk for prostate cancer
	Abdominal aortic aneurysm screening	One time screening for men aged 65 to 75 who have ever smoked
	Tuberculin skin test (PPD)[5]	Every 12 to 36 months
	Testing for sexually transmitted disease[6]	As recommended by provider
	Electrocardiogram "ECG"[7]	As recommended by provider
	Aspirin counseling[7]	As recommended by provider
	Chronic kidney disease screening for those at increased risk[8]	As recommended by provider
	Papanicolaou smear	As recommended by physician for women at risk for cervical cancer
	Ovarian cancer screening[9]	Screening using transvaginal ultrasound and rectovaginal pelvic exam for women who are at risk for ovarian cancer

Footnotes:

1 Recommended for men 35 and older and women 45 and older. Younger adults with other risk factors for coronary disease. Screening for lipid disorders to include measurement of lipid profile (total cholesterol low-density lipoprotein cholesterol, high-density lipoprotein cholesterol and triglycerides).

2 Symptoms to note include either those suggestive of a mood disorder or frequency of somatic complaints (more than 5 visits in the past year with problems in more than one organ system).

3 Risk factors include: family history of prostate cancer, age (risk increases beginning at ages 55-60), being of African-American descent, consuming a high-fat diet, having had a vasectomy.

4 History of smoking is determined as at least 100 cigarettes in a person's lifetime.

Continued on the following page.

5 Risk factors include those with household members with disease, recent immigrants from countries where disease is common, migrant families and residents of homeless shelters.

6 Risk factors include history of prior STD, new or multiple sex partners, inconsistent use of barrier contraceptives, use of injection drugs. STD tests may include HIV, syphillis, and gonorrhea.

7 Recommended for patients with two or more of the following risk factors: family history of heart disease, smoking, high cholesterol, diabetes, or hypertension.

8 Individuals with diabetes, hypertension, autoimmune diseases, systemic infections, exposure to drugs or procedures associates with acute decline in kidney function, recovery from acute kidney failure, age greater than 60 years, family history of kidney disease, reduced kidney mass (includes kidney donors and transplant recipients) are considered at increased risk for chronic kidney disease.

9 At risk for ovarian cancer means either (a) having a family history with at least one first-degree, relative with ovarian cancer; and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or (b) testing positive for a hereditary ovarian cancer syndrome.

These guidelines are subject to the limitations of the member's preventive care benefits.

6.5 Routine immunizations

Our health plan adopts the immunization guidelines published by Centers for Disease Control and Prevention.

Recommended adult immunization schedule (October 2007 – September 2008) can be accessed at ***http://www.cdc.gov/nip/recs/adult-schedule.htm***

This schedule applies to the 19-64 years old preventive health guidelines and the 65 years and older preventive health guidelines.

Recommended childhood, adolescent and catch-up immunization schedules (2007) can be accessed at: ***http://www.cdc.gov/nip/recs/child-schedule.htm***.

This schedule applies to the 0-24 months preventive health guidelines and the 2-18 years old preventive health guidelines.

These guidelines are subject to the limitations of the member's preventive care benefits.

6.6 Clinical practice guidelines for coronary artery disease

Blue Medicare HMO℠ and Blue Medicare PPO℠ adopt guidelines published by the following sources as clinical practice guidelines for primary and secondary management of coronary artery disease:

Source: American Heart Association: *AHA Guidelines for Primary Prevention of Cardiovascular Disease and Stroke:* 2002 update

Web site: ***www.americanheart.org***

Source: American Heart Association: *AHA/ACC Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease:* 2006 update

Web site: ***www.americanheart.org***

Source: American Heart Association: *Secondary Prevention of Coronary Heart Disease in the Elderly (with Emphasis on Patients Greater than or Equal to 75 years of Age)*

Web site: ***www.americanheart.org***

6.7 Clinical practice guidelines for the management of diabetes mellitus

Blue Medicare HMO℠ and Blue Medicare PPO℠ adopt guidelines published by the following source as clinical practice guidelines for the management of diabetes mellitus:

Source: American Diabetes Association: *Clinical Practice Recommendations*

Web site: ***www.diabetes.org***

6.8 Clinical practice guidelines for the management of members with heart failure

Blue Medicare HMO℠ and Blue Medicare PPO℠ adopt guidelines published by the following sources as clinical practice guidelines for the management of heart failure:

Evaluation and management
Source: American Heart Association: *ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult*

Web site: *www.americanheart.org*

Pharmacological approaches
Source: Heart Failure Society of America: *HFSA Guidelines for Management of Patients with Heart Failure Caused by Left Ventricular Systolic Dysfunction – Pharmacological Approaches*

Web site: *www.hfsa.org*

6.9 Clinical practice guidelines for secondary intervention for members with Chronic Obstructive Pulmonary Disease (COPD)

Blue Medicare HMO℠ and Blue Medicare PPO℠ adopt guidelines published by the following source as clinical practice guidelines for the management of Chronic Obstructive Pulmonary Disease "COPD:"

Source: Global Initiative for Chronic Obstructive Lung Disease, based on the collaborative recommendations of the World Health Organization and the National Heart, Lung and Blood Institute: *Executive Summary: Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (Guidelines)*

Web site: *http://www.goldcopd.com/*

6.10 Clinical practice guidelines for prenatal care

Blue Medicare HMO℠ and Blue Medicare PPO℠ adopt guidelines published by the following source as clinical practice guidelines for the management of prenatal care:

Source: *AAP/ACOG Guidelines for Perinatal Care, 5th Edition (2002)*

Web site to order a copy of this publication in its entirety: *http://sales.acog.com/acb/stores/1/product1.cfm?SID=1&Product_ID=242*

Prenatal practice guidelines

Summary based on *AAP/ACOG Guidelines for Perinatal Care, 5th Edition, 2002*

Preconception care*

Maternal assessment

- Family history
- Genetic history (both maternal and paternal)
- Medical history
- Current medications (prescription and nonprescription)
- Substance use, including alcohol, tobacco, and illicit drugs
- Domestic abuse or violence assessment
- Nutrition
- Environmental exposures
- Obstetric history
- General physical examination
- Exercise patterns

Immunizations for women at risk such as:

- Rubella (at least one month prior to conception or else hold until post-partum)
- Hepatitis B
- Varicella (at least one month prior to conception or else hold until post-partum)
- Influenza (and all women > 13 weeks during flu season)

Screening /testing

- Human Immunodeficiency Virus "HIV"
- Sexually transmissible infections, based on risk assessment (repeated at 32-36 weeks if risk factors persist)
- Testing to assess recurrent pregnancy loss
- Testing for maternal diseases based on medical or reproductive history
- Testing for tuberculosis (e.g., Mantoux skin test with purified protein derivative)
- Genetic disorders based on racial and ethnic background, such as:
  - ‡ Sickle hemoglobinopathies
  - ‡ B-thalassemia, a-thalassemia
  - ‡ Tay-Sachs disease
  - ‡ Cystic Fibrosis (offer for high risk, but have information available to all)

or family history such as:

- ‡ Cystic Fibrosis (offer for high risk, but have information available to all)
- ‡ Mental retardation
- ‡ Duchenne muscular dystrophy

* Women who do not seek preconception care should have these issues addressed as early in pregnancy as possible.

Recommended patient evaluation

Counseling

- Prevention and testing for HIV
- Determining the time of conception (i.e., by encouraging the patient to keep an accurate menstrual calendar)
- Abstaining from tobacco and alcohol use
- Consuming folic acid, at least 0.4 mg per day, while attempting pregnancy and during the first trimester for prevention of neural tube defects "NTDs"
- Maintaining good control of any preexisting medical conditions (e.g., diabetes, hypertension). Type I insulin dependent diabetic women should be encouraged to see an endocrinologist for optimal diabetic control prior to conception.
- Scope of care that is provided in the office
- Laboratory studies that may be performed
- Expected course of the pregnancy
- Signs and symptoms to be reported to the physician (e.g., bleeding or rupture of membranes)
- Anticipation of schedule of visits
- Practices to promote health maintenance (e.g., use of safety belts)
- Educational programs and literature, including childbirth education classes
- Options for intrapartum care
- Planning for discharge and child care
- Nutrition, including ideal caloric intake and weight gain
- Dietary consultation about intake of fish, mercury, soft cheeses, etc.
- Exercise and daily activity
- Use of tobacco, alcohol, and drugs before and during pregnancy
- Roles of the various members of the health care team, office policies (including emergency coverage), and alternate physician coverage should be explained
- Role of the pediatrician
- Plans for hospital admission and labor, delivery, and anesthesia services
- What to do when labor begins, when membranes rupture, or if bleeding occurs
- Consequences of ingesting solid food after onset of labor
- Aspects of maternal postpartum care, including postpartum contraception and sterilization
- Infant feeding plans including contraindications of breast-feeding
- Available lactation support services
- Aspects of newborn care, such as cord care, physiological jaundice, and circumcision of male neonates
- Timing of discharge from the hospital and any necessary preparations (i.e., obtaining a car seat)
- Resources available for home health services after discharge
- Education on stopping and resuming work
- Counseling and assistance when appropriate regarding: psychosocial services, adolescent pregnancy, domestic violence, and substance abuse

Prenatal practice guidelines

Early and ongoing pregnancy risk identification

(patients with these risk factors should be managed by an obstetrician-gynecologist and/or a maternal-fetal medicine specialist)

Medical history/conditions

Pre and early pregnancy

Asthma
- Symptomatic on medication
- Severe (multiple hospitalizations)

Cardiac disease
- Cyanotic, prior myocardial infarction, aortic stenosis, primary pulmonary hypertension, Marfan syndrome, prosthetic valve, American Heart Association Class II or greater; other

Diabetes mellitus

Drug/alcohol use (including tobacco)

Epilepsy (on medication)

Family history of genetic problems
(Down syndrome, Tay-Sachs disease)

Hemoglobinopathy (SS, SC, S-thal)

Hypertension
- Chronic, with or without renal or heart disease

Previous Pap or GYN history

Prior pulmonary embolus/deep vein thrombosis

Psychiatric illness, especially risk for post partum depression

Pulmonary disease
- Severe obstructive or restrictive
- Moderate

Renal disease
- Chronic, creatinine > with or without hypertension
- Chronic, other

Requirement for prolonged anticoagulation

Severe systemic disease

Ongoing pregnancy

Drug/alcohol use

Proteinuria (≥ 2+ by catheter sample, unexplained by UTI)

Pyelonephritis

Severe systemic disease that adversely affects pregnancy
(such as Systemic Lupus Erythematosus)

Obstetric history/conditions

Pre and early pregnancy

- Age ≥ 35 at delivery
- Cesarean delivery, prior classical or vertical incision
- Incompetent cervix
- LEEP or cone biopsy
- Prior fetal structural or chromosomal abnormality
- Prior neonatal or fetal death
- Prior preterm delivery or preterm rupture of membranes (PROM)
- Prior low birth weight (< 2,500 g)
- Second-trimester pregnancy loss
- Uterine leiomyomata or malformation

Ongoing pregnancy

Blood pressure elevation (diastolic ≥ 90 mm HG, or 20 point increase in diastolic blood pressure over baseline), no proteinuria
Fetal growth restriction suspected
Fetal abnormality suspected by ultrasound
- Anencephaly
- Other

Fetal demise
Gestational age 41 weeks (to be seen by 42 weeks)
Gestational diabetes mellitus
Herpes, active lesions 36 weeks
Hydramnios by ultrasound
Hyperemesis, persisting beyond first trimester
Multiple gestation
Oligohydramnios by ultrasound
Pre-term labor, threatened, < 37 weeks PROM
Vaginal bleeding ≥ 14 weeks

Laboratory tests / examination

Pre and early pregnancy

HIV
- Symptomatic or low CD4 count
- Other

CDE (Rh) or other blood group isoimmunization (excluding ABO, Lewis)
Condylomata (extensive, covering labia/vaginal opening)

Ongoing pregnancy

Abnormal MSAFP (low or high)
Abnormal pap test
Anemia (Hct < 28%, unresponsive to iron therapy)

Abbreviations: MSAFP = maternal serum alpha feto-protein; Hct = hematocrit; UTI = Urinary Tract Infection

Prenatal practice guidelines

Antepartum surveillance

Examinations

Schedule

(Appropriate for an uncomplicated pregnancy: women with medical or obstetrical problems, as well as younger adolescents may require closer surveillance)

- Every 4 weeks for the first 28 weeks
- Every 2-3 weeks until 36 weeks
- Weekly after 36 weeks of gestation

Goals

- Establish an accurate estimated date of delivery
- Monitor the progression of the pregnancy
- Provide education and recommended screening and interventions
- Reassure the mother
- Assess the well-being of the fetus and mother
- Detect medical and psychosocial complications and institute indicated interventions

Assessment

- Blood pressure
- Weight
- Urine protein and glucose
- Uterine size for progressive growth and consistency with estimated date of delivery
- Fetal heart rate
- After the patient reports quickening, she should be asked about: fetal movement, contractions, leakage of fluid and vaginal bleeding

Routine testing

- Hematocrit or hemoglobin
- Urinalysis, including microscopic examination
- Urine testing to detect asymptomatic bacteriuria
- Determination of blood groups and CDE (Rh) type
- Antibody screen
- Rubella virus immunity
- Group B Strap vaginal and rectal cultures (35-37 weeks)
- Neural tube defects screen (offered, but not required)
- Varicella titer if no history of immunization or if health care provider documentation of varicella disease
- Syphillis screen (initial, between 28 and 30 weeks* and at delivery if at increased risk*)
- Chlamydia screen (initial and repeat in 3rd trimester if < 25 years old or high risk*)
- Gonorrhea (initial and at delivery if high risk)*
- Cervical cytology (as needed)
- Hepatitis B virus surface antigen (initial and repeat late in pregnancy if HbsAg negative, but high risk for HBV infection)
- HIV (recommended with patient consent at initial)
- Additional tests as needed on the basis of the patient's history

Non-routine testing

- **Ultrasound** for specific indications at various gestational ages, such as 16-18 weeks of gestation for mothers with diabetes mellitus or at 32-34 weeks of gestation to assess fetal growth restriction for women at high risk. Repeated or planned serial ultrasound examinations may be indicated, such as for women with D (Rh) isoimmunization or other causes of fetal hydrops.
- **Antibody testing** repeated in an unsensitized D-negative patient at approximately 28 weeks of gestation. If negative, the patient should receive D (Rho [D] immune globulin) prophylactically. In addition, D-negative patients should receive D immune globulin if they have had one of the following:
  - ‡ Ectopic gestation
  - ‡ Abortion (either spontaneous or induced)
  - ‡ Procedure associated with possible fetal-to-maternal bleeding, such as chronic villus sampling (CVS) or amniocentesis
  - ‡ Condition associated with fetal-maternal hemorrhage (e.g., abdominal trauma, abruptio placentae)
  - ‡ Delivery of a D-positive infant
- **Maternal infection testing** for those whose history suggests increased risk. Test for Hepatitis C (HCV) and other infections as needed based on the patient's history.
- **Diabetes screening:** Risk assessment for gestational diabetes mellitus (GDM) should be taken at first prenatal visit.† Screening for gestational diabetes can be universal or selective, and should be performed at 24-48 weeks of gestation. Women with clinical characteristics consistent with high risk for GDM should undergo clinical testing as soon as possible.† For selective screening, the following risk factors may be used:
  - ‡ Family history of diabetes in first degree relatives†
  - ‡ Previous history of a macrosomic, malformed, or stillborn baby
  - ‡ Hypertension
  - ‡ Glycosuria
  - ‡ Maternal aged ≥ 25 years†
  - ‡ < 25 years of age and obese (i.e., ≥ 20% over desired body weight or BMI ≥ 27 kg/m^2)†
  - ‡ Member of an ethnic/racial group with a high prevalence of diabetes†
  - ‡ Previous gestational diabetes
- **Maternal serum screening:** Women < 35 years of age should be offered serum screening to assess the risk of Down Syndrome, ideally between 15 and 18 weeks of gestation. In women ≥ 35 years of age, multiple marker testing cannot be recommended as an equivalent alternative to cytogenetic diagnosis for detection of Down Syndrome. Serum screening for neural tube defects by MSAFP (maternal serum alpha fetoprotein) testing should also be offered to all pregnant women; ideally between 15 and 18 weeks of gestation.

† Recommended for gestational diabetes by the American Diabetic Association.

* State of North Carolina Administrative Code (10A NCAC 41A.0204 (e)) requirement.

Prenatal practice guidelines

Risk assessment and management

1) **Prenatal diagnosis of genetic disorders in patients at increased risk:** Prenatal genetic screening should be voluntary and informed. For straightforward genetic disorders, a primary care physician may perform counseling. A referral to a geneticist may be necessitated by the complexities of determining risks, evaluating a family history of such abnormalities, interpreting laboratory tests, or providing counseling.

   Diagnostic testing:

   - Amniocentesis – (usually performed around 16 weeks of gestation)
   - Chorionic Villus Sampling or CVS – (usually performed between 10 and 12 weeks of gestation)
   - Testing D-negative women – (because both amniocentesis and CVS can result in fetal-to-maternal bleeding, the administration of D immune globulin is indicated for D-negative, unsensitized women who undergo either of these procedures.)

2) **Fetal well-being surveillance:** Testing may be indicated and includes the following: decreased fetal movement, hypertensive disorders, insulin-dependent diabetes mellitus, oligohydramnios or hydramnios, fetal growth restriction, post-term pregnancy, or multiple gestation with discordant fetal growth. In most clinical situations, a normal test result indicates that intrauterine fetal death is highly unlikely in the next 7 days. An abnormal result or nonreassuring fetal status is associated with a high rate of false-positive results, based on clinical situations require additional testing to corroborate or refute.

   Diagnostic testing:

   - Assessment of fetal movement (e.g., kick counts)
   - Nonstress test
   - Contraction stress test
   - Biophysical profile
   - Modified biophysical profile

3) **Risk assessment for preterm labor:** Risk factors associated with spontaneous preterm labor and birth (The prevention of preterm birth remains controversial and no clear course of treatment has been established.):

Past pregnancy	Current pregnancy
• Preterm birth	• Hydramnios
• Midtrimester spontaneous abortion	• Second-or-third-trimester bleeding
• Known uterine anomaly	• Preterm labor
• Exposure to diethylstilbestrol	• Multiple premature rupture of membranes
• Incompetent cervix	• Preterm cervical dilatation of ≥ 2 cm in a multipara and ≥ 1 cm in primipara
	• Prepregnancy weight < 115 pounds
	• Age < 15 years
	• Multiple gestation

4) **Post-term gestation:** In most instances, a patient is a candidate for induction of labor if the pregnancy is at greater than 41 weeks of gestation and the condition of the cervix is favorable. If the cervix is not favorable, a test of fetal well-being should be performed, and delivery effected if the test is non-reassuring.

Key process and outcome measures (indicators for all pregnancies)

- Blood group and CDE (Rh) testing
- Antibody screening
- Hct/Hgb testing
- Pap testing
- MSAFP testing
- Rh screening (for Rh negative mother)
- Diabetes/glucose screening
- Rubella screening
- VDRL screening
- Urine culture/screening
- HbsAg testing
- HIV testing
- Maternal complication at birth
- Fetal complications at birth
- Premature birth

Prenatal practice guidelines

Postpartum follow-up care

Examinations

Follow-up care	Goals	Assessment
(Postpartum surveillance may be modified according to the needs of the patients with medical, obstetric, or intercurrent complications) • Approximately 4-6 weeks after delivery, mother should visit her physician for post-partum review • A visit within 7-14 days of delivery may be advised after Cesarean delivery or a complicated gestation	• Obtain an interval history • Evaluate patient's current status and adaptation of the newborn • Review of birth control methods • Counsel to address specific issues regarding future health and pregnancies	• Blood pressure • Weight • Examination of breasts • Examination of abdomen • Pelvic exam (including Pap) • Laboratory data should be obtained as indicated • Episiotomy repair evaluation as necessary • Uterine involution evaluation • Methods of birth control should be reviewed or discussed • Review immunizations • Evaluation of emotional status

6.11 Clinical practice guideline: management of major depression in adults by primary care providers

Blue Medicare HMO℠ and Blue Medicare PPO℠ adopt guidelines published by the following sources as clinical practice guidelines for the management of depression in adults by primary care providers:

Clinical guidelines:

Source: American Psychiatric Association: *Treating Major Depressive Disorder: A Quick Reference Guide*

Web site: *www.psych.org*

Depression screening tool:

Asking two simple questions about mood and anhedonia may be as effective as using longer instruments.[1]

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?
2. Over the past 2 weeks, have you felt little interest or pleasure in doing things?

[1]**Source:** The United States Department of Health and Human Services Agency for Healthcare Research and Quality: *U.S. Preventive Services Task Force: Screening for Depression*

Web site: *www.ahrq.gov*

Tip sheet:

Source: Magellan Health Services: *Assessing and Managing the Suicidal Patient*

Web site: *www.magellanhealth.com*

6.12 Network quality

BCBSNC quality management consultants visit primary care and OB/GYN physician practices to assess compliance to established access to care, facility and medical records standards. This occurs at least every three years, in conjunction with the re-credentialing process.

Quality management consultants also play an educational role for physicians, providing updates with BCBSNC latest documentation and facility requirements and keeping communication lines open between BCBSNC and the network physicians.

The following are components of BCBSNC network quality guidelines:

- Access to care standards
- Facility standards
- Medical records standards

6.13 Access to care standards – primary care physician

All BCBSNC members will have an identified primary care physician. BCBSNC members select their primary care physician at the time of enrollment. The member's benefits begin on the effective date of their policy.

Therefore, the primary care physician becomes responsible for providing care to a member who has chosen him/her as primary care physician on the effective date of the member's policy.

Members are encouraged to contact a new primary care physician's office soon after enrollment to initiate a medical record, arrange for transfer of medical records if necessary, review and update preventive care procedures, learn procedures to follow in case of emergencies, learn coverage arrangements and begin the physician-patient relationship essential for quality medical care.

Primary care physician responsibilities

Primary care physician responsibilities include the following:

- providing or arranging all necessary medical services
- overall case management of the patient
- maintaining a medical record according to BCBSNC guidelines
- performing preventive services according to BCBSNC guidelines
- being available by telephone or in person 24 hours/day, 7 days/week or arranging coverage with an appropriate surrogate physician

Termination of the physician-patient relationship

If a physician chooses to terminate a physician-patient relationship, either for cause or change in the physician's availability, the member must be given written notice 30 days prior to termination in order to have sufficient time to select another primary care physician.

A copy of the notice must be sent to BCBSNC customer services department so we may assist in transferring the member to another PCP.

During the 30-day period following the notice, or until the member has chosen another physician, whichever is less, the physician must respond appropriately to requests for emergency and/or urgent care.

When the BCBSNC member is a physician or a physician's relative

In the interest of providing quality medical care and consistency in applying BCBSNC policies, BCBSNC does not allow a physician to be the primary care physician for himself or herself or for a member of his or her immediate family.

Access to care

Primary care physicians are expected to be available 7 days a week, 24 hours a day for BCBSNC members or have arrangement for provision of services for emergency and urgent conditions. When the primary care physician is not available, arrangements should be made with identified primary care physicians who will act as surrogate. Members should easily obtain contact with the covering physician through a telephone answering system or an alternate method approved by BCBSNC.

Coverage arrangements with non-participating physicians:

Physicians who arrange for coverage are responsible for identifying the covering physician and, if non-participating, obtaining the agreement of that physician to accept BCBSNC reimbursement and to abide by BCBSNC guidelines, including prohibition of balance billing of the patient. Other than for short term, unforeseeable situations, coverage should be arranged only with participating physicians.

Answering service or machine should clearly direct patients to the on-call provider.

BCBSNC and the physician advisory group have established the following access to care standards for primary care physicians.

Emergent concerns (life threatening) should be referred directly to the closest emergency department. It is not necessary to see the patient in the office first.

1. Waiting time for appointment (number of days):

A. Urgent – not life-threatening, but a problem needing care within 24 hours

Pediatrics	see within 24 hours
Adult	see within 24 hours

B. Symptomatic non-urgent – e.g., cold, no fever

Pediatrics	within 3 calendar days
Adult	within 3 calendar days

C. Follow-up of urgent care

Pediatrics	within 7 days
Adult	within 7 days

D. Chronic care follow-up – e.g., blood pressure checks, diabetes checks

Pediatrics	within 14 days
Adult	within 14 days

E. Complete physical/health maintenance

Pediatrics	within 30 calendar days
Adult	within 60 calendar days

2. Time in waiting room (minutes)

(A) Scheduled	30 minutes after 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment. Maximum waiting time = 60 minutes
(B) Walk-ins	BCBSNC discourages walk-ins except at practice established walk-in clinics. Reasonable effort should be made to accommodate patients. Life threatening emergencies must be managed immediately.
(C) Walk-ins (called that day prior to coming)	Pediatrics and adults – after 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling Maximum waiting time = 90 minutes

3. Response time returning call after-hours (minutes)

(A) Urgent*	20 minutes
(B) Other	1 hour

***Note:** Most answering services cannot differentiate between urgent and non-urgent. Times indicated make assumption that the member notifies the answering service that the call is urgent, and the physician receives enough information to make a determination.

4. Office hours – indicates hours during which appropriate personnel are available to care for members, i.e., MD, DO, FNP, PA

Daytime hours/week	7 hours per day x 5 days = 35 hours
Night hours/week	Optional, but encouraged
Weekend hours/week	Optional, but encouraged

5. A clear mechanism to convey results of all lab/diagnostic procedures must be documented and followed. An **active** mechanism (i.e., not dependent on the patient) to convey **abnormal** values to patients must be documented and followed.

6.14 Access to care standards – specialists

Specialists who are not primary care physicians for any BCBSNC members are expected to be available if any BCBSNC member is actively under their care or has requested care. Any physician covering for a specialist must be a physician credentialed in the same specialty unless approved by BCBSNC. The following access to care standards for specialists have been established:

1. Waiting time for appointment (number of days):

A. Urgent – not life-threatening, but a problem needing care within 24 hours

Pediatrics	within 24 hours
Adult	within 24 hours

B. Regular

Pediatrics	(e.g., tube referral) - within 2 weeks
Adult	**Sub-acute problem** (of short duration): within 2 weeks **Chronic problem** (needs long time for consultation): within 4 weeks

2. Time in waiting room (minutes)

(A) Scheduled	after 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment. Maximum waiting time = 60 minutes
(B) Walk-ins (called that day prior to coming)	Pediatrics and adults – after 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling Maximum waiting time = 90 minutes

3. Response time returning call after-hours (minutes)

(A) Urgent*	20 minutes
(B) Other	1 hour

***Note:** Most answering services can not differentiate between urgent and non-urgent. Times indicated make assumption that the member notifies the answering service that the call is urgent, and the physician receives enough information to make a determination.

4. Office hours – indicates hours during which appropriate personnel are available to care for members, i.e., MD, DO, FNP, PA

Daytime hours/week	15 hours per week minimum covering at least 4 days

5. Availability hours

Daytime hours/week	40 hours/week
Night hours/week	24 hours/day

6.15 Facility standards

The following standards for the facilities of practices participating in the BCBSNC network have been adopted by Blue Cross and Blue Shield of North Carolina and endorsed by the physician advisory group for use in assessing the environment in which health care is provided to BCBSNC members.

1. The general appearance of the facility provides an inviting, organized and professional demeanor including, but not limited to, the following:
   a. The office name is clearly visible from the street.
   b. The grounds are well maintained; patient parking is adequate with easy traffic flow.
   c. The waiting area(s) are clean with adequate seating for patients and family members.
   d. Exam and treatment rooms are clean, have adequate space and provide privacy for patients. Conversations in the office/treatment area should be inaudible in the waiting area.
2. There are clearly marked handicapped parking space(s) and handicapped access to the facility.
3. A smoke-free environment is promoted and provided for patients and family members.
4. a. A fire extinguisher is clearly visible and is readily available.
   b. Fire extinguishers are checked and tagged yearly.
5. There is a private area for confidential discussions with patients.
6. Health related materials are available (i.e., patient education, office and insurance information is displayed).
7. Designated toilet and bathing facilities are easily accessible and equipped for handicapped (i.e., grab bars).
8. a. There is an evacuation plan posted in a prominent place or exits are clearly marked, visible and unobstructed.
   b. There is an emergency lighting source.
9. Halls, storage areas and stairwells are neat and uncluttered.
10. There are written policies and procedures to effectively preserve patient confidentiality. The policy specifically addresses (1) how informed consent is obtained for the release of any personal health information currently existing or developed during the course of treatment to any outside entity, i.e., specialist, hospitals, 3rd party payers, state or federal agencies; and (2) how informed consent of release of medical records, including current and previous medical records from other providers which are part of the medical record, is obtained.

*11. a. Restricted, biohazard or abusable materials (i.e., drugs, needles, syringes, prescription pads and patient medical records) are secured and accessible only to authorized office/medical personnel. Archived medical records and records of deceased patients should be stored and protected for confidentiality.

b. Controlled substances are maintained in a locked container/cabinet. A record is maintained of use.

c. There is a procedure for monitoring expiration dates of all medications in the office.

*12. a. At least one staff member is certified in CPR or basic life support.

b. Emergency procedures are in place and are periodically reviewed with staff members.

c. Emergency supplies include, but are not limited to, emergency medications, oxygen, mask, airway and ambu bag.

d. Emergency supplies are checked routinely for expiration dates. A log is maintained documenting the routine checks.

13. There is a written procedure that is in compliance with state regulations for oversight of mid-level practitioners.

14. There is a procedure for ensuring that all licensed personnel have a current, valid license.

15. a. A written infection control policy/program is maintained by the practice.

b. There is a periodic review and staff in-service on infection control.

c. Sterilization procedures and equipment are available.

Note: Standards preceded by an asterisk* are critical elements. Failure to comply with any of these (number 11 and 12 inclusively) could result in a shortened credentialing cycle or possible removal from the network.

6.16 Medical record standards

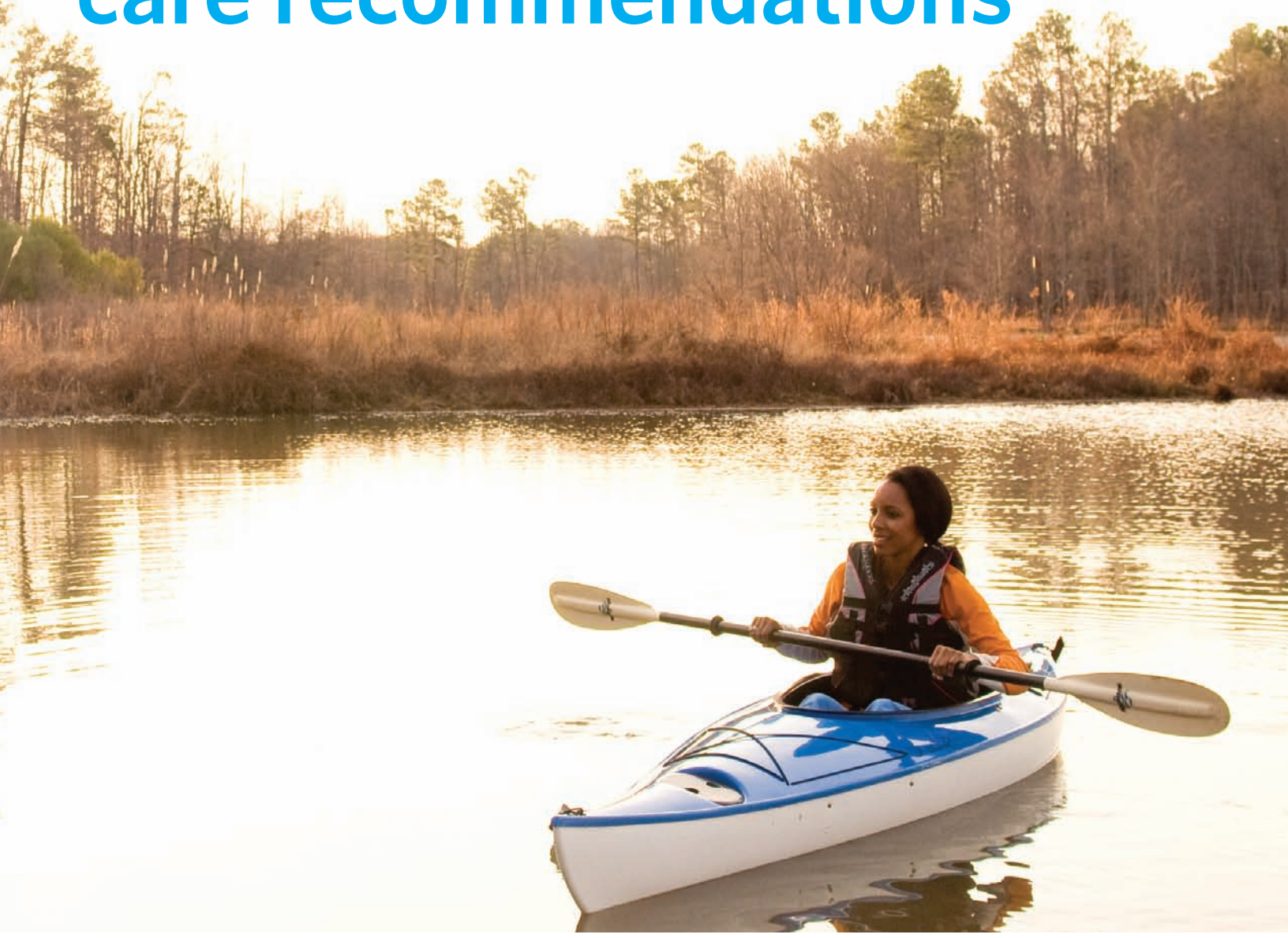
All BCBSNC members who have been seen at least one time within two years will have a readily available, easily identified, unique medical record. All member medical records shall be treated as confidential in compliance with all state and federal laws and regulations regarding confidentiality of patient records, as stated in the provider's agreement.

Standard	Supporting documentation
1. All pages contain patient identification	1. Each page in the medical record must contain the patient's name or I.D. number.
2. Each record contains biological/personal data	2. Biographical/personal data is noted in the medical record. This includes the patient's address, employer, home and work telephone numbers, date of birth and marital status. This data should be updated periodically.

Chapter 7

The Blue Book℠
Provider e-Manual

Wellness and preventive care recommendations



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BlueCross BlueShield of North Carolina

7.1 Wellness and preventive care guidelines

We thought you would be interested in the wellness and preventive care guidelines that BCBSNC sends to its members. BCBSNC encourages members to take an active role in preventing illness. To help members stay healthy, BCBSNC provides coverage for, and access to, preventive care and wellness services. Each year we review, update and publish our wellness and preventive care guidelines. These recommendations are chosen using national guidelines and input from our providers.

If you have questions, call Blue Medicare HMO℠ customer services at: **1-888-310-4110**, Monday-Friday, 8:00 a.m. until 8:00 p.m. TTY/TDD **1-888-451-9957**.

7.2 Physician availability

BCBSNC Primary Care Physicians "PCPs"*

BCBSNC PCPs are available twenty-four (24) hours a day, seven (7) days a week. If a physician is not available, another BCBSNC Medicare contracted doctor will be available to provide access to care.

Blue Medicare members may go directly to a specialist without obtaining a referral. They have the freedom to select any provider in the BCBSNC network. Blue Medicare PPO℠ member may go out-of-network for specialist services at a greater financial cost.

For more wellness programs and services, please visit us at ***bcbsnc.com***.

* Please see your certificate of coverage for more details, or call BCBSNC customer service at **1-888-310-4110**, Monday-Friday, 8:00 a.m. until 8:00 p.m. TTY/TDD **1-888-451-9957**.

7.3 Preventive care for adults sixty-five (65) years and older

Preventive care for adults 65 years and older

Detection intervention

- Office visit which includes assessment, routine testing and education

Routine visit

Service	Schedule
History and physical exam	Annually
Blood pressure (screening for hypertension)	Annually
Diet and exercise counseling	Annually
Tobacco, alcohol and substance abuse counseling	Annually
Sexual practices counseling	Annually
Total blood cholesterol (can be non-fasting)	Annually
Hearing test	Periodically question patients about hearing, counsel about hearing aid devices, and make referrals for abnormalities.
Depression screening (new in 2003)	Initial visit, then every 1 to 3 years and as suggested by symptoms. [12]

Continued on the following page.

Routine visit	
Service	**Schedule**
Colorectal cancer screening	The following screening tests are recommended: • Rectal exam: annually • Fecal Occult Blood Test "FOBT": annually • Sigmoidoscopy: Every 3 to 5 years • Colonoscopy: Every 10 years or within 4 years of last sigmoidoscopy
Influenza vaccination	Annually
Pneumococcal vaccination[11]	Once if patient has not already received, booster after 5 years
Hormone replacement counseling	As recommended by physician
Osteoporosis prevention counseling	Annually for post-menopausal women
Bone mineral density screening[15]	As recommended by physician
Papanicolaou smear (pap test) – cervical cancer screening	Annually, as recommended by physician, for women who are/have been sexually active and who have a cervix. May discontinue if previous regular testing results were consistently normal. As recommended by physician
Clinical breast exam, teaching breast self-exam	As recommended by physician
Mammogram – breast cancer screening	Annually for women who have not had a bilateral mastectomy
Advanced medical directives counseling	Annually
Prevention of falls counseling	Annually
Digital rectal exam – prostate cancer screening[14]	As recommended by physician for men considered to be at risk for prostate cancer.
Prostate-Specific Antigen "PSA"[14]	As recommended by physician for men considered to be at risk for prostate cancer.
Tuberculin Skin Test "PPD"[5]	As recommended by physician
Testing for Sexually Transmitted Disease "STD"[16]	As recommended by physician
Electrocardiogram "ECG"[17]	As recommended by physician
Aspirin counseling[17] (new in 2003)	As recommended by physician

Continued on the following page.

7.4 Preventive care for adults (18-64 years old)

Preventive care for adults (18-64 years old)

Detection intervention

- Office visit every 1-3 years which includes assessment, routine testing and education

Routine visit

Service	Schedule
All adults History and physical exam	• Within first year of enrollment • 18-39 years, every 3 years • 40-49 years, every 2 years • 50-64 years, annually
Height and weight	Every visit
Height and weight	Every visit
Blood pressure – screening for hypertension	Every visit
Tetanus and diphtheria immunization	Every 10 years
Diet and exercise counseling	Every history and physical exam
Tobacco, alcohol and substance abuse counseling	Every history and physical exam
Sexual practices counseling	Every history and physical exam
Chlamydia screening	Annually for women who are/have been sexually active, ages 19-26 years
Folic acid supplement counseling (new in 2003)	Annually for women of reproductive age
Total blood cholesterol (can be non-fasting)	Every 5 years, if normal
Depression screening (new in 2003)	Initial visit then every 1 to 3 years and as suggested by symptoms[12]
Influenza vaccination	Annually for age 50 and older
Colorectal cancer screening	One of the following screening tests is recommended for age 50 and older[13] • Rectal exam: 18 to 49 years, NR*; 50 to 64 years, annually • Fecal occult blood test (FOBT): 18 to 49 years, NR*; 50 to 64, annually

Continued on the following page.

Routine visit	
Service	**Schedule**
Colorectal cancer screening	• Sigmoidoscopy: 18 to 49 years, NR*; 50 to 64 years, every 3 to 5 years • Colonoscopy: 18 to 49 years, NR*; 50 to 64 years, every 10 years or within 4 years of last sigmoidoscopy
Hormone replacement counseling	Every visit for peri- and post-menopausal women
Osteoporosis prevention counseling	Every visit for peri- and post-menopausal women
Mammography counseling	Every visit, women age 40 and over
Mammogram – breast cancer screening	Women who have not had bilateral mastectomy; • 1 baseline screening for women ages 35 to 39 • 40 to 64, every 1 to 2 years
Clinical breast	As recommended by physician
Papanicolaou smear – cervical cancer	Annually until menopause for women who have a cervix (less frequent screening is permitted once 3 or more annual tests have been normal, if recommended by physician)
High risk groups	
Service	**Schedule**
Digital rectal exam groups – prostate cancer screening[14]	As recommended by physician for men considered to be at risk for prostate cancer
Prostate-Specific Antigen "PSA"[14]	As recommended by physician for men considered to be at risk for prostate cancer
Tuberculin Skin Test "PPD"[5]	Every 5 years
Influenza vaccination[6]	As recommended by physician
Pneumococcal vaccination[11]	As recommended by physician
Bone mineral density screening[15]	Initial assessment and subsequent follow-up for peri-menopausal and post-menopausal women at risk for osteoporosis.
Testing for sexually transmitted disease[16]	As recommended by physician
Electrocardiogram "ECG"[17]	As recommended by physician
Aspirin counseling[17] (new in 2003)	As recommended by physician

7.5 Preventive care for children and adolescents (2-17 years old)

Preventive care for children and adolescents (2-17 years old)

Detection intervention

- 4 office visits between ages 2-6 years for routine periodic health assessment
- Office visit every 24 months for ages 7-10 years for routine periodic health assessment
- Office visit every year for ages 11-17 years for routine periodic health assessment

Routine visit

Service	Schedule
All children/history and physical exam[7]	4 visits between ages 2-6 years
Adolescents/history and physical exam[7]	1 visit every 24 months between ages 7-10 years 1 visit every year between ages 11-17
Hearing screening	At age 4, 5, 6, 8, 10, 12, 15 and 17 years
Height and weight	At each visit for routine health exam
Blood pressure (screening for hypertension)	Sphygmomanometry should be performed at each visit beginning at age 3, in accordance with the recommended technique for children, and hypertension should only be diagnosed on the basis of readings at each of 3 separate visits.
Behavioral/developmental assessment	Every visit
Anticipatory guidance[8]	Every visit
Fluoride supplement, if appropriate[3]	Daily for children between 6 months to 16 years of age
Vision screen for amblyopia and strabismus[9]	Recommended for all children once before entering school, preferably between ages 3 and 4 years. Vision screening generally provided by school system ages 7-12.
Scoliosis (curvature of the spine) screen	During complete physical exams for patients age 13-18 years
Eating disorders screen	Every visit for patients age 13-18 years
Hgb/hct	Annually for menstruating adolescent females and 3 times 24 months to 17 years; once 15 months to 4 years; once 5-12 years; once 14-17 years
Urinalysis	5 years and then once between 11-17, unless at risk
Hernia/testicular cancer screen	Every visit for male patients age 13-18 years

Continued on the following page.

High risk groups	
Service	**Schedule**
Hearing[2]	Before age 3 years for high risk children, if not tested earlier
Tuberculin Skin Test (PPD)[5]	As recommended by physician
Lead screening[10]	Annually
Pneumococcal vaccination[11]	As recommended by physician
Influenza vaccination[6]	As recommended by physician
Cholesterol	1 time at age 6 or older when positive family history for early cardiovascular disease or hyperlipidemia
Chlamydia screening	Annually for female patients who are/have been sexually active and have reached age 16.
Papanicolaou smear (pap test) – cervical cancer screening	Annually for female patients who are/have been sexually active and have reached age 18.

7.6 Preventive care for infants to twenty-four (24) months

Preventive care for infants to 24 months

Detection intervention

- 7 office visits during first year for routine health assessment
- 3 office visits during months 13-24 for routine health assessment

First week	
Service	**Schedule**
All infants[1]: ocular prohylaxis	No later than 1 hour after birth: erythromycin 0.5% ophthalmic ointment, tetracycline 1% ophthalmic ointment, or 1% silver nitrate solution should be applied topically to the eyes of all newborns.
Phenylketonuria screening	Before discharge from nursery
Hypothyroidism screening	Before discharge from nursery
Galactosemia screening	Before discharge from nursery
Sickle cell screening	Before discharge from nursery
Congenital adrenal hyperplasia screen	Before discharge from nursery

Continued on the following page.

Routine visit	
Service	**Schedule**
All infants: history and physical exam (including height and weight)	7 visits during first year; 3 visits during second year
Height, weight and head circumference	Every visit
Developmental/behavioral assessment and counseling	Every visit
Anticipatory guidance for parent (including diet, injury prevention, dental health, effects of passive smoking, sleep positioning counseling)	Every visit
Fluoride supplement, if appropriate[3]	Daily for children between 6 months to 16 years of age
Lead screening	Once between 12-24 months of age (or upon first entry to a health care system, if older). All children should be assessed for risk of exposure to lead through administration of a questionnaire at each routine well-child visit between 6-72 months of age.
Hbg/hct	Once 9-12 months and once 15 months to 4 years
High risk groups	
Service	**Schedule**
Hgb/hct[4]	Once during infancy (6-12 months of age)
Tuberculin skin test "PPD"[5]	At 12 months of age
Influenza vaccination[6]	As recommended by physician

1 Newborn screening tests per North Carolina state guidelines. Premature of ill infants should be screened between 24 to 72 hours of age. Infants tested before the 24th hour of age should receive a repeat screening by 1 week of age.

2 Risk factors include family history of hereditary childhood sensorineural hearing loss, congenital perinatal infection, malformations of the head or neck, birth weight below 1,500 g, bacterial meningitis, hyperbilirubinemia and severe perinatal asphyxia.

3 AAPD recommends the supplementation of a child's diet with fluoride when fluoridation in drinking water is suboptimal. Fluoride supplements should be considered for all children drinking fluoride deficient (<0.6ppm F) water.

4 For pre-term, low-birth weight, low income, migrant or infants on principal diet of whole milk.

5 Risk factors include those with household members with disease, recent immigrants from countries where disease is common, migrant families and residents of homeless shelters.

6 Recommended for immunocompetent patients 6 months to 50 years of age with chronic cardiac or pulmonary disease, diabetes mellitus, renal dysfunction, hemoglobinopathies, and those living in special environments or social settings with an identified increased risk of influenza. It is also recommended for women in their second or third trimester of pregnancy during influenza season and for persons 6 months to 18 years of age receiving long-term aspirin therapy. Recommended for all adults older than age 50.

Note: Influenza vaccine is encouraged for healthy persons 6 to 23 months of age, if feasible (this guideline is emerging, but is not universally accepted; practitioners should use their discretion in implementing this guideline).

Continued on the following page.

7 AAP guidelines recommend a complete physical exam annually for children 7 to 18 years of age.

8 For patients up to age 12, this includes diet, injury and violence prevention, dental health, and effects of passive smoking. For patients ages 13 to 18 years, anticipatory guidance should include diet and exercise, injury prevention, sexual practices and substance abuse. For patients with family history of skin cancer, large number of moles, or fair skin, eyes or hair, guidance should also include skin protection from UV light.

9 Clinicians should be alert for signs of ocular misalignment. Stereoacuity testing may be more effective than visual acuity testing in detecting these conditions.

10 Risk factors include living in or frequently visiting an older home (built before 1950), having close contact with a person who has an elevated lead level, living near lead industry or heavy traffic, living with someone whose job or hobby involves lead exposure.

11 The heptavalent Conjugate Pneumococcal Vaccine "PCV" is recommended for certain persons 24 months to 59 months of age with chronic illness. Pneumococcal Polysaccharide Vaccine "PPV" is recommended in addition to PCV for certain high-risk groups. Recommended for immunocompetent patients 19 years of age and over with chronic cardiac or pulmonary disease, diabetes mellitus, anatomic asplenia (excluding sickle cell disease), alcoholics, and those living in special environments or social settings with an identified increased risk of pneumococcal disease. Persons vaccinated prior to age 65 should be vaccinated at age 65 if 5 or more years have passed since the first dose. For all persons with functional or anatomic asplenia, transplant patients, patients with chronic kidney disease, immunosuppressed or immunodeficient persons, and others at high risk of fatal infection, a second dose should be given – at least 5 years after first dose.

12 Symptoms to note include either those suggestive of a mood disorder or frequency of somatic complaints (more than 5 visits in the past year with problems in more than 1 organ system).

13 Begin screening earlier for higher-risk adults, including those with a first-degree relative diagnosed with colorectal cancer before age 60.

14 Risk factors include: family history of prostate cancer, age (risk increases beginning at ages 55-60), being of African-American descent, consuming a high-fat diet, or having had a vasectomy.

15 Eastell, R, Treatment of Postmenopausal Osteoporosis, N.Eng. J. Med., 338-11, Mar. 12, 1998; p736-46.

16 Risk factors include history of prior STD, new or multiple sex partners, inconsistent use of barrier contraceptives, use of injection drugs, STD tests may include HIV, syphilis and gonorrhea.

17 Recommended for patients with 2 or more of the following risk factors: family history of heart disease, smoking, high cholesterol, diabetes or hypertension.

* NR – Not recommended or required, based on physician discretion

7.7 Routine immunizations

Routine immunizations

Primary sources: CDC 2003 Immunizations Schedule; American Academy of Family Physicians

	Months								Years					
	Birth	1	2	4	6	12	15	18	4-6	11-12	11-17	18+	50+	65+
Hepatitis B "Hep B"[1]	■	■	■	■	■	■	■	■	*catch-up vaccination					
Diphtheria, Tetanus & Pertussis "DTaP & Td"[2]			DTaP	DTaP	DTaP		DTaP		DTaP	Td				
Inactivated Polio[3]			•	•	■	■	■	■	•					
Haemophilus Influenza Type B "Hib"[4]			•	•	•	■	■							
"MMR"[5]						■	■			*catch-up vaccination				
Chickenpox (Varicella)[6]						■	■	■	*catch-up vaccination					
Pneumococcal[7]			•	•	•	■	■							•
Influenza[8]													•	
Hepatitis A[9] (high risk)									■	■	■	■	■	■
Meningococcal[10]												•		

* Catch-up vaccinations – indicates age groups that warrant special effort to administer those vaccines not previously given

1 All infants should receive the first dose of Hepatitis B vaccine soon after birth and before hospital discharge. The first dose may also be given by age two (2) months if the infants mother is HBsAg-negative. Only monovalent Hepatitis B vaccine can be used for the birth dose. Monovalent or combination vaccine containing Hep B may be used to complete the series; four (4) doses administered if combination vaccine is used. The second dose should be given at least four (4) weeks after the first dose, except for Hib-containing vaccine which cannot be administered before age six (6) weeks. The third dose should be given at least sixteen (16) weeks after the first dose and at least eight (8) weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age six (6) months. Infants born to HbsAg-positive mothers should receive Hepatitis B vaccine and 0.5 ml Hepatitis B Immune Globulin "HBIG" within twelve (12) hours of birth at separate sites. The second dose is recommended at age one (1) to two (2) months and the vaccination series should be completed (third or fourth dose) at age six (6) months.

Continued on the following page.

Infants born to mothers whose Bag status is unknown should receive the first dose of the Hepatitis B vaccine series within twelve (12) hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's Bag status; if the Bag test is positive, the infant should receive HBIG as soon as possible (no later than age one (1) week).

2 The fourth dose of Dap (diphtheria and tetanus toxoids and acellular pertussis vaccine) may be administered as early as twelve (12) months of age, provided six (6) months have elapsed since the third dose and the child is unlikely to return at age fifteen (15) to eighteen (18) months. Td (tetanus and diphtheria toxoids) is recommended at eleven (11) to twelve (12) years of age if at lease five (5) years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every ten (10) years.

3 An all-IPV schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four (4) doses of IPV at two (2) months, four (4) months, six (6) to eighteen (18) months, and four (4) to six (6) years of age.

4 Three (3) Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at two (2) and four (4) months of age, a dose at six (6) months is not required. DtaP/Hib combination products should not be used for primary immunization in infants at ages two (2), four (4), or six (6) months, but can be used as boosters following any Hib vaccine.

5 The second dose of measles, mumps, and rubella "MMR" vaccine is recommended routinely at four (4) to six (6) years of age but may be administered during any visit, provided at least four (4) weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after twelve (12) months of age. Those who have not previously received the second dose should complete the schedule by the eleven (11) to twelve (12) year old visit.

6 Varicella vaccine is recommended at any visit or after age twelve (12) months for susceptible children, i.e., those who lack a reliable history of chickenpox. Persons aged ≥ thirteen (13) years without a reliable history of varicella disease or vaccination, or who are seronegative for varicella should receive two (2) doses, given at least four (4) weeks apart.

7 The heptavalent Conjugate Pneumococcal Vaccine "PCV" is recommended for all children two (2) to twenty-three (23) months of age. It is also recommended for certain persons twenty-four (24) months to fifty-nine (59) months of age with chronic illness. Pneumococcal Polysaccharide Vaccine "PPV" is recommended in addition to PCV for certain high-risk groups.

8 The influenza vaccine is recommended for certain persons six (6) months to fifty (50) years of age with chronic illness and for those considered at high risk for influenza. Children aged ≤ twelve (12) years should receive vaccine in a dosage appropriate for their age (0.25 ml if age six (6) to thirty-five (35) months or 0.5 ml if aged ≥ three (3) years). Children aged ≥ eight (8) years who are receiving influenza vaccine for the first time should receive two (2) doses separated by at least four (4) weeks.

Note – Influenza vaccine is encouraged for healthy persons six (6) to twenty-three (23) months of age, if feasible (this guideline is emerging, but is not universally accepted; practitioners should use their discretion in implementing this guideline).

9 Recommended for those at high risk, including: medical, behavioral, occupational or other indications: institutionalized persons or those working in institutions, users of injection/street drugs, men who have sex with men or have since 1975, adults living, working, or traveling to areas where Hep A is endemic and periodic outbreaks occur, military personnel.

Note – Immunization for travel or employment requirements are not covered by the certificate of coverage.

10 Recommended for entering college students, particularly those living in or planning to live in dormitories and residence halls. Immunizations may not be covered if provided by non-participating physicians (e.g., many student health clinics or health departments).

7.8 Sources for preventive guidelines*

Advisory Committee on Immunization Practices
http://www.cdc.gov/nip/acip

American Academy of Family Physicians
http://www.aafp.org

American Academy of Pediatric Dentistry
http://www.aapd.org

American Academy of Pediatrics
http://aap.org
(Report of the Committee on Infectious Diseases of the American Academy of Pediatrics – The Red Book, 2000)

American Cancer Society
http://www.cancer.org

American Medial Association
http://www.ama-assn.org

Centers for Disease Control
http://www.cdc.gov

National Center for Education in Maternal and Child Health
http://www.ncemch.org

National Osteoporosis Foundation Physician's Guide to Prevention and Treatment of Osteoporosis
http://www.nof.org

North Carolina Department of Health and Human Services
http://www.dhhs.state.nc.us

North Carolina General Statutes (section 58-65-92 for mammograms and pap smears)

U.S. Preventive Services Task Force
http://odphp.osophs.dhhs.gov/pubs/guidecps/
(Guide to Clinical Preventive Services, Report of the US Preventive Services Task Force, 3rd ed., 2000-2002)

* These guidelines are subject to the limitation of the member's preventive care benefits.

Emergency care coverage

8.1 Emergency care coverage

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity; including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition, that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in placing the health of an individual or unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.

Emergency services are covered inpatient or outpatient services which are (1) furnished by a provider qualified to furnish emergency services and (2) needed to stabilize or evaluate a emergency medical condition.

Coverage is provided worldwide and prior authorization is not required.

If a member experiences an emergency medical condition, he/she is advised to seek care from the nearest medical facility, call 911 or to seek direction and/or treatment from a physician.

8.2 Urgently needed services

Urgently needed services are covered services, that are not emergency services, provided when an enrollee is temporarily absent from the Plan's service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the Plan's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required:

1) As a result of an unforeseen illness, injury or condition, and
2) It was not reasonable given the circumstances to obtain the services through Plan providers

If such a medical need arises, we request that member or a representative contact the member's PCP if possible, then seek care from a local doctor or other provider as directed by the PCP. If the member is unable to do the above, he/she may seek care from a hospital emergency room or urgent care center. Prior authorization is not required for urgently needed services.

Chapter 9

The Blue Book℠
Provider e-Manual

Utilization management programs

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BlueCross BlueShield of North Carolina

9.1 Affirmative action statement

Blue Cross and Blue Shield of North Carolina "BCBSNC," and its associated delegates require practitioners, providers and staff who make utilization management-related decisions to make those decisions solely based on appropriateness of care and service and existence of coverage. BCBSNC does not compensate or provide any other incentives to any practitioner or other individual conducting utilization management review to encourage denials. BCBSNC makes it clear to all staff who make utilization management decisions that no compensation or incentives are in any way meant to encourage decisions that would result in barriers to care, service or under-utilization of services.

9.2 Pre-authorization review

BCBSNC reviews health care service requests prior to an admission or initiation of a course of treatment for those services that require pre-authorization (as specified elsewhere in this manual). Pre-authorization decisions will be made as expeditiously as the member's condition requires, but no later than fourteen (14) calendar days after the Plan receives the request (or within seventy-two [72] hours for expedited requests). An extension of up to fourteen (14) calendar days may be given if the member so requests or if the Plan justifies a need for additional information and exhibits how the delay is in the interest of the member. Authorized services and subsequent review dates are communicated verbally to the requesting provider, and in writing where required by Federal or CMS regulations. Notification of organization determinations will comply with requirements outlined by CMS.

9.3 Inpatient review

BCBSNC licensed nurses perform both telephonic and on-site reviews for emergency admissions and ongoing hospital stays to determine medical necessity, facilitate early discharge planning and to assure timely and efficient health care services are provided. Coverage determinations are made as expeditiously as the member's health condition requires.

9.4 Medical case management

BCBSNC reviews specific needs of members whose conditions are complex, serious, complicated or indicative of long term or high cost medical care, and assists physicians and health care team members to coordinate delivery of high quality services for members in the most effective manner possible. See additional information at ***bcbsnc.com/providers/medical-management/casemanagement***.

9.5 Ambulatory review

Some services performed or provided in an outpatient setting, such as physician offices, hospital outpatient facilities or, freestanding surgicenters, require prior approval. If prior approval is not required, retrospective review may be conducted to ensure that care provided is necessary and medically indicated.

9.6 Hospital observation

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

An admission to observation by the attending physician does not require prior plan approval.

In order to be successful in assuring medically appropriate, quality care, we rely on your cooperation. Timely, appropriate reviews require prompt notification of inpatient admissions, the submission of complete medical information or access to patient charts and specification of discharge needs. If after the initial observation period the member's clinical status deteriorates or remains unstable and/or additional clinical information is provided which meets Milliman care guidelines for admission, the nurse may authorize an inpatient stay retroactive to the date of the member's admission to the facility as an observation patient.

9.7 Medical director's responsibility

It is the policy of BCBSNC to have a medical director review any case involving questionable medical necessity.

This policy is designed to ensure that medical directors are involved in the Utilization Management "UM" decision process. Final determinations ensure that medically necessary, safe and cost-effective care is rendered in the most appropriate setting or level of care.

The medical director may be able to make a determination based on the information provided; however, in some cases, the medical director may request additional clinical information or elect to contact the attending physician to obtain additional information, to discuss an alternative treatment plan, or to review the decision with the provider.

9.8 New technology and new application of established technology review

BCBSNC reviews new technologies and new applications of established technologies in a timely manner and may approve or deny coverage for use of a new technology or new application of an established technology. "Technologies" may include treatments, supplies, devices, medications and procedures. The review of new technologies and new applications of existing technologies is based on a standardized process which considers formal research, existing protocols, potential risks and benefits, costs, effectiveness and governmental approvals. BCBSNC complies with decisions of local carriers based on local coverage determinations and CMS national coverage determinations and guidelines.

9.9 Retrospective review

Retrospective medical necessity review may be conducted when notification is received for services already provided. Coverage determinations are made within fourteen (14) calendar days after the Plan receives the request.

9.10 Non-certification of service requests

BCBSNC may deny coverage for an admission, continued stay or other health care service. Non-certification determinations based on BCBSNC requirements for medical necessity, appropriateness, health care setting or level of care or effectiveness, are made by the BCBSNC medical director. BCBSNC remains liable for inpatient hospital care until the covered member has received notification of the non-certification.

Written notification of general non-certifications are mailed by BCBSNC to the member and provider(s) within the CMS timelines for the case under review. Non-certifications will include reasons for the non-certification, including the clinical rationale, type of treatment that BCBSNC deems appropriate, and instructions for initiating a voluntary appeal or reconsideration of the non-certification. Non-certifications related to skilled nursing facilities, home health and comprehensive outpatient rehabilitation facility services are distributed by the provider within two (2) business days prior to the end of the service authorization or termination of services.

Coverage for services which are subject to the exclusions, conditions and limitations outlined in the member's certificate of coverage and consistent with original Medicare coverage guidelines may be denied by the BCBSNC review staff without review by the BCBSNC medical director.

9.11 Standard data elements

Information required to make utilization management decisions and to certify admission, procedure or treatment, length of stay and frequency and duration of health care may include:

- Clinical information, including primary diagnosis, secondary diagnosis, procedures or treatments, if any.
- Pertinent clinical information to support appropriateness and level of service requests, such as history and physical, laboratory findings, progress notes, second opinions and any discharge planning.
- Resources, including facility type, name, address and telephone, any surgical assistant information, anesthesia if any, admission date, procedure date and requested length of stay.
- Continued stay if any, including date, entity contact, provider contact, additional days or visits requests, reason for extension, diagnosis and treatment plan.

Occasionally after making a reasonable effort, the necessary clinical information may not be available or obtainable to make a coverage determination. Coverage decisions will be based on the clinical information available at the time of review.

9.12 Disclosure of utilization management criteria

Participating providers, covered members and bona fide prospective participants may receive copies of the following upon request:

- An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by covered or prospective members. The explanation may be in writing if so requested.
- Written reasons for denial of recommended treatments and an explanation of the clinical review criteria or treatment protocol upon which the denial was based.
- The BCBSNC formulary and prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a non-formulary drug may be covered.
- The BCBSNC procedures and medically based criteria for determining whether a specified procedure, test or treatment is experimental.

9.13 Care coordination services

Because of the unique health care needs of the Medicare population, health care providers must work as a team to provide and arrange for those necessary health care services. To accomplish this, BCBSNC and some of the contracting providers are using a care coordination approach.

Care coordination is personal, individualized and proactive assistance/intervention for providers and members. Continuing interaction between a nurse case manager and a patient under the supervision of the primary care physician can accomplish the following goals:

- Improve access to appropriate care through the availability of a full continuum of health care services including: preventive care, acute care, primary care, specialty care, long term care and home health services
- Match and manage patient health care needs to ensure appropriate, effective and efficient delivery of care
- Instruct and reassure the patients and families
- Increase the utilization and benefit of patient education, particularly in the areas of understanding disease processes and therapy, promotion of wellness and health risk reduction
- Coordinate care between different providers
- Avoid duplication of diagnostic tests and procedures

The case manager functions as an ombudsman for the patient and the patient's family and as a facilitator and extender for the primary care physician. In this role, the care coordinator:

- Conducts health status/risk assessments
- Investigates, reports and assists in resolving complicating social and environmental problems
- Increases compliance with preventive and therapeutic programs
- Transfers information between providers and sites of care
- Facilitates home care
- Reviews and follows pharmaceuticals and other therapy to improve compliance and avoid unwanted drug interactions and reactions
- Coordinates social services outside the hospital setting

9.14 Service determination

Requests from providers for coverage of services will be responded to as expeditiously as the member's health requires (BCBSNC normally has up to fourteen [14] days). In instances where the member's health or ability to regain maximum function could be jeopardized by waiting up to fourteen (14) days, the provider requesting coverage of services may request an expedited review, in which case the request will be responded to within seventy-two (72) hours. In either case, an extension of up to fourteen (14) calendar days is permitted, if the member requests the extension or if the Plan justifies a need for additional information and the extension of time benefits the member. For example, the Plan might need additional medical records from non-contracting medical providers that could change a denial decision. When the Plan takes an extension, the member will be notified of the extension in writing. Also in either case, the member will be notified in writing of any adverse coverage determination.

In situations where a member requests that a physician provide a service, and the provider does not believe that the service is appropriate and therefore chooses not to provide it, the member may contact BCBSNC to appeal the provider's decision. To ensure that a member is notified of appeals rights regarding determinations, providers must notify the member of his/her right to receive from BCBSNC, upon request, a detailed written notice regarding the denial and provide the member with information regarding how to contact BCBSNC.

Prior authorization requirements

10.1 Prior authorization guidelines

Prior authorization is a system whereby a provider or in the case of the PPO, the member must receive approval from BCBSNC before the member is eligible to receive coverage for certain health care services.

Services requiring prior authorization by BCBSNC depends on whether the member has chosen PPO or HMO coverage.

Cosmetic procedures are excluded in the certificate of coverage. Please contact the health services department for assistance in determining whether a procedure would be considered cosmetic or medically necessary.

Refer to BCBSNC formulary for medications which may require prior approval. Refer to member's certificate of coverage for specific coverage of benefits.

To obtain authorization, providers can call **1-336-774-5400** or **1-888-296-9790** to reach BCBSNC health services.

Services on the BCBSNC prior authorization guideline list require the PCP authorized specialist or PPO member to contact BCBSNC health services to obtain an authorization. A list of the prior authorization guidelines has been included in this section for your convenience. This list is reviewed periodically and may be changed with appropriate notification to physicians. This list is current as of this manual's publication date. Prior authorization guidelines are available for review on the Web site at ***bcbsnc.com***.

Updated guidelines are available for review at ***bcbsnc.com***. You can also contact your Network Management field office to request a current copy.

Blue Cross and Blue Shield of North Carolina prior authorization guidelines

Services marked by a square in the columns to the left require prior authorization for the designated line of business.

HMO	PPO	
■	■	**Cosmetic procedures** (or those potentially cosmetic), such as but not limited to:
■	■	• Abdominoplasty
■	■	• Blepharoplasty
■	■	• Breast reduction
■		**Dental services**
■		**Diagnostic testing**
■		Neuropsychological testing
■		Psychological evaluations for medical reasons
■	■	**Durable medical equipment** (see prosthetics listed separately below)
■	■	All return items
■	■	Items > $600.00 (purchase)
■		Penile implants
■	■	**Home health agency services**
■	■	**Inpatient admissions**
■	■	Scheduled admissions, including acute hospital admissions, acute-to-acute hospital transfers, rehabilitation facility, hospice and skilled nursing facility admissions
■	■	**Note:** for urgent/emergency adults (including obstetric admits), prior authorization is **not** required. However, notification of urgent/emergency admits (including obstetric admits) within 24 hours or the first business day after the admission is required.
■		**Investigational procedures** (or those potentially investigational)
■		**Nonparticipating providers and services**
■	■	**Pharmaceuticals** (see formulary)
■	■	**Prosthetics**
■		**Rehabilitation/therapy**
■		Cardiac rehabilitation (initial 36 visits during a 16-week period are covered without PA. Additional rehabilitation requires PA)
■		Pulmonary rehabilitation (initial 31 visits during a 16-week period are covered without PA. Additional rehabilitation requires PA)
■		Speech therapy
		Surgery
■	■	Extracapsular cataract extraction with intraocular lens
■		MOHS surgery
■		Refractive surgical procedures
■		Sacral neurostimulators

Continued on the following page.

HMO	PPO	
■		Spinal neurostimulators
■		Deep brain stimulators
■		Neuromuscular stimulators
■		Vagal nerve stimulators for epilepsy
■		Surgical treatment of morbid obesity
■		Surgical treatment of sleep apnea
■		Temporomandibular joint surgery
■	■	Transplants, bone marrow and organ
■		Varicose vein treatment
■		Vertebroplasty and kyphoplasty, percutaneous
■		**Transportation** (non-emergency)

Effective 1/1/2010

Blue Medicare HMO℠ and Blue Medicare PPO℠ plans are offered by Blue Cross and Blue Shield of North Carolina "BCBSNC." BCBSNC is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans.

10.2 Requesting durable medical equipment and home health services

Contracting providers with Blue Cross and Blue Shield of North Carolina "BCBSNC" agree to follow BCBSNC's prior approval guidelines when ordering or dispensing Durable Medical Equipment "DME" for BCBSNC members. BCBSNC's prior approval guidelines can be found on the BCBSNC Web site at ***bcbsnc.com***.

Prior authorization is not required for DME that costs less than $600 if all of the following criteria are met:

1. The DME must be for purchase only.
2. A BCBSNC contracting provider prescribes the DME.
3. BCBSNC considers the DME to be medically necessary.
4. The DME is provided by or obtained from a provider/vendor who is contracting with BCBSNC.
5. The DME claim is submitted to BCBSNC with a valid HCPCS code and is assigned a BCBSNC contracted rate.

Prior approval from BCBSNC is required for all DME in the following circumstances:

1. DME items which cost more than $600.
2. All rental items require prior approval from BCBSNC.
3. Support devices and supplies require prior approval if the cost exceeds $600.
4. Any eligible DME item that is provided as incidental to a physician's office visit.
5. DME provided by a home care provider during a covered home care visit.
6. Equipment and/or supplies used to assure the proper functioning of BCBSNC-approved DME (equipment or prosthetic).
7. DME provided by a home infusion provider during a covered visit.

Providers may obtain prior authorization by calling BCBSNC provider services at **1-888-296-9790**. Please be prepared to provide the relevant clinical information to support the medical necessity of the DME request along with the following required information:

- Patient's name
- Patient's BCBSNC ID number
- Type of service or DME requested
- Patient's diagnosis/medical justification in relation to the requested service
- Start and stop date of services
- Ordering physician's name

Participating home health/DME vendors are listed in the on-line provider directory for information only and should not be directly contacted for services.

Home health/DME services requiring arrangement on weekends and after BCBSNC business hours may be retrospectively authorized the next business day if medical justification is met and participating vendors are utilized.

The worksheet on the following page has been prepared to assist you in having the required information ready when you call the health services department for home health/DME services. For additional copies you may make copies from the worksheet in this manual.

10.2.1 Sample request for durable medical equipment/home health services

Request for Durable Medical Equipment/Home Health Services

Member Name: _____

Member Number: _____ Ordering Physician: _____

Diagnosis/Medical Justification:

Durable Medical Equipment

Item(s) requested:

Start date: _____

Stop date: _____

Special instructions:

Skilled Home Health Visits

Type of service requested:

- ☐ RN visit
- ☐ LPN visit
- ☐ PT visit
- ☐ ST visit
- ☐ OT visit
- ☐ Respiratory therapy visit

Frequency of visits:

_____ time(s) per day

_____ hour(s) per day

Start date: _____

Stop date: _____

Special instructions:

IV Therapy

Service requested:

- ☐ IV antibiotics
- ☐ IV pain control
- ☐ IV Chemotherapy
- ☐ IV hydration
- ☐ TPN
- ☐ Other _____

Current venous access:

- ☐ Subclavian line
- ☐ Peripheral line/heplock
- ☐ Will need peripheral line started

Mode of infusion:

- ☐ Pump
- ☐ Gravity
- ☐ No preference

Does the member have a primary care giver at home? ☐ Yes ☐ No

Allergies? _____

Has the patient tried this medication before? ☐ Yes ☐ No

Medication/solution requested: _____

Dosage: _____

Frequency: _____

Start date: _____

Stop date: _____

Special instructions:

10.3 Power-operated vehicle/motorized wheelchair request

In response to the Centers for Medicare & Medicaid Services' "CMS" revised policy for the coverage of power wheelchairs, power-operated vehicles (scooters), and manual wheelchairs, and because power-mobility devices require prior approval from BCBSNC, we have developed the Medicare Advantage Power-Operated Vehicle "POV"/Motorized Wheelchair Request form. The ordering physician's office must contact BCBSNC to obtain prior approval from BCBSNC health services.

You may copy and use the Medicare Advantage Power-Operated Vehicle "POV"/Motorized Wheelchair Request form (see chapter 25, Forms). Additional copies of this form may be downloaded from the provider resources section on our Web site at ***bcbsnc.com***.

The complete CMS policy for Power-Mobility Devices "PMD" may be viewed on the CMS Web site at ***cms.hhs.gov/coverage***.

10.3.1 Sample Medicare Advantage – Power Operated Vehicle "POV"/motorized wheelchair request

Medicare Advantage – Power Operated Vehicle "POV"/Motorized Wheelchair Request Form

Patient Name:	Patient ID# and Date of Birth:
Physician Name:	Physician Phone Number:
DME Item Requested (check only one box): ☐ POV/Scooter ☐ Motorized Wheelchair	Patient's Medical Diagnosis(es):

Please answer the questions below. Submit this form and all medical records to support your answers and the medical necessity of the requested equipment. The medical notes must be submitted with this request.

1. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of a daily living (MRADLs) in the home? ☐ Yes ☐ No

   If yes, please describe the specific mobility limitation and quantify the degree of impairment. _____

   _____

2. Does the patient have other conditions that limit the patient's ability to participate in MRADLs at home? ☐ Yes ☐ No

   If yes, what are the conditions? _____

3. Can the patient's mobility needs in the home be sufficiently resolved with the use of a cane or walker? ☐ Yes ☐ No
4. Can the patient's mobility needs in the home be sufficiently resolved with the use of a manual wheelchair? ☐ Yes ☐ No
5. Does the patient's typical environment support the use of wheelchairs including scooters/POVs? ☐ Yes ☐ No
6. Does the patient have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? ☐ Yes ☐ No
7. Does the patient have sufficient strength and postural stability to operate a POV/scooter? ☐ Yes ☐ No
8. If a power wheelchair is being requested, are the features requested needed to allow the patient to participate in one or more MRADLs? ☐ Yes ☐ No

I certify that, to the best of my knowledge, my answers to the above questions are accurate and supported by the attached medical records.

Physician Signature: _____

Please return completed form to case management:

Fax Number: **1.336.659.2945** or

Address: **Blue Cross and Blue Shield of North Carolina**
Attention: Health Services – Case Management
PO Box 17509
Winston-Salem, NC 27116-7509

10/26/2005

10.4 Protocol for potential organ transplant coverage

When a member is considered for any type of transplant, the following information needs to be submitted to health services case management staff for review:

- Member name
- Member number
- Type of transplant being considered
- All transplants require prior approval except corneal transplant
- Sufficient data to document diagnosis including a recent complete history and physical examination
- Treatment history
- Procedures/scans used to determine current stage of disease
- Reports of any specialty evaluations
- Copy of reports confirming diagnosis such as bone marrow examinations and/or biopsies

Upon receipt of the information, we will evaluate the records to determine coverage by BCBSNC.

Our process needs to be completed before a referral is scheduled to any transplant facility for transplant evaluation. If the transplant is approved for coverage, BCBSNC will provide you with a list of our approved hospitals for you and your patient to select a facility from.

Chapter 11

The Blue Book℠
Provider e-Manual

Pre-admission certification

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BlueCross BlueShield of North Carolina

11.1 Pre-admission certification guidelines

All non-emergency hospital admissions require pre-certification by calling BCBSNC health services department.

The following information will be requested:

- Patient's name
- Patient's BCBSNC ID number
- Hospital name
- Admission date
- Admitting physician name
  (**Note:** if the admitting physician is not the primary care physician, a referral may be needed for the proposed treatment)
- Admitting diagnosis as well as any supportive or related information
  (i.e., lab/x-ray results, symptoms, relevant social and medical history, prior treatment and other medical conditions)
- Description of the proposed plan of treatment
  (i.e., surgery, medical justification for any pre-operative days, lab/radiological testing, medications, need for inpatient care vs. outpatient, admission orders if available, anticipated number of hospitalized days).

The following page is an example of the BCBSNC hospital pre-certification worksheet. The worksheet will help you prepare the required information prior to calling the health services department for pre-certification. Please contact the network development department for additional copies or you may make copies from the worksheet in this manual.

If a patient is in the hospital longer than the anticipated initial length of stay, the health services department will contact you for updates. The information requested will include the following:

- Current medical status
- Current treatment warranting hospitalization
- Anticipated length of stay
- Anticipated discharge plan, including home care or equipment

11.1.1 Sample BCBSNC hospital pre-certification worksheet

Information Necessary for Hospital Precertification

Member Name: _____ Member Number: _____

Hospital: _____ Admit Date: _____

Admitting Physician: _____ Telephone Number: _____

Admitting Diagnosis:
1. Reason for admission to an inpatient facility (symptoms and objective findings to substantiate diagnosis, please include comorbid conditions):
2. Treatment plan that requires inpatient admission:
3. Anticipated hospital length of stay:
4. Is this admission Worker's Compensation related? ☐ Yes ☐ No

11.1.2 Non-emergency pre-admission certification

In non-emergency situations, the hospital will permit admissions of BCBSNC members to the hospital only upon the written or verbal authorization of a participating physician who has medical staff membership and admitting privileges at the hospital, and upon verification prior to admission that such admission is approved by BCBSNC by telephoning a number supplied by BCBSNC to the hospital, or if the hospital is unable to obtain such authorization by telephone, the hospital may permit the admission of the BCBSNC member provided it verifies that such admission is approved by BCBSNC on the morning of the next business day. For coverage and payment, the hospital agrees that in the event a physician is not designated as a participating physician on the BCBSNC roster of participating providers seeks to admit a BCBSNC member to the hospital, the hospital shall contact BCBSNC prior to admission or treatment, to verify such physician's status and/or the referral before rendering provider services, unless it is an emergency medical condition. The hospital shall not be entitled to compensation from BCBSNC for provider services rendered if the hospital admits a BCBSNC member without following the procedures set forth herein or BCBSNC determines that the admission was not medically necessary or not in compliance with BCBSNC policies, procedures and guidelines.

This does not prevent the hospital from providing services to BCBSNC members admitted by non-participating physicians in non-emergency situations when such admission is not approved by BCBSNC.

11.1.3 Emergency admissions

In cases of emergencies concerning BCBSNC members, the hospital is required to notify BCBSNC either within 48 hours after admission of a BCBSNC member as an inpatient to the hospital, or by the end of the first business day following the rendering of the emergency care, whichever is later, and to permit review of the admission by a BCBSNC medical director or his or her designated representative. The hospital shall not be entitled to compensation from BCBSNC for provider services rendered if the hospital fails to notify BCBSNC of an admission of a BCBSNC member within the time period agreed to above or BCBSNC determines that the admission was not a covered service, or medically necessary and/or not in compliance with the terms of this agreement. The hospital's obligation to notify BCBSNC shall be deemed to be satisfied when an employee of the hospital notifies a representative of BCBSNC by telephone of the admission.

Disease management

12.1 Disease management overview

Disease management is directed toward patients with chronic disease processes and seeks to identify those patients timely, facilitating early education and intervention. Patients are identified by review of claims submissions, authorizations, health risk assessments, or physician referrals. Once patients are identified, they are subdivided into three (3) groups according to risk. These groups are assessed as low, medium, or high risk and targeted for specific interventions.

Patients identified as having a chronic disease process and determined to be low or medium risk receive population-based interventions focusing on disease awareness and education.

Patients identified as having a chronic disease state for which BCBSNC has a disease management program, and determined to be high risk are forwarded to BCBSNC disease case managers to assist with appropriate health management needs.

12.2 Disease management programs

BCBSNC currently offers disease management programs for congestive heart failure, chronic obstructive pulmonary disease, and diabetes to eligible patients at no cost to the patient.

12.2.1 Congestive Heart Failure "CHF" disease management program

To assist with the management of high-risk CHF patients, BCBSNC utilizes a home monitoring system that provides advanced technology to identify problems early, facilitate interventions, and avoid unnecessary hospitalizations. Daily, patients report their data, via the home monitoring device, including their objective weight, to the nursing staff at BCBSNC for review. If a patient's data exceeds the preset parameters, the nurses contact the patient for further assessment. Nurses collaborate with the patients' managing physicians to promote effective quality care.

Patients will be considered appropriate for the monitoring program when the disease case manager confirms the patient is high risk or has one (1) or more of the following:

- The level of symptoms associated with heart failure creates a severe functional limitation for the patient.
- A lack of knowledge for self-management is identified through assessment.
- A history of relatively rapid deterioration in clinical status when heart failure symptoms appear.
- Social isolation or other psychosocial barrier to compliance that places the patient at increased risk for complications. This includes inability to obtain medications and/or follow diet and recommended treatment plan.
- Presence of co-morbidities that are contributing to the severity of symptoms and control of heart failure clinical status such as COPD, diabetes, and symptomatic CAD.
- Physician referral for the system supported by the CHF diagnosis.
- Recommendation by the disease case manager involved in the initial and ongoing assessment of the patient to participate in the program.

12.2.2 Chronic Obstructive Pulmonary Disease "COPD" disease management program

To assist with the management of high-risk COPD patients, BCBSNC utilizes a home monitoring system that provides advanced technology to identify problems early, facilitate interventions, and avoid unnecessary hospitalizations. Daily, patients report their data via the home monitoring device to the nursing staff at BCBSNC for review. The nurses contact the patient for further assessment if the reported data indicates a change in the patient's health status. Nurses collaborate with the patients' managing physicians to promote effective quality care.

Patients will be considered appropriate for the monitoring program when the disease case manager confirms the patient is high risk or has one (1) or more of the following:

- The level of symptoms associated with COPD creates a severe functional limitation for the patient.
- A lack of knowledge for self-management is identified through assessment.
- A history of relatively rapid deterioration in clinical status when COPD symptoms appear.
- Social isolation or other psychosocial barrier to compliance that places the patient at increased risk for complications. This includes inability to obtain medications and/or follow diet and recommended treatment plan.

- Presence of co-morbidities that are contributing to the severity of symptoms and control of chronic obstructive pulmonary disease clinical status such as CHF, diabetes and symptomatic CAD.
- Physician referral for the system supported by the COPD diagnosis.
- Recommendation by the disease case manager involved in the initial and ongoing assessment of the patient to participate in the program.

12.2.3 Diabetes disease management programs

To assist with the management of high-risk diabetes patients, BCBSNC utilizes a telephonic nursing management approach to identify problems early, facilitate interventions, and avoid unnecessary hospitalizations. Nurses direct the frequency of patient contact using a scored progress report and follow-up schedule. Patient contact frequencies may change based on individual needs to better accommodate the patient's health status, and/or in collaboration with the patient's physician to promote effective quality care.

Patients will be considered appropriate for the monitoring program when the disease case manager confirms the patient is high risk or has one (1) or more of the following:

- The level of symptoms associated with diabetes creates a severe functional limitation for the patient.
- A lack of knowledge for self-management is identified through assessment.
- A history of relatively rapid deterioration in clinical status when diabetes symptoms appear.
- Social isolation or other psychosocial barrier to compliance that places the patient at increased risk for complications. This includes inability to obtain medications and/or follow diet and recommended treatment plan.
- Presence of co-morbidities that are contributing to the severity of symptoms and control of diabetes clinical status such as COPD, congestive heart failure, hypertension, obesity, dyslipidemia, CVD, or neuropathy.
- Physician referral for the system supported by the diabetes diagnosis.
- Recommendation by the disease case manager involved in the initial and ongoing assessment of the patient to participate in the program.
- Diabetes with concomitant cardiovascular disease.

All program participants receive:

- Educational materials consistent with nationally accepted, evidenced-based standards of practice directed toward the specific disease process and co-morbidities
- Telephone monitoring and education with registered nurses
- Twenty-four (24) hour availability to educational tapes and/or registered nurses through the Telephone Learning Center (TLC line), toll free **1-888-215-4069**

The BCBSNC disease management programs are not intended to be and should not be relied upon as a substitute for appropriate medical care. In all cases, BCBSNC patients should continue to see and follow the recommendations of their treating doctors. In the event the patient experiences severe shortness of breath, chest pain or any other urgent symptom, the patient should immediately call their doctor, 911, or the emergency services number in their area.

12.3 Referrals or requests for provider guides

To refer patients to one (1) of the disease management programs, or to request a copy of a detailed provider's guide for any of the three programs, please call toll free **1-877-672-7647**.

Medical guidelines

13.1 Medical guidelines

Medical guidelines detail when certain medical services are considered medically necessary and are based on Original Medicare National Coverage Determinations "NCD's" and Local Coverage Determinations "LCD's" when available. The guidelines are reviewed and updated in response to changing CMS guidelines for medical coverage or change in scientific literature if applicable.

As a Medicare Advantage "MA" plan, we are required by Centers for Medicare & Medicaid Services "CMS" to provide, at a minimum, the same medical benefits to our members as Original Medicare. As an MA plan, we also cannot be less restrictive that Original Medicare, however, we are allowed to clarify or more fully explain coverage in our policies. If Original Medicare does not have an NCD or LCD applicable to the service under review, the MA plan can develop a guideline to define the plan's coverage. Each individual's unique, clinical circumstances may be considered in light of current CMS guidelines and scientific literature.

Blue Medicare HMO℠ and Blue Medicare PPO℠ medical coverage policies are available for viewing online. Providers can search for a policy to determine the medical necessity criteria needed for a coverage approval. These policies are located on Blue Medicare HMO℠ and Blue Medicare PPO℠ providers' page of ***bcbsnc.com***, available at: ***http://www.bcbsnc.com/content/providers/blue-medicare-providers/medical-policies/index.htm***.

Medical policies can be searched by alphabetical listing, as well as, a categorical listing to aid you in locating a coverage policy. Questions relative to a specific procedure or pre-certification requirements may be obtained by contacting healthcare services at **1-800-296-9790**.

Chapter 14

The Blue Book℠
Provider e-Manual

Claims billing and reimbursement

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Claims billing and reimbursement information contained as part of this supplemental guide is offered in conjunction with the claims billing and reimbursement information contained in The **Blue** Book℠, online e-manual for BCBSNC commercial products. In the event that any information stated within this supplemental guide conflicts with information contained within The **Blue** Book℠, online e-manual for BCBSNC commercial products, providers should defer to this supplemental guide when submitting claims for Blue Medicare HMO℠ and/or Blue Medicare PPO℠ members.

14.1 General filing requirements

All Blue Medicare HMO℠ and Blue Medicare PPO℠ claims must be filed directly to BCBSNC at our Winston-Salem location and not to an intermediary, or carrier such as CIGNA or Palmetto GBA. Claims must be submitted within 180 days of providing a service. Claims submitted after 180 days will be denied unless mitigating circumstances can be documented.

BCBSNC is committed to processing claims efficiently and promptly. Our imaging system requires that the print on claims submitted be dark and legible to enable accurate scanning. Claims that are clear and complete are normally processed and paid within seven to 14 calendar days. Claims that are difficult to interpret, incomplete, do not follow usual and customary procedures, or that are received with a faint image, will be delayed or returned for revision. If filing on paper, please submit OCR (optical character recognition) originals and do not submit carbon copies or photocopies.

The following general claims filing requirements will help improve the quality of the claims we receive and allow us to process and pay your claims faster and more efficiently:

- For fastest claims processing, file electronically! If you're not already an electronic filer, please visit Blue Medicare HMO℠ and Blue Medicare PPO℠ provider resources for electronic commerce on the Web at ***http://www.bcbsnc.com/providers/blue-medicare-providers/electronic-commerce/*** and find out how you can become an electronic filer.
- Submit all claims within 180 days.
- Do not submit medical records unless they have been requested by BCBSNC.
- If BCBSNC is secondary and you need to submit the primary payor Explanation of Payment "EOP" with your paper claim, do not paste, tape or staple the explanation of payment to the claim form.
- Always verify the patient's eligibility. Providers with HealthTrio Connect can verify a member's eligibility and benefits immediately, and from the convenience of their desktop computer. Providers without HealthTrio Connect access should call the BCBSNC provider line at **1-888-296-9790** or **1-336-774-5400**. To find out more about HealthTrio Connect, visit electronic commerce on the Web at ***http://www.bcbsnc.com/providers/blue-medicare providers/electronic-commerce/***.
- Always file claims with the correct member ID number including the alpha prefix J and member suffix. This information can be found on the member's ID card.
- File under the member's given name, not his or her nickname.
- Watch for inconsistencies between the diagnosis and procedure code, sex and age of the patient.
- Use the appropriate provider/group NPI(s) that matches the NPI(s) that is/are registered with BCBSNC, for your health care business.
- If you are a paper claims filer that has not applied or received an NPI, or if you have not yet registered your NPI with BCBSNC, claims should be reported with your provider number (and group number if applicable) that's been assigned specifically for Blue Medicare HMO℠ and/or Blue Medicare PPO℠ use.
  - ‡ Remember that a distinct number may be assigned for different specialties.
  - ‡ Refer to your BCBSNC welcome letter to distinguish the appropriate provider number for each contracted specialty.
  - ‡ If your provider number has changed, use your new number for services provided on or after the date your number changed.
  - ‡ Terminated provider numbers are not valid for services provided after the assigned end date.
- BCBSNC cannot correct claims when incorrect information is submitted. Claims will be mailed back.

14.1.1 Requirements for professional CMS-1500 (08-05) Claim Form or other similar forms

(Not to be considered an all inclusive list)

- All professional claims should be filed on a CMS-1500 (08-05) Claim Form or other similar forms.
  - ‡ If filing on paper, the red and white printed version should be used.

- Once you have registered your NPI with BCBSNC, you should include your NPI on each subsequent claim submission to us.
  - ‡ If you have not obtained or registered your NPI with us, your BCBSNC assigned provider number should be reported on each paper claim submission.
  - ‡ If your physician or provider number changes, use your new number for services provided on or after the date your number was changed.
  - ‡ The tax ID number should correspond to the physician or provider number filed in block 33.
- When submitting an accident diagnosis, include the date that the accident occurred in block 14.
- Anesthesia claims are to be submitted using anesthesia CPT codes as defined by the American Society of Anesthesiologists. Claims submitted using surgery codes instead of anesthesiology codes will be returned requesting anesthesiology codes.
- File supply charges using HCPCS health service codes. If there is no suitable HCPCS code, give a complete description of the supply in the shaded supplemental section of field 24.
- If you are billing services for consecutive dates (from and to dates), it is critical that the units are accurately reported in block 24G.
- To ensure correct payment, include drug name, NDC #, and dosage in field 24.
  - ‡ Please note that the supplemental area of field 24 is for the reporting of NDC codes. Report the NDC qualifier "N4" in supplemental field 24a followed by the NDC code and unit information (UN = unit; GR = gram; ML = milliliter; F2 = international unit).

Please note that fields 21 and 24e of the CMS-1500 Claim Form or other similar forms are designated for diagnosis codes and pointers/reference numbers. Only four diagnosis codes may be entered into block 24e. Any CMS-1500 Claim Form or other similar forms submitted with more than four diagnosis codes or pointers/reference numbers will be mailed back to the submitting provider.

- Claims will be rejected and mailed back to the provider if the NPI number that is registered with BCBSNC or the BCBSNC assigned provider number is not listed on the claim form.
  - ‡ Once a provider has registered their NPI information with BCBSNC and BCBSNC has confirmed receipt, claims should be reported using the NPI only, and the provider's use of the BCBSNC assigned provider and/or group number should be discontinued.

14.1.2 Requirements for institutional UB-04 claim forms

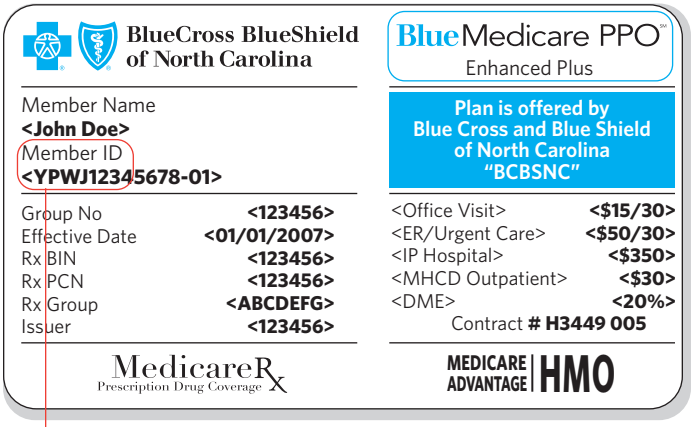
(Not to be considered an all inclusive list)

- All claims should be filed on a UB-04 claim form.
  - ‡ If filing on paper, the red and white printed version should be used.
- The primary surgical procedure code must be listed in the principle procedure field locator 74.
  - ‡ ICD-9 code required on inpatient claims when a procedure was performed.
  - ‡ Field locator 74 should not be populated when reporting outpatient services.
- Please do not submit a second/duplicate claim without checking claim status first on HealthTrio Connect.
  - ‡ Providers should allow 30 days before inquiring on claim status via HealthTrio Connect.
  - ‡ Please wait 45 days before checking claim status through the BCBSNC provider line.

14.2 Using the member's ID for claims submission

When sending claims for services provided to Blue Medicare HMO℠ and Blue Medicare PPO℠ members, it's important that the member's ID be included on the claim form (electronic and paper claims). The alpha-prefix helps North Carolina providers identify what plan type a member has enrolled, but only the last alpha-character of J is utilized for claims filing and claims processing. As example use the card image for John Doe below:

Sample card image – front


BlueCross BlueShield of North Carolina

BlueMedicare PPO℠
Enhanced Plus

Member Name
<John Doe>
Member ID
<YPWJ12345678-01>

Plan is offered by Blue Cross and Blue Shield of North Carolina "BCBSNC"

Group No	**<123456>**
Effective Date	**<01/01/2007>**
Rx BIN	**<123456>**
Rx PCN	**<123456>**
Rx Group	**<ABCDEFG>**
Issuer	**<123456>**

<Office Visit>	**<$15/30>**
<ER/Urgent Care>	**<$50/30>**
<IP Hospital>	**<$350>**
<MHCD Outpatient>	**<$30>**
<DME>	**<20%>**

Contract **# H3449 005**

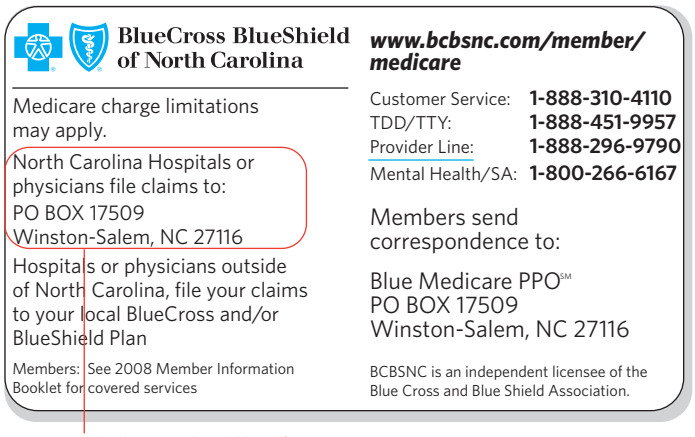
MedicareRx Prescription Drug Coverage

MEDICARE ADVANTAGE HMO

Member's identification includes an alpha-prefix

Tips for claims filing: only the last letter of J is required for claim submission.

Sample card image – front


BlueCross BlueShield of North Carolina

www.bcbsnc.com/member/medicare

Medicare charge limitations may apply.

North Carolina Hospitals or physicians file claims to:
PO BOX 17509
Winston-Salem, NC 27116

Hospitals or physicians outside of North Carolina, file your claims to your local BlueCross and/or BlueShield Plan

Members: See 2008 Member Information Booklet for covered services

Customer Service:	**1-888-310-4110**
TDD/TTY:	**1-888-451-9957**
Provider Line:	**1-888-296-9790**
Mental Health/SA:	**1-800-266-6167**

Members send correspondence to:

Blue Medicare PPO℠
PO BOX 17509
Winston-Salem, NC 27116

BCBSNC is an independent licensee of the Blue Cross and Blue Shield Association.

Winston-Salem claims mailing address for BCBSNC

- The above sample card displays the member ID for John Doe as: <YPFJ12345678-01>
- The alpha-prefix of YPF identifies the member's plan type but is not necessary for claims submission (YPW = HMO and YPF = PPO).
- The letter J is always the last alpha-character of a Blue Medicare HMO℠ or Blue Medicare PPO℠ member's ID. It is used in conjunction with the member's identifying numeric code and is essential for claims routing and processing.
- The numbers 12345678 are part of the member's identifying numeric code – as part of our on-going efforts to help protect member's privacy, BCBSNC assigns member identification codes by use of randomly selected numbers instead of using social security numbers.
- The numbers 01 comprise the member's numeric suffix, identifying a specific member.

To submit claims for Blue Medicare members always include the member's alpha-prefix of J, the member's numeric code and the member's two-digit suffix. As example, J1234567801 would be reported on a claim submission for member John Doe.

14.3 Electronic claims filing and acknowledgement

The best way to submit claims to BCBSNC is electronically. Electronic claims process faster than paper claims and save on administrative expense for your health care business. For more information about electronic claims filing and other Electronic Data Interchange "EDI" capabilities, please refer to electronic commerce on the Web at ***http://www.bcbsnc.com/providers/edi/***.

EDI Services supports applications for the electronic exchange of health care claims, remittance, enrollment and inquiries and responses. EDI Services also provides support for health care providers and clearinghouses that conduct business electronically. If you are already submitting electronically, and need assistance, contact EDI Services through the BCBSNC provider line at **1-888-296-9790**.

Our procedures are designed to have claims processed within twenty-four (24) to thirty-six (36) hours upon claims receipt and provide an EDI acknowledgment report to indicate the status of your claim submission. Please note that payments and Explanation of Payments "EOP"s are based on financial processing schedules. Providers are expected to work their rejected claims report so claims can be resent to BCBSNC and accepted for payment.

Requests for service

Health care providers or clearinghouses electing to transmit electronic transactions directly with BCBSNC must sign a trading partner agreement and submit the original copy to EDI Services. The trading partner agreement establishes the legal relationship between BCBSNC and the trading partner. Health care providers, who submit their transmissions indirectly to BCBSNC via a clearinghouse, do not need to complete the trading partner agreement but are required to fill out an electronic connectivity form. The following procedures should be followed to obtain the electronic connectivity form:

- The health care provider calls BCBSNC customer services at **1-800-942-5695** and makes the request to be set up for electronic submission. The health care provider will need to supply a contact name, phone number and email address.
- An email containing an electronic form will then be emailed to the health care provider, which can be filled out electronically. The form will then need to be printed, must be signed and the hard copy returned to BCBSNC EDI services by mail.
- Once the form is received containing all the required information, the health care provider will be set up in the BCBSNC system to submit electronically.
- After successful set up, the provider will be mailed a confirmation letter containing their payor ID, user ID, password and instructions for claims filing.
- The health care provider must call BCBSNC EDI services once the confirmation letter is received, and an EDI specialist will go over the instructions with the provider and answer any questions at that time. The health care provider should allow 8-10 business days to complete the set up process.

Acceptable file type:

- ANSI 837 version 4010A1 professional and institutional implementation 2b (used by Medicare)

Hardware requirements:

- Hayes compatible modem
- 9600 baud rate or higher
- Xmodem, Zmodem or Kermit protocols

Filing requirements:

- Once a transmission is established, all claims (including new claims, additions, corrections and 2nd notices) are to be submitted via EDI
- Coordination of benefits and office notes are to be filed on paper

14.3.1 Sample electronic claims acknowledgement report

Summary section								
				Rejected status			Accepted	
Submitter BBS ID	Provider ID number	Total claims	Total lines	Map errors	Load errors	Denied claims	Pended claims	Accepted claims
A	B	C	D	E	F	G	H	I

A: Submitter identifier
B: Provider's unique identifier as defined by BCBSNC
C: Number of claims submitted per provider
D: Number of service lines submitted per provider
E: Number of claims failed in the existence of data check
F: Number of claims failed in the data cross-reference validation
G: Number of claims denied
H: Number of claims pended
I: Number of claims accepted for payments C = E + F + G + H + I

Detailed rejected section			
Original claim number	**BCBSNC claim number**	**Error type**	**Error description**
1	2	3	4

1: Invoice number or patient account number as provided by the submitter

2: Blue Medicare claim number

3: Relates to the summary section under rejected status and can be one of three possibilities: map, load or denied

4: Reason why a claim was rejected

14.4 Blue Medicare claims mailing addresses

Mailing addresses – BCBSNC Blue Medicare HMO℠ and Blue Medicare PPO℠	
Main mailing address	**FedEx, UPS and 4th class**
BCBSNC **PO Box 17509** **Winston-Salem, NC 27116-7509**	**BCBSNC** **5660 University Parkway** **Winston-Salem, NC 27105-1312**

Beginning January 1, 2008, claims for services provided to Blue Medicare HMO℠ and Blue Medicare PPO℠ members should be submitted electronically (or by paper when necessary) to Blue Cross and Blue Shield of North Carolina "BCBSNC." Claims sent in error to BCBSNC for Blue Medicare HMO℠ and Blue Medicare PPO℠ members (filed electronically or by mail) will be returned to the submitting provider, which will result in delayed payments.

14.5 Claim filing time limitations

Participating providers agree to complete and submit a claim to BCBSNC for services and/or supplies provided to Blue Medicare HMO℠ and/or Blue Medicare PPO℠ members.

The claim should include all information reasonably required by BCBSNC to determine benefits according to the member's benefit plan and the provider's typical charge to most patients for the service and/or supply.

The claim should be submitted only after all complete services have been provided, with the exception of continuous care services or ongoing services.

Claims must be submitted within 180 days of providing the service.

File claims for rental services monthly (after 30 consecutive days of rental), or at the time the rental is determined to no longer be medically necessary, whichever is first.

14.6 Verifying claim status

You can inquire about the status of a claim in one of the following ways:

- Check claim status from your desk top computer using HealthTrio Connect. Just make an inquiry and HealthTrio Connect enable users to verify the status of Blue Medicare claims. Providers without HealthTrio Connect access can call the BCBSNC provider line at **1-888-296-9790**. To find out more about HealthTrio Connect, visit electronic commerce on the Web at ***http://www.bcbsnc.com/providers/blue-medicare-providers/electronic-commerce/***.
- Complete a provider claim inquiry form and fax it to BCBSNC customer service department, **1-336-659-2962** or **1-336-774-5400**.

Please note that we will be able to research claims and provide better service to you if you wait until after 45 days from a claims submission date before initiating an inquiry or resubmitting a previously filed claim. Routinely refiling all claims at the end of the month may cause extra paperwork for everyone involved. We advise all offices to file claims at least once per week, post payments to your accounts within three working days and deposit your checks daily. Also, we would advise you to generate a listing of past due claims at least quarterly. If you need to check on the status on more than five claims at a time, please complete a provider claims inquiry form.

14.6.1 Sample provider inquiry form

Provider Inquiry Form

Please let us know whenever you have a problem or a question. Complete all sections if your inquiry concerns a specific patient. If it is a general inquiry, complete the applicable sections. Please fax to the following number **1-336-659-2962**.

Please print or type:

Provider's last name _____ First name _____ Provider number _____

Practice name _____ Office address (number, street, suite number) _____

City, State, ZIP _____ Phone number _____ Fax number _____

Patient's last name _____ First name _____ Member ID number _____

Date of service _____ Date of inquiry _____ Contact name for follow-up _____

Nature of inquiry (please check the box that applies and comment):
- ☐ Claim status
- ☐ Reason for denial
- ☐ Requested information attached
- ☐ Other: please explain _____

Provider's comments: _____

Status of claim

- ☐ Claim paid on: _____ Check number: _____ Amount: _____
- ☐ Claim is pending for: _____
- ☐ No record of claim receipt: _____
- ☐ Claim denied due to: _____
- ☐ Claim in process: _____
- ☐ Other: _____

14.7 Reimbursement for services

Participating physicians agree to bill only BCBSNC for all covered services for BCBSNC members, collecting only appropriate copayments or coinsurance from the member. BCBSNC members are directly obligated only for the copayment amounts indicated on their member card (and in their certificate of coverage or evidence of coverage), payment for non-covered services, and payment for services after the expiration date of the member's coverage. The physician should not collect any deposits and does not have any other recourse against a BCBSNC member for covered services.

In the event that the participating physician provides services which are not covered by the Plan, the provider will, prior to the provision of such non-covered services and verification of benefits by calling the provider line at **1-888-296-9790** or **1-336-774-5400**, inform the patient (1) of the services to be provided, (2) that the Plan will not pay for the services, and (3) that the patient will be financially liable for the services. BCBSNC shall make the relevant terms and conditions of each Plan reasonably available to participating physicians. The participating physician may bill a participant directly for medically necessary non-covered services.

14.8 Amounts billable to members

- Applicable copayments may be collected at the time service is rendered. Copayment amounts are indicated on the members Blue Medicare ID card.
- Applicable coinsurance and deductible amounts may be collected from Blue Medicare members only after the provider has received the Notification of Payment "NOP" or Explanation of Payment "EOP."
- Following are examples of services that may be eligible for the collection of copayment and/or coinsurance:
  - ‡ Office visit
  - ‡ Office visit with lab and/or x-ray
  - ‡ Office based surgery (when performed in the office and appropriate to be billed in conjunction with an office visit – please refer to current CPT professional edition coding).
  - ‡ ER visit
  - ‡ Outpatient services
  - ‡ Inpatient admission
  - ‡ Non-covered services may be collected, only if they meet the criteria outlined in the instruction of the hold harmless policy (see chapter 14.8.3 for details).
  - ‡ Any amounts collected erroneously by you from a member for any reason shall be refunded to the member within 45 days of the receipt of the notification/explanation of payment from BCBSNC or your discovery of the error.

14.8.1 Items for which providers cannot bill members

Providers may not collect any payments from members for covered services, except for any applicable copayment, coinsurance and/or deductible amounts.

Providers may not balance bill Blue Medicare members for the difference between billed charges and the amount allowed by BCBSNC, as set forth in the agreement. Any differences between a provider's charges and the allowed amount are considered contractual adjustments and are not billable to members.

Providers may not bill or otherwise hold members responsible for payment for services, which are deemed by BCBSNC to be out of compliance with BCBSNC utilization and management programs and policies or medical necessity criteria or are otherwise non-covered.

Providers may not seek payment from either members or BCBSNC if a proper claim is not submitted to BCBSNC within 180 days of the date a service is rendered.

14.8.2 Billing members for non-covered services

From time to time a provider may be asked to provide services to members that are not covered by their benefit plan with BCBSNC. Only under the following conditions may the provider bill the member for such services:

- The provider informs the member in advance of providing the service via written notification that the specific service might not be covered by BCBSNC.
- The member signs a written acknowledgment that he/she received such notification prior to receiving the specific service at issue. That notification must inform the member that the particular service at issue may not be covered by BCBSNC.
- The member also acknowledges in advance and in writing that he/she has chosen to have the service at issue and if it is indeed not covered, the member is responsible for the expense and will pay the provider directly.

- Providers may only use the written notice regarding a particular service and it must be specific, defining the exact treatment of care being provided to the member. It is not acceptable to use a generic "release" form with a general statement regarding member's obligations to pay for non-covered services.
- Providers may inquire about eligibility of services by calling the customer service number on the back of the member's ID card or by calling the provider line at **1-888-296-9790** or **1-336-774-5400**.
- Confirmation of benefit eligibility does not guarantee payment as other factors may affect payment (e.g. BCBSNC utilization and management programs and policies or medical necessity criteria).

14.8.3 Hold harmless policy

The member will not be held financially responsible for the cost of covered services except for any applicable copayment, coinsurance, or deductible if ALL of the following are true:

- The member has followed the guidelines of the Plan.
- The PCP or participating specialist fails to obtain pre-certification with Blue Medicare HMO℠ and Blue Medicare PPO℠ healthcare services department for those covered services which require pre-certification.
- The non-pre-certified covered services have already been rendered.

The participating provider will be advised that they must write-off the cost of the non-certified services and hold the member financially harmless according to contract provisions.

Ancillary services provided in conjunction with non-precertified services are also not payable by the Plan unless the ancillary provider is a non-participating provider.

This policy will also apply when Plan is the secondary payer of claims.

Members will be held responsible for non-certified services when:

- Blue Medicare HMO℠ or Blue Medicare PPO℠ is able to intervene to redirect/inform a member prior to services being rendered that coverage has been denied; and
- There is evidence that the member clearly understood that the services were not approved for coverage, i.e., the member signed a waiver agreeing to be responsible for payment.

14.8.3.1 CMS-required provisions regarding the protection of members eligible for both Medicare and Medicaid "dual eligibles"

Federal legislation has made changes to the Medicare program. Current network provider agreements; in the section entitled "hold harmless" incorporates certain CMS-required provisions regarding the protection of members. Changes to CMS's requirements that became effective January 1, 2010 resulted in our obligation to amend our contracts to incorporate specific hold harmless provisions as they relate to members that are dually eligible for both Medicare and Medicaid. The amendment is as follows:

The section entitled "hold harmless" is hereby amended to include the following:

- Members eligible for Medicaid. Providers agree that members eligible for both Medicare and Medicaid "dual eligibles" will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Provider agrees to accept the MA plan payment as payment in full or bill the appropriate state Medicaid agency for such amounts.

14.9 Coordination of benefits

Coordination of Benefits "COB" is an approach used by health plans and health insurers to divide the obligation for payment of health care expenses. It is not uncommon to encounter patients who are covered under more than one (1) health plan. Patients could be receiving coverage from sources that could include a large private insurer, another managed care plan, Medicaid, a self-insured plan or a COBRA-continued plan.

In the event a benefit is covered by both BCBSNC and another policy or plan, BCBSNC will coordinate benefits and benefit payments with such plans or policies, whether or not a claim is made for benefits.

- If the member is aged 65 or older and have coverage under an employer group health plan either through his/her own current employment or the employment of a spouse, (including COBRA coverage), that Plan will be the primary payer. This rule applies to the health plans of employers with 20 or more employees. BCBSNC will be the secondary payer.
- If the member is under age 65 and entitled to Medicare due to a disability (other than end stage renal disease) and has coverage under a large employer group plan, either through his/her own

employment or the employment of a family member, that Plan will be the primary payer. BCBSNC will be the secondary payer.

- If automobile medical or no-fault or liability insurance is available to you, in the event of an accident, then that carrier will be the primary payer.
- If the member is eligible for Medicare solely on the basis of End Stage Renal Disease "ESRD" and is covered under an employer group plan, that Plan will be the primary payer for the first 30 months after becoming eligible for Medicare.
- Worker's compensation for treatment of a work-related illness or injury or veteran's benefits for treatment of service-connected disability or under the Federal Black Lung Program would be primary.
- Coverage through Medicaid or through the Tricare for Life program will be coordinated based on Medicare rules.

BCBSNC uses the same guidelines in these cases as does Medicare. Because of this, we do ask the member about other insurance they may have. If the member has other insurance, they are asked to help us obtain payment from the other insurer by promptly providing any information we may request.

BCBSNC will assist you with information concerning a patient's coverage. In addition, BCBSNC will assist you by working directly with patients and their primary insurance sources to ensure that you, the provider, are entitled to the maximum benefit available. Consistent with our contractual obligations, it is also our intent to maximize a member's benefit under our Plan. Therefore, if a patient's primary insurance issues a benefits payment that is greater than the BCBSNC copayment, the copayment will be waived.

14.10 Worker's compensation claims

If a Blue Medicare member sustains an injury while at work, it is important that the member follow

BCBSNC's rules and procedures in order to be eligible for Blue Medicare HMO℠ or Blue Medicare PPO℠ benefits, should Worker's Compensation deny the claim. All applicable authorizations must be obtained under BCBSNC guidelines in order for Blue Medicare HMO℠ or Blue Medicare PPO℠ benefits to be payable in the event Worker's Compensation denies the claim. Failure to follow BCBSNC policies will release BCBSNC from any payment responsibility.

If you are informed or have reason to believe a patient has sustained an injury at work, please call BCBSNC to notify us. We may need to inform other providers so they may also file for benefits under Worker's Compensation.

For further details on governing rules, or assistance with COB, Medicare or Worker's Compensation, please contact BCBSNC customer services department.

14.11 Subrogation

A Blue Medicare member may incur medical expenses due to injuries suffered in an accident. The accident may have been caused by the alleged negligence or misconduct of another person. If so, the member may have a claim against that person for payment of medical bills.

Subrogation means the right of BCBSNC to pursue the claim for medical expenses against the other person, so that the other person (or their insurer) pays for the member's medical expenses.

Subrogation of benefits is allowed. Therefore, BCBSNC has the right to pursue and recover from a claim that may have been filed against another person.

If the member has a claim against another person, BCBSNC will be subrogated to the right of recovery the member has against that person. Therefore, BCBSNC will deny payment of all medical bills pending settlement of the claim against the other person. If there is not a prompt settlement, BCBSNC will conditionally pay the medical bills and require that the member reimburse BCBSNC. For this purpose, the definition of prompt will be 120 days after the earlier of the following:

- The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or the date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

BCBSNC's right of subrogation will not exceed the lesser of the following:

- The amount of benefits paid by BCBSNC; or the portion of the recovery attributable to covered medical expenses.

If the portion of the recovery that is attributable to medical expenses is not specified in a judgment or settlement, then one-third (1/3) of the net recovery shall be deemed to be the portion of the recovery attributable to medical expenses. Net recovery shall mean the total amount of the recovery less reasonable attorneys' fees and expenses incurred in obtaining the recovery.

14.12 Claims reimbursement disputes

In the event an error is found on an Explanation of Payment "EOP" on behalf of the provider; a request for correction may be initiated either via telephone or in writing. To request a review for correction in writing, the following information must be included:

- Letter of explanation relative to any error in the processing of claim
- Copy of the original claim
- Copy of corresponding EOP with the claim in question circled
- Requests for correction should be mailed to the following address:

  Blue Cross and Blue Shield of North Carolina
  PO Box 17509
  Winston-Salem, NC 27116

To request a review for correction via telephone, please contact BCBSNC provider line at **1-888-296-9790** and be prepared to give the following information:

- Patient name and Blue Medicare member ID
- Date of service
- Claim number
- Explanation of any suspected error

14.13 Pricing policy for Part B procedure/service codes (applicable to all PPO and HMO products)

Effective June 1, 2005, updated 05/29/2009

The following policy applies to BCBSNC's payment to contracted providers for procedure/service codes billed on a CMS-1500 (Part B Medicare) Claim Form or other similar forms. When services billed on UB-92 forms are contracted using FFS rates, this procedure would also apply.

General pricing policy

- When new codes are published, and an external pricing source exists for such codes, BCBSNC will price these codes within 30 days of publication using the following procedure:
  - ‡ If NC Medicare pricing is available, the most current NC Medicare pricing available will be applied to that code.
  - ‡ If NC Medicare pricing is unavailable, BCBSNC will apply the most current CIGNA Medicare allowable pricing if available, using the same methodology described above.
  - ‡ For durable medical equipment, the CIGNA Government Services DME Jurisdiction C fee schedule will be used in place of the above-referenced external sources.

    Source: *http://www.cignagovernmentservices.com/jc/coverage/fees/index.html*
  - ‡ BCBSNC reimburses the lesser of your charge or the applicable pricing.
  - ‡ Nothing in this policy will obligate BCBSNC to make payment on a claim for a service or supply that is not covered under the terms of the applicable benefit plan. Furthermore, the presence of a code and allowable on your sample fee schedule does not guarantee payment.

External source pricing

All references in this procedure to external source pricing refer to the following:

- NC Medicare (available at ***www.cms.hhs.gov***)
- CIGNA Medicare allowables (available at ***www.cignagovernmentservices.com***)

In the event that the names of such external source pricing change (e.g. a new Medicare intermediary is selected), references in this procedure will be deemed to refer to the updated names. In the event that new external source pricing generally acceptable in the industry and acceptable to BCBSNC becomes available, such external source pricing may be incorporated by BCBSNC into this procedure.

14.13.1 Prescription drug CPT and HCPCS codes

These codes are priced following CMS guidelines and do not include those services covered under the CMS Part D program. Codes not falling under a separate prospective payment system will be based on a percentage of Average Sales Price "ASP" or average wholesale price, depending on the drug. Resources used to arrive at rates include Web sites for CMS and CIGNA as well as Red Book References.

For HIT services, drugs covered by Medicare will be based on the current year DME Regional Carrier priced AWP if infused through DME per section 303(b) of the Medicare Modernization Act.

Infused drugs not covered by Medicare will be based on Average Wholesale Price "AWP" listed in the most recently published and available edition of the Medicare Economics Red Book Guide to Pharmaceutical Prices as of the date of service. BCBSNC will require the name and dose of the drug provided. Parenteral and enteral nutrition will be based on the PEN rates contained in the DMEPOS fee schedule published quarterly by the DME Regional Carrier (CIGNA government services at this time).

Drugs not assigned a specific HCPCS codes by CMS will be priced using the Not Otherwise Classified "NOC" file as published by the Part B fiscal intermediary (CIGNA Medicare at this time).

14.13.2 Policy on payment for remaining codes

Procedure/service codes that remain unpriced after each application of the above procedure will be paid in the interim at the lesser of the provider's charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable providers for similar services. BCBSNC's methodology is based on several factors including payment guidelines as published in the BCBSNC provider manual. Under these guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes. BCBSNC may use clinical judgment to make these determinations, and may use medical records to determine the exact services rendered. For codes that BCBSNC approves as clinically necessary, have no price applied using any of the procedures described above, and are billed as less than $100, BCBSNC will pay 50% of the provider's billed charge.

14.13.3 Policy on payment based on charges

When application of BCBSNC's reimbursement procedures results in payment of a given claim based on your charge or a percentage of your charge, you are obligated to ensure that all charges billed to BCBSNC are reasonable and do not exceed your typical charge to the general public.

14.13.4 Policy on pricing of general or unlisted codes

If a general code (e.g. 21499, unlisted musculoskeletal procedure, head) or unlisted code is filed because a code specific to the service or procedure is nonexistent, BCBSNC will assign a fee to the service which will be the lesser of the provider's charge or a reasonable charge established by BCBSNC using a methodology which is applied to comparable providers for similar services under a similar health benefit plan. BCBSNC may use clinical judgment to make these determinations, and may use medical records to determine the exact services rendered.

Durable medical equipment claims or medical or surgical supply claims that are filed under general or unlisted codes must include the applicable manufacturer's invoice and will be paid at the invoice price. BCBSNC will not pay more than 100% of the respective charge for these claims.

If a general or unlisted code is filed despite the existence of a code specific to the service or procedure, BCBSNC will apply the more specific code to determine payment under BCBSNC's applicable reimbursement policies.

BCBSNC's assignment of a fee for a given general or unlisted code does not preclude BCBSNC from assigning a different fee for subsequent service or procedure under the same code. Fees for these services may need to be changed based on new or additional information that becomes available regarding the service in question or other similar services.

14.14 What is not covered

This is a list of general exclusions. In some cases, a member's benefit plan may cover some of these services or have additional exclusions. Please call the BCBSNC provider line at **1-888-296-9790** or **1-336-774-5400** to verify benefit coverage.

- **Abortion:** Any abortion which is considered illegal under laws which govern the state in which BCBSNC is licensed, and any abortion which is not covered by Medicare.
- **Acupuncture:** Unless performed by BCBSNC-approved physician.
- **Allergy testing:** Skin titration (RINKEL method); cytotoxicity testing (Bryan's test); MAST testing; urine autoinjections; subcutaneous or sublingual provocative and neutralization testing for allergies.
- **Behavioral disorders:** Services, treatment or diagnostic testing related to behavioral (conduct) problems or behavioral training.
- **Chiropractic care:** Except for manual manipulation of the spine for subluxation, x-rays ordered by a chiropractor to diagnose subluxation of the spine.

- **Circumcision:** For non-medically indicated reasons after one month of age.
- **Clinical trials:** Services not covered under original Medicare, and not covered by BCBSNC.
- **Custodial care:** The provision of room and board, nursing care, and personal care designed to assist member in the activities of daily living; or such other care which is provided to member who, in the opinion of BCBSNC, has reached the maximum level of physical or mental function and will not make further significant improvement. Custodial care rendered in the home and adult day care facilities.
- **Dental services:** All dental services, unless otherwise specified, including bridges, dentures, crowns, treatment for periodontal disease, dental root form implants, root canals, orthodontic appliances or any other treatment primarily to align teeth, appliances, orthognathic surgery (unless deemed medically necessary) or extraction of wisdom teeth except as provided in the member certificate of coverage; treatment for teeth which are chipped or broken from biting or chewing; and anesthesia for dental procedures, except as provided in the member certificate of coverage.
- **Foot care:** Routine foot care including corn and callous removal; nail trimming; and other hygienic or maintenance care; cleaning, soaking and skin cream application for ambulatory and bed-confined patients unless covered by Original Medicare.
- **Hospice:** Not covered by BCBSNC. A Medicare beneficiary with Medicare Part A, may elect traditional Medicare hospice coverage (through traditional Medicare, not BCBSNC) and can decide to keep Blue Medicare coverage for services not related to the terminal illness or elect traditional Medicare coverage for everything by disenrolling from Blue Medicare. Claims for all hospice related services must be billed to traditional Medicare, not BCBSNC.

  Note: Even though traditional Medicare covers the services related to the terminal illness, BCBSNC will provide the member with a listing of Medicare certified hospice providers in their area.
- **Lenses:** Contact lenses or the fitting thereof, except for the first pair of lenses or eyeglasses following a cataract operation (this may include contact lens or placement of intraocular lens).
- **Long-term skilled care services:** Skilled care services in the home that do not qualify as part-time or intermittent, as defined by Medicare, or skilled care services in a skilled nursing facility or unit, or a sub-acute facility or unit, for a period exceeding one hundred (100) days per benefit period (beginning with the first day a member received these services).
- **Naturopathy**
- **Obesity:** Services and drugs in connection with obesity, including but not limited to, surgical procedures such as gastric bypass surgery, balloon insertion and removal; and experimental services and complications. Services specifically used for treatment of obesity, except other services and treatments within standard medical practice policies or covered by original Medicare and which are authorized and approved by BCBSNC.
- **Occupational injury or sickness:** The cost of services for any injury which occurs in the work place, or a sickness which occurs as a result of employment, normally covered under worker's compensation or other employer's liability laws. Should a member have the cost of services denied by one of the above insurance programs, BCBSNC will consider payment of covered services. BCBSNC will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.
- **Organ transplants:** Experimental/investigational transplants. Combined kidney and liver transplant is not covered. Coverage is limited to Medicare covered services. Pancreas transplantation for diabetic patients who have not experienced end stage renal failure secondary to diabetes continues to be excluded from Medicare.
- **Orthopedic shoes:** Unless covered by Medicare (for individuals with diabetic foot disease) or part of a leg brace and included in the cost of the leg brace.
- **Orthotics:** Foot orthotics, i.e., custom shoes or custom inserts for shoes or boots except as covered by original Medicare or as specified in the member certificate of coverage.
- **Personal comfort or convenience items, convenience fees, household fixtures and equipment and member refused items and services:** Chairs, personal comfort or convenience items such as household fixtures and equipment or related services and supplies not directly related to the care of the member, including but not limited to, guest meals and accommodations; telephone charges; travel expenses; take-home supplies and similar costs; health and fitness club expenses and membership fees; convenience fees charged by

providers to members; convenience products for injections; home or vehicular evaluations and modifications to meet the environmental needs of the member or caregiver; fees charged by providers for services, supplies, or equipment requested by member, but later refused by member. The purchase or rental of household fixtures, including, but not limited to: exercise equipment; air purifiers; central or unit air conditioners, water purifiers; humidifiers/dehumidifiers; hypoallergenic pillows; whirlpools and spas; mattresses or waterbeds unless covered by original Medicare.

- **Prosthetic and corrective devices:** Prosthetics that are primarily for patient convenience or are more costly than equally effective alternative equipment. BCBSNC and Medicare coverage determinations will be used.
- **Religious, marital, family and sex counseling:** Services and treatment related to religious counseling, family counseling, marital/relationship counseling, sex therapy, adoption and pastoral counseling unless covered by original Medicare.
- **Respite care:** Medical care required to be arranged for, and provided to, a patient whose condition has not changed (i.e., is stable) due only to the fact that the patient's caregiver is absent.
- **Sclerotherapy:** Except when covered by original Medicare as medically necessary and prior approved by BCBSNC.
- **Services the member is not legally obligated to pay, and services performed by a relative:** Any service for which the member legally would not be required to pay in the absence of this coverage; services performed by a relative of member.
- **Services furnished under a private contract:** Services (other than for emergency or urgently needed services) furnished by a physician as defined by the Social Security Act who has filed with the Medicare carrier an affidavit promising to furnish Medicare covered services to Medicare beneficiaries only through private contracts with the beneficiaries under section 1802(b) of the Social Security Act.
- **Sex change or transformation:** Any procedure or treatment designed to alter physical characteristics of member from member's biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation.
- **Treatment in a federal, state or governmental entity:** To the extent allowed by applicable laws, coverage for care and treatment provided in a hospital owned or operated by any federal, state or other governmental entity, and care of military service-connected conditions for which the member is legally entitled to services. This includes services provided to veterans in Veteran's Affairs "VA" facilities. However, reimbursement is allowed for the cost sharing for emergency services receive at a VA hospital, up to the appropriate cost sharing under the Plan.
- **Vision:** Vision care, except as provided by original Medicare or as specified in the member's certificate of coverage. This exclusion/limitation includes, but it is not limited to: eye exercises; visual training; orthoptics; and all types of contact lenses or corrective lenses unless specified in this certificate of coverage.
- **Vehicular modifications:** Unless covered by Medicare.
- **Weight control:** All services and supplies for the purpose of weight control; weight management and commercial weight loss/reduction programs, unless covered by Original Medicare.

14.15 Using the correct NPI or BCBSNC assigned proprietary provider number for reporting your health care services

The National Provider Identifier "NPI" is a HIPAA mandate effective May 2007 for electronic transactions. The NPI is a ten digit unique health care provider identifier, which replaces the BCBSNC Proprietary Provider Number "PPN" on electronic transactions. Additional information about NPI can be found at the Centers for Medicare & Medicaid Services "CMS" Web site at ***http://www.cms.hhs.gov/NationalProvIdentStand*** and at ***bcbsnc.com/providers/npi.cfm***.

If your health care business submits claims using:

- Electronic transactions – filing with NPI is required
- Paper only (never electronically) – file with NPI or a BCBSNC assigned provider number

There are two types of NPI that are assigned via the CMS "Centers for Medicare & Medicaid Services" enumeration system, NPPES "National Plan and Provider Enumeration System:"

- **Type 1:** Assigned to an individual who renders health care services, including physicians, nurses, physical therapists and dentists. An individual provider can receive only one NPI.
- **Type 2:** Assigned to a health care organization and its subparts that may include hospitals, skilled nursing facilities, home health agencies, pharmacies and suppliers of medical equipment (durable medical equipment, orthotics, prosthetics, etc). An organization may apply and receive multiple NPIs to support their business structure.

14.16 Using the correct claim form for reporting your health care services

BCBSNC recognizes and accepts the CMS-1500 (08-05) Claim Form or other similar forms for professional providers and the UB-04 (CMS-1450) claim form for institutional/facility providers. The National Uniform Billing Committee "NUBC" approved these forms that accommodate the reporting of the National Provider Identifier "NPI," as the replacements of the forms predecessors CMS-1500 (version 12-90) and UB-92.

Most providers, billing agencies or computer vendors file claims to BCBSNC electronically using the HIPAA compliant 837 formats. Providers who are not set up to file claims electronically should refer to the chart below to determine the correct paper claim form to use:

Provider type/service	Claim form
Providers office	CMS-1500 (08-05) Claim Form or other similar forms
Home Durable Medical Equipment "HDME"	CMS-1500 (08-05) Claim Form or other similar forms
Reference lab	CMS-1500 (08-05) Claim Form or other similar forms
Licensed registered dietitian	CMS-1500 (08-05) Claim Form or other similar forms
Specialty pharmacy	CMS-1500 (08-05) Claim Form or other similar forms
Ambulance provider	CMS-1500 (08-05) Claim Form or other similar forms
Hospital facility	Form UB-04 (CMS-1450)
Ambulatory surgical center	Form UB-04 (CMS-1450) or CMS-1500 (08-05) Claim Form or other similar forms
Skilled nursing facility	Form UB-04 (CMS-1450)
Lithotripsy provider	Form UB-04 (CMS-1450)
Dialysis provider	Form UB-04 (CMS-1450)
Home health care • Home health provider • Private duty nursing • Home infusion provider	 Form UB-04 (CMS-1450) Form UB-04 (CMS-1450) CMS-1500 (08-05) Claim Form or other similar forms

Please note that providers with electronic capability who submit paper claims will be asked to resubmit claims electronically.

For more information on the CMS-1500 (version 08/05) Claim Form or other similar forms; or the UB-04 claim form, visit the National Uniform Claim Committee "NUCC" Web site at ***www.nucc.org***.

14.16.1 CMS-1500 (08-05) Claim Form or other similar forms claim filing instructions

Field #	Description
1	Leave blank
1a	Insured's ID - Enter the member identification number as it appears on the patient's ID card. The member's ID number is the letter J followed by the subscriber number and the two-digit suffix listed next to the member's name on the ID card. This field accepts alpha and numeric characters.
2	The patient's name should be entered as last name, first name, and middle initial.
3	Enter the patient's birth date and sex. The date of birth should be eight positions in the MM/DD/YYYY format. Use one character (X) to indicate the sex of the patient.
4	Enter the name of the insured. If the patient and insured are the same, then the word same may be used. This name should correspond with the ID # in field 1a.
5	Enter the patient's address and telephone number.
6	Use one character (X) to indicate the patient's relationship to the insured.
7	Enter insured's address and telephone number. If patient's and insured's address are the same then the word "same" may be used.
8	Enter the patient's marital and employment status by marking an (X) in one box on each line.
9	Show the last name, first name, and middle initial of the person having other coverage that applies to this patient. If the same as Item 4, enter same (complete this block only when the patient has other insurance coverage). Indicate none if no other insurance applies.
9a	Enter the policy and/or group number of the other insured's policy.
9b	Enter the other insured's date of birth (MM/DD/YYYY) and sex.
9c	Enter the other insured's employer's name or school name.
9d	Enter the other insured's insurance company name.
10a-c	Use one character (X) to mark yes or no to indicate whether employment, auto accident, or other accident involvement applies to services in item 24 (diagnosis).
11	Enter member's policy or group number.
11a	Enter member's date of birth (MM/DD/YYYY) and sex.
11b	Enter member's employer's name or school name.
11c	Enter member's insurance plan name.
11d	Check yes or no to indicate if there is, or not, another health benefit plan. If yes, complete items 9 through 9d.

Continued on the following page.

Field #	Description
12	Have the patient or authorized person sign or indicate signature on file in lieu of an actual signature if you have the original signature of the patient or other authorized person on file authorizing the release of any medical or other information necessary to process this claim.
13	Have the subscriber or authorized person sign or indicate signature on file in lieu of an actual signature if you have the original signature of the member or other authorized person on file authorizing assignment of payment to you.
14	Enter the date of injury or medical emergency. For conditions of pregnancy enter the LMP. If other conditions of illness, enter the date of onset of first symptoms.
15	If patient has previously had the same or similar illness, give the date of the previous episode.
16	Leave blank.
17	Enter name of referring physician or provider.
17a	Enter ID number of referring physician or provider.
17b	Enter 1B (BCBSNC ID qualifier) in the shaded area and to the immediate right of 17a. Enter the BCBSNC ID number of the referring provider in the shaded box to the right of the ID qualifier. (This field is only required if the NPI number is not reported in box 17b.) **Example:** 17a. | 1B | 12345 17b. | NP1 | 1234567891
18	If services are provided in the hospital, give hospitalization dates related to the current services.
19	Leave blank.
20	Complete this block to indicate billing for clinical diagnosis tests.
21	Enter the diagnosis/condition of the patient indicated by the ICD-9 code. Enter only the diagnosis code, not the narrative description. Enter up to four codes in priority order (primary, secondary conditions). The primary diagnosis should be reported in diagnosis #1. The secondary in #2. Contributing diagnosis in #3 and #4. When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than 3 beginning digits (e.g., E codes), enter the fourth digit on top of the period.
21	**Example:** 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Retype Items 1,2, 3 or 4 to item 24E by Line) 1. 998 . 59 3. V18 . 0 2. 780 . 6 4. E87 . 88
22	Leave blank.
23	Enter certification of prior review # here if services require it.

Continued on the following page.

Field #	Description
24	The 6 service lines in section 24 have been divided horizontally to accommodate submission of both the NPI number and BCBSNC identifier during the NPI transition, and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Use of the supplemental information fields should be limited to the reporting of NDC codes. If reporting NDC codes, report the NDC qualifier "N4" in supplemental field 24a followed by the NDC code and unit information (UN = unit; GR = gram; ML = milliliter; F2 = international unit). **Example:** 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # N400026064871 Immune Globulin Intravenous UN2 — 1B 12345678901 10 01 05 10 01 05 11 J1563 13 500 00 20 N NPI 0123456789
24a	Enter the month, day, and year (six digits) for each procedure, service and/or supply in the unshaded date fields. Dates must be in the MM/DD/YY format.
24b	Enter the appropriate place of service codes in the unshaded area.
24c	Leave blank.
24d	Enter procedure, service, or supplies using the appropriate CPT or HCPCS code in the unshaded area. Also enter, when appropriate, up to four two-digit modifiers.
24e	Enter the diagnosis reference number (pointer) in the unshaded area. The diagnosis pointer references the line number from field 21 that relates to the reason the service(s) was performed (ex. 1, 2, 3, or 4, or multiple numbers if the service relates to multiple diagnosis from field 21). The field accommodates up to 4 digits with no commas between numbers.
24f	Enter the total charges for each line item in the unshaded area. Enter up to 6 numeric positions to the left of the vertical line 2 positions to the right. Dollar signs are not required.
24g	Enter days/units in the unshaded area. This item is most commonly used for units of supplies, anesthesia units, etc. Anesthesia units should be 1 unit equals a 1- minute increment. Do not include base units of the procedure with the time units. If you are billing services for consecutive dates (from and to dates) it is critical that you provide the units accurately in block 24g.
24h	Leave blank.
24i	Enter 1B (BCBSNC ID qualifier) in box 24i above the dotted line (not required if submitting NPI number).
24j	Enter the assigned BCBSNC provider identification number for the performing provider in the shaded area. If several members of the group shown in item 33 have furnished services, this item is to be used to distinguish each provider of service. (This field is only required if the NPI number is not being reported.) Enter the NPI number of the performing provider below the dotted line. If several members of the group shown in Item 33 have furnished services, this item is to be used to distinguish each provider of service. **Example:** I. ID. QUAL. | J. RENDERING PROVIDER ID. # 1B 01234 NPI 12345678901

Continued on the following page.

Field #	Description
25	Enter federal tax identification number. ☐ Indicate whether this number is Social Security Number "SSN" or Employer Identification Number "EIN."
26	Enter the patient account number assigned by physician's/provider's/supplier's accounting system.
27	Accept assignment ☐ Yes must be indicated in order to receive direct reimbursement. Contracting providers have agreed to accept assignment.
28	Enter the total charges for all services listed on the claim form in item 24F. Up to 7 numeric positions can be entered to the left of the vertical lines and 2 positions can be entered to the right. Dollar signs are not required.
29	Enter the amount paid by the primary insurance carrier. (**Reminder:** Only copayments may be collected at time of service.)
30	Enter total amount due - charges minus any payments received.
31	Signature and date of the physician/provider/supplier. (Stamped signatures are accepted.)
32	Enter the name and address of the facility site where services on the claim were rendered. This field is especially helpful when this address is different from billing address in item 33.
32a	Enter the NPI number of the service facility.
32b	Enter the ID qualifier 1B immediately followed by the BCBSNC assigned five-digit provider identification number for the service facility (this field is not required if submitting the NPI number in field 32a). **Example:** 32. SERVICE FACILITY LOCATION INFORMATION CRABTREE MEDICAL CENTER 100 AIRPORT ROAD RALEIGH, NC 27610 a. 12344567891 b. 1B01234
33	Enter the name, address, and phone number for the billing provider or group.
33a	Enter the NPI number of the billing provider or group.
33b	Enter the ID qualifier 1B immediately followed by the BCBSNC assigned five-digit provider identification number for the billing provider or group (this field is not required if submitting the NPI number in field 33a). **Example:** 33. BILLING PROVIDER INFO & PH # ( ) DR. JUDD KILGORE P O BOX 1678 RALEIGH, NC 27610 a. 1987654321 b. 1B03456

14.16.2 Sample CMS-1500 (08-05) Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

14.16.3 UB-04 claim filing instructions

Form locator #	Description of content
1	• Provider name • Street address or post office box • City, state, zip code • (Area code) telephone number
2	Required when the address for payment is different than that of the billing provider information located in form locator[1] • Pay-to name • Pay-to address • Pay-to city, state, zip
3a	Provider assigned patient control number
3b	Provider assigned medical/health record number (if available)
4	**Type of bill** (4 digit classification) • **Digit 1: Leading zero** • **Digit 2: Type of facility** ‡ 1 = Hospital ‡ 2 = Skilled nursing facility ‡ 3 = Home health ‡ 7 = Clinic ‡ 8 = Special facility • **Digit 3: Bill classification** ‡ 1 = Inpatient ‡ 3 = Outpatient ‡ 4 = Other • **Digit 4: Frequency** ‡ 1 = Admit through discharge claim ‡ 2 = Interim - first claim ‡ 3 = Interim - continuing claim ‡ 4 = Interim - last claim ‡ 5 = Late charge ** For further explanation on type of bill, please refer to the NUBC UB-04 official data specifications manual
5	Provider's federal tax identification number
6	Date(s) of service (enter MMDDYY, example 010106)
7	Leave blank.
8a	Patient ID (required if different than the subscriber/insured ID in form locator 60)
8b	Patient's name (last name, first name, middle initial)

Continued on the following page.

Form locator #	Description of content
9a	Patient's address – street
9b	Patient's address – city
9c	Patient's address – state
9d	Patient's address zip
9e	Patient's address – county code (if outside US) (Refer to USPS Domestic Mail Manual)
10	Patient's date of birth (enter MMDDYYYY, example 01012006)
11	Patient's sex (M/F/U)
12	Admission/start of care date (MMDDYY)
13	**Admission hour:** Code – Time **AM**: 00 12:00-12:59 midnight; 01 01:00-01:59; 02 02:00-02:59; 03 03:00-03:59; 04 04:00-04:59; 05 05:00-05:59; 06 06:00-06:59; 07 07:00-07:59; 08 08:00-08:59; 09 09:00-09:59; 10 10:00-10:59; 11 11:00-11:59 Code – Time **PM**: 12 12:00-12:59 noon; 13 01:00-01:59; 14 02:00-02:59; 15 03:00-03:59; 16 04:00-04:59; 17 05:00-05:59; 18 06:00-06:59; 19 07:00-07:59; 20 08:00-08:59; 21 09:00-09:59; 22 10:00-10:59; 23 11:00-11:59
14	**Type of admission/visit** 1. Emergency 2. Urgent 3. Elective 4. Newborn 5. Trauma 9. Information not available
15	**Source of admission or visit** 1. Physician referral 2. Clinic referral 3. HMO referral 4. Transfer from a hospital

Continued on the following page.

Form locator #	Description of content
15	5. Transfer from a skilled nursing facility 6. Transfer from another health care facility 7. Emergency room 8. Court/law enforcement 9. Information not available A. Transfer from a critical access hospital B. Transfer from another home health agency C. Readmission to same home health agency D. Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer **For newborns** 1. Normal delivery 2. Premature birth 3. Sick baby 4. Extramural birth
16	**Discharge hour:** Code / Time AM / Code / Time PM 00 12:00-12:59 midnight / 12 12:00-12:59 noon 01 01:00-01:59 / 13 01:00-01:59 02 02:00-02:59 / 14 02:00-02:59 03 03:00-03:59 / 15 03:00-03:59 04 04:00-04:59 / 16 04:00-04:59 05 05:00-05:59 / 17 05:00-05:59 06 06:00-06:59 / 18 06:00-06:59 07 07:00-07:59 / 19 07:00-07:59 08 08:00-08:59 / 20 08:00-08:59 09 09:00-09:59 / 21 09:00-09:59 10 10:00-10:59 / 22 10:00-10:59 11 11:00-11:59 / 23 11:00-11:59
17	**Patient discharge status** 01 – Discharged to home/self care (routine discharge) 02 – Discharged/transferred to hospital 03 – Discharged/transferred to skilled nursing facility 04 – Discharged/transferred to an intermediate care facility 05 – Discharged/transferred to another type of institution 06 – Discharged/transferred to home under care of Home Health 07 – Left against medical advice 20 – Expired 30 – Still patient 43 – Discharged/transferred to a federal health care facility 50 – Hospice - home

Continued on the following page.

Form locator #	Description of content
17	51 – Hospice - medical facility (certified) providing hospice level of care 61 – Discharged/transferred to a hospital based Medicare approved swing bed 62 – Discharged/transferred to an Inpatient Rehabilitation Facility "IRF" including rehabilitation distinct part units of a hospital 63 – Discharged/transferred to a Medicare certified Long Term Care Hospital "LTCH" 64 – Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 – Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 – Discharged/transferred to a Critical Access Hospital "CAH"
18-28 (as applicable)	**Condition codes** 09 – Neither patient nor spouse is employed 11 – Disabled beneficiary but no LGHP 71 – Full care in unit C1 – Approved as billed C5 – Post payment review applicable C6 – Admission preauthorization ** For additional condition codes, please refer to the NUBC UB-04 official data specifications manual
29	Accident state (situational) • Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code
30	Leave blank.
31-34 (as applicable)	**Occurrence codes and dates** 01 – Accident/medical coverage 02 – No fault insurance involved 03 – Accident/tort liability 04 – Accident employment related 05 – Accident no medical/liability coverage 06 – Crime victim **Medical condition codes** 09 – Start of infertility treatment cycle 10 – Last menstrual period (only applies for maternity related care) 11 – Onset of symptoms/illness **Insurance related codes** 24 – Date insurance denied 25 – Date benefits terminated by primary payer **Covered by EGHP** A1 – Birthdate of primary subscriber B1 – Birthdate of second subscriber

Continued on the following page.

Form locator #	Description of content
31-34 (as applicable)	C1 – Birthdate of third subscriber A2 – Effective date of the primary insurance policy B2 – Effective date of the secondary insurance policy C2 – Effective date of the third insurance policy ** For additional occurrence codes, please refer to the NUBC UB-04 official data specifications manual
35-36 (as applicable)	**Occurrence span codes and dates** 70 – Qualifying stay dates for SNF use only 71 – Prior stay dates 72 – First/last visit dates 74 – Non-covered level of care/leave of absence dates ** For additional occurrence span codes, please refer to the NUBC UB-04 official data specifications manual
37	Leave blank.
38	Responsible party name and address
39-41	**Value codes** 01 – Most common semi-private rooms 02 – Provider has no semi-private rooms 08 – Lifetime reserve amount in the first calendar year 45 – Accident hour 50 – Physical therapy visit A1 – Inpatient deductible Part A A2 – Inpatient coinsurance Part A A3 – Estimated responsibility Part A B1 – Outpatient deductible B2 – Outpatient coinsurance ** For additional value codes, please refer to the NUBC UB-04 official data specifications manual
42	Revenue code (refer to UB-04 manual)
43	Revenue description (refer to UB-04 manual)
44	**HCPCS/rates** • The HCPCS applicable to ancillary service and outpatient bills • The accommodation rate for inpatient bills
45	**Service date (MMDDYY)** • Applies to lines 1-22 **Creation date (MMDDYY)** • Applies to line 23 – the date bill was created/printed

Continued on the following page.

Form locator #	Description of content
46	Unit of service.
47	Total charges by revenue code category (0001=total charges should be reported on line 23 with the exception of multiple pages which should be reported on line 23 of the last page)
48	Non-covered charges
50 (A, B, C)	Insurance carrier name (payer) • Line A - primary payer • Line B - secondary payer • Line C - tertiary payer
51	Health plan identification number (leave blank until mandated)
52 (A, B, C)	**Release of information** • I = Informed consent to release medical information for conditions or diagnoses (signature is not on file) • Y = Provider has a signed statement permitting release of medical/billing date related to a claim
53 (A, B, C)	**Assignment of benefits** • N = No • Y = Yes (must be indicated in order to receive direct reimbursement) • Contracting providers have agreed to accept assignment
54 (A, B, C)	**Prior payments/source** • A - Primary payer • B - Secondary payer • C - Tertiary payer
55 (A, B, C)	Estimated amount due (not required)
56	National Provider Identifier "NPI" – billing provider
57 (A, B, C)	Other billing provider ID (BCBSNC provider number on appropriate line) – required if NPI is not reported on FL56
58 (A, B, C)	Subscriber's/insured name (last name, first name)
59 (A, B, C)	**Patient's relationship to subscriber/insured** 01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 – Organ donor

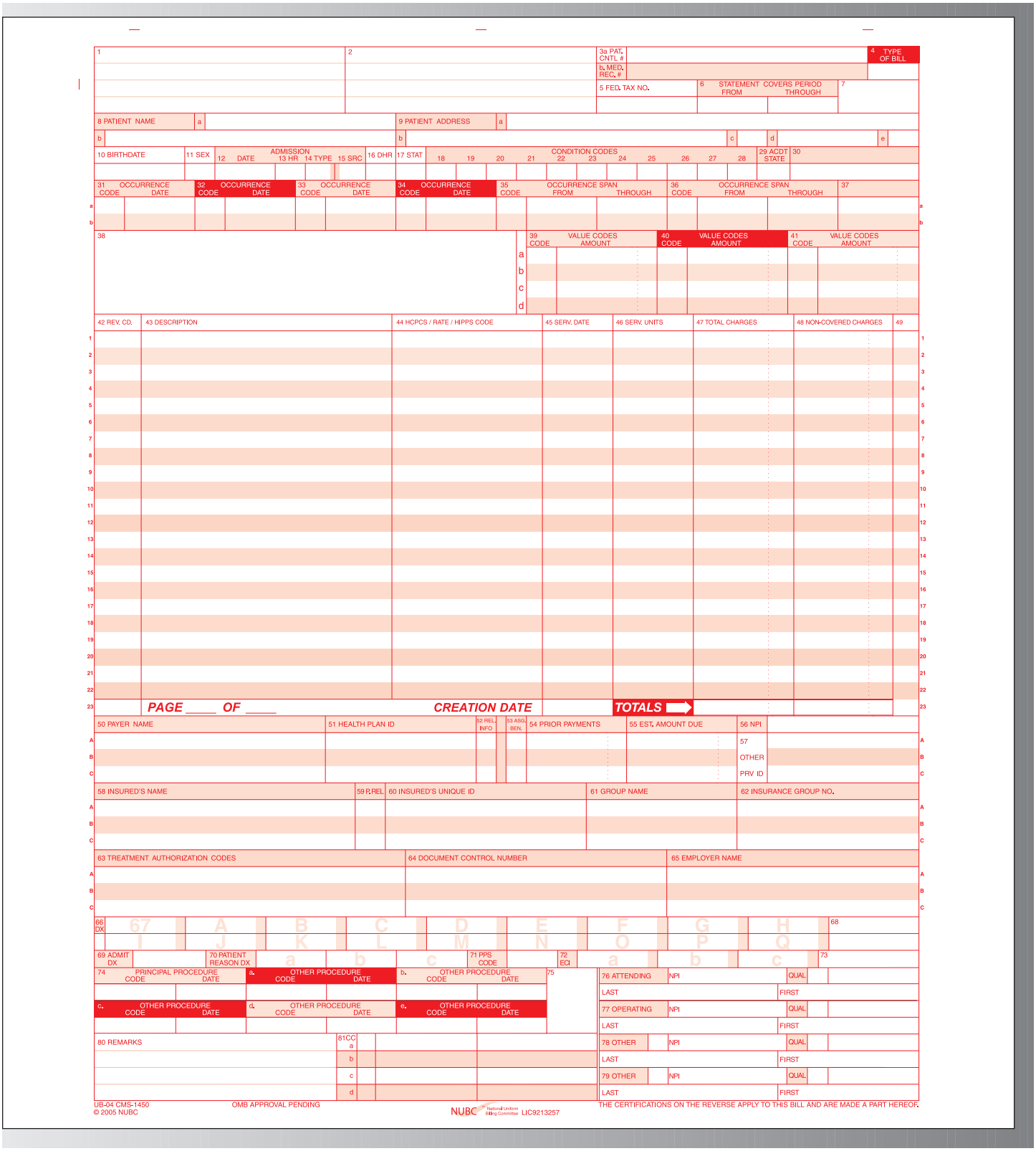
Continued on the following page.

Form locator #	Description of content
59 (A, B, C)	40 – Cadaver donor 53 – Life partner G8 – Other relationship
60 (A, B, C)	Subscriber's/insured identification number
61 (A, B, C)	Subscriber's/insured group name
62 (A, B, C)	Subscriber's/insured group number
63 (A, B, C)	Treatment authorization code
64 (A, B, C)	Document Control Number "DCN" (leave blank)
65 (A, B, C)	Subscriber's/insured employer name
66	Diagnosis and procedure code qualifier (ICD version indicator) – this will be ICD-9 until ICD-10 is in effect
67	**Principal diagnosis code "ICD-9"** (do not enter decimal, it is implied) • Eighth position indicates Present on Admission indicator "POA" – not required for BCBSNC commercial business ‡ **Y** = Yes ‡ **N** = No ‡ **U** = No information in the record ‡ **W** = Clinically undetermined
67 (A-Q)	**Other diagnosis codes "ICD-9"** • Eighth position indicates Present on Admission indicator "POA" – required for inpatient claims ‡ **Y** = Yes ‡ **N** = No ‡ **U** = No information in the record ‡ **W** = Clinically undetermined
68	Leave blank.
69	Admitting diagnosis (inpatient only)
70 (A, B, C)	Patient's reason for visit (outpatient only)
71	Prospective payment system code – PPS (not required)
72 (A, B, C)	External cause of injury code "E-Code"
73	Leave blank.
74	Principal procedure code and date • ICD-9 code required on inpatient claims when a procedure was performed (do not enter decimal, it is implied)

Continued on the following page.

Form locator #	Description of content
74	Principal procedure code and date • Leave blank for outpatient claims • Date format MMDDYY
74 (A-E)	Other procedures codes and dates (procedures performed during the billing period other than those coded in FL74) • ICD-9 code required on inpatient claims when a procedure was performed (do not enter decimal, it is implied) • Leave blank for outpatient claims • Date format MMDDYY
75	Leave blank.
76	Attending physician (NPI, last name and first name) • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
77	Operating physician (NPI, last name and first name) • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
78-79	Other physician (NPI, last name and first name) • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
80	Remarks
81 (A-D)	Code - code field (overflow field to report additional codes)

14.16.4 Sample UB-04 claim form



14.16.5 Sample of claim form completion

Sample versions of completed claim forms are available in The Blue Book℠ provider manual, located in chapter ten, Claims billing and reimbursement. These forms may be viewed on the ***bcbsnc.com*** Web site for providers at ***http://www.bcbsnc.com/providers/blue-book.cfm***. When viewing the sample claim forms contained in The Blue Book℠, it's important to remember that when submitting claims for Blue Medicare HMO℠ and Blue Medicare PPO℠ members, always use your assigned provider and/or group number for Blue Medicare HMO and/or Blue Medicare PPO℠ transactions, if not filing via NPI.

14.17 HCPCS codes

Reminder:

BCBSNC has been and will continue to allow the submission of HCPCS codes. In fact, their use is encouraged especially when filing for the administration of medications.

When submitting claims with a medication code of "J," it is important to refer to the HCPCS code book, paying particular attention to the dose that is listed to ensure appropriate reimbursement exactly as they appear in the HCPCS book.

Example 1:

A patient is given 10 mg of valium. The HCPCS code for valium, J3360, reads "injection, diazepam up to 5 mg." The provider should enter 2 (# of units) in the "G" field (days and unit field) to indicate that a total of 10 mg of valium was given. If the number of milligrams is entered instead of the number of units, the claim will be incorrect.

Also, when filing code J3490, unclassified drugs, a description or name of the medication and dose given must be submitted on the claim form for payment. The claim cannot be processed without this vital piece of information and would more than likely be denied for medical justification.

Example 2:

A 48 year-old man with mild diabetes on single drug therapy with an oral agent receives a comprehensive examination. He had not had a similar evaluation in three years, being seen only rarely for brief visits, as he was asymptomatic and doing well on his previous examination. A CBC, Chem Profile, Urinalysis and Glycosolated Hemoglobin are obtained.

The patient is counseled regarding cigarette smoking; with control and prudent low cholesterol diet is advised and briefly described.

For this visit, the diagnosis code V70.0 should be used. Code 250.0 for Diabetes Mellitus should be listed next to the Glycosolated Hemoglobin as a secondary diagnosis.

The appropriate procedure code would be 99396, which is the preventive medicine CPT code for an established patient 40-64.

Example 3:

A 63 year-old female received a comprehensive evaluation after not being seen in the physician's office for over one year. Two years prior to this visit she had a successful resection of colon carcinoma and four years prior to the visit she had an uncomplicated myocardial infarction. The current visit was precipitated by the development of shortness of breath, swelling of the lower extremities and weight gain. The patient was known to have mild diabetes, but was taking no medication. Physical examination was normal except for obesity and a trace of pretibial edema.

Since it had been several years since she had had an internal examination and pap smear, that procedure was performed. There were no symptoms or findings related to that part of her examination. Multiple laboratory tests, as well as an electrocardiogram and chest x-ray were requested. The patient was counseled regarding weight loss and a low sodium diet. A return visit was scheduled.

For this visit, the procedure code 99215 should be used. An appropriate diagnosis code should be utilized as the primary diagnosis. The preventive code V70.0 should also be listed as a secondary diagnosis since certain preventive services are rendered. Code V72.3 should be used beside the pap smear to justify this as a routine procedure.

Example 4:

An 18 year-old high school student is seen for a scheduled covered routine general health evaluation. The student also requests completion of a pre-employment form for a summer job. He plans to enter college in the fall and anticipates needing student health forms and immunization records at that time. The patient is healthy and has no complaints. He had been seen in the office before, but not for several years. No problems are revealed by a complete review of his history, and a complete physical examination is normal. The required pre-employment form is completed. No counseling of significance is necessary. For this visit, the appropriate diagnosis code would be V70.0.

The procedure code should be preventive code 99385 or 99395, depending on whether the patient had been seen prior to this visit, within the last three years.

Note: If a physical was scheduled for the pre-employment physical alone, this would not be covered, as this is an exclusion per the certificate of coverage.

14.18 ICD-9 and CPT codes for well exams

When filing claims for well exam, you must use the correct ICD-9 and CPT codes. Please refer to the chart or call customer services or your Network Management coordinator if you need assistance.

Preventive medicine CPT codes 99381-99397 include counseling.

Age groups	New	Established
Less than 1 year	99381	99391
1 to 4	99382	99392
5 to 11	99383	99393
12 to 17	99384	99394
18 to 39	99385	99395
40 to 64	99386	99396
65 years and over	99387	99397
Routine GYN exam	99203 or 99204 or 99384-99387	99213 or 99214 or 99394-99397
Preventive counseling codes*	99401-99404	99401-99404

* Codes used to report services provided at a separate encounter. These codes are not appropriate to use with CPT codes 99381-99397 or 99201-99215 or to use with ICD-9 codes V70.0, V20.2 or V72.3.

Diagnosis codes:

- ICD-9 general medical examination code V70.0 (adults, age 18 and over) and V20.0 (children, newborn to 17 years of age) should be used as the primary code for services that are predominantly preventative.
- ICD-9 code V72.3 should be used as the diagnosis code for the annual routine pelvic examinations including pap smears.

Procedure codes:

- Preventative medicine codes 99385-99387 and 99395-99397 must be used when ICD-9 code V70.0, adult preventive care, is the primary or submitted diagnosis; 99381-99384 and 99391-99394 must be used when ICD-9 code V20.0, pediatric preventive care, is the submitted diagnosis.
- CPT evaluation and management service codes 99201-99205 and 99211-99215 should be used when services are predominantly for patient complaints and/or illness and should be selected according to criteria described in the CPT manual.

14.19 Immunizations (Part-D covered vaccines)

Physicians and other providers who bill Medicare carriers or Medicare administrative contractors (A/B MACs) for the administration of Part-D covered vaccines to Medicare cannot bill Medicare Part B (i.e., BCBSNC medical claims) for the administration of Medicare Part D-covered vaccines. Providers billing staff should be aware of Part D-covered vaccine administration guidance for 2008. Section 202(b) of the Tax Relief and Health Care Act of 2006 "TRHCA" established a permanent policy for payment by Medicare for administration of Part D-covered vaccines, beginning in 2008. Specifically, the policy states that effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of "covered Part D drug" under the Part-D statute. During 2007, in transition to the policy, providers were permitted to bill Part B for the administration of a Part D vaccine using a special G code (G0377). However, special edition (SE) 0723 reminds providers of the requirement that payment for the administration of Part-D covered vaccines was only during 2007. Therefore, effective January 1, 2008 and dates after, providers may no longer bill the G code to Part B, instead the Part D plan should be billed for reimbursement.

14.19.1 Safe handling of vaccines

Vaccines for immunizations can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered. Blue Medicare HMO℠ and Blue Medicare PPO℠ members are not to pick-up vaccines from the pharmacy for transport to a provider's office, as this may result in unsafe temperature changes. Vaccines may only be obtained by the administering provider and never by a Blue Medicare HMO℠ or Blue Medicare PPO℠ member. Providers with questions are encouraged to contact their local Network Management representative.

14.19.2 Medicare Part-D vaccine manager for claims filing

Participating providers have an easy online option to submit Medicare Part-D vaccine claims to Medco@2 through *e*Dispense™. *e*Dispense Part-D vaccine manager, a product of Dispensing Solutions, Inc. (DSI), is a Web-based application, that offers a solution for the submission and adjudication of claims for physician-administered Part-D vaccine covered by member's Medicare Part-D pharmacy benefits (vaccination claims that cannot be submitted on a standard CMS-1500 medical claim form or other similar forms).

*e*Dispense makes real-time claims processing for in-office administered Medicare Part-D vaccines available through its secure online access. Services offered with *e*Dispense allow providers to quickly and electronically verify member's Medicare Part-D vaccination coverage and submit claims to our pharmacy benefits manager Medco directly from your in-office internet connection.

*e*Dispense offers providers the ability to:

- Verify members' Medicare Part-D vaccination eligibility and benefits in real time
- Advise members of their appropriate out-of-pocket expense for Medicare Part-D vaccines
- Submit Medicare Part-D vaccine claims electronically to Medco

Enrollment is an easy two-step process:

- **Step 1** – select an authorized staff member who is most likely to be the primary user of the system to enroll the practice. This person should be prepared to provide the following information about the practice:
  - ‡ Tax identification number
  - ‡ National Provider Identifier "NPI"
  - ‡ Medicare ID number
  - ‡ Drug Enforcement Administration "DEA" number
  - ‡ State medical license number
- **Step 2** – go to Dispensing Solutions' Web site and complete a simple onetime online enrollment application at ***enroll.edispense.com***.

Providers can contact Dispensing Solutions directly for assistance with enrollment and claims by calling their customer support center at **1-866-522-EDVM** (**3386**).

Provider enrollment in *e*Dispense vaccine manager and *e*Dispense facilitated transactions between Medco and providers is a voluntary option for providers. Medicare Part-D vaccine claims eligible for electronic processing with *e*Dispense Part-D vaccine manager are reimbursed according to the Medco allowance, less member liability. BCBSNC offers network providers access to *e*Dispense vaccine manager for Medicare Part-D transactions through our pharmacy benefits manager Medco Health Solutions, Inc., "Medco" by agreement between Medco and Dispensing Solutions, Inc. "DSI."

14.20 Allergy testing

All allergy testing for members must be provided by participating allergists who are board certified by the American Board of Allergy and Immunology, or participating board certified ENT allergists who have completed requirements for fellowship in the American Academy of Otolaryngic Allergy and have been approved by the BCBSNC credentials committee.

The following are the exceptions:

- Allergy patch testing has been approved to be performed by our participating dermatologists. CPT code is 95044.
- Ophthalmic mucous membrane testing has been approved to be performed by our ophthalmologists. CPT code is 95060.
- Inhalation bronchial challenge testing has been approved to be performed by our participating pulmonary specialists. CPT code is 95070-95071.

Subsequent allergy injections may be provided by other participating physicians such as the primary care physician or other participating specialists when referred by the primary care physician.

CPT codes used for allergy testing are 95004-95075 (95078 is not covered).

CPT codes used for allergy immunotherapy are 95115-95180.

Skin tests for specific drug immediate reactions would be appropriate for any participating physician specialty.

14.21 Criteria for approving additional providers for allergy testing

- To certify that allergy testing throughout the BCBSNC network of otolaryngic providers is performed in a consistent manner, and by physicians who have been adequately trained in evaluation of allergic manifestations, the need has arisen for standardization of criteria for credentialing of privileges by otolaryngologists.
- Blue Cross and Blue Shield of North Carolina "BCBSNC" will recognize and approve allergy testing to otolaryngologists who are participating providers in the BCBSNC network and who have fulfilled the requirements and received certification by the American Academy of Otolaryngic Allergy "AAOA." Verification of certification by the American Academy of Otolaryngic Allergy should be provided by the otolaryngologist upon application for privileges for otolaryngic allergy testing.
- **Background:** Allergy testing for BCBSNC members can be an important part of determining causes of significant illnesses, as well as being the basis for selecting a treatment regimen for members who exhibit allergic manifestations. After review of available information, it appears appropriate and reasonable to expect otolaryngic providers to have gone through the requirements of the American Academy of Otolaryngic Allergy and to receive certification as ENT allergists in order to be certified as a participating provider of otolaryngic allergy testing.
- Exceptions may be made, on an individual basis, by BCBSNC credentialing committee, based on evidence of sufficient training and experience in the field of ENT allergy.

14.22 Use of office or other outpatient service code 99211

CPT code 99211 is described as "office or other outpatient visit for evaluation and management of an established patient, that may not require the presence of a physician." Usually the presenting problems are minimal. Typically five (5) minutes are spent performing or supervising these services.

The CPT code should not be used for an additional charge when only laboratory, immunizations or other diagnostics are performed.

For BCBSNC patients, this service code requires a co-payment to be charged and patients should not have to pay a co-payment if they are only reporting for laboratory tests or x-rays.

For the service described by CPT code 99211 to be billed:

- There should be a documented service by the physician or physician office staff that is separate from other procedures that are being performed at the same time, such as injections and diagnostic tests.
- The service should be clearly identifiable.
- A record of the service performed should be entered into the patient's medical record.

Examples:

- Office visit for a 67 year-old established patient to re-dress an abrasion.
- Office visit of a 72 year-old established patient, for a blood pressure check and review medication.

14.23 Dispensing DME from the office

Prior approval will not be required for covered Durable Medical Equipment "DME" or medical supply items if the item is:

- $600 or less by contracted rate and
- Filed with a valid HCPCS code and
- Filed by a participating provider/vendor

Prior approval is required for all Durable Medical Equipment "DME" less than $600 for payment by BCBSNC. Unlisted, miscellaneous or customized items will not have a contracted price as they are priced based on individual consideration; therefore these items generally will require prior approval. This allows us to make a determination of coverage and inform you of the member's copayment. To pre-authorize the item, call medical services at **1-800-942-5695** or **1-336-760-4822** with the following information:

- Name of item required and the HCPCS code
- Diagnosis
- What the device will be used for
- Clarification that the device is medically necessary

The following are some examples of non-covered items or services:

- Theraputty
- Lumbar pillows or rolls
- Cervical pillows or rolls
- Educational supplies, such as books or manuals
- Theraband

You may bill the member if services are denied as non-covered, (for example, EX 02). These services are excluded in the member's certificate of coverage. You may not balance bill the member if services denied exceeds HMO guidelines (for example, EX 56) or are considered included in a global service, EX 36.

You should not have any problem receiving reimbursement for the HCPCS "L" codes submitted if you prior authorize the DME. Be aware that all authorized HCPCS "L" code devices are considered durable medical equipment and the applicable DME copayment/ coinsurance will be deducted by BCBSNC at the time of claims submission.

14.24 Assistant surgery

Following are BCBSNC criteria for reimbursement for assistant surgery procedures.

The CPT code submitted must be on BCBSNC list of approved procedures for reimbursement for assistant surgery.

The physician assisting surgery must be credentialed by and participating with BCBSNC, (but does not have to be same specialty or have training equal to the primary surgeon).

Maximum benefits for physician assisted surgery is limited to 16% of the BCBSNC allowable for the CPT code submitted by primary surgeon or charges, whichever is less, for BCBSNC members.

We use BCBSNC assistant surgeon indicators to determine if the procedure indicates the use of an assistant surgeon. When assistant at surgery services are eligible for reimbursement, providers are to bill using industry standard modifiers.

RN – First assistants and nurse practitioners are not eligible for reimbursement as surgical assistants.

Physician assistants are not standardly eligible for reimbursement as surgical assistants.

14.25 Ancillary billing and claims submissions

For Blue Medicare HMO℠ and Blue Medicare PPO℠ members, authorization of certain outpatient services such as home health, durable medical equipment, rehabilitation and requests for non-participating providers may be required prior to the initiation of services. Please verify member benefits and review BCBSNC prior authorization requirements detailed in chapter 10, Prior authorization requirements, of this manual, prior to providing services.

DME providers should file claims for rental services monthly, after 30 consecutive days of rental, or at the time the rental is determined to no longer be medically necessary (whichever is first).

14.26 Ancillary billing

14.26.1 Participating reference lab billing

Definition – Reference clinical laboratory testing services as may be requested by BCBSNC participating providers. This would include, but not be limited to, consulting services provided by provider, courier service, specimen collection and preparation at designated provider locations, and all supplies necessary solely to collect, transport, process or store specimens to be submitted to provider for testing.

Billing

- Bill on CMS-1500 Claim Form or other similar forms using CPT/HCPCS coding
- Specify services provided and include all of the statistical and descriptive medical, diagnostic and patient data
- Use appropriate provider number
- File claims after complete services have been provided
- Laboratory procedure reimbursement includes the collection, handling and conveyance of the specimen
- All services provided should be billed as global

14.26.2 Dialysis services billing

Definition – For services involved in the process of removing blood from a patient whose kidney functioning quality is faulty, purifying that blood by dialysis, and returning it to the patient's bloodstream.

Billing – Provider agrees to:

- Billing on the UB-92 claim form using only those revenue codes indicated as billable dialysis facility services, along with the corresponding CPT codes and HCPCS codes.
- Not bill for routine laboratory, pharmaceutical, and supplies that Medicare considers to be included under the composite dialysis rate (dialysis inclusive rate).
- Bill for non-routine (separately billable) laboratory, and pharmaceuticals that Medicare considers to be not included under the composite dialysis rate.

The in-home hemodialysis inclusive rate per treatment is the same as the in-center hemodialysis inclusive rate per treatment.

14.26.3 Skilled Nursing Facility "SNF" billing

Definition – Skilled nursing care is care and/or skilled rehabilitation services, which must be furnished by or under the supervision of registered or licensed personnel and under the direction of a physician to assure the safety of the member and achieve the medically desired result. Skilled rehabilitation therapy includes services provided by physical therapists, occupational therapists, and speech pathologists or audiologists. The member must require continuous (daily) skilled nursing services for the level of care to be considered covered.

Billing

- Bill on UB-04 claim form.
- The patient must require continuous (daily) skilled nursing services for the level of care to be considered covered.
- The medical record will contain documentation substantiating coding classification, such as in the form of a completed MDS (minimum data set) scoring tool.
- The following exclusionary services require prior approval from BCBSNC health service department: specialty beds, DME for personal and/or home use, customized prosthetics and orthotics, ambulance transport, diagnostic procedures and lab work not routinely carried out by the facility.

14.26.4 Ambulatory Surgical Center "ASC" billing

Definition – Surgical procedures grouped by complexity (as defined by Medicare).

Billing

- Outpatient surgery, radiology, laboratory, and other diagnostic services must be billed by CPT code.
- Providers should always submit the appropriate CPT code to indicate the primary procedure.
- All ancillary services and supplies provided in conjunction with an ambulatory surgical procedure, including those delivered within seventy-two (72) hours prior to the surgical procedure, must be billed on the same UB-04 form.

Incidental procedure – An incidental procedure is one that is carried out at the same time as a more complex primary procedure and requires little additional resources and/or is clinically integral to the performance of the primary procedure. For these reasons, an incidental procedure should not be reimbursed separately on a claim. Procedures that are considered incidental when billed with related primary procedures on the same date of service will be denied. Incidental procedures are identified by medical review and are considered a contractual adjustment.

Integral procedure – Procedures considered integral occur in multiple surgery situations when one or more of the procedures are considered an integral part of the major or principle procedure. Integral procedures are considered to be those commonly carried out as part of a total service and will not be reimbursed separately.

14.26.5 Home durable medical equipment "DME" and billing

Definition – Durable medical equipment services are defined by CPT codes, and by HCPCS codes as set forth in the AMA HCPCS Level I and Level II guidelines.

Billing – Bill on a typed electronic CMS-1500 Claim Form or other similar forms.

Payment – rentals

- All rentals and all rentals converted to purchase require prior approval.
- Always include rental modifier code on rental claim forms.
- Bill each month of rental as one unit.

Payment – repairs/maintenance

- Non-routine repairs that require the skill of a technician may be eligible for reimbursement.

- The labor component of the repair should be billed under the appropriate repair code.
- All replacement parts should be billed separately under the appropriate HCPCS code(s).
- Repairs may only be billed on purchased items and require prior approval.
- Repairs may not be billed on rented equipment.
- All claims with a repair code should be submitted with a complete description of the services provided.
- When submitting a claim with a repair or maintenance modifier code and other modifier codes, list the repair or maintenance modifier code first after the procedure code.
- Losses resulting from abuse/misuse of equipment or items are excluded from coverage.
- Maintenance services require prior authorization.

Certain drugs and supplies

With the January 1, 2006, implementation of Medicare Part D, which is Medicare prescription drug coverage, certain drugs and supplies are covered only under the BCBSNC member's prescription drug benefits. This means that providers need to know whether or not they are in-network for the prescription drug benefits, as well as be able to distinguish between Medicare Part B and Part D coverage in order to know how to bill properly for a given drug or supply.

In order to be in-network for the Medicare Part D prescription drug benefits, durable medical equipment providers must be in the Medco Health Solutions, Inc. "Medco" network. Medco is BCBSNC's Part D pharmacy benefits manager. Durable medical equipment providers who contract only with BCBSNC, but not with Medco, are in-network only for Part B benefits and are out-of-network for Part D benefits. Durable medical equipment providers that are also pharmacies that would like to participate with Medco may contact Medco directly at **1-800-922-1557** or online at ***www.medco.com***.

When billing for the drugs and supplies that are covered under Medicare Part B, providers need to follow all Medicare Part B coverage guidelines. Providers must follow the Medicare Part D coverage guidance when billing for drugs and supplies that are covered under Medicare Part D.

Modifiers RP applicable to purchased items only

- Modifier RP must be filed when submitting claims for maintenance and repairs

Miscellaneous

- For manual and motorized wheelchairs and scooters, the Plan has the right to authorize these items as rental items if Medicare has rental rates.

Use of E1399 and other miscellaneous codes

Do not use E1399 or other miscellaneous HCPCS codes for items which have a designated HCPCS code.

- Special documentation is required for claims using miscellaneous codes, including E1399.
  Always submit:
  1. With each claim a complete description of the item.
  2. With each initial claim a factory invoice for the item (catalogs and retail price listings are not acceptable) and, if appropriate, certificate of medical necessity form with physician's signature (use appropriate form in chapter 25, Forms).
- Failure to provide appropriate documentation when using E1399 and other miscellaneous codes can result in processing delays and/or denials.

Please note:

- Do not staple these or any other enclosures to the claim form.
- Submit all initial claims on paper to ensure the appropriate documentation is received in the same envelope.
- Electronically submitted claims will not transmit additional documents.

14.26.6 Home Health "HH" billing

Definition – Home health services are defined as follows:

Visits to the home to provide skilled services, including:

Home health services	Must be rendered by
Skilled Nursing "SN"	Registered nurse or licensed practical nurse
Physical Therapy "PT"	Licensed physical therapist or licensed physical therapist assistant
Occupational Therapy "OT"	Licensed occupational therapist
Speech Therapy "ST"	Licensed speech pathologist
Medical Social Service "MSW"	Medical social service "MSW"
Medical Social Service "MSW"	Home health aide

Patient must be homebound.

Billing

Provider agrees:

- To bill on UB-04 claim form. Appropriate HCPCS codes are required in Box 44 of the UB-04 in order to receive payment.
- To bill your retail charges.
- To use your appropriate provider number.
- To file claims after complete services have been provided.
- In addition to the home health visit, bill only the non-routine medical supplies listed in the agreement. These are the only covered supplies that may be billed under the revenue codes listed (all other covered supplies are considered routine).
- BCBSNC will not pay overtime/holiday rates.
- For non-routine supplies, include a valid HCPCS code with the revenue code on the UB-04.

Revenue codes and service units

Service	Revenue code	Payment
Home health aide	571	visit
Medical social worker	561	visit
Occupational therapy	431	visit
Physical therapy	421	visit
Skilled nursing LPN	550	visit

Continued on the following page.

Service	Revenue code	Payment
Skilled nursing RN	551	visit
Speech therapy	441	visit

Home health services not billable as separate services (integral part of home health visit):

- Routine medical supplies provided in conjunction with home health services including those left at the member's home are considered an integral part of the home health visit reimbursement and cannot be billed separately (under Home Durable Medical Equipment "HDME" provider number or any other provider number).
- Assessment visits unless a skilled service is also rendered during the same visit.
- Supervisory visits unless a skilled service is also rendered during the same visit.
- Skilled nursing visits may not be billed on the same days as private duty nursing visits.

Billable non-routine home health supplies

Routine medical supplies provided in conjunction with home health services including those left at the member's home are considered an integral part of the home health visit reimbursement and cannot be billed separately (under HDME provider number or any other provider number).

14.26.7 Home Infusion Therapy "HIT" billing

Definition – Home infusion therapy is defined as follows:

- The administration of prescription drugs and solutions in the home via one of these routes:
  - ‡ intravenous
  - ‡ intraspinal
  - ‡ epidural
  - ‡ subcutaneous

Notice: Other medications eligible for reimbursement under the Home Infusion Therapy "HIT" schedule must be injections administered during the same visit as the infusion therapy and require administration by a health care provider such as a Registered Nurse "RN" or Licensed Practical Nurse "LPN."

Benefits for home infusion services are limited. The following is applicable only to services that have been authorized by BCBSNC.

Billing

- Home infusion therapy requiring regular nursing services must be billed in three components by the home infusion therapy provider:
  1. Per diem component (covering all home infusion services, equipment and supplies except the prescription drug and licensing nursing services) for each day the drug is infused.
  2. Nursing services provided by a Registered Nurse "RN" or Licensed Practical Nurse "LPN," and
  3. Drug component (only bill for the quantity of drug actually administered, not unused mixed, compounded or opened quantities)
- Bill on the CMS-1500 Claim Form or other similar forms
- Use your appropriate provider number
- File claims after services have been provided
- File claims within 180 days of providing service
- Miscellaneous codes are valid for use only if no suitable billing code is available. All claims using miscellaneous codes must be submitted with a complete description of the services rendered, including the NDC numbers for the drugs administered. Failing to provide appropriate documentation when using miscellaneous codes can result in delays and/or denials.

Bundled services

The following are included in the home infusion therapy rates established in your contract and reimbursement schedule and may not be billed separately unless defined:

- All training and nursing visits and all nursing services
- Initial assessment and patient set-up
- Providers may not request members obtain supplies or treatment from an office; to get supplies/ treatment, home infusion must be done in the home.

14.27 Hospital policies

The following are excerpts from the hospital agreement that outlines the provider's responsibility as a participating facility. These policies are provided in addition to the remainder of the policies in this manual. Please review all sections of this manual that pertain to you.

Access to medical records

The hospital agrees, as stated in the hospital agreement, that BCBSNC shall have the right, upon request and during normal business hours, to inspect and copy records maintained by the hospital pertaining to claims for hospital services.

Concurrent review

The hospital will participate in and cooperate with BCBSNC in its utilization management and quality improvement programs. Summaries of these programs follow.

Credentialing

The hospital will participate in and cooperate with BCBSNC credentialing and recredentialing processes, and will comply with determinations made pursuant to the same. Please also see chapter 20, Credentialing.

The hospital will complete requests for verifications of privilege status regarding individual providers. These verifications will include information regarding a provider's:

- Status and standing with hospital
- Specialty classification
- Level of privileges
- Description of past actions
- Description of limitations

14.28 Utilization management program

BCBSNC has developed and implemented a UM program with the objective of assuring that medical services delivered to BCBSNC members are timely, appropriate and cost-effective.

Utilization management applies to all covered members. For inpatient services, utilization management activities include pre-admission and admission review, continued stay or concurrent review and discharge planning.

Pre-admission review is designed for monitoring and evaluating the medical necessity, appropriateness and required level of care for an elective admission prior to its occurrence. The patient's primary care physician or the consulting specialist typically initiates this process by obtaining authorization through BCBSNC health services department.

Admission review and concurrent review are performed by BCBSNC registered nurses either telephonically or through on-site visits to the facility. Both processes, whether performed on-site or telephonically, are coordinated through the hospital's utilization review department.

Admission review involves the determination of the type of admission, either emergency or urgent, and documentation that acute care is the appropriate level of care for the patient's illness or condition. Concurrent review is a review of the member's medical record by BCBSNC registered nurses during hospitalization to assess the continued medical necessity and appropriateness of care. This information is also used to begin the discharge planning process.

BCBSNC primary objective of discharge planning is to help patients, their families, health care professionals and the community ensure that the gains achieved from hospital care are maintained or enhanced for the continued health and welfare of the patients following discharge. The discharge plan is a process where patients' needs are identified, evaluated and assistance given in preparing them to move from one level of care to another.

During the discharge planning process, BCBSNC nurses assist in arranging and authorizing the services needed upon discharge. They work with the attending physicians, hospital discharge planners or social workers, the patients and their families and BCBSNC participating home health vendors to coordinate the services that are covered by BCBSNC.

The case management team follows the ongoing treatment, status and needs of the patient until services are no longer needed or covered.

Retrospective review or claims review may also be conducted as part of the utilization management process. This process reviews the necessity and appropriateness of medical services by compilation and analysis of data after medical care is rendered to determine practitioner and consumer patterns of care.

If hospital cannot provide a hospital bed or otherwise provide adequate services to a BCBSNC member seeking provider services from Hospital, Hospital shall cooperate with the BCBSNC member and the participating physician who ordered the BCBSNC member's admission or treatment in obtaining appropriate care for the BCBSNC member. Referrals shall be made to a participating provider if required services are available from such a facility.

14.29 UB-04 claims filing and billing coverage policies and procedures for BCBSNC

14.29.1 Anesthesia

- May be charged individually as used or included in a charge, based on time.
- A charge that is based on time must be computed from the induction of anesthesia until surgery is complete. This charge includes the use of equipment (e.g., monitors), all supplies and all gases.
- Anesthesia stand-by services are not covered unless they are actually used. Bill anesthesia services using revenue code R370.

14.29.2 Certified Registered Nurse Anesthetist "CRNA"

- Must be filed on a CMS-1500 Claim Form or other similar forms
- Minutes of time must be included
- Anesthesia codes must be submitted

14.29.3 Autologous blood

- Charges for autologous donations are covered when such services are rendered for a specific purpose (e.g., surgery is scheduled or the need for using autologous blood is documented) and then only if the patient actually receives the blood.
- Prophylactic autologous donations and long-term storage (e.g., freezing components) for an indeterminate time period in case of future need are not considered eligible for benefits.
- Blood used must be billed on the same claim as the related surgery charges.

14.29.4 Autopsy and morgue fee

- Autopsy and morgue fees are not covered under BCBSNC certificates.

14.29.5 Critical care units

The following conditions must be met to be considered a critical care unit:

- The unit must be in a hospital and physically separate from general patient care areas and ancillary service areas.
- There must be specific written policies that include criteria for admission to and discharge from the unit.
- Registered nursing care must be furnished on a 24-hour basis. A nurse-patient ratio of one (1) nurse to two (2) patients per patient day must be maintained.
- A critical care unit is not a post-operative recovery room or a post-anesthesia room.

The charge for critical care unit (i.e., coronary care or intensive care unit) has two (2) components:

- The room charge includes all items listed under acute care.
- The nursing increment/equipment charge includes the use of special equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.) cardiac defibrillators, oxygen, supplies (e.g., electrodes, guidewires, telemetry pouches) and additional nursing personnel.

To ensure appropriate benefit payments, the critical care room charge should equal the corresponding routine room rate (i.e., either the routine semi-private or private rate). An accurate breakdown of these components ensures correct claims processing. Any claims received without a breakdown of these components may be returned for correction.

14.29.6 Diabetes education (inpatient)

- Admissions solely for the purpose of diabetic education are not covered under BCBSNC certificates

14.29.7 Dietary nutrition services

- Medically necessary nutritional counseling may be a covered benefit
- Other nutritional assessment services (e.g., Optifast) are not covered under BCBSNC certificates

- If covered nutritional counseling is included on the UB-04 claim form use revenue code R942

14.29.8 EKG

- The charge for EKG services includes the use of a room, qualified technicians and supplies (e.g., electrodes, gel)

14.29.9 Hearing aid evaluation

- Hearing aid evaluation, hearing aid fitting and hearing screening are not covered under BCBSNC certificates

14.29.10 Lab/blood bank services

- The charge for clinical laboratory must include the cost of all supplies related to the tests performed and a fee for the administration of the department.
- Arterial puncture charge should be included in the charge for the test.

14.29.11 Labor and delivery rooms

The labor room charge and delivery room charge must include the cost of:

- The use of the room
- The services of qualified technical personnel
- Linens, instruments, equipment and routine supplies

The hospital should not bill BCBSNC for an obstetrics room in addition to the labor room when patient is still in the labor room at the time of patient census.

14.29.12 Leave of absence days

- BCBSNC does not provide coverage for therapeutic leave of absence days occurring during an inpatient admission whether in connection with the convenience of the patient or the treatment of the patient.
- This charge should be billed directly to the patient as it is the patient's liability.
- If billed on the UB-04 claim form use revenue code R180 with zero charge in form locator 47.

14.29.13 Observation services

Observation beds are covered outpatient services when it is determined that the patient should be held for observation, but not admitted to inpatient status.

Use the following guidelines when billing observation charges:

- Bill observation services under revenue code R762.
- The charges related to an observation bed may not exceed the most prevalent semi-private daily room rate.
- BCBSNC should not be billed for both an observation charge and a daily room charge for the same day of service.
- Observation charges must include all services and supplies included in the daily room charge.
- The daily room rate should not be billed for an observation patient sent home before the midnight census hour.
- When a patient receives services in, and is admitted directly from an observation holding area, such services are considered part of inpatient care.
- Fees for use of emergency room or observation holding area and other ancillary services provided are covered as a part of inpatient ancillaries.

14.29.14 Operating room

- The operating room charge may be based on time or per procedural basis. When time is the basis for the charge, it must be calculated from the induction of anesthesia to the completion of the procedure.
- Operating room services should be billed using revenue code R360.

14.29.15 Outpatient surgery

- All ancillaries and supplies associated with an outpatient surgical procedure should be billed on one claim. This includes use of facility (pre-operative area, operating room, recovery room), all surgical equipment, anesthesia, surgical supplies, drugs and nourishment.
- All charges associated with preoperative testing performed within 72 hours of the surgical procedure should also be billed on the same claim with the ancillaries and supplies for outpatient surgery.

14.29.16 Personal supplies

- Personal supplies include items not ordered by the physician or not medically necessary.
- These items are not covered by BCBSNC health insurance. These items should be billed using UB-04 revenue code R999.

- Example of personal supplies include:
  - ‡ Hair brush
  - ‡ Mouthwash
  - ‡ Nail clippers
  - ‡ Powder
  - ‡ Razor
  - ‡ Shampoo and conditioner
  - ‡ Shaving cream
  - ‡ Shoe horn
  - ‡ Toothpaste
  - ‡ Toothbrush

14.29.17 Pharmacy

Please also refer to chapter 15.1, "The BCBSNC formulary in chapter 15, Specialty networks.

- All pharmacy charges should be billed to BCBSNC using revenue code R250-R259.

14.29.18 Recovery room

- The charge for recovery room includes the costs of nursing personnel, routine equipment (e.g., oxygen) and supplies, monitoring equipment (e.g., blood pressure, cardiac, and pulse oximeter), defibrillator, etc.
- Warming systems (e.g., Bair Hugger Patient Warming System, hypo/hyperthermic unit, radiant warmer, etc.) should not be billed to BCBSNC or the patient.

14.29.19 Emergency room services

- Charges for ER visits and services resulting in an admission, must be billed on the UB-04 for the inpatient admission. These charges should not be split out and billed separately.
- Charges for ER visits that do not result in an approved admission, must be submitted separately for consideration of payment. These services will be subject to existing Prudent Layperson Language and if approved will reimburse according to the current outpatient reimbursement for your facility.

14.29.20 POA indicators required

The Centers for Medicare & Medicaid "CMS" requires completion of the Present on Admission "POA" indicator for every diagnosis on an inpatient acute care hospital claim.

Hospitals providing care for Blue Medicare HMO℠ and Blue Medicare PPO℠ members are required to follow CMS' POA reporting guidelines when submitting claims for services provided to our members.

For inpatient acute care Prospective Payment System "PPS" discharges on or after October 1, 2008, certain diagnosis codes on claims could trigger a higher paying DRG (diagnosis related groups) at the time of discharge (but not at the time of admission). The DRG that must be assigned to the claim will be the one that does not result in the higher payment.

Effective for discharges on or after October 1, 2008, Blue Medicare PPO℠ and Medicare supplemental products should apply CMS POA adjudication logic. Providers will not be compensated for those services that are non-reimbursable as identified in CMS' hospital-acquired conditions and present on admission indicator reporting program, or successor program(s), in accordance with CMS payment policies.

14.29.21 Room and board

- The following are included in daily hospital service acute care and should not be billed as separate items to BCBSNC or its members:
  - ‡ Room and complete linen service
  - ‡ **Dietary service:** meals, therapeutic diets, required nourishment, dietary consultation and diet exchange list
  - ‡ General nursing services include patient education such as instruction and materials. This does not include or refer to private duty nursing
  - ‡ All equipment needed to weigh the patient (e.g., scales)
  - ‡ Thermometers, blood pressure apparatus, gloves, tongue depressors, cotton balls and other items typically used in the examination of patients
  - ‡ Use of examining and/or treatment rooms for routine examination
  - ‡ Routine supplies as a part of normal patient care
  - ‡ **Administration** of enemas and medications including IVs
  - ‡ Postpartum services
  - ‡ Recreation therapy
  - ‡ Enterostomal therapy (the costs of enterostomal supplies are covered ancillary items)

14.29.22 Special beds

- Bill these beds using UB-04 revenue codes R946 and R947.
- The following beds are covered as a separate charge when medically necessary:
  - ‡ Bio-Dyne bed
  - ‡ Clinitron bed
  - ‡ Flexicare bed
  - ‡ Fluidair bed
  - ‡ Just Step mattress
  - ‡ Ken-Air bed
  - ‡ Kinetic therapy bed
  - ‡ Pegasus airwave system
  - ‡ Restcue bed (Hill-Rom EFICA CC)
  - ‡ Roto-Rest bed
  - ‡ Therapulse bed

14.29.23 Special monitoring equipment

- Includes dinemapp, swan ganz, cardiac, pressure monitor and telemetry.
- Charges include the use of supplies (e.g., electrodes, guidewires and telemetry pouches).
- When special monitoring equipment is used by a patient in routine or general accommodations, a separate monitoring equipment charge may be billed.
- When a patient is using special monitoring equipment in the operating room, recovery room or anesthesia department and is transported to another ancillary department or a room, a separate monitoring equipment charge should not be billed.
- Monitoring equipment used during transport is considered a continuation of services.
- Set up fees that only represent personnel time are considered part of the procedure/treatment fee.

14.29.24 Speech therapy

- Covered speech therapy services should be billed using UB-04 revenue code R440-R449.
- The itemization must be submitted on the claim.
- Speech therapy is covered only when used to restore function following surgery, trauma or stroke.
- Speech therapy is not considered medically necessary treatment for the following diagnoses:
  - ‡ Attention disorder
  - ‡ Behavior problems
  - ‡ Conceptual handicap
  - ‡ Mental retardation
  - ‡ Psychosocial speech delay
  - ‡ Developmental delay
- To be considered eligible for coverage, speech therapy services must be delivered by a qualified provider of speech therapy services. A qualified provider is one who is licensed where required and is performing within the scope of the license.

14.29.25 Take-home drugs

- BCBSNC certificates do not provide basic inpatient hospital benefits for take-home drugs.

14.29.26 Take-home supplies

- Covered take-home supplies should be billed using UB-04 revenue code R273.
- BCBSNC certificates do not provide basic inpatient hospital benefits for take-home items.
- Benefits are provided for take-home items by major medical and extended benefits when these items are properly identified on the claim.

Specialty networks

15.1 The BCBSNC formulary

15.1.1 BCBSNC formulary medications

BCBSNC formulary is a list of drugs selected by BCBSNC in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. BCBSNC will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a BCBSNC network pharmacy, and other plan rules are followed.

15.1.2 Formulary changes/updates

BCBSNC may add or remove drugs from our formulary during the year. To get updated information about the drugs covered by BCBSNC Medicare prescription drug coverage, please visit our Web site at ***bcbsnc.com*** or call customer service at **1-888-296-9790**, Monday - Friday, 8 a.m. to 8 p.m. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug (or move a drug to a higher cost-sharing tier), we must notify members who take the drug that it will be removed at least 60 days before the date that the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the food and drug administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. Physicians will receive formulary updates in the BCBSNC provider newsletter. Physicians may also refer to the formulary on the BCBSNC Web site.

To request a copy of the BCBSNC Medicare prescription drug coverage standard or enhanced plan formulary, please contact customer service at **1-888-296-9790** or you may visit our Web site at ***bcbsnc.com***.

15.1.3 Generic substitution policy (⋆)

Some drugs, which have generic equivalents, are only covered at a generic reimbursement level and, for maximum coverage, should be dispensed in the generic form. These drugs are indicated with an asterisk (⋆) in the BCBSNC formulary. Maximum allowable costs "MAC" limits of reimbursement have been established for these drugs.

15.1.4 Prior Authorization "PA"

BCBSNC requires prior authorization for certain drugs on the formulary or drugs that are not on the formulary and those approved for coverage through our exception process that require prior authorization. Physicians on behalf of members may request prior authorization for these drugs. These drugs are indicated with the following symbol: "PA."

- Prior authorization must be obtained prior to the member going to the pharmacy.
- The physician or the physician's representative must contact BCBSNC to request prior authorization.

15.1.5 Prior authorization and non-formulary requests

Prior authorization and non-formulary requests require members to meet certain clinical criteria prior to a drug being covered. For prior authorization and non-formulary requests, the member or the member's prescribing physician may contact BCBSNC. A physician's supporting statement is required for all requests before the prescription can be approved for payment. Physicians may contact the Plan by calling BCBSNC at **1-888-296-9790** or using the applicable fax request form to request an exception. Please see the formulary on the Web at bcbsnc.com for detailed information regarding covered drugs and drugs requiring prior approval.

Non-formulary requests

- Should list drug alternatives tried by member for the same condition and the clinical reason these drugs have not been as effective as the drug being requested.

Medicare Advantage - prescription drug plan prior approval requests and non-formulary drug requests:

Fax number: 1-888-446-8535

Address:
BCBSNC
Attention: Exceptions-Health Services
PO Box 17509
Winston-Salem, NC 27116-7509

Provider Telephone: 1-888-296-9790

15.1.6 Sample Medicare Advantage – prescription drug plan prior approvals request form

Medicare Advantage – Prescription Drug Plan Prior Approvals Request Form

Incomplete form may delay processing.

Physician name		Patient name
Office contact person		Patient ID number
Physician phone	Physician FAX	Patient date of birth
Physician address Street _____ City _____ State _____ ZIP _____		

Name of medication requested _____

Dosage form of medication requested _____
(injectable, pill/capsule/tablet, suppository, liquid, etc.)

PART D coverage of certain drugs is available only if coverage is not available under PART B.
(Please see the DMERC Web site at ***http://palmettogba.com*** for PART B coverage clarification.)

Clinical reasons drug covered under PART D drug benefit: _____

_____

_____

_____

I certify that the member meets criteria for PART D coverage of this drug.

Physician signature _____

Please return completed form to:

Fax Number: **1.888.446.8535**

Address: **Blue Cross and Blue Shield of North Carolina**
Attention: Exceptions-Health Services
PO Box 17509
Winston-Salem, NC 27116-7509

Provider telephone: **1.888.296.9790**

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15.1.7 Sample Medicare Advantage – prescription drug plan non-formulary drug request form

Medicare Advantage – Prescription Drug Plan Non-Formulary Drug Request Form

Incomplete form may delay processing.

Physician name		Patient name
Office contact person		Patient ID number
Physician phone	Physician FAX	Patient date of birth
Physician address Street _____ City _____ State _____ ZIP _____		

Name of medication requested _____

Dosage form of medication requested _____
(injectable, pill/capsule/tablet, suppository, liquid, etc.)

Formulary alternatives tried and failed _____

Reason for failure _____

Additional clinical justification for alternative medication requested (please be specific):

_____

_____

Please complete the following if applicable:
Certain drugs may be covered under Medicare PART D or PART B. (Please see the DMERC Web site ***http://palmettogba.com*** for PART B coverage clarification.) If drug is covered under PART D, please give reasons below:

_____

_____

I certify that the member meets criteria for PART D coverage of this drug.

Physician signature _____

Please return completed form to:

Fax Number: **1.888.446.8535**

Address: **Blue Cross and Blue Shield of North Carolina**
Attention: Exceptions-Health Services
PO Box 17509
Winston-Salem, NC 27116-7509

Provider telephone: **1.888.296.9790**

9/26/2005

15.1.8 Quantity Limits "QL"

For certain drugs, BCBSNC limits the amount of the drug covered. For example, BCBSNC provides 9 tablets per prescription for Imitrex 100mg. These drugs are indicated with the following symbol: "QL."

15.1.9 Drugs with Part B and D coverage

Drugs that can be covered under both Part B and Part D. Please see the formulary on the Web at ***bcbsnc.com*** for a list of drugs that require prior authorization. Drugs that are currently authorized by law as covered under Part B will remain covered under Part B and should be billed to the Part B payer as before. For information about and a listing of drugs covered under Part B, visit the **Palmetto GBA Web site**. This site includes access to the Region C DMERC manual and local coverage determinations. You may also visit the **CMS Web site** for additional information regarding Part B and Part D coverage.

15.1.10 Request for drugs to be added to the formulary

To request an addition to the formulary, physicians may forward a written request indicating the advantage of the drug over current formulary medications to:

Blue Cross and Blue Shield of North Carolina
PO Box 17168
Winston-Salem, NC 27116-7509

15.1.11 Exceptions process

BCBSNC provides a process for situations when a member demonstrates a medical need for BCBSNC Medicare Advantage Prescription Drug Plan "MAPD" to make an exception to its standard plan terms. A member, member's authorized representative, or member's prescribing physician may request an exception in one of the following situations:

- Coverage of a drug not on the formulary (list of drugs the plan covers)
- Continued coverage of a drug that has been removed from the formulary for reasons other than safety because the Part D prescription drug cannot be supplied by or was withdrawn from the market by the drug's manufacturer.
- Coverage of a drug requiring prior authorization
- Exceptions to quantity limits

To request an exception to the coverage rules for the member's Medicare prescription drug plan, the member or the member's prescribing physician may call or submit a written request. The prescribing physician must provide a supporting statement that the exception is medically necessary to treat the enrollee's disease or medical condition. Health services will review the exception request and make a determination as expeditiously as the member's health requires, but no later than 72 hours from the date we receive the request. The member and the member's prescribing physician will be given notice of the coverage determination. If the decision is not in the member's favor, the notice must be given orally followed within three (3) days by a written notice which includes notification of the appeals and grievance processes to be followed if the member is dissatisfied with our decision.

Physicians may request an exception by calling, faxing, or writing to health services:

Telephone: **1-888-296-9790**

Fax: **1-888-446-8535**

Written requests:
Blue Medicare HMO℠
Attention: Part D Coverage Determination
P.O. Box 17509
Winston-Salem, NC 27116-7509

Members may request an exception by calling the customer service department or may send a written request to:

Blue Medicare HMO℠
Attention: PART D Coverage Determination
P.O. Box 17509
Winston-Salem, NC 27116-7509

Members should refer to their evidence of coverage for more details on the exception process.

15.1.12 Medication therapy management program

Members enrolled in BCBSNC Medicare Advantage prescription drug plan "MA-PD" may be eligible for the Medication Therapy Management Program "MTMP," in accordance with CMS requirements. The purpose of the program is to provide medication therapy management services to targeted MA-PD members. These services are designed to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes by improving medication use and reducing the risk of adverse drug events including adverse drug interactions. The MTMP is developed in cooperation with licensed and practicing pharmacists and physicians.

The goals of the program are to educate members regarding their medications, increase member adherence to medication therapy, and identify and prevent medical complications related to medication therapy.

Individual members eligible for the MTMP services must meet all three criteria below:

- Have multiple chronic diseases, such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure.
- Must have filled multiple Part D covered medications, and
- Are likely to incur annual costs for covered Part D medications that exceed $4,000 annually.

Targeted members will be identified by the Pharmacy Benefit Manager "PBM" through prescription claims information. The PBM will provide a list of identified and eligible members to BCBSNC.

Medicare beneficiaries who meet the criteria below will be identified for MTM services:

- Have at least 5 chronic conditions, with at least 2 of the following: hypertension, high cholesterol, congestive heart failure, diabetes, asthma.
- Have claims for at least 6 different covered Part D medications during a 12-month period of less based on receipt of claims data. Both chronic and acute medications are considered in the evaluation process.
- Will be likely to incur a minimum threshold of $4,000 in annual drug costs for covered Part D medications.

Eligible members not already participating in a care or disease management program will be contacted by a nurse for possible participation in the program. Participation in the program is voluntary. Members already participating in a care or disease management program will receive information about the program at the next scheduled contact by the disease or care manager.

Members who agree to participate will be contacted by a nurse telephonically. Services available include medication education, safety, adherence, and review of medical condition associated with the medication therapy. Members will have the option of speaking directly with a Plan pharmacist, as appropriate. The member and/or prescribing physician(s) will be notified of potential adverse drug events and interactions, and patterns of over-use or under-use of medication. In addition, Members may receive educational materials via the mail.

Members should refer to their certificate of coverage for more details on the MTMP.

15.2 Chiropractic services

BCBSNC contracts directly with chiropractic providers to provide services to Blue Medicare HMO℠ and Blue Medicare PPO℠ members. Blue Medicare HMO℠ and Blue Medicare PPO℠ network participating chiropractic providers file claims direct to BCBSNC without accessing an intermediary vendor. Chiropractic benefits for Blue Medicare HMO℠ and Blue Medicare PPO℠ members are limited to only the services that traditional Medicare covers. Currently, services covered by traditional Medicare include manual manipulation of the spine to correct subluxation. Other services, such as x-rays taken in the chiropractor's office, massage, electric stimulation and other forms of treatment and therapy given in the chiropractor's office are not covered benefits as part of the Blue Medicare HMO℠ or Blue Medicare PPO℠ plans.

15.3 Medical eye care

BCBSNC is contracted with Community Eye Care to provide medical/routine vision care to BCBSNC members using a panel of optometrists and ophthalmologists.

- No referral needed
- Direct access to contracting ophthalmologists and optometrists
- Routine vision
- Medical surgical

Community Eye Care **1-888-254-4290**

15.4 Mental health/substance abuse management programs

Mental health and substance abuse services do not require a referral from the primary care physician. BCBSNC delegates mental health and substance management and administration (including certification, concurrent review, discharge planning and case management) to Magellan Behavioral Health. Contact Magellan Behavioral Health to conduct full utilization management for mental health and substance abuse services at **1-800-359-2422**.

15.5 Laboratory services

Reference labs:
If a specimen is drawn and the laboratory work is sent to a reference lab, the only services billable to BCBSNC is the administrative/handling charge (i.e., 36415-venipuncture). The reference lab will bill directly to BCBSNC for the services it provides.

In-office labs:
If you are performing the laboratory service in your office, and your lab is CLIA certified, the services can be filed directly with BCBSNC for reimbursement. Selected counties are subject to BCBSNC laboratory office allowable lists. Under that program only procedures included in the appropriate office allowable lists can be billed directly to BCBSNC. Questions regarding this lab program should be directed to your Network Management coordinator.

15.6 BCBSNC office laboratory allowable list

BCBSNC developed an office lab allowable program that has been implemented in selected counties. Current lab allowables listings are included in this manual. Reviews of these lists are completed at least yearly. If this lab program is enhanced or expanded, appropriate notice and information will be sent to your office. For questions about laboratory services billable under the terms of your provider agreement or for additional information about the office allowable program, please contact your local Network Management field office.

Exhibit A

This list was revised January 1, 2010. Physician offices with Physician Performed Microscopy "PPM" certification or unrestricted (full) CLIA certification may bill BCBSNC directly for the following procedures.

All procedures not listed should be sent to any BCBSNC participating reference lab or participating hospital lab.

CPT code	Description
80051	Electrolyte panel
80162	Digoxin assay
81000-81001	Urinalysis-dipstick or tablet w/microscopy
81002-81003	Urinalysis-dipstick or tablet w/o microscopy
81015	Urine sediment examination
81025	Urine pregnancy test - color comparison method
82044	Microalbumin, rapid test
82150	Amylase
82270	Occult blood-fecal
82374	Carbon dioxide
82435	Chloride

Continued on the following page.

CPT code	Description
82550	Creatine kinase-total
82565	Creatinine
82800-82810	Blood gases with and without direct measure 02
82947	Glucose
82948	Glucose, blood reagent strip
82962	Glucose - whole blood
83986	Assay of body fluid acidity
84132	Potassium
84295	Sodium
84484	Troponin
84520	BUN
84703	Pregnancy test
85002	Bleeding time
85007	Blood smear, microscopic with manual differential WBC count
85013-85014	Microhematocrit
85018	Hemoglobin-non-automated
85025	Complete CBC automated and automated differential WBC count
85027	Complete CBC automated
38220	Bone marrow aspiration
85097	Bone marrow smear interpretation
38221	Bone marrow biopsy
85610	Prothombin time
86308	Monospot
86485-86580	Selected skin tests (candida, coccidia, etc.) (86585 deleted)

Continued on the following page.

CPT code	Description
87172	Pinworm exam
87177	Ova and parasites direct smears
87210	Wet prep with simple stain
87220	Tissue exam for fungi (e.g., KOH slide)
87430 or 87880	Rapid strep screen
87449	Influenza rapid test
89050	Fecal Leukocyte exam
89100-89105	Duodenal intubation and aspiration
89130-89141	Gastric intubation and aspiration
89190	Nasal smear for Eosinophils
89220	Sputum induction
89230 or 82438	Sweat collection
89235	Water load test
89250-89330	Fertility procedures

All procedures not listed above should be sent to any BCBSNC participating reference lab or participating reference lab or participating hospital lab.

*(This list was revised 1/1/2010 to reflect code changes in the 2010 CPT codes.)

Exhibit B

This list was revised January 1, 2010. Physician offices with documented CLIA-waived certification may bill BCBSNC directly for the following procedures.

All procedures not listed should be sent to any BCBSNC participating reference lab or participating hospital lab.

CPT code	Description
81002-81003	Urinalysis-dipstick or tablet w/o microscopy
81025	Urine pregnancy test-color comparison method
82270	Occult blood-fecal
82948	Glucose, blood reagent strip

CPT code	Description
82962	Glucose-whole blood
83986	Assay of blood fluid acidity
85013-85014	Microhematocrit
85018	Hemoglobin-non-automated
85610	Prothombin time
38220	Bone marrow aspiration
38221	Bone marrow biopsy
86485-86580	Selected skin tests (candida, coccidia, etc.) (86585 deleted)
87177	Ova and parasites, direct smears
87210	Wet prep with simple stain
87220	Tissue exam for fungi (e.g., KOH slide)
87430 or 87880	Rapid strep screen
87449	Influenza rapid test
89100-89105	Duodenal intubation and aspiration
89130-89141	Gastric intubation and aspiration
89220	Sputum induction
89230 or 82438	Sweat collection
89235	Water load test
89250-89330	Fertility procedures

All procedures not listed above should be sent to any BCBSNC participating reference lab or participating reference lab or participating hospital lab.

*(This list was revised 1/1/2010 to reflect code changes in the 2010 CPT codes.)

Chapter 16

The Blue Book℠
Provider e-Manual

Post-service provider appeals

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16.1 Level I post-service provider appeals

Post-service provider appeals consist of retrospective claim reviews and do not require a member signed authorization. Post-service provider appeals are performed based on your belief that a claim has been denied or adjudicated incorrectly.

The post-service provider appeal process is separate from the member appeals and grievance process and is listed in chapter 16 of this provider manual. If at any time the member files a post-service claim appeal during the review of a provider appeal, the member's appeal supersedes the provider appeal. Providers may not appeal items related to member benefit or contractual issues on their own behalf. Post-service provider appeals for review of a processed claim may be submitted for the following reasons:

- Coding/bundling, or fees
- Cosmetic
- Experimental/investigational
- Financial recovery (available to physicians, physician groups and physician organizations only)
- Global period denial
- No authorization for inpatient admission
- Non-contracted provider payment dispute
- Not medical necessary
- Re-bundling
- Services not eligible for separate reimbursement

Level I post-service provider appeals for billing/coding disputes and medical necessity determinations are handled by BCBSNC and are available to physicians, physician groups, physician organizations and facilities. Providers have (ninety) 90 calendar days from the claim adjudication date to submit a Level I post-service provider appeal for billing/coding disputes and medical necessity determinations for claims adjudicated on and after April 1, 2010.

Level I financial recovery physician appeals are handled by BCBSNC and are available to physicians, physician groups and physician organizations. Physicians, physician groups and physician organizations will have 30 calendar days from the date of the invoice or demand letter to submit the Level I financial recovery appeal for refund requests requested on and after April 1, 2010. To request a review, contact BCBSNC using one of the following methods:

- Call the Provider Blue Line℠ at **1-888-296-9790**
- Complete the Level One Appeal Form for Blue Medicare HMO℠ and Blue Medicare PPO℠ available to copy from the forms section of this manual and for download from the ***bcbsnc.com*** Web site located at ***http://www.bcbsnc.com/content/providers/appeals/index.htm*** (when sending to BCBSNC, include objective medical documentation).
- Mail a letter of explanation, including objective medical documentation, to the following address:

  Blue Cross and Blue Shield of North Carolina
  Provider Appeals Unit
  Blue Medicare HMO℠ and Blue Medicare PPO℠
  P.O. Box 17509
  Winston-Salem, NC 27116-7509
- Fax your inquiries to:
  Provider Appeals Unit: 919-287-8815

All inquiries regarding the status of an appeal should be routed through customer service.

Level I post-service provider appeals are handled within 30 days from the date of receipt of all information. Supporting objective medical documentation should be submitted for post-service provider appeal reviews.

16.2 Level II post-service provider appeals

Level II post-service provider appeals are available to physicians, physician groups, and physician

Organizations and will be performed by an independent review organization. Physicians, physician groups, and physician organizations may file a Level II post-service provider appeal for medical necessity or billing disputes with MES Solutions, an independent review organization. There is a filing fee associated with all requests for a Level II post-service provider appeal.

16.2.1 Process for submitting a Level II post-service provider appeal

The Level II post-service provider appeal requests should clearly identify the issue that is in dispute and rationale for the appeal. Demographic information including subscriber name, patient name, patient BCBSNC ID number, provider name, and provider ID number should also be included with any request for appeal. Level II post-service provider appeals require a filing fee to be submitted before the review can begin.

A physician, physician group, or physician organization may file a Level II post-service provider appeal if an adverse determination was given on a Level I post-service provider appeal billing dispute or medical necessity denial, as described below.

16.2.2 Level II post-service provider appeal for billing disputes

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, or physician organizations must submit a written request for Level II post-service provider billing dispute appeal within ninety (90) calendar days of the date of the Level I post-service provider appeal denial letter.

Physicians, physician groups, or physician organizations must exhaust BCBSNC's Level I post-service provider appeal process before submitting a Level II post-service provider appeal. A physician, physician group, or physician organization is 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 on the Level I post-service provider appeal.

Physicians, physician groups, or physician organizations should contact MES Solutions directly to submit a Level II post-service provider appeal for a billing dispute.

Mailing Address:

MES Solutions
BDRP Department
100 Morse Street
Norwood, MA 02062

Phone: 800-437-8583
Fax: 888-868-2087

www.mesgroup.com

A request submitted online through the MES Web site, requires new user registration. Once registered, the user should sign-in and select the Love Settlement link to proceed with their request.

Level II provider appeals for billing disputes administered by an independent review organization, will be reviewed based on the information previously submitted with the Level I provider appeal. BCBSNC will supply all documentation from the Level I provider appeal to the billing dispute reviewer. For additional questions, please contact MES Solutions directly.

16.2.3 Level II post-service provider appeal for medical necessity

Level II post-service provider appeals are available to physicians, physician groups, and physician organizations to resolve disputes over the denial of investigational, experimental, cosmetic, and medical necessity determinations.

Physicians, physician groups, or physician organizations must submit a written request for a Level II post-service provider medical necessity appeal within sixty (60) calendar days of the date of the Level I post-service provider appeal denial letter. Physicians, physician groups, or physician organizations must exhaust BCBSNC Level I post-service provider appeal process before submitting a Level II post-service provider appeal. Physicians, physician groups, or physician organizations should contact MES Solutions directly to submit a Level II post-service provider appeal for medical necessity.

Mailing Address:

MES Solutions
Love Settlement Department
100 Morse Street
Norwood, MA 02062

Phone: 800-437-8583
Fax: 888-868-2087

www.mesgroup.com

A request submitted online through the MES Web site, requires new user registration. Once registered, the user should sign-in and select the Love Settlement link to proceed with their request.

Level II post-service provider appeals for medical necessity administered by an independent review organization, will be reviewed based on the information previously submitted with the Level I post-service provider appeal. BCBSNC will supply all documentation from the Level I post-service provider appeal to the billing dispute reviewer. For additional questions, please contact MES Solutions directly.

16.2.4 Filing fee matrix

Billing dispute	
Amount of dispute	**Filing fee calculation**
$1000 or less	Filing fee shall be equal to $50
Greater than $1000	Filing fee shall be equal to $50 plus 5% of the amount by which the amount in dispute exceeds $1000 but in no event shall the fee be greater than 50% of the cost of the review.

Medical necessity dispute	
Amount of dispute	**Filing fee calculation**
$1000 or less	Filing fee shall be equal to $50
Greater than $1000	Filing fee shall be equal to $250

Billing Disputant of Dispute

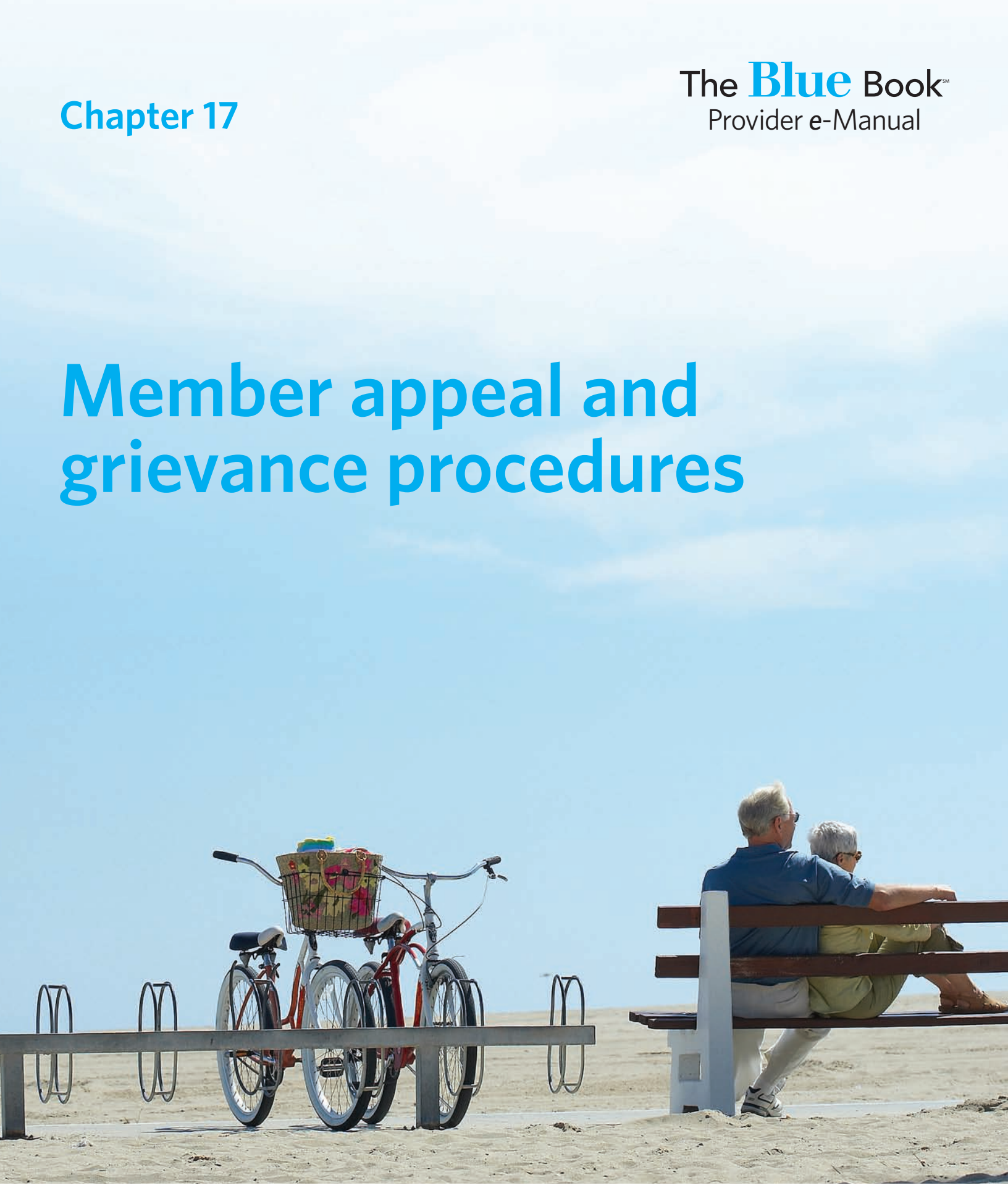
Note: For Level II post-service provider appeals related to billing disputes, the disputed amount must exceed $500.00. In instances where the disputed amount is less than $500, the physician, physician group, or physician organization may submit similar disputes to the independent review organization within one (1) year of the original submission date. If the physician, physician group, or physician organization intends to submit additional similar disputes during the year, the physician must contact the billing dispute reviewer to notify that additional similar submissions will be sent. If the 1 year lapses and the disputes submitted are not in excess of $500 in the aggregate, the original dispute will be dismissed.

The filing fee will be refunded in the event that the physician, physician group, or physician organization prevails in the Level II post-service appeal process.

Chapter 17

The Blue Book℠
Provider e-Manual

Member appeal and grievance procedures



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17.1 Member complaints, grievances and appeals

BCBSNC members are encouraged to let BCBSNC know if they have questions, concerns or problems related to covered services or the care they receive. Members are also encouraged to first attempt to resolve issues about treatment though his/her primary care physician. If the member's issue cannot be resolved in this manner, the member has the right to file a formal complaint with BCBSNC.

17.2 What is an appeal?

An appeal is a request to change a coverage decision about what services are covered or what we will pay for a service. Appeals must be filed within sixty (60) calendar days from the date of the written denial notice. Each denial notice will include information on the member's right to file an appeal or grievance with instructions on how to do so. Once BCBSNC receives an appeal or grievance, it is handled through the mandated CMS appeal or grievance process.

17.3 Who can file an appeal?

For a standard appeal, only a member or their authorized representative has the right to file an appeal through a formal process. If someone other than the member requests to file a standard appeal, the request is not valid until the member and the requesting party sign an appointment of representative form. A standard appeal must be in writing.

For expedited or fast appeals, the member's physician can file the appeal in addition to the member or their authorized representative. A fast appeal is usually filed orally or by fax.

17.4 How quickly does BCBSNC handle an appeal?

CMS states that all appeals must be handled as quickly as the member's health requires. However, there are specific, maximum timeframes for handling the different types of appeals. For example:

- An appeal of a medical claim denial must be handled within sixty (60) calendar days after we receive the request.
- An appeal of a medical service denial must be handled within thirty (30) calendar days after we receive the request unless an expedited or fast appeal is requested. An expedited appeal must be handled within 72 hours.
- An appeal of a prescription drug denial must be handled within seven (7) calendar days unless an expedited or fast appeal is requested. An expedited prescription drug appeal must be handled within 72 hours.

17.5 What is a grievance?

A grievance is a type of complaint that is made if a member is dissatisfied with any aspect of BCBSNC or with service or quality of care rendered by a contracting provider.

Only the member or his/her authorized representative may file a grievance. BCBSNC will respond to a written grievance within thirty (30) calendar days after we receive the written complaint.

Complaints from members about contracting providers may relate to a provider's compliance with BCBSNC procedures, personal relations between providers and members, access to medical care, service issues with the provider's office, or potential medical quality problems. All complaints about providers are documented and placed in the provider's file for trending and review during credentialing. Every quality of care grievance is reviewed by a plan medical director who will decide if further investigation with the provider in question is indicated.

17.6 What involvement does a contracting physician have with an appeal?

A contracting physician can be involved in an appeal in several ways:

- If a member files an appeal, he/she may ask their physician for support by asking the physician to write a letter on their behalf.
- BCBSNC may contact the physician's office to obtain additional medical records for review during the appeal process. Quick compliance with this request is necessary as BCBSNC is required to handle a service appeal as quickly as the member's health requires. If the case is forwarded to MAXIMUS CHDR, CMS's contracted independent review entity for a decision, CHDR will ask for medical records if they do not believe all records have been submitted to them. Again, the requested records will need to be provided expeditiously.
- If a member's physician believes a member's situation is time sensitive, the physician (not his/her staff) may file a fast appeal on the member's behalf. The physician can do this by calling BCBSNC customer services or health services departments, or by faxing a fast appeal request to **1-336-794-8836**.

Please note that neither the mandated CMS appeals process nor the grievance process is available to providers who have a dispute with BCBSNC over payment of a claim or over a contractual denial. See chapter 14.12, Claims reimbursement disputes for how to request a review of a claim or contractual denial for which the member has no financial liability.

Chapter 18

The Blue Book℠
Provider e-Manual

Member rights and responsibilities

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BCBSNC is committed to informing the providers of Blue Medicare HMO℠ of the member's rights and responsibilities.

18.1 Member rights

1) You have the right to be treated with respect, dignity and consideration for your privacy by health care providers and by BCBSNC staff.
2) You have the right to receive information about the Plan, its services, its health care providers and your rights and responsibilities as a member of the Plan.
3) You have the right to private, confidential treatment of your records by Plan staff and providers, and you have the right to access your medical records by contacting the provider of service.
4) You have the right to accessible services from the Plan and from providers of health care, regardless of your English proficiency, reading skill, cultural or ethnic background, and/or physical or mental disabilities.
5) You have the right to receive medically necessary services as described in your BCBSNC Blue Medicare HMO℠ certificate of coverage agreement.
6) You have the right to coverage for emergency and urgently needed care without prior authorization using prudent layperson standards outlined in your certificate of coverage. (Refer to the certificate of coverage for details.)
7) You have the right to a second opinion if you question a contracting provider's decision about the need for surgery. A list of contracting providers can be found in the provider directory. With authorization from either your primary care physician or the Plan a second opinion from the provider you select is covered.
8) You have the right to prompt resolution of any problems or complaints regarding BCBSNC Blue Medicare HMO℠ or contracting providers via the Plan's grievance process. You have a right to prompt resolution of any request for reconsideration or pre-service or claim denials via the Medicare appeals process. Questions about benefits, claims payment, contracting providers, Plan services or the appeals and grievance procedures referenced above should be directed to a Blue Medicare HMO℠ customer service representative by calling **1-888-310-4110** or **1-888-451-9957** (TDD/TTY).
9) You have the right to disenroll from Blue Medicare HMO℠, within guidelines governing restriction of election changes beginning 1/1/02, by giving written notice to the Plan of your intent to do so. Coverage will end on the first day of the month following the receipt of your request. To end your coverage, you may either: (a) send written notice to BCBSNC Blue Medicare HMO℠, PO Box 17509, Winston-Salem, NC 27116-7509; or (b) disenroll at any Social Security Administration Office or Railroad Retirement Board Office.
10) You have the right to continue coverage with Blue Medicare HMO℠, except in the following situations: (a) non-payment of Plan premiums, (b) fraud, (c) abuse of the organization's membership card, (d) permanent moves outside the Blue Medicare HMO℠ service area, (e) loss of Medicare entitlement, or (f) "for cause" subject to CMS approval.
11) You have the right to participate with providers in making decisions about your health care and to receive information on available treatment options (including no treatment) or alternative courses of care. In addition, you have the right to designate someone to make your health care decisions for you in the event you are unable to make these decisions yourself. (These are known as advance directives. For more information, ask your primary care physician.)
12) You have the right to receive the services of the Blue Medicare HMO℠ primary care physician of your choice. Your choice of PCP must be reported to and recorded by the Plan. Your PCP is required to provide or arrange care twenty-four (24) hours a day, seven (7) days a week.

18.2 Member responsibilities

1) It is your responsibility to select a primary care physician and have all your medical care provided by or arranged by your PCP except for emergency or urgently needed care. Blue Medicare HMO℠ does not cover services which you arrange on your own except for emergencies and urgently needed care or as specified in your certificate of coverage.
2) In the event of an emergency, go to the nearest emergency room or call 911 for assistance. We ask that you notify your PCP within forty-eight (48) hours or as soon as possible if you seek emergency care so that he or she can arrange for appropriate follow-up care. If you are out of the service area and require urgently needed care, we request that you, if possible, first telephone your PCP and then seek care from an appropriate local medical facility, according to your PCP's instructions. (Refer to the certificate of coverage for details.)
3) It is your responsibility to make monthly Plan premium payments for your coverage on or before the first day of the month of coverage, unless your employer/retiree group makes these payments on your behalf. If the premium is not paid on time, we will send you notice of late payment, indicating that your Blue Medicare HMO℠ coverage may be ended according to our Blue Medicare HMO℠ payment guidelines. For more Plan payment information, call customer service at **1-888-310-4110** or **1-888-451-9957** (TDD/TTY).
4) It is your responsibility to inform us of changes in name, address and telephone number, PCP selection, etc.
5) It is your responsibility to pay any required copayments when they are requested of you, such as copayments for office visits.
6) It is your responsibility to pay for any service that is not covered under the Plan. This includes services which are excluded from coverage, services obtained from a specialist without referral from your PCP (except in instances where direct access is available), and services obtained from non-Plan providers without prior approval.
7) It is your responsibility to notify the Plan if you move out of the Blue Medicare HMO℠ service area. According to Medicare regulations, persons who live outside of the BCBSNC Blue Medicare HMO℠ service area are not eligible to continue enrollment in BCBSNC.
8) It is your responsibility to keep appointments or follow procedures to avoid missed appointment charges.
9) It is your responsibility to understand how the Plan works and follow Plan procedures. This includes understanding the referral process to avoid unauthorized, non-covered services.
10) It is your responsibility to supply health care providers information needed to provide adequate care, and to follow treatment advice given by those providing health care services.
11) It is your responsibility to consult with your primary care physician in all matters regarding your health care. This includes contacting your primary care physician for instructions on care after regular office hours, except for emergency or urgently needed care.

Inquiries regarding member rights and responsibilities should be directed to the Blue Medicare HMO℠ customer service department at **1-336-774-5410** or **1-888-310-4110** or **1-888-451-9957** (TDD/TTY), Monday-Friday from 8:00 am to 6:00 pm. You may also write to:

Blue Medicare HMO℠
Blue Cross and Blue Shield of North Carolina
PO Box 17509
Winston-Salem, NC 27116-7509

Quality improvement and sanction process

19.1 Overview of quality improvement

BCBSNC quality improvement program is an important component of our Blue Medicare product. BCBSNC improves quality by:

- Fostering better health through innovative preventive programs
- Delivering the right care, at the right time, in the right setting
- Ensuring better medical outcomes for our members
- Providing hassle-free service
- Improving affordability
- Improving customer satisfaction
- Caring for our customers and our communities

Consistent with current professional knowledge, BCBSNC defines quality of care for individual populations as the degree to which health services increase the likelihood of desired health outcomes. Quality of service is defined as the ease and consistency with which customers obtain high quality care, as measured by customer perception and objective benchmarks.[1] This includes appropriate access to care.

In determining the scope and content of its quality improvement program, BCBSNC recognizes the factors that influence the delivery of health care such as:

- Quality of care and service is a crucial and integral component of health care delivery
- Existing and potential customers'/groups' unique needs and expectations must be satisfied and exceeded
- Provider relationships with patients and the Plan must be continually improved
- Legislative and regulatory requirements must be met

The QIP is ongoing and designed to be proactive. It objectively and systematically monitors the quality and appropriateness of the care, service and access provided to members through our provider networks. The QIP then identifies, implements and follows appropriate interventions to improve the quality of care and service. In other words, the QIP is designed to link the concern for quality and the demonstrated improvement. The program goals are:

- Support corporate objectives and strategies, especially cost-effectiveness and efficiency, while continuously improving care and service delivered to our members
- Increase the accountability for results of care and service
- Maintain member confidentiality, dignity and safety as they seek and receive care
- Foster a supportive environment to help practitioners and providers improve the safety of their practice
- Meet or exceed customer expectations for quality of care, service, and access, utilizing evaluative feedback from customers and providers to assess and continually enhance care
- Improve clinical effectiveness
- Incorporate QIP results into the selection and recredentialing of network providers and enhance the network providers' ability to deliver appropriate care and meet or exceed the expectations of the patient/customer
- Enhance the overall marketability and positioning of Blue Medicare HMO℠ as the best Medicare + Choice organization in North Carolina
- Promote healthy lifestyles and reduce unhealthy behaviors in our members and throughout the communities we serve
- Collaborate with the MBHO, to promote continuity and coordination between medical and behavioral health care
- Minimize the administrative costs and burdens incurred by managed care methods
- Maintain and enhance quality improvement processes and outcomes that satisfy the Center for Medicare & Medicaid Services "CMS."

19.2 Grievance procedure/ sanction process

There are times when immediate action must be taken to terminate a provider's contract in order to maintain the integrity of the network and/or to maintain the availability of quality medical care for members. Reasons justifying immediate terminations are specified in the provider's contract, and may include:

- Loss of license to practice (revocation or suspension)
- Loss of accreditation or liability insurance
- Suspension or termination of admitting or practice privileges of a participating physician

[1] Adapted from the Institute of Medicine

- Actions taken by a court of law, regulatory agency or any professional organization which, if successful, would materially impair the provider's ability to carry out the duties under the contract
- Insolvency, bankruptcy or dissolution of a practice

Upon receipt of notification of these actions the affected provider will be notified of the Plan's intent to terminate him or her from the network. In addition to the circumstances outlined above, other information may be received regarding a network provider which may impact the participation status of that physician. This would include reports on providers describing serious quality of care deficiencies. Whenever information of this nature is received, it is evaluated through the normal credentialing review process which includes review and recommendation by our credentialing committee.

19.3 Provider notice of termination for recredentialing

19.3.1 Level I appeal

If the credentialing committee's recommendation is to terminate a provider from the network for documented quality deficiencies or failure to comply with recredentialing policies and procedures, the provider file is forwarded for an expedient review by law and regulatory affairs.

- The provider is formally notified, via certified mail, of our intent to terminate and the specific reason for the proposed action. The provider is informed of his or her right to appeal.
- The provider may request a Level I appeal by providing additional written documentation which may include further explanation of facts, office or other medical records or other pertinent documentation within thirty (30) days from the date or the initial notification of termination.
- Our credentialing committee will review the additional information provided and make a recommendation to either uphold or reverse the original determination. The provider will be notified via certified mail of the decision and of his or her right to request a Level II appeal if the decision is unchanged.

19.3.2 Level II appeal

A request for a Level II appeal must be made within fifteen (15) days of the date of the certified letter from the results of the Level I appeal.

Practitioners requesting hearings within the specified timeframe will be sent an acknowledgement letter within five (5) days giving notice as to the date, time and location of the hearing. The date of the hearing should not be less than thirty (30) days after the date of the notice.

A list of witnesses (if any) expected to testify on behalf of BCBSNC's credentialing committee should be given to the practitioner and similar information requested from the practitioner, i.e., notice of representation, witness(es).

BCBSNC will determine if the hearing will be held before an arbitrator mutually acceptable to the provider and the Plan, before a hearing officer who is appointed by the Plan and is not in direct economic competition with the practitioner involved.

A description of the formal hearing process includes, but is not limited to, the following:

- **Representation:** The practitioner/provider and the Plan may be represented by counsel or other person of their choice.
- **Court reporter:** BCBSNC may arrange for a court recorder to provide a record of the hearing. If BCBSNC does not arrange for a court recorder, it will arrange for an audio-taped record to be made of the hearing. Copies of this record will be made available to the practitioner/provider upon payment of a reasonable charge.
- **Hearing officer's statement of the procedure:** Before evidence or testimony is presented, the hearing officer of the Level II appeals committee will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- **Presentation of evidence by BCBSNC:** The Plan may present any oral testimony or written evidence it wants the appeals committee to consider. The practitioner/provider or his or her representative will have the opportunity to cross-examine any witness testifying on the Plan's behalf.
- **Presentation of evidence by practitioner/provider:** After the Plan submits its evidence, the practitioner/provider may present evidence to rebut or explain the situation or events described by the Plan. The Plan will have the opportunity to cross-examine any witness testifying on the practitioner's/provider's behalf.

- **Plan rebuttal:** The Plan may present additional witnesses or written evidence to rebut the practitioner's/provider's evidence. The practitioner/provider will have the opportunity to examine any additional witnesses testifying on the Plan's behalf.
- **Summary statements:** After the parties have submitted their evidence, first the Plan and then the practitioner/provider will have the opportunity to make a brief closing statement. In addition parties will have the opportunity to submit written statements to the appeal committee. The appeals committee will establish a reasonable time for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
- **Examination by the appeals committee:** Throughout the hearing, the appeals committee may question any witness who testifies.

The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear. In the hearing the practitioner has the right to representation by an attorney or other person of the practitioner's choice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated in preparation thereof, to call, examine, and cross-examine witnesses, to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and to submit a written statement at the closing of the hearing. Upon completion of the hearing, the practitioner involved has the right to receive a written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendation, and to receive a written decision of the health care entity, including a statement of the basis for the decision. The practitioner will be notified via certified letter within five (5) days from the date of the hearing of the final determination.

If a request for reconsideration or a formal hearing is not made by the practitioner within thirty (30) days of the receipt of the initial notification or fifteen (15) days from the receipt of the notification of the Level I appeal decision, the Plan will assume the provider has forfeited their appeal rights and proceed with the termination as stated in the initial notification letter. A copy of the original notification will be sent to Network Management operations to proceed with termination from all networks. Communication will be sent from Network Management operations to the credentialing manager's administrative assistant to confirm the termination of the provider with copies sent to the managers of credentialing complaint will be forwarded to the delegated practitioner's credentialing department for follow up. Any actions taken by the delegated practitioner as follow up must be documented and a copy forwarded to BCBSNC.

Based on the credentialing committee recommendation to decredential the practitioner, a report is made to the appropriate licensing board. The report details the disciplinary action taken against the practitioner resulting in their loss of privileges to participate in the BCBSNC managed care network.

Chapter 20

The Blue Book℠
Provider e-Manual

Credentialing

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20.1 Credentialing/recredentialing

The purpose of credentialing physicians and providers is to exercise reasonable care in the selection and retention of competent, participating providers. The initial credentialing process can take up to sixty (60) days for completion from the date a completed application is received by BCBSNC. BCBSNC facilitates all credentialing activity for BCBSNC. The BCBSNC credentialing department deems an application to be complete when all applicable sections of the uniform application are completed accurately, along with all required supporting documentation. This process includes, but is not limited to, verification and/or examination of:

- North Carolina license
- Uniform application to participate as a health care practitioner
- DEA
- Sufficient comprehensive general liability and professional insurance coverage
- Medicare/Medicaid sanctions
- National Practitioner Databank "NPDB"
- Health Care Integrity Protection Databank "HIPDB"
- Hospital privileges or letter stating how patients are admitted
- Board certification*
- Other pertinent documentation
- In some instances a letter of recommendation from the chief of staff or department chair may be required (i.e., if malpractice settlements exceeding $200,000 and/or two (2) or more malpractice settlements)

Initial credentialing requires a signed and dated uniform application to participate as a health care practitioner and the supporting documentation. Full instructions by medical specialty along with a copy of the uniform application can be found on the Web site ***bcbsnc.com***. All documents should be sent to the BCBSNC credentialing department for verification and processing. To ensure that our quality standards are consistently maintained, providers are recredentialed every three (3) years.

We require initial credentialing of any practitioner who seeks reinstatement in any of our networks after being out-of-network for more than thirty (30) days. Please note that this is a change from the previous time frame of ninety (90) days.

* For physicians that are not board certified, letters of reference will be required in support of the application.

20.2 Requirements for provider credentialing and provider rights

BCBSNC follows a documented process governing contracting and credentialing, does not discriminate against any classes of health care professionals, and has policies and procedures which govern the denial, suspension and termination of provider contracts. This includes requirements that providers meet Original Medicare requirements for participation, when applicable. Qualified providers must have a Medicare provider number for participation.

Providers are required to meet and to continue to meet all applicable credentialing standards adopted or utilized by BCBSNC during the term of their participation, including the requirement to possess and maintain a current unrestricted medical license, hospital privileges (if applicable), and DEA registration certificate (if applicable). Providers are required to notify BCBSNC of subsequent changes in the status of any information relating to provider's professional credentials, including a change in the status of his/her medical license, hospital privileges, or DEA registration certificate. Providers are required to participate in and cooperate with BCBSNC credentialing and recredentialing processes, and to comply with determinations made pursuant to the same.

20.3 Policy for practitioners pending credentialing

The BCBSNC credentialing department must deem a practitioner's credentialing complete and effective on or before providing service to a BCBSNC member in order to receive the practitioners contracted reimbursement for member's covered services.

Claims for covered services provided to members by a non-participating practitioner in a participating provider group will be denied unless preapproved. The BCBSNC member will be held harmless, including any copayments, coinsurance and/or deductibles.

20.3.1 Credentialing process

Participating practitioners are encouraged to consider the time required to complete the credentialing process as you add new practitioners to your practices. To assist you in maintaining accessibility in circumstances where your practice, and/or the new practitioner, is unable to submit the credentialing application in a timely manner, we have created a standard operating procedure that will allow reimbursement for covered services provided by a non-participating practitioner who is in the process of joining a BCBSNC participating practice. The following must apply:

- A credentialing application must have been submitted to BCBSNC and a determination on such application is pending, and
- The new practitioner must provide covered services to BCBSNC members under the direct supervision of a BCBSNC-similarly licensed and credentialed practitioner at the practice who signs the medical record related to such treatment and files the claim under his or her current provider number, and
- A statement of supervision form is completed and submitted to your local BCBSNC Network Management office (the form may be obtained by contacting your local Network Management office, if needed).

For a copy of the new standard operating procedure outlining the details of this process, or if you have questions, please call your local Network Management field office for further assistance (see chapter 2, Contacting BCBSNC and general administration).

20.4 Credentialing grievance procedure

There are times when BCBSNC must take immediate action to terminate a provider's contract in order to maintain the integrity of the network and/or to maintain the availability of quality medical care for members. Reasons justifying immediate terminations are specified in the provider's contract, and may include:

- Loss of license to practice (revocation or suspension)
- Loss of accreditation or liability insurance
- Suspension or termination of admitting or practice privileges of a participating physician
- Actions taken by a court of law, regulatory agency, or any professional organization which, if successful, would materially impair the provider's ability to carry out the duties under the contract
- Insolvency, bankruptcy, or dissolution of a practice

Upon receipt of notification of these actions the affected provider will be notified of BCBSNC's intent to terminate him/her from the network. In addition to the circumstances outlined above, other information may be received regarding a network provider, which may impact the participation status of that physician. This would include reports on providers describing serious quality of care deficiencies. Whenever information of this nature is received, it is evaluated through the normal credentialing review process which includes review and recommendation by our credentialing committee.

20.4.1 Provider notice of termination for recredentialing (level I appeal)

If the credentialing committee's recommendation is to terminate a provider from the network for documented quality deficiencies or failure to comply with recredentialing policies and procedures, the provider file is forwarded for an expedient review by law and regulatory affairs.

- The provider is formally notified, via certified mail, of our intent to terminate and the specific reason for the proposed action. The provider is informed of his or her right to appeal.
- The provider may request a level I appeal by providing additional written documentation which may include further explanation of facts, office or other medical records or other pertinent documentation within 30 days from the date or the initial notification of termination.
- Our credentialing committee will review the additional information provided and make a recommendation to either uphold or reverse the original determination. The provider will be notified via certified mail of the decision and of his/her right to request a level II appeal if the decision is unchanged.

20.4.2 Level II appeal (formal hearing)

A request for a level II appeal must be made within 15 days of the date of the certified letter from the results of the level I appeal.

Practitioners requesting hearings within the specified timeframe will be sent an acknowledgement letter within 5 days giving notice as to the date, time and location of the hearing. The date of the hearing should not be less than 30 days after the date of the notice.

A list of witnesses (if any) expected to testify on behalf of BCBSNC's credentialing committee should be given to the practitioner and similar information requested from the practitioner, i.e., notice of representation, witness(es).

BCBSNC will determine if the hearing will be held before an arbitrator mutually acceptable to the provider and the Plan, before a hearing officer who is appointed by the Plan and is not in direct economic competition with the practitioner, or before a panel of Plan appointed individuals not in direct competition with the practitioner involved.

A description of the formal hearing process includes, but may not be limited to, the following:

- **Representation:** The practitioner/provider and BCBSNC may be represented by counsel or other person of their choice.
- **Court reporter:** BCBSNC may arrange for a court recorder to provide a record of the hearing. If BCBSNC does not arrange for a court recorder, it will arrange for an audio-taped record to be made of the hearing. Copies of this record will be made available to the practitioner/provider upon payment of a reasonable charge.
- **Hearing officer's statement of the procedure:** Before evidence or testimony is present, the hearing officer of the level II appeals committee will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- **Presentation of evidence by BCBSNC:** BCBSNC may present any oral testimony or written evidence it wants the appeals committee to consider. The practitioner/provider or his/her representative will have the opportunity to cross-examine any witness testifying on BCBSNC's behalf.
- **Presentation of evidence by practitioner/provider:** After BCBSNC submits its evidence, the practitioner/provider may present evidence to rebut or explain the situation or events described by BCBSNC. BCBSNC will have the opportunity to cross-examine any witness testifying on the practitioner's/provider's behalf.
- **BCBSNC rebuttal:** BCBSNC may present additional witnesses or written evidence to rebut the practitioner's/provider's evidence. The practitioner/provider will have the opportunity to cross-examine any additional witnesses testifying on BCBSNC's behalf.
- **Summary statements:** After the parties have submitted their evidence, first BCBSNC and then the practitioner/provider will have the opportunity to make a brief closing statement. In addition, the parties will have the opportunity to submit written statements to the appeals committee. The appeals committee will establish a reasonable time for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
- **Examination by the appeals committee:** Throughout the hearing, the appeals committee may question any witness who testifies.

The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear. In the hearing the practitioner has the right to representation by an attorney or other person of the practitioner's choice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated in preparation thereof, to call, examine, and cross-examine witnesses, to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and to submit a written statement at the closing of the hearing. Upon completion of the hearing, the practitioner involved has the right to receive a written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendation, and to receive a written decision of the health care entity, including a statement of the basis for the decision.

The practitioner will be notified via certified letter within five (5) days from the date of the hearing of the final determination.

If a request for reconsideration or a formal hearing is not made by the practitioner within thirty (30) days of the receipt of the initial notification or fifteen (15) days from the receipt of the notification of the level I appeal decision, BCBSNC will assume the provider has forfeited their appeal rights and proceed with the termination as stated in the initial notification letter. A copy of the original notification will be sent to Network Management operations to proceed with termination from the network. Communication will be sent from Network Management operations to the credentialing manager's administrative assistant to confirm the termination of the provider with copies sent to the managers of credentialing, Network Management, marketing, and customer service.

If a request is made by the practitioner, the termination process will be suspended awaiting the outcome of the reconsideration or formal hearing.

The practitioner may be reinstated if so indicated by the outcome of the hearing. If the decision is unchanged the Plan will proceed with termination.

If BCBSNC identifies quality concerns related to a delegated practitioner, the complaint will be forwarded to the delegated practitioner's credentialing department for follow up. Any actions taken by the delegated practitioner as follow up must be documented and a copy forwarded to BCBSNC to be placed in the subscriber file.

Based on the credentialing committee recommendation to decredential the practitioner, a report is made to the appropriate licensing board. The report details the disciplinary action taken against the practitioner resulting in their loss of privileges to participate in the BCBSNC managed care network.

Chapter 21

The Blue Book℠
Provider e-Manual

Brand regulations – how to use our name and logos

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Brand regulations are the legal rules that must be followed when using the BCBSNC brand, and must be consistent with the terms of the participation agreement with BCBSNC.

21.1 Logo usage

Blue Medicare HMO℠ and Blue Medicare PPO℠ logos are available for use. Please do not alter any elements within the logos.

21.2 Approvals

All marketing pieces (excluding general/operational business letters) that are being developed for dissemination to the public must be reviewed and approved by BCBSNC or its designer prior to use.

All BCBSNC Medicare materials, after approval by advertising and brand marketing, must be submitted by BCBSNC for review and/or approval by CMS, which carries up to a 45-day mandated allowable approval time.

For questions, please contact your provider relations coordinator who can facilitate the process for you.

21.2.1 Sample Blue Medicare HMO℠ and Blue Medicare PPO℠ logos

Blue Medicare HMO℠
Offered by Blue Cross and Blue Shield of North Carolina

Blue Medicare PPO℠
Offered by Blue Cross and Blue Shield of North Carolina

Chapter 22

The Blue Book℠
Provider e-Manual

Health Insurance Portability and Accountability Act "HIPAA"

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The Health Insurance Portability and Accountability Act of 1996 "HIPAA" calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans, and employer groups.

Processes targeted for simplification include:

- Electronic transactions
- Code sets and identifiers
- Security
- Privacy

Please also reference the HIPAA companion guide on the BCBSNC Web site at ***http://www.bcbsnc.com/content/providers/blue-medicare-providers/electronic-commerce/index.htm***.

22.1 Electronic transactions

The administrative simplification provisions mandate of HIPAA requires that all payers, providers, and clearinghouses use specified standards when exchanging data electronically. Providers and payers must be able to send and receive transactions in the designated EDI format. Providers will be able to send and receive information from health plans and payers, using the following standardized formats:

- Claims
- Claims status
- Remittance
- Eligibility
- Authorizations/referrals

22.2 Code sets and identifiers

Providers should use the following standardized codes to submit claims to health plans:

- ICD-9 - CM
- CPT
- HCPCS
- CDT (were HCPCS dental codes, but now ADA code, pre-fixed with "D")

These common code sets enable a standard process for electronic submission of claims by providers. BCBSNC has adopted consistent standards, code sets and identifiers for claims submitted electronically and on paper. Code sets must be implemented by the effective date to avoid claims denials.

BCBSNC will maintain taxonomy or specialty codes currently in use and will continue to assign these codes for new providers. The codes are determined during the credentialing and contracting process.

BCBSNC only accepts active codes from national code set sources such as ICD-9, CPT, and HCPCS, as part of our HIPAA compliance measures. As new codes are released, please convert to them by their effective date in order to prevent claims from being mailed back for recoding or resubmission. Deleted codes will not be accepted for dates of service after the date the code becomes obsolete. Contact your local Network Management representative if you have questions.

Common identification numbers will be created for providers, payers and employers, and will be recognized by all entities when performing electronic transactions. Standards for these unique identifiers are currently under development.

22.3 Security

BCBSNC maintains a comprehensive security program for safeguarding protected health information in order to meet the requirements of the HIPAA security rule and the North Carolina Customer Information Safeguards Act. HIPAA security requires a covered entity to provide administrative, technical and physical safeguards for protected health information maintained in electronic form. The North Carolina Customer Information Safeguards Act requires North Carolina insurance companies to protect customer information in all formats, whether electronic, paper or oral.

22.4 Privacy

Privacy regulations address the way in which a health plan, provider or health care clearinghouse may use and disclose individually identifiable health information, including information that is received, stored, processed or disclosed by any media, including paper, electronic, fax or voice. Regulations do allow for the sharing of information for treatment, payment and health care operations, including such Plan required functions as quality assurance, utilization review or credentialing, without patient consent. Limited sharing of information may be allowed in instances where national security may be impacted. Please refer to our notice of privacy practices enclosed in this provider manual.

22.5 Additional HIPAA information

- BCBSNC has adopted consistent standards, code sets and identifiers for claims submitted electronically and on paper.
- Additional HIPAA information is available through the following organizations:
  - ‡ Department of Health and Human Services at ***www.hhs.gov***
  - ‡ North Carolina Healthcare and Information and Communications Alliance at ***www.nchica.org***
  - ‡ Centers for Medicare and Medicaid Services at ***www.cms.gov/hipaa*** or call **1-410-786-3000**

Chapter 23

The Blue Book℠
Provider e-Manual

Privacy and confidentiality

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BlueCross BlueShield of North Carolina

At Blue Cross and Blue Shield of North Carolina "BCBSNC," we take very seriously our duty to safeguard the privacy and security of our members protected health information "PHI," as we know you do. In connection with recent developments concerning the law of privacy and security of PHI, including the HIPAA Privacy and Security Rules and the North Carolina Customer Information Safeguards Act, we have updated our corporate privacy policies and procedures. The highlights of these policies are described below. As contracting providers, we want you to understand how we protect our members' information.

- We protect all personally identifiable information we have about our members, and disclose only the information that is legally appropriate. Our members have the right to expect that their PHI will be respected and protected by BCBSNC.
- Our privacy and security policies are intended to comply with current state and federal law, and the accreditation standards of the national committee for quality assurance. If these requirements and standards change, we will review and revise our policies, as appropriate. We also may change our policies (as allowed by law) as necessary to serve our members better.
- To make sure that our policies are effective, we have designated a chief privacy official and a privacy and security committee that are charged with approving and reviewing BCBSNC's privacy and security policies and procedures. They are responsible for the oversight, implementation and monitoring of the policies.

23.1 Our fundamental principles for protecting PHI

- We will protect the confidentiality and security of PHI, in all formats, and will not disclose any PHI to any external party except as we describe in our privacy notice or as permitted or required by law or regulation.
- Each of our employees receives training on our policies and procedures and must sign a statement when they begin work with us, acknowledging that they will abide by our policies. Only employees who have legitimate business needs to use members' PHI will have access to personal information.
- When we use outside parties (business associates) to perform work for us, as part of our insurance business, we require them to sign an agreement, stating that they will protect members' PHI and will only use it in connection with the work they are doing for us.
- We communicate our practices to our members, through our privacy notice, newsletter articles and during the enrollment process they follow when becoming a BCBSNC member.
- We will disclose and use PHI only where:
  - ‡ required or permitted by law
  - ‡ we obtain the member's authorization
- We will respect and honor our members' rights to inspect and copy their PHI, request an amendment or correction to their PHI, request a restriction on use and disclosure of PHI, request confidential communications, file a privacy complaint, request an accounting of disclosures and request a copy of our notice of privacy practices.

Please read BCBSNC notice of privacy practices for more information about our privacy policies. Our notice may be updated from time to time. Please visit our Web site, ***bcbsnc.com***, for the most current version.

23.2 Privacy

If a member pays the total cost of medical services and requests that a provider keep the information confidential, the provider must abide by the member's wishes and not submit a claim to BCBSNC for the specific services covered by the member. In accordance with section 13405, "Restrictions on certain disclosures and sales of health information," of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, "ARRA" and any accompanying regulations, you may bill, charge, seek compensation or remuneration or collection from the member for services or supplies that you provided to a member if the member requests that you not disclose personal health information to us, and provided the member has paid out-of-pocket in full for such services or supplies. Unless otherwise permitted by law or regulation, the amount that you charge the member for services or supplies in accordance with section 13405 of ARRA may not exceed the allowed amount for such service or supply. Additionally, you are not permitted to (i) submit claims related to, or (ii) bill, charge, seek compensation or remuneration or reimbursement or collection from us for services or supplies that you have provided to a member in accordance with section 13405 of ARRA.

Chapter 24

The Blue Book℠
Provider e-Manual

Medicare Advantage and Part-D compliance training

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BlueCross BlueShield of North Carolina

24.1 Medicare Advantage and Part-D compliance training for participating providers and their business affiliates

As you are aware, Blue Cross and Blue Shield of North Carolina "BCBSNC," has a contract with the Centers for Medicare & Medicaid Services "CMS" to provide Medicare Advantage Plans. The services that you provide help us to fulfill our contractual obligations with the federal government. Because of these obligations it's important to us that we remind you, as a participating provider, about regulatory requirements that affect your Medicare Advantage contract and require you and your business partners to comply with all laws and regulations applicable to your services.

On December 5, 2007, CMS issued a final rule clarifying requirements for Medicare subcontractors, including Medicare Advantage providers. This rule requires that all such providers participate in a CMS approved compliance program. As a result, a new training requirement was instituted as of January 1, 2009, which in general, requires the following:

1) **Compliance training:** All of your employees working under our contract with you must complete annual Medicare compliance training.
2) **SIU hotline:** All personnel working on our contract must be informed about our Special Investigation Unit's "SIU" hotline number for reporting suspected fraud, waste or abuse of noncompliance with Medicare rules.
3) **Your subcontractors:** Any of your subcontractors working on our contract must be made aware of these requirements, take the compliance training, and be informed of our SIU hotline number for reporting suspected fraud.

SIU hotline **1-800-324-4963**

As an available option to fulfill this training requirement, we've partnered with the nationally-recognized, National Health Care Anti-Fraud Association "NHCAA" and the Blue Cross and Blue Shield Association "BCBSA" to develop a computer-based training program entitled, "Medicare Advantage and Part-D Compliance Training – Recognizing and Reporting Fraud Waste and Abuse." This training has been reviewed by CMS and should satisfy your training requirement under your other Medicare Advantage contracts, in addition to your agreement with BCBSNC.

Our vendor, LearnSomething, Inc. is administering the online mandatory training, which includes an access fee that is payable upon enrollment. We have arranged a discounted rate of $14.95 per person. Bulk rates are also available through the vendor. The online training can be accessed via the Blue Cross and Blue Shield of North Carolina "BCBSNC" Web site, located at:

- ***http://www.bcbsnc.com/content/providers/blue-medicare-providers/training.htm***

Please note that if your organization has completed a CMS-approved compliance training through another organization or vendor, you may not have to retake the training.

Please note that we are currently evaluating an additional piece of the requirement that may require our collection of an attestation form to document training completion of providers who have received compliance training from a source other than our vendor LearnSomething, Inc.

If you've already completed the required compliance training, we thank you! If you've not yet completed the required compliance training, we thank you in advance for your cooperation.

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

Chapter 25

The Blue Book℠
Provider e-Manual

Forms

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The following forms are referenced in the preceding sections of this guide. We have included copies of the following forms for you to copy and use at your convenience.

- Request for durable medical equipment/home health service
- Medicare Advantage – power operated vehicle "POV"/motorized wheelchair request form
- Medicare Advantage – prescription drug plan prior approvals request form
- Medicare Advantage – prescription drug plan non-formulary drug request form
- Provider inquiry form
- Level one provider appeal form for Blue Medicare HMO℠ and Blue Medicare PPO℠

Sample request for durable medical equipment/home health services

Request for Durable Medical Equipment/Home Health Services

Member Name: _____

Member Number: _____ Ordering Physician: _____

Diagnosis/Medical Justification:

Durable Medical Equipment

Item(s) requested:

Start date: _____

Stop date: _____

Special instructions:

Skilled Home Health Visits

Type of service requested:

- ☐ RN visit
- ☐ LPN visit
- ☐ PT visit
- ☐ ST visit
- ☐ OT visit
- ☐ Respiratory therapy visit

Frequency of visits:

_____ time(s) per day

_____ hour(s) per day

Start date: _____

Stop date: _____

Special instructions:

IV Therapy

Service requested:

- ☐ IV antibiotics
- ☐ IV hydration
- ☐ IV pain control
- ☐ TPN
- ☐ IV Chemotherapy
- ☐ Other _____

Current venous access:

- ☐ Subclavian line
- ☐ Peripheral line/heplock
- ☐ Will need peripheral line started

Mode of infusion:

- ☐ Pump
- ☐ Gravity
- ☐ No preference

Does the member have a primary care giver at home? ☐ Yes ☐ No

Allergies? _____

Has the patient tried this medication before? ☐ Yes ☐ No

Medication/solution requested: _____

Dosage: _____

Frequency: _____

Start date: _____

Stop date: _____

Special instructions:

Sample Medicare Advantage – Power Operated Vehicle "POV"/motorized wheelchair request

Medicare Advantage – Power Operated Vehicle "POV"/Motorized Wheelchair Request Form

Patient Name:	Patient ID# and Date of Birth:
Physician Name:	Physician Phone Number:
DME Item Requested (check only one box): ☐ POV/Scooter ☐ Motorized Wheelchair	Patient's Medical Diagnosis(es):

Please answer the questions below. Submit this form and all medical records to support your answers and the medical necessity of the requested equipment. The medical notes must be submitted with this request.

1. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of a daily living (MRADLs) in the home? ☐ Yes ☐ No

   If yes, please describe the specific mobility limitation and quantify the degree of impairment. _____

   _____

2. Does the patient have other conditions that limit the patient's ability to participate in MRADLs at home? ☐ Yes ☐ No

   If yes, what are the conditions? _____

3. Can the patient's mobility needs in the home be sufficiently resolved with the use of a cane or walker? ☐ Yes ☐ No
4. Can the patient's mobility needs in the home be sufficiently resolved with the use of a manual wheelchair? ☐ Yes ☐ No
5. Does the patient's typical environment support the use of wheelchairs including scooters/POVs? ☐ Yes ☐ No
6. Does the patient have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? ☐ Yes ☐ No
7. Does the patient have sufficient strength and postural stability to operate a POV/scooter? ☐ Yes ☐ No
8. If a power wheelchair is being requested, are the features requested needed to allow the patient to participate in one or more MRADLs? ☐ Yes ☐ No

I certify that, to the best of my knowledge, my answers to the above questions are accurate and supported by the attached medical records.

Physician Signature: _____

Please return completed form to case management:

Fax Number: **1.336.659.2945** or

Address: **Blue Cross and Blue Shield of North Carolina**
Attention: Health Services – Case Management
PO Box 17509
Winston-Salem, NC 27116-7509

10/26/2005

Sample Medicare Advantage – prescription drug plan prior approvals request form

Medicare Advantage – Prescription Drug Plan Prior Approvals Request Form

Incomplete form may delay processing.

Physician name		Patient name
Office contact person		Patient ID number
Physician phone	Physician FAX	Patient date of birth
Physician address Street _____ City _____ State _____ ZIP _____		

Name of medication requested _____

Dosage form of medication requested _____
(injectable, pill/capsule/tablet, suppository, liquid, etc.)

PART D coverage of certain drugs is available only if coverage is not available under PART B.
(Please see the DMERC Web site at ***http://palmettogba.com*** for PART B coverage clarification.)

Clinical reasons drug covered under PART D drug benefit: _____

_____

_____

_____

I certify that the member meets criteria for PART D coverage of this drug.

Physician signature _____

Please return completed form to:

Fax Number: **1.888.446.8535**

Address: **Blue Cross and Blue Shield of North Carolina**
Attention: Exceptions-Health Services
PO Box 17509
Winston-Salem, NC 27116-7509

Provider telephone: **1.888.296.9790**

9/26/2005

Sample Medicare Advantage – prescription drug plan non-formulary drug request form

Medicare Advantage – Prescription Drug Plan Non-Formulary Drug Request Form

Incomplete form may delay processing.

Physician name	Patient name	
Office contact person	Patient ID number	
Physician phone	Physician FAX	Patient date of birth
Physician address Street _____ City _____ State _____ ZIP _____		

Name of medication requested _____

Dosage form of medication requested _____
(injectable, pill/capsule/tablet, suppository, liquid, etc.)

Formulary alternatives tried and failed _____

Reason for failure _____

Additional clinical justification for alternative medication requested (please be specific):

_____

_____

Please complete the following if applicable:
Certain drugs may be covered under Medicare PART D or PART B. (Please see the DMERC Web site ***http://palmettogba.com*** for PART B coverage clarification.) If drug is covered under PART D, please give reasons below:

_____

_____

I certify that the member meets criteria for PART D coverage of this drug.

Physician signature _____

Please return completed form to:

Fax Number: **1.888.446.8535**

Address: **Blue Cross and Blue Shield of North Carolina**
Attention: Exceptions-Health Services
PO Box 17509
Winston-Salem, NC 27116-7509

Provider telephone: **1.888.296.9790**

9/26/2005

Sample provider inquiry form

Provider Inquiry Form

Please let us know whenever you have a problem or a question. Complete all sections if your inquiry concerns a specific patient. If it is a general inquiry, complete the applicable sections. Please fax to the following number **1-336-659-2962**.

Please print or type:

Provider's last name _____ First name _____ Provider number _____

Practice name _____ Office address (number, street, suite number) _____

City, State, ZIP _____ Phone number _____ Fax number _____

Patient's last name _____ First name _____ Member ID number _____

Date of service _____ Date of inquiry _____ Contact name for follow-up _____

Nature of inquiry (please check the box that applies and comment):
- ☐ Claim status
- ☐ Requested information attached
- ☐ Reason for denial
- ☐ Other: please explain _____

Provider's comments: _____

_____

_____

_____

_____

_____

_____

Status of claim

- ☐ Claim paid on: _____ Check number: _____ Amount: _____
- ☐ Claim is pending for: _____
- ☐ No record of claim receipt: _____
- ☐ Claim denied due to: _____
- ☐ Claim in process: _____
- ☐ Other: _____

_____

_____

_____

Sample level one provider appeal form for Blue Medicare HMO℠ and Blue Medicare PPO℠

Level One Provider Appeal Form for Blue Medicare HMO℠ and Blue Medicare PPO℠

BlueCross BlueShield of North Carolina
An independent licensee of the Blue Cross and Blue Shield Association.

Section I: patient information

Alpha prefix (copy from the member's BCBSNC identification card)

Patient date of birth

Subscriber number (copy from the member's BCBSNC identification card)

Patient name (first, middle initial, last)

Section II: physician information

Requesting physician (print first, last name)

Requesting physician's signature (signature and date)

Fax

Fax

BCBSNC physician number

Physician NPI number

Physician mailing address (street or P.O. box, city, state and zip code)

Section III: appeal information

Date of service

Date of notification of payment

CPT codes

Diagnosis codes

Claim identification number

Appeal reason (select one reason only)

- ☐ Coding/bundling or fee denials
- ☐ Cosmetic
- ☐ Experimental/investigational
- ☐ Financial recovery
- ☐ Global period denial
- ☐ No authorization for inpatient information
- ☐ Non-contracted provider payment dispute
- ☐ No medically necessary
- ☐ Re-bundling
- ☐ Services not eligible for separate reimbursement

Fax number for post service appeals – 919.287.8815

Note: All other requests should be submitted using the provider inquiry form in the Blue Medicare HMO℠ and Blue Medicare PPO℠ provider manual.

Comments (if additional space is needed, please use the back of this form)

☐ Records Attached

This form is intended for use only when requesting a review for a post service appeal requests for Medicare Advantage membership. Completed forms accompanied by any supporting documentation should be sent to: **Provider Appeals Unit, Blue Medicare HMO℠ and Blue Medicare PPO℠, P.O. Box 17509, Winston-Salem, NC 27116-7509** or **Fax: 919.287.8815**.

Glossary of terms

Additional benefits – Health care services not covered by Medicare.

Agreement – The agreement between BCBSNC and members that includes certificate of coverage, riders, amendments and attachments.

Annual Election Period "AEP," enrollment period – The AEP is the period of November 15 through December 31 during which Medicare beneficiaries may elect enrollment in an MA Plan for the following year. This period will also be the period during which an enrollee in an MA Plan may elect to return to original Medicare or elect a different MA Plan. In addition to the AEP, BCBSNC will accept applications during a continuous enrollment period each month unless it provides notice to CMS and the public that it has changed its continuous open enrollment policy.

Basic benefits – All health care services that are covered under the Medicare Part A and Part B programs (except hospice services), and additional services that we use Medicare funds to cover.

Benefit period – A "spell of illness" is a period of consecutive days that begins with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services and the spell of illness ends with the close of a period of sixty (60) consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of a skilled nursing facility. To determine the sixty (60) consecutive day period, begin counting with the day on which the individual was discharged. Spell of illness also applies to home health.

Calendar year – A twelve (12) month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Certificate of Coverage "COC" – The document which describes services and supplies provided to a member. Same as evidence of coverage.

Center for Health Dispute Resolution "CHDR" – An independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Blue Medicare HMO℠ and Blue Medicare PPO℠.

CMS – Refers to the center for Medicare & Medicaid services. It is the agency responsible for administering Medicare and federal participation in Medicaid. It also oversees the provision of health care benefits to Medicare beneficiaries by CMS-approved Medicare Advantage organizations.

Coinsurance – A fixed percentage of the recognized charges for a covered service that a member is required to pay to a provider.

Coordination of Benefits "COB" – Means those provisions, which BCBSNC uses to coordinate benefits for costs incurred due to an incident of sickness or accident, which may also be covered by another insurer, group service plan or group health care plan. These provisions are also known as Medicare Secondary Payer "MSP."

Copayment – Means a fixed dollar amount of payment made by a member to a provider. Copayments must be made at the time services and/or supplies are received. The schedule of copayments can be found in attachment A of the certificate of coverage.

Custodial care – Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets and taking medication. Custodial care is not covered by BCBSNC or original Medicare unless provided in conjunction with BCBSNC approved skilled nursing care.

Designated provider/authorized provider – Refers to the provider appointed by BCBSNC to provide a specific covered service.

Disenrollment – Means the process of ending or terminating membership in BCBSNC.

Drugs – Defined as inpatient medications which require a physician's order or outpatient medications which require a prescription. To be covered, a drug must be covered by Medicare and BCBSNC using Medicare coverage guidelines.

Durable Medical Equipment "DME" – Means equipment which is: (a) designed and intended for repeated use; and/or (b) primarily and customarily used to serve a medical purpose; and (c) generally not useful to a person in the absence of disease or injury; and (d) appropriate for use in the home. Must meet Medicare guidelines for coverage. Braces and prosthetic devices as defined by Medicare are considered part of the DME benefit.

Emergency medical condition – A medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in placing the health of an individual or unborn child in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

Emergency services – Covered inpatient or outpatient services that are (1) furnished by a provider qualified to furnish emergency services; and (2) needed to evaluate or stabilize an emergency medical condition.

Evidence of coverage – Shall have the same meaning as certificate of coverage and refers to this document, which explains covered services and defines our obligations and your rights and responsibilities as a member of BCBSNC.

Exclusions – Items/services, which are not covered under this certificate of coverage.

Experimental and/or investigational – Refers to medical, surgical, psychiatric and other health care services, supplies, treatments, procedures, drug therapies or devices that are determined by BCBSNC to be either: (a) not generally accepted or endorsed by health care professionals in the general medical community as safe and effective in treating the condition, illness or diagnosis for which their use is proposed, or (b) not proven by scientific evidence to be safe and effective in treating the condition, illness or diagnosis for which their use is proposed.

Grievance and appeal procedure – The method of resolving member complaints, grievances and appeals.

Home health services – Shall mean skilled nursing care or therapeutic services provided by an agency or organization licensed by the state and operating within the scope of its license. For home health services to be a covered benefit, the member must be homebound (confined to home), under a plan of treatment established and periodically reviewed and approved by a physician, and in need of intermittent skilled nursing services, physical therapy or speech therapy. (**Please note:** custodial care is not included under this definition.)

Hospice – An organization or agency, certified by Medicare, that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Indemnification, beneficiary financial protection – Ensures that the member can not be held financially liable for payment of fees which are the legal responsibility of BCBSNC. This would include the services of BCBSNC contracting providers as well as non-contracting providers.

Lifetime – Means any period of time throughout the member's life when member is covered by BCBSNC.

"Lock in" – Means, as a member, all of your necessary health care treatment and services (other than emergency medical condition, urgently needed services, out of area renal dialysis and required post-stabilization care), must be provided by a contracting provider, or authorized by BCBSNC.

MA – Refers to the term, Medicare Advantage organization, formerly Medicare+Choice. Provisions of the program are defined under Medicare Part C.

Medically necessary – Refers to the medical need for diagnosis and care of treatment of a member. Medically necessary supplies and services are supplies and services that are: (a) provided for the diagnosis, treatment, cure or relief of a condition, illness, injury or disease and not for experimental, investigational or cosmetic purposes; (b) necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms; (c) within generally accepted standards of medical care in the community; and (d) not solely for the convenience of the member, member's family or the provider. Plan may compare the cost effectiveness of the alternative services or supplies when determining which of the services or supplies will be covered.

BCBSNC shall have the full power and discretionary authority to determine whether any care, service or treatment is medically necessary, subject only to a member's right of grievance and appeal defined in the certificate of coverage, and BCBSNC may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Medicare Part A – Hospital insurance benefits including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

Medicare Part B – Supplementary medical insurance that is optional and requires a monthly premium. This a called the Medicare Part B premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.

Medicare Part C – A federal program with a primary goal of providing Medicare beneficiaries with a range of health plan choices through which to obtain their Medicare benefits. CMS contracts with private organizations offering a variety of private health plan options for Medicare beneficiaries, including both traditional managed care plans, such as HMOs, and new options that were not previously authorized. Originally known as the Medicare+Choice program, it was renamed by CMS and is now known as the Medicare Advantage program.

Medicare Part D – Effective January 1, 2006, this is a new federal program offering prescription drug benefits to Medicare beneficiaries. This benefit can be offered by private organizations including pharmacies and private health plans.

Medicare, Original Medicare – The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Advantage organization – A public or private entity organized and licensed by the State as a risk-bearing entity that is certified by CMS as meeting MA requirements. MA organizations can offer one (1) or more MA Plans. BCBSNC is a Medicare Advantage organization.

There are three (3) types of M+COs, (1) coordinated care plans, like BCBSNC, which include a network of providers that are under contract or arrangement with the MA to deliver the services approved by CMS, (2) Medicare Advantage Medical Savings Accounts "MSA" and (3) Medicare Advantage private fee-for-service plans.

Member – Refers to the Medicare beneficiary, entitled to receive health care services under the terms of this BCBSNC certificate of coverage, who has voluntarily elected to enroll and whose enrollment in the BCBSNC Medicare Advantage Plan has been confirmed by CMS.

National coverage decisions – Refer to coverage issues mandated by Medicare.

Non-contracting medical provider or facility – Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by nor under contract with BCBSNC to deliver covered services. (These providers differ from contracting providers who affiliate with BCBSNC to provide care for Plan members.)

Non-covered services – Those medical services and supplies described in the member's certificate of coverage as not covered by BCBSNC.

Optional supplemental benefits – Those benefits not covered by Medicare which are purchased for an additional Plan premium at the option of the Medicare beneficiary. The existence or availability of optional supplemental benefits may vary by county. BCBSNC does not offer any optional supplemental benefits.

Out-of-area service – Refers to those services and supplies provided outside the Blue Medicare HMO℠ or Blue Medicare PPO℠ service area.

Post-service appeal – Shall have the meaning assigned to that term in section 7.11(c)(ii)(A) of the Thomas/Love Settlement Agreement.

Post-stabilization care – Covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition, as specified by CMS.

Primary Care Physician "PCP" – A contracting physician selected by a BCBSNC member and is responsible for providing or arranging for medical and hospital services covered under this certificate of coverage. **Note:** A person who has acquired the requisite qualifications for licensure and is licensed in the practice of medicine.

Prior authorization – A system whereby a provider must receive approval from BCBSNC before the member is eligible to receive coverage for certain health care services.

Quality Improvement Organization "QIO" – An independent contractor paid by CMS to review medical necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. Upon request, the QIO also reviews hospital discharges for appropriateness and quality of care complaints.

Recognized charge(s) – Means the charge for a covered service which is the lower of (a) the provider's usual charge for furnishing it; or (b) the charge BCBSNC determines to be the recognized charge made for that service or supply. In determining the recognized charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, BCBSNC may take into account factors such as: the complexity; degree of skill needed; type or specialty of the provider; range of services provided by a facility and the prevailing charge in other areas.

Service area – The geographic area approved by CMS within which an eligible Medicare beneficiary may enroll in a particular Medicare Advantage Plan offered by BCBSNC. A listing of the approved service area can be found in chapter 4 of this manual.

Skilled nursing facility – A facility certified by Medicare which provides inpatient skilled nursing care, rehabilitation services or other related health services. The term skilled nursing facility does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Spell of illness – See benefit period.

Supplemental benefits – Those benefits not covered by Medicare for which the MA organization may charge the enrollee an additional Plan premium. These benefits are offered as an option for the Medicare enrollee to select (optional supplemental benefits) or as a requirement for enrollment (mandatory supplemental benefits). BCBSNC does not offer any optional supplement benefits.

Termination date – The date that coverage no longer is effective, (i.e., at 12:00 midnight on the last day coverage is effective). Also referred to as disenrollment date. Coverage typically ends on the last day of the month.

Urgent care facility – A health care facility whose primary purpose is the provision of immediate, short-term medical care for non-life-threatening urgently needed services.

Urgently needed services – Means covered services, that are not emergency services, provided when you are temporarily absent from the BCBSNC service area (or, under unusual and extraordinary circumstances, provided when you are in the service area but your PCP is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required (1) as a result of an unforeseen illness, injury or condition, and (2) it is not reasonable given the circumstances to obtain the services through your PCP.

The Blue Book

Blue Medicare HMO℠ and Blue Medicare PPO℠ Supplemental Guide

Provider *e*-Manual

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