THE Blue BOOK℠

Provider Manual

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BlueCross BlueShield of North Carolina

BlueCross BlueShield of North Carolina

November 2008

Dear Health Care Provider and Office Manager:

Blue Cross and Blue Shield of North Carolina "BCBSNC" is pleased to provide you with this edition of *The Provider eManual Blue Book*℠, your provider reference manual. Information in this guide pertains to all lines of business offered and/or administered by BCBSNC. It is a comprehensive collection of information regarding our products, value-added programs and services.

We hope this information will make it easier for you and your staff to assist us in providing excellent service to your BCBSNC patients. *The Blue Book*℠ *Provider eManual* is intended to supplement your network participation agreement "NPA" with BCBSNC. Nothing in this manual is intended to amend, revoke, contradict or otherwise alter the terms and conditions of your BCBSNC network participation agreement. Please discard any previous BCBSNC reference manual amendments and/or office guides, as many chapters in this edition have been updated making the older material obsolete.

Thank you for your continued support of BCBSNC. Please contact us at **1-336-316-5372** if you have specific suggestions for making *The Blue Book*℠ *Provider eManual* a more useful tool. We value your feedback and want to hear from you.

Sincerely,

Milo M. Brunick
Vice President
Network Management

Enclosure

BlueCross BlueShield
of North Carolina

The Blue Book℠
Provider eManual for Physicians, Ancillary Providers, Hospitals and Facilities

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***.

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, and other Blue Cross and/or Blue Shield Plans, 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 BCBSNC 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.

For the purposes of this manual: insured, policyholder, participant, patient, member, enrollee, subscriber and covered person are terms used to refer to a person who is entitled to receive benefits underwritten or administered by BCBSNC, however such person may be referred to or described in said policy.

November 2008

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SM - Service Mark of the Blue Cross and Blue Shield Association
SM1 - Service Mark of Blue Cross and Blue Shield of North Carolina
® - Registered Mark of the Blue Cross and Blue Shield Association

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Introduction

1. Introduction

1.1 About This Manual

We are pleased to provide you with a completely revised and comprehensive *Blue Book*℠ Provider eManual, 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 BCBSNC insurance products, health coaching and intervention policies and procedures, and the health care claims billing guidelines of Blue Cross and Blue Shield of North Carolina "BCBSNC."

Web site Resource

Please note that BCBSNC will periodically update this manual. The most current version of *The Blue Book*℠ 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's comprehensive major medical "CMM" plans and managed health care programs efficiently with regard to claims and customer service issues.

BCBSNC Health Care Benefit Plans

Health care benefit plans can typically be categorized into four basic plan types: Health Maintenance Organization, "HMO, Preferred Provider Organization, "PPO," Point of Service, "POS" and Comprehensive Major Medical, "CMM." Contracting providers with questions about in which plan(s) they participate, should refer to their individual, health care businesses, Network Participation Agreement "NPA" with BCBSNC, or contact their local network management field office for assistance. Local field office contact information can be found in chapter two of this manual. Except where otherwise indicated, this manual refers to all of the following BCBSNC products as indicated in the following chart:

BCBSNC HMO "Health Maintenance Organization"
• Blue Care® *(open access HMO)*
• Blue HMO℠ *(gatekeeper HMO [RAI only])*
BCBSNC PPO "Preferred Provider Organization"
• Blue Options℠ *(open access PPO)*
• Blue Advantage® *(open access PPO)*
• NC Smart*Choice*℠ *(open access PPO [SHP PPO membership only])*
• Blue Options℠ *(open access PPO [with deductible and coinsurance only])*
• Blue Options℠ *(open access PPO [in-network only])*

CMM "Comprehensive Major Medical"
• Classic Blue® "CMM" • Blue Assurance℠ "CMM" • Access℠ "CMM" • Short Term Health Care "CMM"
BCBSNC POS "Point of Service"
• Currently not offered for BCBSNC active membership

Please note the following:

- Information relative to the Federal Employee Program "FEP" PPO plan can be found in chapter four of this manual.
- Information relative to the North Carolina State Health Plan "SHP" Comprehensive Major Medical Plan "CMM" and NC Health Choice can be found in chapter five of this manual.
- Information relative to the Inter-Plan programs *(including* BlueCard®*)* can be found in chapter six of this manual.
- Information relative to Medicare and Medicare Supplement programs can be found in chapter seven of this manual.

Additionally, we would like to highlight several items that may be of importance to you and the sections in which to find them:

- Phone numbers for contacting BCBSNC — chapter two
- Health benefit plans and sample identification cards — chapter three
- Health coaching and intervention — chapter eight

This manual is intended as a supplement to your network participation agreement "NPA," the agreement by which you as the provider participate in the BCBSNC network(s), the agreement between you as the provider and Blue Cross and Blue Shield of North Carolina "BCBSNC." The NPA is the primary document controlling the relationship between provider and BCBSNC. Nothing contained in the manual is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the NPA.

BCBSNC policies and procedures will change periodically and providers will receive notification of relevant changes as they occur. Providers are encouraged to frequently visit the providers section of the BCBSNC Web site to receive updates and information about issues affecting BCBSNC network participating providers, ***http://www.bcbsnc.com/providers/***.

1.2 Provider eManual Online

The Blue Book℠ 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. In addition to the providers section of the Web, the Provider eManual is also available to providers having free ***Blue e***℠ connectivity. Whether accessing the Provider eManual from the providers section or from ***Blue e***℠, the process to view is the same.

Just click on *The Blue Book*SM 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 computer's tool bar, and select the option to save a copy. Then decide where you want to keep your updated edition of the Provider eManual on your computer, and click on the tab to save.

If you experience any difficulty accessing or opening *The Blue Book*SM from our Web site, or if you're already a ***Blue e***SM user and need assistance with *The Blue Book*SM viewing, please contact your local network management field office *(field office contact information is available on page 2-11 in this manual)*. Additionally, if you cannot access the Web site or ***Blue e***SM, please contact your local network management field office to receive a copy of the manual in another format.

Important: Please note that providers are reminded that this manual 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 eManual in the providers section of the BCBSNC Web site at ***http://www.bcbsnc.com/providers/***, or by using ***Blue e***SM.

1.3 Additional References

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

- Your health care businesses provider network provider agreement "NPA" with BCBSNC
- Our Web site ***bcbsnc.com***
- BCBSNC Provider Blue Line℠ at **1-800-214-4844**
- The *Blue Link*SM online provider newsletters, also located on our Web site ***bcbsnc.com***
- Your network management service team as listed in chapter two, *(Contact Information)*
- BCBSNC medical policies and guidelines, evidence based guidelines, payment guidelines for providers, and our diagnostic imaging management policies that can be accessed on our Web site at ***http://www.bcbsnc.com/services/medical-policy/***.

1.4 Feedback

We value your feedback. Please direct comments regarding this manual to our Network Management Education/Communication Associate at **1-336-316-5372**.

Quick Contact Information

BCBSNC

Magellan Behavioral Health

Value Options

Chiropractic Network of the Carolinas

American Imaging Management

2. Quick Contact Information

(To find contact information for the Federal Employee Program "FEP," The State of North Carolina Teachers' and State Employees' "SHP" Comprehensive Major Medical Plan "CMM" and NC Health Choice, please refer to the corresponding plan specific section that's contained within this manual [see chapter four for FEP, chapter five for SHP CMM]).

To the reader, this chapter of the manual provides basic contact information. Please refer to the topic-specific sections contained within this manual for more detailed subject information.

2.1 Helpful Telephone Numbers

2.1.1 Provider Blue Line℠ 1-800-214-4844

For BCBSNC provider customer service, our Provider Blue Line℠ is a one-stop shop. Providers only need to call one phone number **1-800-214-4844**, and follow the prompts to be connected to the appropriate customer service department. The Provider Blue Line℠ is available to assist if you have questions about:

- Eligibility
- Benefits
- Claims

> ***In a Hurry?***
>
> Providers with ***Blue e℠*** can verify eligibility, benefits/accumulators and claim status, immediately, and from the convenience of their desktop computer. To find out more about signing up for ***Blue e℠***, visit BCBSNC electronic solutions on the Web at:
>
> ***http://www.bcbsnc.com/providers/edi***
>
> or refer to chapter 13 of this manual.
>
> ***Blue e℠*** is quick and easy to use – plus, it's free to our network providers!

The Provider Blue Line℠ **1-800-214-4844** can also assist with information pertaining to:

- Coinsurance/deductibles
- Coordination of benefits
- Overpayments
- Refund requests
- Pre-existing conditions
- Non-clinical appeals
- Authorization status of existing requests, either approved, denied or currently in review *(Please note that new requests for certification should be placed to BCBSNC health coaching and intervention).*

Before calling the Provider Blue Line℠, please have the following information available:

- Your National Provider Identifier "NPI" *(if you do not have a NPI, you may also use your Tax Identification Number "TIN" or BCBSNC issued provider identification number)*
- Patient's identification number and alpha prefix *(when applicable)*
- Patient's date of birth *(mm/dd/yyyy)*
- If calling about a submitted claim, please have the date of service *(mm/dd/yyyy)*
- Amount of charge

About the Provider Blue Line℠ Automated System

The speech recognition system will allow you to speak your responses to all questions. If you encounter speech recognition problems, you may also use your telephone keypad to enter numeric responses. For example, you can use your keypad to enter your NPI, your TIN, the numeric portion of the subscriber number, the patient's date of birth, and any date of service responses. If you have questions about more than one patient, the system will collect information about all your patient inquiries, determine what representatives will need to assist you, and route you to the corresponding call center with the shortest wait time. Assuming that you have provided the basic information asked for by the system, you will not have to repeat anything to the representative. He or she will be ready to assist you with the first member upon answering the call.

Help Us to Help You!

When calling the Provider Blue Line℠ **1-800-214-4844** you should:

- Use a regular handset *(rather than a speakerphone, headset or cell phone)*
- Speak in your normal voice *(speaking louder or more slowly than normal will actually make it more difficult for our system to understand you)*
- Try to place your calls from a quiet area where there is not a lot of background noise
- When the system asks you for the letters at the beginning of the patient's subscriber number, please provide all the letters, including the "W," if there is one.

Once you are familiar with the system, you don't need to listen to the full text of each prompt. If you already know what the system is asking you to do, go ahead and interrupt it! Remember, you may use your telephone keypad for any entries that consist entirely of numbers.

The Provider Blue Line℠ automated services are available:

Day	Hours
Monday - Friday	7 a.m. - 9 p.m.
Saturday	7 a.m. - 3 p.m.
Sunday	8 a.m. - 12 noon

The Provider Blue Line℠ representatives are available:

Day	Hours
Monday - Friday	8 a.m. - 6 p.m.

Please note that the Provider Blue Line℠ automated system will route inquiries to the appropriate representative – but only when it is necessary to speak with a representative.

Also, please remember that many of your customer service needs, including eligibility and claim status inquiries, admission and treatment notifications, and remittance information can be handled using ***Blue e***℠.

2.2 BlueCard® Eligibility 1-800-676-BLUE (2583)

Eligibility and benefits information for BlueCard® out-of-area members can easily and quickly be found from your desktop computer by using ***Blue e***℠. However, if you have not yet signed up for ***Blue e***℠ connectivity, which is free of charge, eligibility and benefits information is still available to you for out-of-area members covered by another Blue Cross and/or Blue Shield Blue Plan. You only need to call BlueCard® Eligibility **1-800-676-BLUE (2583)** to connect to the member's home Plan. BlueCard® Eligibility **1-800-676-BLUE (2583)** should also be called for health coaching and intervention questions about other Blue Plan members. When calling, you will need to the 3-letter alpha prefix at the beginning of the member's identification number. Enter only the first three alpha characters and your call will be automatically routed to the member's Blue Plan.

Please note that the BlueCard® Eligibility Line **1-800-676-BLUE (2583)**, does not handle claims inquiries. Answers to questions about claims for BlueCard® members can be found by using ***Blue e***℠ or by contacting BCBSNC Inter-Plan, BlueCard® Customer Service by calling **1-800-487-5522**.

To find out more about BlueCard® and the Inter-Plan Program, please refer to chapter six of this manual.

2.3 Health Coaching and Intervention 1-800-672-7897

The BCBSNC health coaching and intervention department works with physicians and members to facilitate the most medically appropriate, and cost-effective, quality care for our members. Staff in the health coaching and intervention department is available to assist with arranging:

- Certification requests *(except for mental health/substance abuse)*
  - Certification requests for members enrolled in NC Smart*Choice*℠ **1-800-672-7897**
- Prior review requests *(except for mental health/substance abuse)*
  - Prior review requests for members enrolled in NC Smart*Choice*℠
- Discharge planning *(when calling include extension **51019** to be connected with discharge services)*
  - Discharge planning requests for members enrolled in NC Smart*Choice*℠ **1-800-672-7897** at extension **53065** *(except for mental health/substance abuse)*
- Pharmacy quantity limitations *(when calling include extension **51689**)*
- Transplants

- Medical director reviews *(when calling include extension **57078**)*
- Request a reconsideration of an initial medical necessity denial
- Physician hotline *(when calling include extension **51019**)*

To learn more about health coaching and intervention services, processes and policies, please refer to chapter eight of this manual. Additionally, the BCBSNC health coaching and intervention department makes available fax capability for providers arranging member services and supplying BCBSNC requested documentation. Fax numbers for sending to health coaching and intervention are assigned by region; please refer to chapter eight of this manual to find the regional fax number appropriate for use based on the area of the state that you are located.

Health coaching and intervention is available 24 hours *(to learn more, please see chapter eight of this manual)*:

Support	Day	Hours
Representative	Monday - Friday	8 a.m. - 5 p.m.
Voice Messaging System	Monday - Sunday	Other than regular business hours

2.4 Mental Health and Substance Abuse Services

Magellan Behavioral Health **1-800-359-2422**
Value Options **1-800-367-6143**

The below chart displays the mental health and substance abuse services, intermediary delegated activities for Magellan Behavioral Health, and the member plan exceptions that utilize Value Options or BCBSNC *(to learn more about these delegated activities, please refer to the specialty networks information located in chapter 19 of this manual)*:

Activity	HMO/POS	PPO	CMM
Utilization Management Programs	Magellan Behavioral Health Exception(s): **BCBSNC for members enrolled in Blue HMO℠	Magellan Behavioral Health Exception(s): BCBSNC for members enrolled in Blue Advantage® *Value Options for members enrolled in NC Smart*Choice*℠	Magellan Behavioral Health Exception(s): BCBSNC for members enrolled in Access℠ or Blue Assurance℠
Quality Management	Magellan Behavioral Health Exception(s): **BCBSNC for members enrolled in Blue HMO℠	BCBSNC Exception(s): *Value Options for members enrolled in NC Smart*Choice*℠	BCBSNC

Activity	HMO/POS	PPO	CMM
Claims Processing	Magellan Behavioral Health Exception(s): **BCBSNC for members enrolled in Blue HMO℠	BCBSNC	BCBSNC
Provider Contracting and Network Management	Magellan Behavioral Health Exception(s): **BCBSNC for members enrolled in Blue HMO℠	BCBSNC	BCBSNC
Customer Service	Magellan Behavioral Health Exception(s): **BCBSNC for members enrolled in Blue HMO℠	BCBSNC	BCBSNC
Eligibility and Benefit Verification	Magellan Behavioral Health Exception(s): **BCBSNC for members enrolled in Blue HMO℠	Magellan Behavioral Health or BCBSNC Exception(s): *Value Options for members enrolled in NC Smart*Choice*℠	Magellan Behavioral Health or BCBSNC
First Level Appeals	Magellan Behavioral Health Exception(s): **BCBSNC for members enrolled in Blue HMO℠	Utilization first level appeals: Magellan Behavioral Health Claims first level appeals: BCBSNC Exception(s): *Utilization first level appeals for members enrolled in NC Smart *Choice*℠ are reviewed by Value Options	Utilization first level appeals: Magellan Behavioral Health Claims first level appeals: BCBSNC

*Value Options is the vendor that coordinates mental health and substance abuse services for State Health Plan members enrolled in NC Smart*Choice*℠ PPO. Value Options can be contacted by calling **1-800-367-6143**.

BCBSNC coordinates mental health and substance abuse services for members enrolled in Blue HMO℠. To arrange mental health and substance abuse services for Blue HMO℠ members, providers should call BCBSNC at **1-888-293-7575. Blue HMO℠ is a gatekeeper HMO benefit plan designed for employees of Reynolds American Inc., "RAI." To learn more about Blue HMO℠ please refer to chapter three in this manual.

Please note that intermediaries contract with providers on an individual and/or group basis, which could result in the non-participation of some of the individual providers within a group. Please verify participation status with the intermediary prior to providing services.

2.5 Chiropractic Network of the Carolinas "CNC" 1-704-895-8117

The below chart displays the intermediary, delegated activities, for Chiropractic Network of the Carolinas "CNC" *(to learn more about these delegated activities, please refer to the specialty networks information located in chapter 19 of this manual)*:

Activity	HMO/POS	PPO	CMM
Utilization Management Programs	BCBSNC	BCBSNC	BCBSNC
Quality Management	BCBSNC	BCBSNC	BCBSNC
Claims Processing	*BCBSNC	*BCBSNC	*BCBSNC
Provider Contracting and Network Management	Chiropractic Network of the Carolinas "CNC"	Chiropractic Network of the Carolinas "CNC"	BCBSNC
Customer Service	BCBSNC	BCBSNC	BCBSNC
Eligibility and Benefit Verification	BCBSNC	BCBSNC	BCBSNC
First Level Appeals	BCBSNC	BCBSNC	BCBSNC

*Provider submits claim to CNC – CNC submits claim to BCBSNC – BCBSNC provides appropriate payment to CNC – CNC provides appropriate payment to provider.

Please note that intermediaries contract with providers on an individual and/or group basis, which could result in the non-participation of some of the individual providers within a group. Please verify participation status with the intermediary prior to providing services.

2.6 American Imaging Management, Inc., "AIM" 1-866-455-8414

BCBSNC requires that for non-emergency outpatient CT/CTA, MRI/MRA, PET, and nuclear cardiology procedures when performed in a physician's office, outpatient department of a hospital, or freestanding imaging center, ordering physicians must obtain certification from American Imaging Management, Inc., "AIM." When contacting AIM to arrange these services, please have the following information available:

- Member ID number, name, date of birth, health plan and group number
- Ordering physician information
- Imaging provider information
- Imaging exam(s) being requested *(e.g., body part, right, left or bilateral)*
- Patient diagnosis *(suspected or confirmed)*
- Clinical symptoms/indications *(intensity/duration)*
- For complex cases more information may be necessary, including results of treatment history *(e.g., previous tests, duration of previous therapy, relevant clinical medical history)*

Ordering physicians can obtain and confirm authorizations by contacting AIM in one of three ways:

- By logging on to the AIM portal, accessed through ***Blue e***℠
  Available seven days a week, 4 a.m. to 1 a.m. eastern time
- By calling AIM, **1-866-455-8414** *(toll free)*
  Monday through Friday, 8 a.m. to 5 p.m., eastern time
- By faxing AIM, **1-800-610-0050** *(toll free)*

Imaging service providers can also contact AIM either through the provider portal or by calling **1-866-455-8414** to ensure that an authorization has been issued or to confirm that the authorization information is correct.

If you are not currently registered to use ***Blue e***℠, you will need to register online at ***https://bcbsnc.com/providers/edi/bluee.cfm***. BCBSNC provides ***Blue e***℠ to providers free-of-charge.

Please note that most BCBSNC member groups will be participating in the diagnostic imaging management program, however, not all groups are participating. BCBSNC offers a Web-based search tool that is available on the ***bcbsnc.com*** providers section and on ***Blue e***℠, which will allow you to quickly determine whether an authorization is needed. BCBSNC maintains and updates this system as new groups enter the program. To learn more about the diagnostic imaging management program and what is required, please refer to chapter eight of this manual.

2.7 Mailing Addresses

For fastest claims processing, file electronically! **Visit BCBSNC electronic solutions on the Web at** ***http://www.bcbsnc.com/providers/edi/***	***Blue e*℠**

Health Care Claims	Address
Health care claims – BCBSNC Exception(s): NC Smart*Choice*℠ Blue HMO℠	BCBSNC P.O. Box 35 Durham, NC 27702
Health care claims – NC Smart*Choice*℠	BCBSNC P.O. Box 30087 Durham, NC 27702
Health care claims – Blue HMO℠ *(*Blue HMO℠ *is a "gatekeeper" HMO benefit plan specific to employees of Reynolds American Inc., "RAI." Please send health care claims for other BCBSNC HMO members to P.O. Box 35.)*	BCBSNC P.O. Box 17510 Winston-Salem, NC 27116-7510
Mental Health and Substance Abuse Services Claims	**Address**
Mental health and substance abuse services claims – BCBSNC Exception(s): BCBSNC HMO NC Smart*Choice*℠ Blue HMO℠	BCBSNC P.O. Box 35 Durham, NC 27702
Mental health and substance abuse services claims – BCBSNC HMO	Magellan Behavioral Health NC Unit P.O. Box 1659 Maryland Heights, MO 63043
Mental health and substance abuse services claims – NC Smart*Choice*℠	BCBSNC P.O. Box 30087 Durham, NC 27702
Mental health and substance abuse services claims – Blue HMO℠	BCBSNC P.O. Box 17510 Winston-Salem, NC 27116-7510

Level I Member Appeals	Address
Level I member appeals including a member signed Appeal Authorization Form – BCBSNC Exception(s): BCBSNC HMO mental health and substance abuse services NC Smart*Choice*SM mental health and substance abuse services	BCBSNC Level One Appeals P.O. Box 2291 Durham, NC 27702-2291
Level I member appeals for BCBSNC HMO mental health and substance abuse services	Magellan Behavioral Health NC Unit – Attn: Appeals Coordinator P.O. Box 1619 Alpharetta, GA 30009
Post-Service Provider Courtesy Reviews (also known as Level I Provider Appeals) – BCBSNC Exceptions: BCBSNC HMO mental health and substance abuse services NC Smart*Choice*SM mental health and substance abuse services	BCBSNC Provider Appeals P.O. Box 2291 Durham, NC 27702-2291 *(Please use the Level I Provider Appeal form located in Chapter 23 of this manual.)*
Overpayments	**Address**
Overpayments – BCBSNC Exception(s): BCBSNC HMO mental health and dental	BCBSNC Financial Processing Services P.O. Box 30048 Durham, NC 27702-3048 *(Please use form G252 located in chapter 23 of this manual.)*

2.8 Written Claim Inquiries

If you have a question about how a claim that's been filed to BCBSNC has processed, what amount's paid or disallowed, or maybe you just want to ask the status – ***Blue e***SM can help. Providers with ***Blue e***SM can find out this information and much more, from the convenience of their computer screen and faster than making a phone call. To find out more about ***Blue e***SM visit electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/*** or refer to chapter 13 in this manual.

If you choose to send your claims question in writing, we offer two forms that can help:

1. Provider Claim Inquiry form
2. Provider Resolution form

Both forms are available to be copied from chapter 23 of this manual or can be printed from the BCBSNC Web site ***http://www.bcbsnc.com/providers/***.

Both forms are available to help you find the answers to your questions. However, we do ask that you please use the appropriate form for your question type, to help us route your question to the appropriate department for an answer. If your question pertains to:

- A refund or overpayment, a request about a denial for service(s) not included in a member's health benefit plan, or a claim believed to be processed incorrectly but not due to bundling and/or unbundling, please use the Provider Claim Inquiry form.
- A specific service code(s) and how it bundled or unbundled and/or how charges pertaining to a corresponding code(s) were considered, please use the Provider Resolution form.
  - When using the Provider Resolution form, supporting medical documentation should be submitted. Providers may reduce administrative cost associated with records submissions by first verifying that the records document information consistent with BCBSNC medical policy, pricing and adjudication policy, and Claim Check Clinical "C-3" edit rationale.

Provider Claim Inquiry form	BCBSNC Provider Inquiry Customer Service Department P.O. Box 2291 Durham, NC 27702-2291
Provider Resolution form	BCBSNC Provider Inquiry Attn: Provider Resolution P.O. Box 2291 Durham, NC 27702-2291

Find out what *Blue e*℠ can offer you: *http://www.bcbsnc.com/providers/*

2.9 Provider Demographics – Contacting You

BCBSNC routinely updates the online provider directory with addresses, phone numbers and current lists of all providers at a participating facility/practice, so that our members can quickly locate health care providers and schedule appointments. Our ability to successfully direct members to you for their medical care depends on the accuracy of the information we have on file for your facility/practice. You are encouraged to visit the find a doctor page located on the BCBSNC Web site ***bcbsnc.com*** to validate your health care businesses information.

If you find that your information needs to be updated, please let us know by contacting your local BCBSNC network management field office or complete and return a provider demographic form that can be found on the I'm a provider page on our Web site at ***http://www.bcbsnc.com/providers/***.

Please note that our having accurate mailing information on file for your practice also ensures you receive claims payments and other important correspondence in a timely manner from BCBSNC.

You are required to maintain an e-mail address that can be used by BCBSNC to contact you, and are required to provide that e-mail address to BCBSNC upon request.

2.10 Online Availability

The providers section of our Web site ***bcbsnc.com*** contains a variety of helpful information. Some of the information available includes:

Visit Us On The Web – *bcbsnc.com*	
• Most current *The Blue Book*℠ Provider eManual • Blue Link℠ newsletters • Provider information • Most current prior authorization listing • Medical policies and guidelines • Evidence based guidelines • Payment guidelines for providers • Diagnostic imaging management policies • Medical policy • News releases • Online provider directory • Office-administered specialty drug network • Product information • Health and wellness programs • Online services • Access to care standards • Pharmacy formulary information • and much more. . .	***http://www.bcbsnc.com/providers/***
• ***Blue e***℠ • RealMed • Electronic solutions important news • HIPAA information • Electronic solutions • Electronic solutions vendor list	***http://www.bcbsnc.com/providers/edi/***

Click on the providers tab to access information pertaining to you. Make sure to access the Web site often to stay current on BCBSNC news and publications.

2.11 Electronic Solutions Customer Support 1-888-333-8594

Electronic Claim Filing Issues, *Blue e*℠ and RealMed	**1-888-333-8594 Option 1** **1-919-765-3514** **1-919-765-7101 Fax**

BCBSNC electronic solutions enables the transmission of electronic files for the business processing of health care information. BCBSNC provides electronic solutions in both batch and real-time modes to our contracted health care providers.

Electronic solutions manages the electronic exchange of health care transactions, including claims, remittances, admission notifications, eligibility and claim status inquiries. Electronic solutions provides customer support for all of our trading partners that submit electronic transaction files.

Electronic solutions also offers two Web-based products, ***Blue e***℠ and RealMed, for interactive inquiries about eligibility and claim status, admission notifications and claims entry. BCBSNC has developed electronic solutions that allow contracted health care providers to access detailed claim management information from BCBSNC, and customize that information to the workflows in their organizations. To find out more about BCBSNC electronic solutions, please refer to chapter 13 of this manual, visit our electronic solutions Web site at ***bcbsnc.com/providers/edi***, or contact your local field consultant.

Eastern Region		
Greenville Region **1-704-561-2751** Anson, Cabarrus, Cherokee, Clay, Gaston, Henderson, Jackson, Lincoln, Macon, Mecklenburg, Polk, Rowan, Stanly, Transylvania, Union and Rutherford	**Raleigh Region** **1-336-316-5346** Alamance, Alleghany, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Randolph, Richmond, Rockingham, Stokes, Surry and Yadkin	**Wilmington Region** **1-828-431-3142** Alexander, Ashe, Avery, Buncombe, Burke, Caldwell, Catawba, Cleveland, Graham, Haywood, Iredell, McDowell, Mitchell, Swain, Watauga, Wilkes and Yancey
Western Region		
Charlotte Region **1-704-561-2751** Anson, Cabarrus, Cherokee, Clay, Gaston, Henderson, Jackson, Lincoln, Macon, Mecklenburg, Polk, Rowan, Rutherford, Stanly, Transylvania and Union	**Greensboro Region** **1-336-316-5346** Alamance, Allegheny, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Randolph, Richmond, Rockingham, Stokes, Surry and Yadkin	**Hickory Region** **1-828-431-3142** Alexander, Ashe, Avery, Buncombe, Burke, Caldwell, Catawba, Cleveland, Graham, Haywood, Iredell, McDowell, Mitchell, Swain, Watauga, Wilkes and Yancey

Electronic solutions customer support is available to assist Monday through Friday, 8:00 a.m. to 5:00 p.m.

2.12 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. BCBSNC 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:

Network Management Contact Information:

Network Management		
Region and Office	**Phone**	**Fax**
Greenville/Fayetteville/ Wilmington Region Wilmington Office 2005 Eastwood Road Suite 201 Wilmington, NC 28403	**1-877-889-0001**	**1-910-509-3822**
Raleigh Region Raleigh Office 2501 Aerial Center Drive Suite 225 Morrisville, NC 27560	**1-800-777-1643**	**1-919-765-7109**
Greensboro Region Greensboro Office The Kinston Building 2303 W. Meadowview Road Greensboro, NC 27407	**1-888-298-7567**	**1-336-316-0259**
Hickory Region Hickory Office P.O. Box 1588 Hickory, NC 28601	**1-877-889-0002**	**1-828-431-3155**
Charlotte Region Charlotte Office P.O. Box 35209 Charlotte, NC 28235	**1-800-754-8185**	**1-704-676-0501**

Network management staff is available to assist Monday through Friday, 8:00 a.m. to 5:00 p.m.

Please note that for providers located in Montgomery, Moore, Richmond, and Hoke counties, servicing assistance is provided by our Greensboro network management office and contract requests are made to our Charlotte network management office.

2.13 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 *(W-9 form required)*
- National Provider Identifier "NPI"
- Telephone number, including daytime and twenty-four hour numbers
- Hours of operation
- Covering physicians

Whenever possible, please notify us in advance of a planned change but no later than 30 days after a change has occurred.

The following table summarizes which network management field office to contact based on the location of your health care business:

County	Office		County	Office
Alamance	Greensboro		Johnston	Raleigh
Alexander	Hickory		Jones	Wilmington
Alleghany	Greensboro		Lee	Raleigh
Anson	Charlotte		Lenoir	Wilmington
Ashe	Greensboro		Lincoln	Charlotte
Avery	Hickory		Macon	Hickory
Beaufort	Greenville		Madison	Hickory
Bertie	Greenville		Martin	Greenville
Bladen	Wilmington		McDowell	Hickory
Brunswick	Wilmington		Mecklenburg	Charlotte
Buncombe	Hickory		Mitchell	Hickory
Burke	Hickory		Montgomery	Greensboro
Cabarrus	Charlotte		Moore	Greensboro
Caldwell	Hickory		Nash	Wilmington
Camden	Greenville		New Hanover	Wilmington
Carteret	Wilmington		Northampton	Greenville
Caswell	Greensboro		Onslow	Wilmington
Catawba	Hickory		Orange	Raleigh
Chatham	Raleigh		Pamlico	Greenville
Cherokee	Hickory		Pasquotank	Greenville
Chowan	Greenville		Pender	Wilmington
Clay	Hickory		Perquimans	Greenville
Cleveland	Charlotte		Person	Raleigh
Columbus	Wilmington		Pitt	Wilmington
Craven	Wilmington		Polk	Hickory
Cumberland	Wilmington		Randolph	Greensboro
Currituck	Greenville		Richmond	Greensboro
Dare	Greenville		Robeson	Wilmington
Davidson	Greensboro		Rockingham	Greensboro
Davie	Greensboro		Rowan	Charlotte
Duplin	Wilmington		Rutherford	Charlotte
Durham	Raleigh		Sampson	Wilmington
Edgecombe	Wilmington		Scotland	Greensboro
Forsyth	Greensboro		Stanly	Charlotte
Franklin	Raleigh		Stokes	Greensboro
Gaston	Charlotte		Surry	Greensboro
Gates	Greenville		Swain	Hickory
Graham	Hickory		Transylvania	Hickory
Granville	Raleigh		Tyrrell	Greenville
Greene	Wilmington		Union	Charlotte
Guilford	Greensboro		Vance	Raleigh
Halifax	Raleigh		Wake	Raleigh
Harnett	Raleigh		Warren	Raleigh
Haywood	Hickory		Washington	Greenville
Henderson	Hickory		Watauga	Hickory
Hertford	Greenville		Wayne	Wilmington
Hoke	Greensboro		Wilkes	Greensboro
Hyde	Greenville		Wilson	Wilmington
Iredell	Greensboro		Yadkin	Greensboro
Jackson	Hickory		Yancey	Hickory

Health Care Benefit Plans and Member Identification Cards

3. Health Care Benefit Plans and Member Identification Cards

3.1 Health Care Benefit Plan Types and Provider Participation

BCBSNC health care benefit plans can typically be categorized into four basic plan types: Health Maintenance Organization, "PPO", Preferred Provider Organization, "PPO," Point of Service, "POS" and Comprehensive Major Medical, "CMM." Contracting providers with questions about in which plan(s) they participate, should refer to their individual, health care businesses, Network Participation Agreement "NPA" with BCBSNC, or contact their local network management field office for assistance. Local field office contact information can be found in chapter two of this manual.

3.2 Health Care Benefit Plans Overview

BCBSNC offers a variety of product lines to meet the health care coverage needs of our customers. The following health care benefit plans are available product offerings by BCBSNC:

- Blue Care® *(open access HMO)*
- Blue HMO℠ *(gatekeeper HMO [RAI only])*
- Blue Options℠ *(open access PPO)*
- Blue Advantage® *(open access PPO)*
- NC Smart*Choice*℠ *(open access PPO [SHP PPO membership only])*
- Blue Options℠ *(open access PPO [with deductible and coinsurance only])*
- Blue Options℠ *(open access PPO [in-network only])*
- Classic Blue® *(CMM [Please note that* Classic Blue® *includes benefits for eligible members enrolled in the additional following benefit plans])*:
  - Blue Assurance℠ "CMM"
  - Access℠ "CMM"
  - Short Term Health Care "CMM"

Information relevant to each of the above listed products, including sample member identification cards and benefit summaries can be found within this section. Health care providers should always verify a member's individual health care benefits and coverage eligibility prior to providing services.

In addition to the above listed health care benefit products, BCBSNC offers to its members Blue Extras℠ value-added programs, which provide discounts and information on a wide variety of health related services at no additional cost to the members. BCBSNC also offers life, dental and disability insurance products. To find out more about Blue Extras℠ and other BCBSNC product offerings, please visit our Web site at ***bcbsnc.com***.

Additional health care benefit plans discussed in this manual but not listed above are:

- The Federal Employee Program "FEP"
  - Information relative to FEP can be found in chapter four of this manual.
- The North Carolina State Health Plan "SHP" Comprehensive Major Medical Plan "CMM" and NC Health Choice
  - Information relative to the SHP, CMM plan and NC Health Choice can be found in chapter five of this manual.
- Inter-Plan Program
  - Information relative to the Inter-Plan programs, which includes BlueCard® out-of-area, can be found in chapter six of this manual.
- Medicare and Medicare Supplement
  - Information relative to Medicare and Medicare Supplement programs can be found in chapter seven of this manual.

3.3 Determining Eligibility

Blue e℠ is the fastest and easiest way to obtain a member's eligibility and benefits information. With ***Blue e***℠ you only need to access the ***Blue e***℠ member name search and/or member health eligibility search – and in real-time you can view the member's information from your own computer screen. If your organization does not yet have access to ***Blue e***℠, find out more by visiting BCBSNC electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/***, or refer to chapter 13 of this manual.

Blue e℠ and the Provider Blue Line℠ are the most accurate and up-to-date sources for verifying member's eligibility. If you have not yet signed up for the convenience of ***Blue e***℠, you can still verify member's benefits and eligibility by calling the Provider Blue Line℠ at **1-800-214-4844**. When calling, please have information from the patient's membership identification card available.

3.3.1 Member Identification Cards

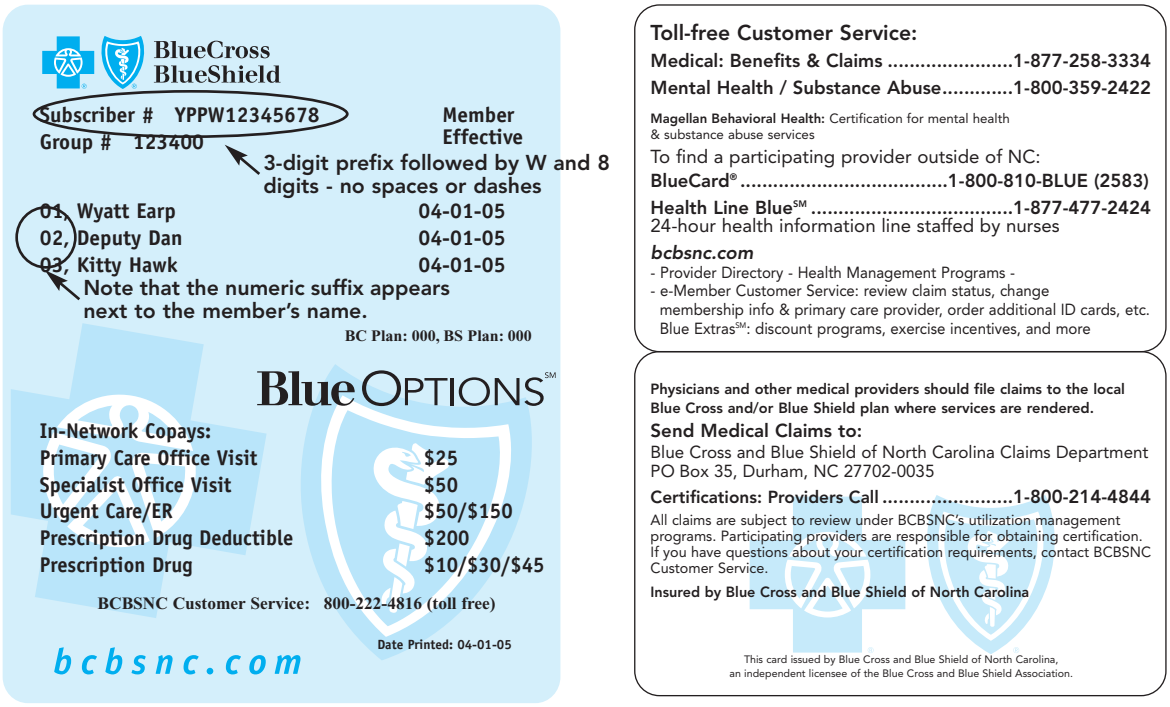
Member identification "ID" cards assist you in identifying the type of health benefit plan in which the member is enrolled. Other helpful information can also be found on the ID card including dependent enrollment, applicable deductible, coinsurance and/or copayment amounts, specific customer service telephone number(s), and information on benefit programs, etc.

3.3.2 Member Identification Numbers

To protect our member's privacy, social security numbers are no longer included as part of the member's ID number. BCBSNC member ID numbers typically have an alpha prefix in the first three positions, followed by a "W" and eight randomly assigned numbers *(e.g., YPPW12345678)*. To help identify members with BCBSNC coverage, look for a "W" in the fourth position *(e.g., YPPW12345678)*. However, exceptions do exist, such as identification numbers for FEP members that have a single alpha prefix beginning with "R" *(e.g., R12345678)*. Member IDs for other Blue Plans may also include the alpha prefix in the first three positions and can contain any combination of numbers and letters up to 17 characters.

We suggest that you always request to see a member's ID card prior to providing service, and verify the member's ID number in your records. If a change has occurred, always update all your systems and records with the new identifying information. Inform any business partners or clearinghouses that you work with of the change, as some systems may limit the number of positions and/or do not accept alpha characters. When submitting claims, enter the complete member ID number without any special characters such as hyphens, spaces or dashes.

Provided here is a sample of how a BCBSNC member's identification card may appear:



Always remember to make a copy of the front and back of the member's identification card and place that copy in the member's file for your records. Please also ensure that any discarded copies are properly destroyed to help protect the patient's identity.

3.3.3 Copy of Enrollment Application

While BCBSNC makes every effort to provide ID cards prior to the first date of coverage, a copy of the signed application for enrollment may be substituted for an ID card *(a sample of the enrollment application can be found in chapter 23, Forms)*.

3.3.4 If You are Unable to Verify Eligibility. . .

If we are unable to verify membership status, you may request payment in full from the patient for office services rendered. If the member is retroactively added to eligibility records, BCBSNC will reimburse you according to your contract. You must reimburse the member the total amount previously collected, less any copayment, coinsurance and/or deductible due from the member.

3.4 Pre-Existing Conditions

Some members may have a waiting period for coverage of care for pre-existing conditions. Call the Provider Blue Line℠ and speak with a representative if you need pre-existing conditions and member coverage clarifications.

3.5 Copayments

3.5.1 Services Covered with an Office Visit Copayment

- Under FEP the copayment covers any face to face encounter with a physician, physician's assistant, clinical nurse practitioner, or nurse midwife.
- Under Blue Care®, Blue Options℠ *(copay product)* and Blue Advantage®, all covered services rendered during the course of the office visit are subject to one copayment.

  Note: Under the Blue Options℠ *(deductible and coinsurance only)* product where all services are subject to deductible and coinsurance, office visit copayments do not apply.
- Covered services rendered to Classic Blue® members are always subject to deductible and coinsurance, regardless of the place of service.

3.5.2 When to Collect an Office Visit Copayment

- A copayment is collected when you charge for an office visit using an Evaluation and Management "E/M" code, surgery in the office, second surgical opinion, or consultation service,

  and
- The patient is seen by a physician, physician's assistant, clinical nurse practitioner, nurse midwife, physical therapist, occupational therapist or speech therapist.

3.5.3 When Not to Collect an Office Visit Copayment

- No E/M service code for an office visit is charged *(e.g., when a member comes in to get an allergy injection, lab service only, second surgical opinion, consultation and surgery in addition to office visit).*
- Chemotherapy, radiation therapy, or dialysis are performed in the office and are not billed with an E/M service code for an office visit.
- Services are performed in a hospital setting.

3.5.4 Note the Following with Respect to Office Visit Copayments:

- You should collect only one copayment per office visit as shown on the member's ID card.
- OB/GYNs should always collect the primary care office visit copayment for Blue Care® and Blue Options℠.

3.6 Reassigning a Member

Reassignment of a member to another provider can occur in the following situations:

- The member consistently refuses to follow a recommended procedure or treatment and you believe there is no professionally acceptable alternative.

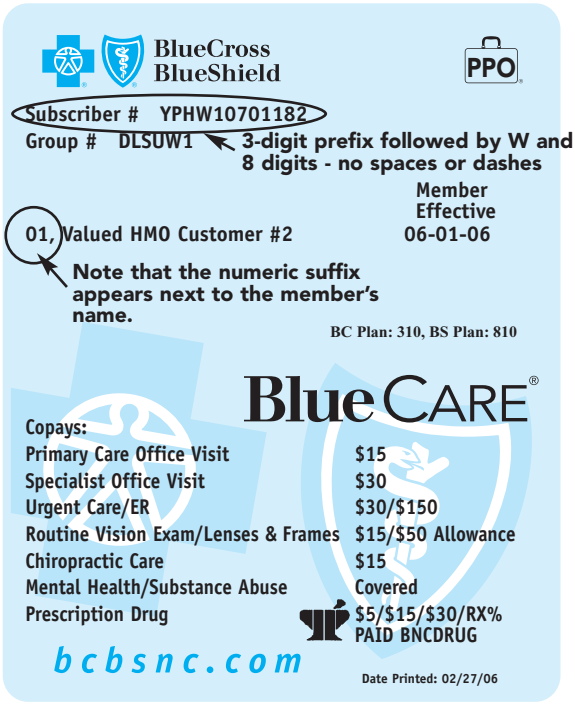
- The member consistently misses appointments without prior notification to you *(you should give the member, in advance, a written explanation of your appointment policy)*.
- The member consistently refuses to maintain a good financial standing for any copayments and balances due *(you should give the member, in advance, a written explanation of your collection/bad debt policy)*.
- The member is violent or threatening to you or your staff.

Providers should follow their office procedure for notifying a patient of the need to find a new primary care physician. A copy of the member letter should be forwarded to your local field office *(see chapter two, Contacting BCBSNC and General Administration)*.

3.7 Blue Care®

Blue Care® is an open access health maintenance organization "HMO" product. Blue Care® members are not required to obtain referrals from their primary care physician prior to receiving care from specialists. A sample ID card and benefit summary follow.

3.7.1 Sample ID Card



- The full subscriber ID begins with a YPHW and is a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.7.2 Health Benefit Summary

- Under Blue Care®, benefits are available for covered services received from Health Maintenance Organization "HMO" network physicians and providers *(called participating providers in member materials)*.
- Members are encouraged, though not required, to select a primary care physician at the time of enrollment *(see chapter 23, Forms, for a sample enrollment application)*.
- Members can change their primary care physician at any time by contacting customer service. Changes are effective immediately. Members are encouraged to transfer their records to their new primary care physician as soon as possible following the change.
- Blue Care® members are not required to obtain a referral from a primary care physician or provider in order to see a specialist.
- Benefits are available from non-participating physicians and providers for emergency and urgent care services.
- In specific situations, BCBSNC may approve coverage for other services received from non-participating physicians or providers. This includes situations where continuity of care or network adequacy issues dictate the use of a non-participating physician or provider.
- Services received from a non-participating physician or provider that are not urgent or emergent, and are not approved by BCBSNC in advance are not covered under Blue Care®.
- The prior review list applies to Blue Care® *(see section 8.5.1.5, Certification List)*.
- Summary of benefits offered as an example of member's benefit options, however this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Blue Care® Typical Coverage for Services Provided in an Office	
Service Category	**Member Liability**
Office visits • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care	• Primary care or specialist copayment *(listed on ID card)* • OB/GYNs always collect the primary copayment

Blue Care® Typical Coverage for Services Provided in an Office	
Service Category	**Member Liability**
Preventive care • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears *(with office visit)* • Immunizations *(with office visit)* • Screening mammograms *(with office visit)* • Prostate Specific Antigen "PSA" tests *(with office visit)* • Colorectal screening	• Primary care or specialist copayment *(listed on ID card)* • OB/GYNs always collect the primary copayment
Maternity • Prenatal • Post-delivery	• Copayment for determination of pregnancy visit only
Short-term rehabilitative therapy • Occupational therapy/physical therapy including chiropractic services • Speech therapy	• Applicable copayment *(listed on ID card)* • On most Blue Care® plans, short-term rehabilitative therapies are limited to a maximum of 30 visits total per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	Office location: • No copayment - covered services are paid at 100% unless billed with an office visit Other locations: • Deductible and coinsurance
Urgent care	• Urgent care copayment *(listed on ID card)*
Prescription drugs	• On most Blue Care® plans, prescription drugs are covered under a three-tier copayment design *(see chapter 19, Specialty Networks)* • The copayments are listed on the ID card • Standard drug plans include a brand penalty. This penalty does not apply when the brand is determined to be necessary by the provider and dispense as written "DAW" is included on the prescription.

Blue Care® Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility	
Service Category	**Member Liability**
Emergency room services	• Emergency care copayment *(listed on ID card)*
Ambulatory surgery centers *Facility must be contracting with BCBSNC as an ambulatory surgery center*	• Ambulatory surgery center
Outpatient services	• Subject to deductible and coinsurance. Professional services subject to deductible and coinsurance • On most Blue Care® plans, facility charges for outpatient services are subject to deductible and coinsurance • All labs and mammograms performed alone paid at 100%. All other diagnostic services, subject to deductible and coinsurance
Inpatient services	• Professional services subject to deductible and coinsurance • On most Blue Care® plans, facility charges for inpatient services are subject to deductible and coinsurance • New options for inpatient hospital copayment of $250 or $500 per admission
Skilled nursing facilities	• On most Blue Care® plans, all charges for services at a skilled nursing facility are subject to deductible and coinsurance • Limited to 60 days per benefit period

Blue Care® Optional Benefits	
Service Category	**Member Liability**
Inpatient and outpatient services for mental health and substance abuse *(Outpatient services do not include office visits, typically limited to 30 days)*	• Coordinated through Magellan Behavioral Health

Blue Care® Typical Coverage for Services Provided by an Ancillary Provider		
Service Category	**In-Network Member Liability**	**Out-of-Network Member Liability**
Home health care	Deductible and coinsurance	Not covered
Hospice care	Deductible and coinsurance	Not covered
Private duty nursing *(certification required)*	Deductible and coinsurance	Not covered
Home infusion therapy	Deductible and coinsurance	Not covered
Durable medical equipment	Deductible and coinsurance	Not covered
Short-term therapy**	Deductible and coinsurance	Not covered
Dialysis	Deductible and coinsurance	Not covered

* Short-term therapy limits are per type of therapy per benefit period.

** Dialysis performed in the physician's office is subject to a copay.

Covered short-term therapies include:

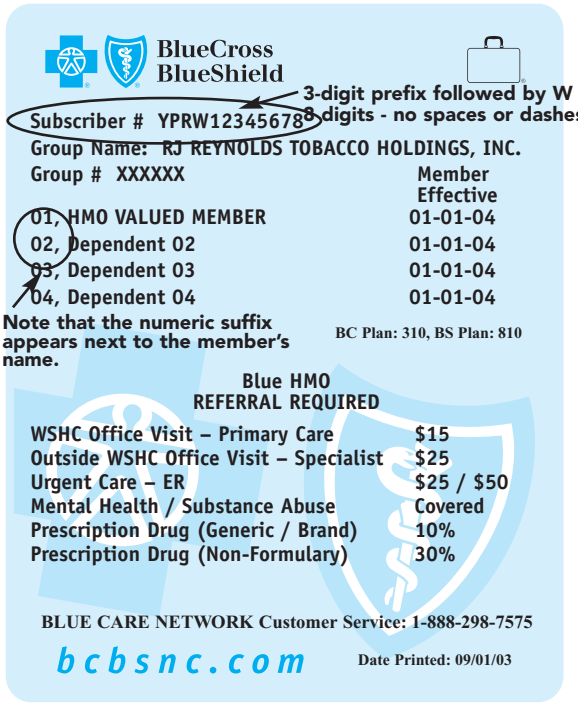
- Physical "PT," occupational "OT," and speech therapies.
- PT and OT have a combined visit maximum; speech therapy has its own visit maximum. Outpatient, office and home therapies are combined to meet visit maximum. Inpatient therapies are excluded from the benefit period visit maximum.

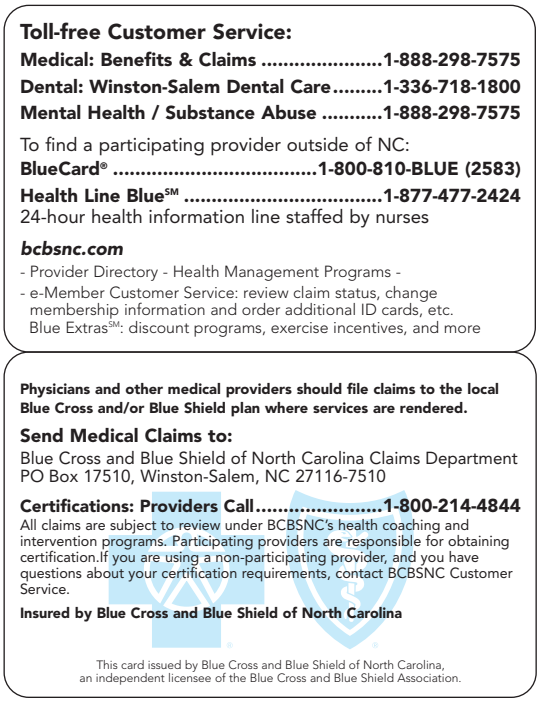
3.8 About Blue HMO℠

3.8.1 Blue HMO℠ *(Typical Coverage for Services Provided in an Office)*

Blue HMO℠ is a "gatekeeper" health maintenance organization "HMO" product for Reynolds American, Inc. "RAI" only. Blue HMO℠ members are required to obtain referrals from their primary care physician at Winston-Salem Health Care "WSHC" prior to receiving care from providers in the Blue Care® network.

3.8.2 Sample ID Card





- Submit medical claims electronically or by mail to: BCBSNC, P.O. Box 17510, Winston-Salem, NC 27116-7510.
- The full subscriber ID begins with a YPRW and is a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.8.3 Health Benefit Summary *(Typical Coverage for Services Provided in an Office)*

- Members may be referred *(written referral only)* to a Blue Care® network provider.
- The member is liable for payment when there is no referral from WSHC.
- Members are required to select a primary care physician at the time of enrollment *(see chapter 23, Forms, of The Blue Book℠ for a sample enrollment application).*
- Blue HMO℠ members are required to obtain a referral from WSHC.
- Benefits are available from non-participating physicians and providers for emergency and urgent care services.

- In specific situations, BCBSNC may approve coverage for services received from non-participating physicians or providers. This includes situations where continuity of care or network adequacy issues dictate the use of a non-participating physician or provider.
- Home ST/OT/PT does not require prior review.
- Services received from a non-participating physician or provider that are not urgent or emergent, and are not approved by BCBSNC in advance are not covered under Blue HMO℠.
- The prior review list applies to Blue HMO℠.
- All benefits are subject to change January 1, 2008.
- Summary of benefits offered as an example of member's benefit options; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Blue HMO℠ Plan Design I

This is a "gatekeeper" HMO. Referrals outside of WSHC are required.

Typical Coverage for Services Provided in an Office

Service Category	Member Liability
Office visits • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy	• WSHC copayment at WSHC • Outside WSHC copayment • OB/GYNs always collect the primary copayment *(no referral required)*
Preventive care • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears *(with office visit)* • Immunizations *(with office visit)* • Screening mammograms *(with office visit)* • Prostate Specific Antigen "PSA" tests *(with office visit)* • Colorectal screening	• WSHC or Outside WSHC copayment • No referral required for OB/GYN
Maternity • Prenatal • Post-delivery	• Copayment for determination of pregnancy visit only • No referral required for OB/GYN
Short-term rehabilitative therapy • Occupational therapy/physical therapy • Speech therapy	• Copayment if outside WSHC • Copayment at WSHC • Unlimited visits

Blue HMO℠ Plan Design 1

This is a "gatekeeper" HMO. Referrals outside of WSHC are required.

Typical Coverage for Services Provided in an Office

Service Category	Member Liability
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	Office Location: • No copayment - covered services are paid at 100% unless billed with an office visit Other Locations: • Between January 1, 2008 and December 31, 2008, benefits are 100% for these services
Urgent care	• Urgent care copayment *(listed on ID card)* • No referral required
Prescription drugs	• At WSHC only
Chiropractic services *(referral required; acute care call only)*	• Outside WSHC copayment • Limited to a maximum of 12 visits per benefit period
Medical eye care	• Copay • No referral required

Blue HMO℠ Plan Design 1

This is a "gatekeeper" HMO. Referrals outside of WSHC are required.

Typical Coverage for Ancillary Services

Service Category	Member Liability
Home health care	• $25 copayment per day
Hospice care* **	• 100%
Private duty nursing *(certification required)*	• Not covered
Home infusion therapy	• 100%
Durable medical equipment*	• Member pays 10% up to maximum of $100 per day
Short-term therapy**	• Copayment
Dialysis	• 100%

* Wheelchairs are not subject to the $100 maximum per day

** Covered short-term therapies include:
- physical "PT," occupational "OT," and speech therapies

***Lifetime maximum of $7,500 per member and 12 family counseling sessions

Blue HMO℠ Plan Design 1 Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility	
Service Category	**Member Liability**
Emergency room services	• Emergency care copayment *(listed on ID card)* • No referral necessary
Ambulatory surgery centers *Facility must be contracting with BCBSNC as an ambulatory surgery center*	• $100 copayment per occurrence • Referral required
Outpatient services	• Copayment • Referral required • Professional services 100% coinsurance, no deductible
Prescription drugs	• At WSHC only
Inpatient services	• Professional services covered at 100% of allowed • Facility services 90% • Prior authorization by BCBSNC required
Skilled nursing facilities	• Not covered • Note: active rehabilitation facilities covered at 100% up to a maximum of $750 per day
Inpatient and outpatient services for mental health and substance abuse *(Outpatient services do not include office visits)*	• Coordinated through WSHC • Referral required for outpatient/office service • Prior authorization by BCBSNC required for inpatient service

- Home ST/OT/PT does not require prior review.
- Services received from a non-participating physician or provider that are not urgent or emergent, and are not approved by BCBSNC in advance are not covered under Blue HMO℠.
- The prior review list applies to Blue HMO℠.
- All benefits are subject to change January 1, 2008.

Blue HMO℠ Plan Design 2 *This is a "gatekeeper" HMO. Referrals outside of WSHC are required.* Typical Coverage for Services Provided in an Office	
Service Category	**Member Liability**
Office visits • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy	• Deductible and coinsurance
Preventive care • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears *(with office visit)* • Immunizations *(with office visit)* • Screening mammograms *(with office visit)* • Prostate Specific Antigen "PSA" tests *(with office visit)* • Colorectal screening	• Deductible and coinsurance
Maternity • Prenatal • Post-delivery	• Deductible and coinsurance • No referral required for OB/GYN
Short-term rehabilitative therapy • Occupational therapy/physical therapy • Speech therapy	• Deductible and coinsurance • Unlimited visits
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	Office Location: • Deductible and coinsurance
Urgent care	• Deductible and coinsurance • No referral required
Prescription drugs	• At WSHC only
Chiropractic services *(referral required; acute care call only)*	• Deductible and coinsurance • Limited to a maximum of 12 visits per benefit period
Medical eye care	• Deductible and coinsurance • No referral required

Blue HMO℠ Plan Design 2 *This is a "gatekeeper" HMO. Referrals outside of WSHC are required.* Typical Coverage for Ancillary Services	
Service Category	**Member Liability**
Home health care	• Deductible and coinsurance
Hospice care* **	• Deductible and coinsurance
Private duty nursing *(certification required)*	• Not covered
Home infusion therapy	• Deductible and coinsurance
Durable medical equipment*	• Deductible and coinsurance
Short-term therapy**	• Deductible and coinsurance
Dialysis	• Deductible and coinsurance

* Wheelchairs are not subject to the $100 maximum per day

** Covered short-term therapies include:
- Physical "PT," occupational "OT," and speech therapies

***Lifetime maximum of $7,500 per member and 12 family counseling sessions

Blue HMO℠ Plan Design 2 Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility	
Service Category	**Member Liability**
Emergency room services	• Deductible and coinsurance • No referral necessary
Ambulatory surgery centers *Facility must be contracting with BCBSNC as an ambulatory surgery center*	• Deductible and coinsurance • Referral required
Outpatient services	• Copayment • Referral required • Deductible and coinsurance
Prescription drugs	• At WSHC only
Inpatient services	• Deductible and coinsurance • Prior authorization by BCBSNC required
Skilled nursing facilities	• Not covered • Note: acute rehabilitation facilities covered up to a maximum of $750 per day, subject to deductible and coinsurance
Inpatient and outpatient services for mental health and substance abuse *(Outpatient services do not include office visits)*	• Coordinated through WSHC • Referral required for outpatient/office service • Prior authorization by BCBSNC required for inpatient service • Subject to deductible and coinsurance

3.8.4 Sample A320 – Referral Form

BlueCross BlueShield of North Carolina
PO Box 17510
Winston-Salem, NC 27116-7510
Fax 336-659-2944

Blue HMO℠
REFERRAL FORM

REFERENCE NUMBER *(BCBSNC use only)*

NOT VALID FOR NON-PARTICIPATING PROVIDERS

INSTRUCTIONS FOR PROCESSING FORM

STEPS FOR PROCESSING

WINSTON-SALEM HEALTHCARE (WSHC)	BLUE CARE® PHYSICIAN/PROVIDER
	• Retain copy for your records. • Limit services to those referred and direct member back to WSHC for new or updated referrals for additional services. • If referral includes treatment, contact BCBSNC at **800-672-7897** to request authorization for services you will render that require Prior Plan Approval.

NOTE

- **DISCLAIMER: This referral form is not a guarantee of benefits. Member eligibility *(including retro-termination of coverage)* and benefit limits *(dollar maximums, visit limits, unit limits, etc.)* apply. Refer to your member benefits for more information on coverage limits.**
- A referral is NOT required for emergency services in or out of the Blue Care® network. Seek emergency services at the nearest facility.
- A referral is NOT required for medical ophthalmology, medical optometry, or OB/GYN services received within the Blue Care® network.
- WSHC must contact BCBSNC at **800-672-7897** to request approval to refer to a non-participating provider *(except for Mental Health/Substance Abuse)*.
- The patient/member is liable for the cost of services rendered without a referral. A Blue Care® provider must only hold member harmless for cost of service that requires Prior Plan Approval by BCBSNC.

SECTION I

PATIENT INFORMATION

NAME	BIRTHDATE	MEMBER NUMBER
FROM	NAME OF PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN NUMBER
TO REFERRAL PROVIDER *(Last Name)* *(First Name)*		PROVIDER NUMBER
START DATE OF REFERRAL	EXPIRATION DATE OF REFERRALS *(If not specified, expires in 6 months)*	NUMBER OF AUTHORIZED VISITS *(If not specified, limited to 3 visits)*

☐ NEW REFERRAL **SERVICES REQUESTED** ☐ UPDATE/EXTENSION OF CURRENT REFERRAL

☐ CONSULT AND TREATMENT ☐ SINGLE CONSULT ☐ SPECIFIC PROCEDURE
(INDICATE INCLUSION OF LAB/X-RAY UNDER "AUTHORIZED ANCILLARY SERVICES")
(SERVICE CODE MUST BE LISTED BELOW)

☐ MH/SA NON-PARTICIPATING

AUTHORIZED ANCILLARY SERVICES

X-RAY ☐ YES ☐ NO *(If blank, default is NO)*

LAB ☐ YES ☐ NO *(If blank, default is NO)*

This referral is valid only for the Provider Number noted above and those physicians associated with that practice. The member must obtain from WSHC a separate referral for each additional provider *(or distinct provider number)* rendering care *(e.g., the specialist, independent lab, free-standing imaging, anesthesia, DME, etc.)*. Failure to do so will result in claims denied with member liable for the payment.

REMARKS:

SECTION II

THIS HMO AUTHORIZATION RELATES TO

PROVISIONAL DIAGNOSIS / PROVISIONAL ICD-9 CODE

A320, 10/03

WHITE – PLAN COPY YELLOW – REFERRAL PROVIDER COPY PINK – PRIMARY CARE COPY GOLDENROD – MEMBER COPY

3.8.5 RAI Benefit Booklet Excerpt

What is not covered...

Exclusions that are specific to a type of service are stated along with the benefit description in *Covered Services.* Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read *Covered Services, Summary of Benefits,* and *What is Not Covered....* In addition, your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not authorized by your personal plan physician, except in an emergency or as otherwise provided in this health benefit plan
- Provided by *non-participating providers*, except when approved in advance by *BCBSNC* or your *personal plan physician*, or in an *emergency*
- Not *medically necessary*
- *Investigational* in nature or obsolete, including any service, drugs, procedure or treatment directly related to an *investigational* treatment
- Any *experimental* drug or any drug not approved by the Food and Drug Administration "FDA" for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription drugs* used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:
  1. The American Medical Association drug evaluations
  2. The American Hospital Formulary Service drug information
  3. The United States Pharmacopoeia drug information
- Side effects and complications of non-covered services, except for *emergency services* in the case of an *emergency*
- Not prescribed or performed by or upon the direction of a *doctor* or *other provider*
- For any condition, disease, illness or injury that occurs in the course of employment, if the *employee*, *employer* or carrier is liable or responsible (1) according to a final adjudication of the claim under a state workers' compensation laws, or (2) by an order of a state's industrial commission or other applicable regulatory agency approving a settlement agreement
- For a health care professional to administer injectable *prescription drugs* which can be self administered, unless medical supervision is required
- For *skilled nursing facility* services
- For private duty nursing services
- For *inpatient* admissions primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy
- For care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*

- For *custodial care*, domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities or any similar facility or institution
- For respite care except as specifically covered by your health benefit plan
- Received prior to the *member's effective date*
- Received on or after the coverage termination date, regardless of when the treatment condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
- *Incurred* more than 18 months prior to submission of a claim to *BCBSNC*, except in the absence of legal capacity of the *member*, or unless otherwise approved by *BCBSNC*
- For *cosmetic* purposes except as specifically covered by your health benefit plan
- For any services that would not be necessary if a non-covered service had not been received, except for *emergency services* in the case of an *emergency*
- For benefits that are provided by any governmental unit except as required by law
- For services that are ordered by a court that are otherwise excluded from benefits under this health benefit plan
- For care that the *provider* cannot legally provide or legally charge or is outside the scope of license or certification
- Provided and billed by a licensed health care professional who is in training
- Available to a *member* without charge
- For care given to a *member* by a *provider* who is in a *member's* immediate family
- For any condition suffered as a result of any act of war or while on active or reserve military duty
- In excess of the *allowed amount* for services usually provided by one *doctor*, when those services are provided by multiple *doctors*
- For palliative, *cosmetic* or *routine foot care*
- For dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by your health benefit plan
- *Dental services* provided in a *hospital*, except when a hazardous medical condition exists at the same time or covered oral *surgery* services are required at the same time as a result of a bodily injury, such as accidental injury of sound and natural teeth
- For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of obesity
- For sclerotherapy, except when used in conjunction with a related surgical procedure or when *medically necessary* for the treatment of esophageal varices
- Wigs, hair pieces and hair implants for any reason

- Received from a dental or medical department maintained by or on behalf of an *employer*, a mutual benefit association, labor union, trust or similar person or group
- Treatment or studies leading to or in connection with sex changes or modifications and related care
- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- Hypnosis
- Acupuncture and acupressure, unless performed by a *participating provider* and with a referral from *WSHC* (limited to 6 visits per *benefit period [calendar year]*)
- *Surgery* for psychological or emotional reasons
- Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by your health benefit plan
- Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control
- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators and ramps
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, jacuzzis, heated spas, pool or memberships to health clubs
- Eyeglasses or contact lenses
- Orthoptics, vision training, and low vision aids
- Fitting for eyewear, radial keratotomy and other refractive eye *surgery*, and related services to correct vision except as specifically covered by your health benefit plan
- Hearing aids or examinations for fitting of hearing aids
- Routine hearing examinations except as specifically covered by your health benefit plan
- For routine eye examination services except as specifically covered by your health benefit plan
- *Medical care* provided by more than one *doctor* for treatment of the same condition
- Take-home drugs furnished by a *hospital* or *non-hospital facility*
- Clomid, Pergonal or other drugs associated with conception by artificial means or *infertility* and *sexual dysfunction*
- Condoms, foams, contraceptive jellies and ointments, and all non-prescription contraceptive devices or supplies
- *Sexual dysfunction* services, including penile prostheses and erect-aid devices *(as well as training in their use)* and any drugs or medications for the treatment of erectile dysfunction, except as otherwise provided in this health benefit plan
- For maintenance therapy. Maintenance therapy includes therapy services that are provided over a long period of time in order to keep your condition stable.
- For massage therapy services

- For *holistic medicine* services
- Chiropractic services except as specifically covered by your health benefit plan
- For services primarily for educational purposes, including but not limited to books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by your health benefit plan
- For genetic testing, except for high-risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing
- Services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the US Public Health Service, except as specifically covered by your health benefit plan
- Shoes of any type, unless an integral part of a brace, or for *members* with diabetes
- For any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- For conditions that federal, state or local law requires to be treated in a public facility
- For physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license by a municipality, state or federal government; securing insurance coverage; foreign travel; care for conditions which federal, state or local law requires be treated in a public facility; or tests or procedures performed for research or for the health or benefit of a non-member
- For vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for *prescription* prenatal vitamins or *prescription* vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency
- For allergy testing, such as skin titration *(Rinkel method)*, cytotoxicity testing *(Bryan's test)*, MAST testing, urine autoinjections, subcutaneous or sublingual provocative and neutralization testing, except as specifically covered by your health benefit plan
- For certain self-injectable *prescription drugs* that can be self-administered
- Not specifically listed in this benefit booklet as a covered benefit, drug, service or supply

3.9 Blue Options℠

Blue Options℠ is a Preferred Provider Organization "PPO" product. Higher in-network benefits are available to Blue Options℠ members who seek care within the provider network. A sample ID card and benefit summary follow.

3.9.1 Sample ID Card

Toll-free Customer Service:

Medical: Benefits & Claims 1-877-258-3334

Dental: Dental Blue®.....1-800-305-6638

Mental Health / Substance Abuse 1-800-359-2422

Magellan Behavioral Health: Certification for all mental health & substance abuse services, except office visits.

To find a participating provider outside of NC:

BlueCard® 1-800-810-BLUE (2583)

Health Line Blue℠ 1-877-477-2424

24-hour health information line staffed by nurses

bcbsnc.com

Provider Directory, Member Health Partnerships℠, My Member Services to review claim status, update contact information, request ID card, etc. Blue Extras℠: discount programs, exercise incentives, and more

Physicians and other medical providers should file claims to the local Blue Cross and/or Blue Shield plan where services are rendered.

Send Medical Claims to:

Blue Cross and Blue Shield of North Carolina Claims Department PO Box 35, Durham, NC 27702-0035

Send Dental Claims to: Blue Cross Blue Shield of North Carolina PO Box 2100, Winston-Salem, NC 27105 or **EDI Web MD** #61473 www.acsbenefitservicesinc.com: HIPAA EDI Eligibility & Claims Status

Certifications: Providers Call.....1-800-214-4844

All claims are subject to review under BCBSNC's health coaching and intervention programs. Participating providers are responsible for obtaining certification.If you are using a non-participating provider, and you have questions about your certification requirements, contact BCBSNC Customer Service.

Blue Cross Blue Shield of North Carolina provides administrative services only and does not assume any financial risk or obligation with respect to claims.

This card issued by Blue Cross and Blue Shield of North Carolina, an independent licensee of the Blue Cross and Blue Shield Association.

- The full subscriber ID begins with YPPW followed by a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.9.2 Health Benefit Summary

- Higher in-network benefits are available for services received from PPO network physicians or providers *(called in-network providers in member materials)*.
- Most benefits are also available for out-of-network physicians and providers at a higher out-of-pocket cost. In the typical plan design, coverage for preventive services *(except mammograms, pap smears and PSAs)* is available only from in-network physicians and providers.
- Summary of benefits offered as an example of member's benefit options, however this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Blue Options℠ Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Office visit • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care	• Primary care or specialist copayment *(listed on ID card)* • OB/GYNs always collect primary care copayment	• Out-of-network deductible and coinsurance
Preventive care • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears *(with office visit)* • Immunizations *(with office visit)* • Screening mammograms *(with office visit)* • Prostate Specific Antigen "PSA" tests *(with office visit)* • Colorectal screening	• Primary care or specialist copayment *(listed on ID card)* • OB/GYNs always collect the primary care copayment	• On most Blue Options℠ plans, the only preventive care services covered out-of-network are mammograms, pap smears, and PSA test. They are subject to out-of-network deductible and coinsurance.
Maternity • Prenatal • Post-delivery	• Copayment for determination of pregnancy visit only • Deductible and coinsurance thereafter	• Out-of-network deductible and coinsurance
Short-term rehabilitative therapy • Occupational/physical therapy *(including chiropractic services)* • Speech therapy	• Primary care or specialist copayment • On most Blue Options℠ plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*	• Out-of-network deductible and coinsurance • On most Blue Options℠ plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*

Blue Options℠ Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	Office Location: • No copayment - covered services are paid at 100% unless billed with an office visit Other Locations: • Deductible and coinsurance • Second surgical opinion consultation • Surgery in addition to office visit for services covered at 100% unless billed with an office visit	
Urgent care	• Urgent care copayment *(listed on ID card)*	• Urgent care copayment *(listed on ID card)* • Members may be required to pay the bill in full at the time of service and file a claim with BCBSNC
Prescription drugs	• On most Blue Options℠ plans, prescription drugs are covered under a four-tier copayment design. The copayments are listed on the ID card *(see chapter 19, Specialty Networks)* • Standard drug plans include a brand penalty. This penalty will not apply when the brand is determined to be necessary by the provider and dispense as written "DAW" is included on the prescription.	• Members will be required to pay the bill in full at the time of service and file a claim with BCBSNC

Blue Options℠ Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Emergency room services	• Emergency care copayment *(listed on ID card)*	• Emergency care copayment *(listed on ID card)* Members may be required to pay the bill in full at the time of service and file a claim with BCBSNC
Ambulatory surgery centers *Facility must be contracting with BCBSNC as an ambulatory surgery center*	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Outpatient services	• On most Blue Options℠ plans, professional and facility charges for outpatient services are subject to deductible and coinsurance • Certain diagnostic services are not paid solely based on place of service. Mammograms and simple lab work are paid at 100% at outpatient hospital centers when not performed with other services at the same time. All other diagnostics are subject to deductible and coinsurance.	• Out-of-network deductible and coinsurance

Blue Options℠ Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Inpatient services	• On most Blue Options℠ plans, professional and facility charges for inpatient services are subject to deductible and coinsurance • New option for inpatient hospital copayment of $250 or $500 per admission	• Out-of-network deductible and coinsurance
Skilled nursing facilities	• On most Blue Options℠ plans, all charges for services at a skilled nursing facility are subject to deductible and coinsurance	• Out-of-network deductible and coinsurance
	• This benefit is limited to 60 days per benefit period *(combined in and out-of-network)*	
Inpatient and outpatient services for mental health and substance abuse	• Coordinated through Magellan Behavioral Health	• On most Blue Options℠ plans, out-of-network inpatient and outpatient mental health and substance abuse services are subject to coinsurance *(no deductible)*

Blue Options℠ Typical Coverage for Services Provided by an Ancillary Provider		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Home infusion therapy	Deductible and coinsurance	Deductible and coinsurance
Durable medical equipment	Deductible and coinsurance	Deductible and coinsurance
Home short term therapy*	Deductible and coinsurance	Deductible and coinsurance
Dialysis	Deductible and coinsurance	Deductible and coinsurance

* Short-term therapy limits are per type of therapy per benefit period.

** Dialysis performed in the physician's office is subject to a copay.

Covered short-term therapies include:

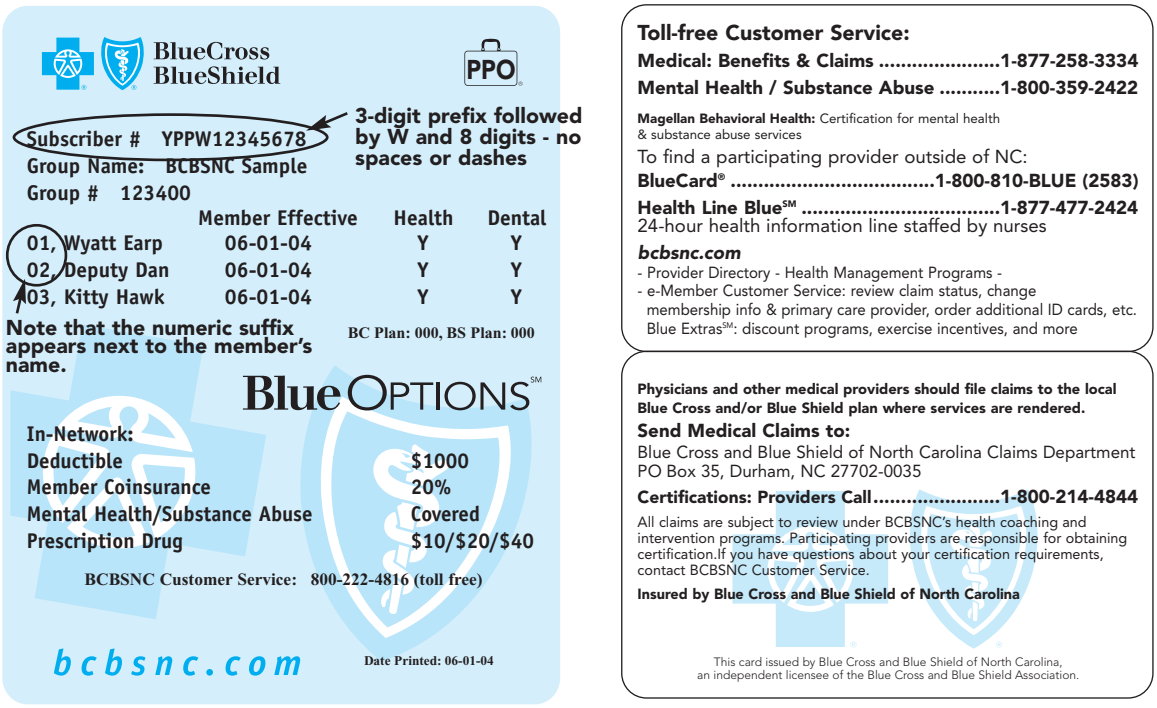
- Physical "PT," occupational "OT," and speech therapies
- PT and OT have a combined visit maximum; speech therapy has its own visit maximum. Outpatient, office and home therapies are combined to meet visit maximum. Inpatient therapies are excluded from the benefit period visit maximum.

3.10 Blue Options℠ *(Deductible and Coinsurance Only)*

Blue Options℠ is a Preferred Provider Organization "PPO" product. Higher in-network benefits are available to Blue Options℠ members who seek care within the provider network. A sample ID card and benefit summary follow.

This product requires the member to pay in-network deductible and coinsurance for all in-network services. There are no copays on this product.

3.10.1 Sample ID Card



- The full subscriber ID begins with YPPW followed by a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.10.2 Health Benefit Summary

- Higher in-network benefits are available for services received from PPO network physicians or providers *(called in-network providers in member materials)*.
- Most benefits are also available from out-of-network physicians and providers at a higher out-of-pocket cost. In the typical plan design, coverage for preventive services *(except mammograms, pap smears and PSAs)* is available only from in-network physicians and providers.
- Summary of benefits offered as an example of member's benefit options; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Blue Options℠ *(Deductible and Coinsurance Only)* Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Office visit • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Preventive care • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears *(with office visit)* • Immunizations *(with office visit)* • Screening mammograms *(with office visit)* • Prostate Specific Antigen "PSA" tests *(with office visit)* • Colorectal screening	• In-network deductible and coinsurance	• On most Blue Options℠ plans, the only preventive care services covered out-of-network are mammograms, pap smears, PSA tests and any other state-mandated tests. They are subject to out-of-network deductible and coinsurance.
Maternity • Prenatal • Post-delivery	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Short-term rehabilitative therapy • Occupational/physical therapy *(including chiropractic services)* • Speech therapy	• In-network deductible and coinsurance • On most Blue Options℠ plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*	• Out-of-network deductible and coinsurance • On most Blue Options℠ plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*

Blue Options℠ *(Deductible and Coinsurance Only)* Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Urgent care	• In-network deductible and coinsurance	• In-network deductible and coinsurance
Prescription drugs	• On most Blue Options℠ plans, prescription drugs are covered under a four-tier copayment design. The copayments are listed on the ID card *(see chapter 19, Specialty Networks)* • Some plans also offer generic copayment/brand coinsurance benefits. Under this program, the brand coinsurance will not be displayed on the ID cards. • Most plans include a brand penalty. This penalty does not apply when the brand is determined to be necessary by the provider and dispense as written "DAW" is included on the prescription.	• Members will be required to pay the bill in full at the time of service and file a claim with BCBSNC

Blue Options℠ *(Deductible and Coinsurance Only)*
Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility

Service Category	In-Network Member Liability	Out-Of-Network Member Liability
Emergency	• In-network deductible coinsurance	• In-network deductible coinsurance
Ambulatory surgery centers *Facility must be contracting with BCBSNC as an ambulatory surgery center*	• In-network deductible coinsurance	• Out-of-network deductible and coinsurance
Outpatient services	• In-network deductible coinsurance	• Out-of-network deductible and coinsurance
Inpatient services	• In-network deductible coinsurance	• Out-of-network deductible and coinsurance
Skilled nursing facilities	• In-network deductible coinsurance	• Out-of-network deductible and coinsurance
	• This benefit is limited to 60 days per benefit period *(combined in and out-of-network)*	
Inpatient and outpatient services for mental health and substance abuse	• In-network deductible coinsurance • Coordinated through Magellan Behavioral Health	• Out-of-network deductible and coinsurance

Blue Options℠ *(Deductible and Coinsurance Only)*
Typical Coverage for Services Provided by an Ancillary Provider

Service Category	In-Network Member Liability	Out-Of-Network Member Liability
Home health care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Hospice care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Private duty nursing	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance

Blue Options℠ *(Deductible and Coinsurance Only)* Typical Coverage for Services Provided by an Ancillary Provider		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Home infusion therapy	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Durable medical equipment	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
	• This benefit is limited to 60 days per benefit period *(combined in and out-of-network)*	
Home short term therapy	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Dialysis	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance

3.11 Blue Options HSA℠

Blue Options HSA℠ is a Preferred Provider Organization "PPO" product, first available 1/1/05. Higher in-network benefits are available to Blue Options HSA℠ members who seek care within the provider network. A sample ID card and benefit summary follow.

This product requires the member to pay in-network deductible and coinsurance for all in-network services. Enhanced preventive care is covered at 100% and the deductible is waived. There are no copayments on this product.

3.11.1 Sample ID Card

- The full subscriber ID begins with YPDW followed by a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.11.2 Blue Options HSA℠ and HRA Collection Policy

For any Blue Options℠ deductible and coinsurance-only product *(not copayment products)*, BCBSNC's in-network providers *(including physicians, professional providers, hospitals and ancillary providers)* may collect an estimated amount from members at the time of service for a member's out-of-pocket costs, as described below. To determine whether a product is covered under this policy, all providers should check the member ID card to make sure that both of the following criteria are met: 1) Make sure that the ID card indicates a *coinsurance* amount for physician services. If so, it is a deductible and *coinsurance*-only product; or 2) If the card indicates a *copayment* for physician services, the product is not subject to this policy and no estimated amounts should be collected for any service by any provider.

Make sure that the card indicates that the product is a Blue Options℠ product *(including* Blue Options HRA℠ *and* Blue Options HSA℠*)*. If the card does not indicate Blue Options℠, it is not subject to this policy and no estimated amounts should be collected. In all cases, in-network hospitals and providers are required to check for a member's remaining deductible or coinsurance amounts using sources such as the HIPAA 270 Inquiry, RealMed, ***Blue e***℠, or BCBSNC Customer Service. Keep in mind that these sources provide the most accurate information available at the time, as the information provided on the Explanation of Payment "EOP" from BCBSNC may differ based on claims that were in transit to BCBSNC or any applicable adjustments.

The limitations on collection of estimated amounts are as follows:

Physician's or professional providers may collect up to *the lesser of the member's estimated out-of-pocket costs or $50* for services received in the provider's office, including services rendered in a hospital-owned clinic.

Hospitals and ancillary providers may collect up to the lesser of the member's estimated out-of-pocket costs or $500 for services received in a hospital or outpatient facility such as an emergency room or ambulatory surgery center. *Providers must inform the member that the amount being collected is an estimate. Providers must also calculate the member's out-of-pocket costs based on the lesser of the allowed (contract) amount or billed charges, taking into account the member's benefit year-to-date deductible or coinsurance benefit status (amount met).*

The final determination of what the member owes will be based on the claim that is submitted to BCBSNC, and will be reflected on the EOP. Any applicable refunds due to the member must be returned within 45 days. If a member is unable to pay at the time of service, the provider should not refuse to provide necessary treatment to the member. If they choose *(and if funds are available)*, the member can use funds from their HSA or HRA to pay for these services.

The provider should be aware of the tax implications if funds are withdrawn for nonqualified medical expenses or for expenses that the member did not incur, without subsequent and timely correction by the member. The member will need to take responsibility for correcting any incorrect withdrawals. Therefore, if your estimated collection was too high, and you are aware that the member used an HRA or HSA fund, you should remind the member to make the appropriate correction.

*Please note that the current policy for the collection of copayments, deductibles and coinsurance amounts for those members enrolled in copayment products and non-*Blue Options℠ *products has not changed.*

3.11.3 Health Benefit Summary

- Higher in-network benefits are available for services received from PPO network physicians or providers *(called in-network providers in member materials)*.
- Most benefits are also available from out-of-network physicians and providers at a higher out-of-pocket cost. In the typical plan design, coverage for enhanced preventive care, including routine physical exam, well-baby and well-child child care and certain immunizations and screenings. Other covered services may be subject to deductible and coinsurance.
- Summary of benefits offered as an example of member's benefit options, however this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Blue Options HSA℠ Typical Coverage for Services Provided by a Physician		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Office visit • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Enhanced preventive care • Immunizations • Well-baby care *(excluding diagnostic tests and screenings)* • Well-child care *(excluding diagnostic tests and screenings)* • The first office visit *(excluding diagnostic tests and screenings)* each *benefit period* for routine physical exams, gynecological exams, and the evaluation and treatment of obesity • The first preventive care diagnostic test and screening each benefit period *(excluding related office visits except as noted above)* for the following: cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, prostate specific antigen tests, newborn vision and hearing screening, cholesterol and lipid screening, bone mass measurement screening, and hemoglobin test.	May be one of the following: • In-network deductible and coinsurance • In-network coinsurance only *(deductible waived)* • Paid at 100% coinsurance *(deductible waived)*	• On most Blue Options℠ plans, the only preventive care services covered out-of-network are mammograms, pap smears, PSA tests and any other state-mandated tests. They are subject to out-of-network deductible and coinsurance.
Other preventive care • Any additional preventive care services and/or diagnostic tests and screenings, including those not listed above, are subject to deductible and coinsurance.	• In-network deductible and coinsurance	

Blue Options HSA℠ Typical Coverage for Services Provided by a Physician		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Maternity • Prenatal • Post-delivery	• Only members with maternity rider have maternity benefits • In-network deductible and coinsurance	• Only members with maternity rider have maternity benefits • Out-of-network deductible and coinsurance
Short-term rehabilitative therapy • Occupational/physical therapy *(including chiropractic services)* • Speech therapy	• In-network deductible and coinsurance • On most plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*	• Out-of-network deductible and coinsurance • On most plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Urgent care	• In-network deductible and coinsurance	• In-network deductible and coinsurance
Emergency room services	• In-network deductible and coinsurance	• In-network deductible and coinsurance
Other professional services *(includes professional services provided in the following settings)*: • Ambulatory surgical center • Hospital • Skilled nursing facility • Diagnostic services *(other than an office setting)*	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance

Blue Options HSA℠ Typical Coverage for Services Provided by a Physician		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Prescription drugs	• Deductible and coinsurance	• Members will be required to pay the bill in full at the time of service and file a claim with BCBSNC
Mental health/substance abuse	• Deductible and coinsurance	• Deductible and coinsurance

Blue Options HSA℠ Typical Coverage for Services Provided by an Ancillary Provider		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Home health care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Hospice care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Private duty nursing *(certification required)*	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Home infusion therapy	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Durable medical equipment	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Home short-term therapy*	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Dialysis	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance

* Short-term therapy limits are per type of therapy per benefit period

Covered short-term therapies include:

Physical "PT," occupational "OT," and speech therapies "ST."

PT and OT have a combined visit maximum; speech therapy has its own visit maximum. Outpatient, office and home therapies are combined to meet visit maximum. Inpatient therapies are excluded from the benefit period visit maximum.

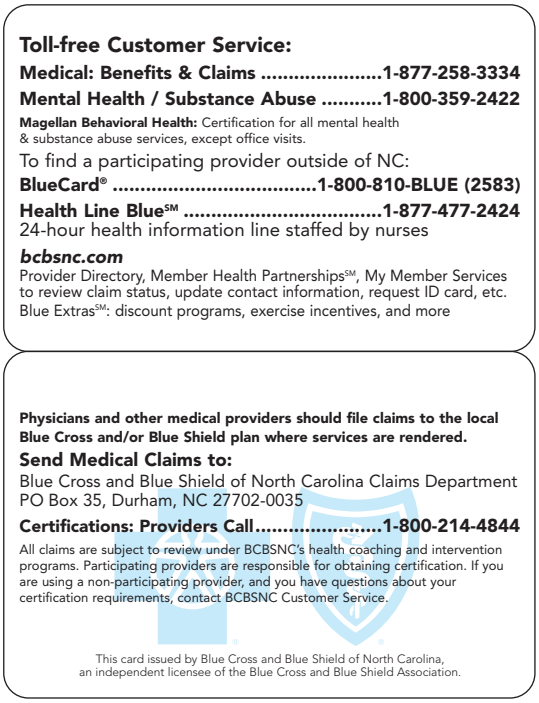
Blue Options HSA℠ Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Emergency room services	• In-network deductible and coinsurance	• In-network deductible and coinsurance
Ambulatory surgery centers *Facility must be contracting with BCBSNC as an ambulatory surgery center*	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Outpatient services	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Inpatient services	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Skilled nursing facilities	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
	• This benefit is limited to 60 days per benefit period *(combined in and out-of-network)*	
Inpatient and outpatient services for mental health and substance abuse	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance

3.12 Blue Options HRA℠

Blue Options HRA℠ is a Preferred Provider Organization "PPO" product. Higher in-network benefits are available to Blue Options HRA℠ members who seek care within the provider network. A sample ID card and benefit summary follow.

This product requires the member to pay in-network deductible and coinsurance for all in-network services. There are no copayments on this product.

3.12.1 Sample ID Card



- The full subscriber ID begins with YPPW followed by a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.12.2 Blue Options HSA℠ and Blue Options HRA℠ Collection Policy

For any Blue Options℠ deductible and coinsurance-only product *(not copayment products)*, BCBSNC's in-network providers *(including physicians, professional providers, hospitals and ancillary providers)* may collect an estimated amount from members at the time of service for a member's out-of-pocket costs, as described below. To determine whether a product is covered under this policy, all providers should check the member ID card to make sure that both of the following criteria are met: 1) Make sure that the ID card indicates a *coinsurance* amount for physician services. If so, it is a deductible and *coinsurance*-only product; or 2) If the card indicates a *copayment* for physician services, the product is not subject to this policy and no estimated amounts should be collected for any service by any provider.

Make sure that the card indicates that the product is a Blue Options℠ product *(including* Blue Options HRA℠ *and* Blue Options HSA℠*)*. If the card does not indicate Blue Options℠, it is not subject to this policy and no estimated amounts should be collected. In all cases, in-network hospitals and providers are required to check for a member's remaining deductible or coinsurance amounts using sources such as the HIPAA 270 Inquiry, RealMed, ***Blue e***℠, or BCBSNC customer service. Keep in mind that these sources provide the most accurate information available at the time, as the information provided on the Explanation of Payment "EOP" from BCBSNC may differ based on claims that were in transit to BCBSNC or any applicable adjustments.

The limitations on collection of estimated amounts are as follows:

Physician's or professional providers may collect up to the lesser of the member's estimated out-of-pocket costs or $50 for services received in the provider's office, including services rendered in a hospital-owned clinic.

Hospitals and ancillary providers may collect up to the lesser of the member's estimated out-of-pocket costs or $500 for services received in a hospital or outpatient facility such as an emergency room or ambulatory surgery center. Providers must inform the member that the amount being collected is an estimate. Providers must also calculate the member's out-of-pocket costs based on the lesser of the allowed *(contract)* amount or billed charges, taking into account the member's benefit year-to-date deductible or coinsurance benefit status *(amount met)*.

The final determination of what the member owes will be based on the claim that is submitted to BCBSNC, and will be reflected on the EOP. Any applicable refunds due to the member must be returned within 45 days. If a member is unable to pay at the time of service, the provider should not refuse to provide necessary treatment to the member. If they choose *(and if funds are available)*, the member can use funds from their HSA or HRA to pay for these services.

The provider should be aware of the tax implications if funds are withdrawn for nonqualified medical expenses or for expenses that the member did not incur, without subsequent and timely correction by the member. The member will need to take responsibility for correcting any incorrect withdrawals. Therefore, if your estimated collection was too high, and you are aware that the member used an HRA or HSA fund, you should remind the member to make the appropriate correction.

Please note that the current policy for the collection of copayments, deductibles and coinsurance amounts for those members enrolled in copayment products and non-Blue Options℠ products has not changed.

3.12.3 Health Benefit Summary

- Higher in-network benefits are available for services received from PPO network physicians or providers *(called in-network providers in member materials)*.
- Most benefits are also available from out-of-network physicians and providers at a higher out-of-pocket cost. In the typical plan design, coverage for enhanced preventive care, including routine physical exam, well-baby and well-child child care and certain immunizations and screenings. Other covered services may be subject to deductible and coinsurance.
- Summary of benefits offered as an example of member's benefit options, however this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Blue Options HRA℠ Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Office visit • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Enhanced preventive care • Immunizations • Well-baby care *(excluding diagnostic tests and screenings)* • Well-child care *(excluding diagnostic tests and screenings)* • The first office visit *(excluding diagnostic tests and screenings)* each *benefit period* for routine physical exams, gynecological exams, and the evaluation and treatment of obesity • The first preventive care diagnostic test and screening each benefit period *(excluding related office visits except as noted above)* for the following: cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, prostate specific antigen tests, newborn vision and hearing screening, cholesterol and lipid screening, bone mass measurement screening, and hemoglobin test.	May be one of the following: • In-network deductible and coinsurance • In-network coinsurance only *(deductible waived)* • Paid at 100% coinsurance *(deductible waived)*	• On most Blue Options℠ plans, the only preventive care services covered out-of-network are mammograms, pap smears, PSA tests and any other state-mandated tests. They are subject to out-of-network deductible and coinsurance.
Other preventive care • Any additional preventive care services and/or diagnostic tests and screenings, including those not listed above, are subject to deductible and coinsurance.	• In-network deductible and coinsurance	

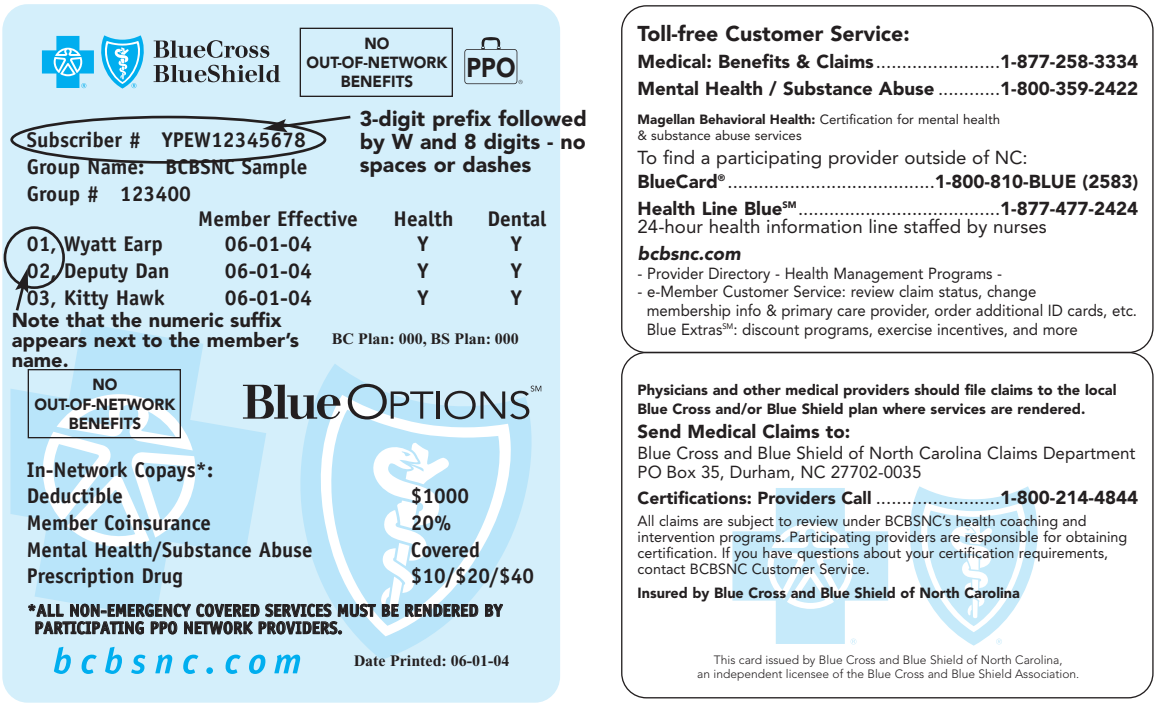
Blue Options HRA℠ Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Maternity • Prenatal • Post-delivery	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Short-term rehabilitative therapy • Occupational/physical therapy *(including chiropractic services)* • Speech therapy	• In-network deductible and coinsurance • On most plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*	• Out-of-network deductible and coinsurance • On most plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Urgent care	• In-network deductible and coinsurance	• In-network deductible and coinsurance
Emergency room services	• In-network deductible and coinsurance	• In-network deductible and coinsurance
Other professional services *(includes professional services provided in the following settings)*: • Ambulatory surgical center • Hospital • Skilled nursing facility • Diagnostic services *(other than an office setting)*	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Prescription drugs	• On most Blue Options HRA℠ plans, prescription drugs are covered as part of the medical plan deductible and coinsurance.	• Members will be required to pay the bill in full at the time of service and file a claim with BCBSNC.

Blue Options HRA℠ Typical Coverage for Services Provided by an Ancillary Provider		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Home health care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Hospice care	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Private duty nursing	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Home infusion therapy	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Durable medical equipment	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Home short-term therapy	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Dialysis	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance

3.13 Blue Options℠ *(In-Network Only)*

Blue Options℠ is a Preferred Provider Organization "PPO" product. A sample ID card and benefit summary follow.

3.13.1 Sample ID Card



- For standard groups, the full subscriber ID begins with YPEW followed by a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.13.2 Health Benefit Summary

- With this plan you must see a participating PPO provider for all covered services except emergency and urgent care *(called in-network providers in member materials)*.
- Summary of benefits offered as an example of member's benefit options; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Blue Options℠ *(In-Network Only)* Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Office visit • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care	• Primary care or specialist copayment *(listed on ID card)* • OB/GYNs always collect primary care copayment	• No benefits
Preventive care • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears *(with office visit)* • Immunizations *(with office visit)* • Screening mammograms *(with office visit)* • Prostate Specific Antigen "PSA" tests *(with office visit)* • Colorectal screening	• Primary care or specialist copayment *(listed on ID card)* • OB/GYNs always collect the primary care copayment	• No benefits
Maternity • Prenatal • Post-delivery	• Copayment for determination of pregnancy visit only • Deductible and coinsurance thereafter	• No benefits
Short-term rehabilitative therapy • Occupational/physical therapy *(including chiropractic services)* • Speech therapy	• Primary care or specialist copayment • On most Blue Options℠ plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*	• No benefits

Blue Options℠ *(In-Network Only)* Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	Office Location: • No copayment - covered services are paid at 100% unless billed with an office visit Other Locations: • Deductible and coinsurance • Second surgical opinion consultation • Surgery in addition to office visit for services covered at 100% unless billed with an office visit	• No benefits
Urgent care	• Urgent care copayment *(listed on ID card)*	• Urgent care copayment *(listed on ID card)*. • Members may be required to pay the bill in full at the time of service and file a claim with BCBSNC
Prescription drugs	• On most Blue Options℠ plans, prescription drugs are covered under a four-tier copayment design. The copayments are listed on the ID card *(see chapter 19, Specialty Networks)*	• No benefits

Blue Options℠ *(In-Network Only)* Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Emergency room services	• Emergency care copayment *(listed on ID card)*	• Emergency care copayment *(listed on ID card)*
Ambulatory surgery centers *Facility must be contracting with BCBSNC as an ambulatory surgery center*	• In-network deductible and coinsurance	• Not covered
Outpatient services	• On most Blue Options℠ plans, professional and facility charges for outpatient services are subject to deductible and coinsurance. • Certain diagnostic services are not paid solely based on place of service. Mammograms and simple lab work are paid at 100% at outpatient hospital centers when not performed with other services at the same time. All other diagnostics are subject to deductible and coinsurance.	• Not covered
Inpatient services	• On most Blue Options℠ plans, professional and facility charges for inpatient services are subject to deductible and coinsurance • New option for inpatient hospital copayment of $250 or $500 per admission	• Not covered

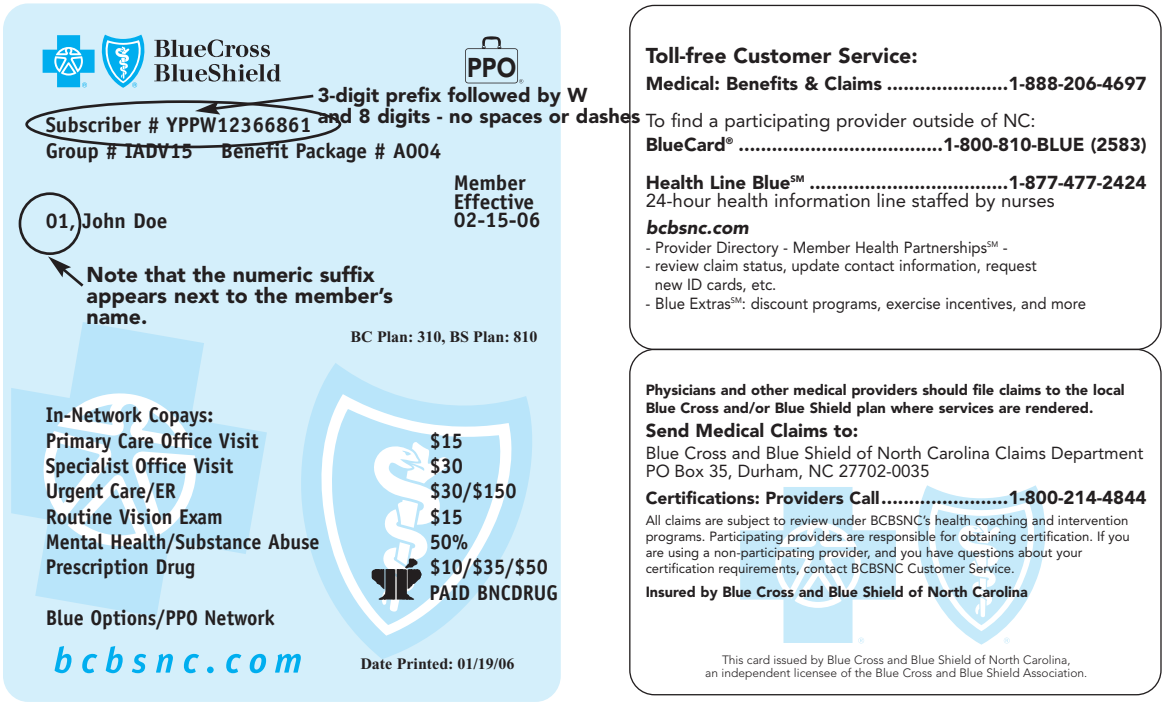
Blue Options℠ *(In-Network Only)* Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Skilled nursing facilities	• On most Blue Options℠ plans, all charges for services at a skilled nursing facility are subject to deductible and coinsurance	• Emergency care copayment *(listed on ID card)*
	• This benefit is limited to 60 days per benefit period *(combined in and out-of-network)*	
Inpatient and outpatient services for mental health and substance abuse	• Coordinated through Magellan Behavioral Health	• Not covered

Blue Options℠ *(In-Network Only)* Typical Coverage for Services Provided by an Ancillary Provider		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Home health care	• In-network deductible and coinsurance	• Not covered
Hospice care	• In-network deductible and coinsurance	• Not covered
Private duty nursing	• In-network deductible and coinsurance	• Not covered
Home infusion therapy	• In-network deductible and coinsurance	• Not covered
Durable medical equipment	• In-network deductible and coinsurance	• Not covered
Home short-term therapy	• In-network deductible and coinsurance	• Not covered
Dialysis	• In-network deductible and coinsurance	• Not covered

3.14 Blue Advantage®

Blue Advantage® is a Preferred Provider Organization "PPO" product. Higher in-network benefits are available to Blue Advantage® members who seek care within the provider network. A sample ID card and benefit summary follow.

3.14.1 Sample ID Card



- The full subscriber ID begins with YPPW followed by a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.14.2 Health Benefit Summary

- Higher in-network benefits are available for services received from PPO network physicians or providers *(called in-network providers in member materials)*.
- Most benefits are also available for out-of-network physicians and providers at a higher out-of-pocket cost. In the typical plan design, coverage for preventive services *(except mammograms, pap smears and PSAs)* is available only from in-network physicians and providers.
- Summary of benefits offered as an example of member's benefit options, however this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Blue Advantage® Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Office visit • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care	• Primary care or specialist copayment *(listed on ID card)* • OB/GYNs always collect primary care copayment	• Out-of-network deductible and coinsurance
Preventive care • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears *(with office visit)* • Immunizations *(with office visit)* • Screening mammograms *(with office visit)* • Prostate Specific Antigen "PSA" tests *(with office visit)* • Colorectal screening	• Primary care or specialist copayment *(listed on ID card)* • OB/GYNs always collect the primary care copayment	• On most Blue Advantage® plans, the only preventive care services covered out-of-network are mammograms, pap smears, and PSA test. They are subject to out-of-network deductible and coinsurance.
Maternity • Prenatal • Post-delivery	• Only members with maternity rider have maternity benefits • Copayment for determination of pregnancy visit only • Deductible and coinsurance thereafter	• Out-of-network deductible and coinsurance
Short-term rehabilitative therapy • Occupational/physical therapy *(including chiropractic services)* • Speech therapy	• Primary care or specialist copayment • On most Blue Advantage® plans, short-term rehabilitative therapies are limited to combined in and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*	• Out-of-network deductible and coinsurance • On most Blue Advantage® plans, short-term rehabilitative therapies are limited to combined in- and out-of-network maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*

Blue Advantage® Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	Office Location: • No copayment - covered services are paid at 100% unless billed with an office visit Other Locations: • Deductible and coinsurance • Second surgical opinion consultation • Surgery in addition to office visit for services covered at 100% unless billed with an office visit	• Out-of-network deductible and coinsurance
Urgent care	• Urgent care copayment *(listed on ID card)*	• Urgent care copayment *(listed on ID card)*. • Members may be required to pay the bill in full at the time of service and file a claim with BCBSNC
Prescription drugs	• On most Blue Options℠ plans, prescription drugs are covered under a three-tier copayment design. The copayments are listed on the ID card *(see chapter 19, Specialty Networks)* • There is an annual per member prescription maximum	• Members will be required to pay the bill in full at the time of service and file a claim with BCBSNC
Mental health/ substance abuse services	• Deductible and mental health coinsurance	• Deductible and mental health coinsurance

Blue Advantage® Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Emergency room services	• Emergency care copayment *(listed on ID card)*	• Emergency care copayment *(listed on ID card)* Members may be required to pay the bill in full at the time of service and file a claim with BCBSNC
Ambulatory surgery centers *Facility must be contracting with BCBSNC as an ambulatory surgery center*	• In-network deductible and coinsurance	• Out-of-network deductible and coinsurance
Outpatient services	• On most Blue Options℠ plans, professional and facility charges for outpatient services are subject to deductible and coinsurance. • Certain diagnostic services are not paid solely based on place of service. Mammograms and simple lab work are paid at 100% at outpatient hospital centers when not performed with other services at the same time. All other diagnostics are subject to deductible and coinsurance.	• Not covered
Inpatient services	• Professional and facility charges for inpatient services are subject to deductible and coinsurance	• Not covered

Blue Advantage® Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Skilled nursing facilities	• All charges for services at a skilled nursing facility are subject to deductible and coinsurance	• Out-of-network deductible and coinsurance
	• This benefit is limited to 60 days per benefit period *(combined in and out-of-network)*	
Inpatient and outpatient services for mental health and substance abuse	• Subject to deductible and coinsurance	• Subject to deductible and coinsurance

Blue Advantage® Typical Coverage for Services Provided by an Ancillary Provider		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Home health care	Deductible and coinsurance	Deductible and coinsurance
Hospice care	Deductible and coinsurance	Deductible and coinsurance
Private duty nursing *(certification required)*	Deductible and coinsurance	Deductible and coinsurance
Home infusion therapy	Deductible and coinsurance	Deductible and coinsurance
Durable medical equipment	Deductible and coinsurance	Deductible and coinsurance
Home short term therapy*	Deductible and coinsurance	Deductible and coinsurance
Dialysis	Deductible and coinsurance**	Deductible and coinsurance

* Short-term therapy limits are per type of therapy per benefit period.

** Dialysis performed in the physician's office is subject to a copay.

Covered short-term therapies include:

- Physical "PT," occupational "OT," and speech therapies
- PT and OT have a combined visit maximum; speech therapy has its own visit maximum. Outpatient, office and home therapies are combined to meet visit maximum. Inpatient therapies are excluded from the benefit period visit maximum.

3.15 NC Smart*Choice*℠

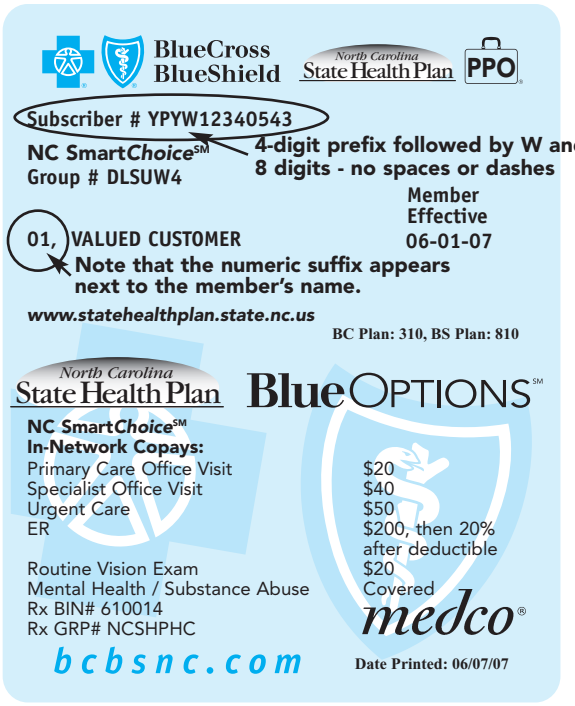
Note to the reader: The following information pertains to NC Smart*Choice*℠ – a Preferred Provider Organization "PPO" plan offered by the State Health Plan to its members. The State Health Plan offers teachers, state employees and state retirees the option to choose from three PPO health plans or a Comprehensive Major Medical "CMM" indemnity plan. Providers can distinguish if a State Health Plan member is enrolled in the CMM coverage plan or enrolled in a PPO plan by reading the member's ID card or by review of the member's alpha prefix. State Health Plan CMM indemnity members have a single letter alpha prefix of "W" and State Health Plan PPO members have an alpha prefix of "YPY-W." Providers who want to learn more about the State Health Plan's Comprehensive Major Medical "CMM" Indemnity Plan, can find information in chapter five of this manual.

NC Smart*Choice*℠ is administered as part of the Blue Cross and Blue Shield of North Carolina "BCBSNC" Blue Options℠ PPO product under the name of NC Smart*Choice*℠. NC Smart*Choice*℠ provides state employees with a choice of three PPO plans: NC Smart*Choice*℠ Basic, NC Smart*Choice*℠ Standard and NC Smart*Choice*℠ Plus. The NC Smart*Choice*℠ PPO plans are based on different levels of physician office visit copays, different levels of coinsurance and different levels of deductible. The amount of money a state employee pays out-of-pocket for PPO benefits cost-sharing differ, based on the option selected by the employee. Here are the option highlights:

- NC Smart*Choice*℠ Basic PPO
  - Members have higher copayments, coinsurance and deductibles
- NC Smart*Choice*℠ Standard PPO
  - Coverage at levels between basic and plus plans
- NC Smart*Choice*℠ Plus PPO
  - Members have lower copayments, coinsurance and deductibles

Under any of the three State Health Plan PPO options, enrolled members can choose to obtain medical services from out-of-network providers. However, out-of-pocket costs for copayments, coinsurance and deductibles will be higher for the member than in-network costs, when out-of-network care is obtained.

3.15.1 Sample ID Card



- The full subscriber member identification "ID" begins with YPY-W followed by a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.15.2 Health Benefit Summary

- Higher in-network benefits are available for services received from PPO network physicians or providers *(called in-network providers in member materials)*.
- The copayment amounts shown in this section are the fixed dollar amounts the member must pay for some covered services.
- The coinsurance percentages shown in this section are the portion of the allowed amount that the State Health Plan PPO covers *(deductible and coinsurance amounts are based on the allowed amount)*.
- For in-network physician *(office visits only)* a copayment applies.
- For out-of-network physician *(office visits only)* deductible and coinsurance applies.
- Services applied to the deductible also count toward any visit or day maximums.
- To receive in-network benefits, care must be received from a BCBSNC Blue Options℠ PPO in-network provider. However, in an emergency, or when in-network providers are not reasonably available as determined by BCBSNC's access to care standards, members may also receive in-network benefits for care from an out-of-network provider. Members who see an out-of-network provider will receive out-of-network benefits unless otherwise approved by the State Health Plan.

Please note that throughout the benefits summaries, wherever percentages are indicated, the percentage represents what the plan pays, not the individual.

Summary of benefits offered as an example of member's benefit options, however this is not a guarantee of benefits, eligibility or plan coverage. Providers should verify member's actual eligibility and benefits prior to providing services.

The benefits contained in the following tables were under legislative review at the time of publication of this manual. Therefore, these tables provide an example of how benefit packages may appear, however, please refer to the State Health Plan Web site to review the current NC Smart*Choice*SM benefit plan summaries at ***http://statehealthplan.state.nc.us/smartchoice-ppo.html***.

State Health Plan Smart*Choice*SM Basic **Benefits At A Glance** **Benefit Period – October 1, 2006 through June 30, 2007**		
Benefit payments are based on where the services are received and how the services are billed.		
Service Category	**In-Network Member Liability**	**Out-of-Network Liability**
Office visit • Primary care provider • Specialist Includes office surgery, x-rays and lab tests.	 • $25 copayment • $50 copayment	 • 50% after deductible • 50% after deductible
See outpatient services for outpatient clinic or hospital-based services. Office visits for the evaluation and treatment of obesity are limited to a combined in- and out-of-network maximum of four visits per benefit period.		
Preventive care • Primary care provider • Specialist	 • $25 copayment • $50 copayment	 • Benefits not available • Benefits not available
Includes routine physical exams, well baby, well-child care, and immunizations. The following preventive care benefits are available out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests.		
Short-term rehabilitative therapies • Chiropractic services	 • $50 copayment • $25 copayment	 • 50% after deductible • 50% after deductible
Combined in- and out-of-network benefit period maximums apply to home, office and outpatient settings. 30 visits per benefit period for physical/occupational therapy, including chiropractic services. 30 visits per benefit period for speech therapy.		

State Health Plan SmartChoice℠ Basic Benefits At A Glance Benefit Period – October 1, 2006 through June 30, 2007 Benefit payments are based on where the services are received and how the services are billed.		
Service Category	**In-Network Member Liability**	**Out-of-Network Liability**
Other therapies	• 100%	• 50% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See outpatient services for other therapies provided in an outpatient setting.		
Infertility and sexual dysfunction services • Primary care provider • Specialist	 • $25 copayment • $50 copayment	 • 50% after deductible • 50% after deductible
Combined in- and out-of-network lifetime maximum of $5,000 per member, provided in all places of service.		
Routine eye exam	• $25 copayment	• Benefits not available
Urgent care centers and emergency room • Urgent care centers • Emergency room visit	 • $75 copayment • $250 copayment then 70% after deductible	 • $75 copayment • $250 copayment then 50% after deductible
If admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided. If the member is held for observation, outpatient benefits apply to all covered services provided. If the member is sent to the emergency room from an urgent care center, the member may be responsible for both the emergency room copayment and the urgent care copayment.		
Ambulatory surgical center	• 70% after deductible	• 50% after deductible
Outpatient clinic or hospital services • Physician services • Hospital and hospital-based services • Outpatient clinic services **Outpatient diagnostic services** • Outpatient lab tests and mammography, when performed alone	 • 70% after deductible • 70% after deductible • 70% after deductible • 100%	 • 50% after deductible • 50% after deductible • 50% after deductible • 50% after deductible

State Health Plan SmartChoice℠ Basic Benefits At A Glance Benefit Period – October 1, 2006 through June 30, 2007 Benefit payments are based on where the services are received and how the services are billed.		
Service Category	**In-Network Member Liability**	**Out-of-Network Liability**
Outpatient diagnostic services *(continued)* • Outpatient lab tests and mammography, when performed with another service • Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests • CT scans, MRIs, MRAs and PET scans received in any location, including in a physician's office	• 70% after deductible • 70% after deductible • 70% after deductible	• 50% after deductible • 50% after deductible • 50% after deductible
Therapy services	• 70% after deductible	• 50% after deductible
Includes short-term rehabilitative therapies and other therapies; see physician office services for visit maximums.		
Inpatient hospital services • Physician services • Hospital and hospital-based services	• 70% after deductible • $200 per admission copay then 70% after *deductible*	• 50% after deductible • $200 per admission copay then 70% after *deductible*
Includes maternity delivery, prenatal and post-delivery care.		
Skilled nursing facility	• 70% after deductible	• 50% after deductible
Combined in- and out-of-network maximum of 100 days per benefit period. Services applied to the deductible count towards this day maximum.		
Other services	• 70% after deductible	• 50% after deductible
Includes ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices – correction of positional plagiocephaly limited to a lifetime maximum of $600 and prosthetic appliances.		
Lifetime maximum, deductible, and coinsurance maximum The following deductibles and maximums apply to the services listed above in the summary of benefits unless otherwise noted.		

State Health Plan Smart*Choice*℠ Basic Benefits At A Glance Benefit Period – October 1, 2006 through June 30, 2007		
Benefit payments are based on where the services are received and how the services are billed.		
Service Category	**In-Network Member Liability**	**Out-of-Network Liability**
Lifetime maximum	• Unlimited	• Unlimited
Unlimited for all services, except orthotic devices for positional plagiocephaly, infertility and sexual dysfunction, infertility drugs and substance abuse.		
Deductible • Individual, per benefit period • Family, per benefit period	 • $600 • $1,800	 • $1,200 • $3,600
Charges for the following do not apply to the benefit period deductible: • Inpatient newborn care for well baby • Mental health and substance abuse services • Prescription drugs		
Coinsurance maximum • Individual, per benefit period • Family, per benefit period	 • $2,500 • $7,500	 • $5,000 • $15,000
Charges for the following do not apply to the benefit period coinsurance maximum: • Mental health and substance abuse services • Prescription drugs		
Certification penalty If certification is not obtained for covered out-of-network inpatient admissions, allowed charges will be reduced by 25% then deductible and coinsurance will be applied.		
Prescription drugs • Generic drugs • Preferred *(no generic equivalent available)* • Preferred *(generic equivalent available)* • Non-preferred drugs	 • $10 copayment • $25 copayment • $40 copayment • $50 copayment	 • $10 copayment • $25 copayment • $40 copayment • $50 copayment
One copayment for up to a 34-day supply. 35-68-day supply is two copayments, and 69-102-day supply is three copayments.		

State Health Plan Smart*Choice*℠ Basic

Benefits At A Glance

Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

Service Category	In-Network Member Liability	Out-of-Network Liability
Mental health and substance abuse services All inpatient and outpatient mental health and substance abuse services must be certified in advance by Value Options. Office visits do not require certification.		
Mental health office services • Combined in- and out-of-network limit of: 30 office visits per benefit period.	• $50 copayment	• 50% after deductible
Mental health inpatient/ outpatient services • Combined in- and out-of-network limit of 30 days per benefit period.	• 70% after deductible	• 50% after deductible
Substance abuse office services	• $50 copayment	• 50% after deductible
Substance abuse inpatient/ outpatient services	• 70% after deductible	• 50% after deductible
Substance abuse benefit period maximum	• $8,000	
Substance abuse lifetime maximum	• $16,000 *(combined in and out-of-network)*	
Complete benefit booklets are available on the Web: ***http://statehealthplan.state.nc.us/smartchoice-ppo.html***		

State Health Plan SmartChoice℠
Benefits At A Glance
Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

Service Category	In-Network Member Liability	Out-of-Network Liability
Office visit • Primary care provider • Specialist Includes office surgery, x-rays and lab tests.	 • $20 copayment • $40 copayment	 • 60% after deductible • 60% after deductible
See outpatient services for outpatient clinic or hospital-based services. Office visits for the evaluation and treatment of obesity are limited to a combined in- and out-of-network maximum of four visits per benefit period.		
Preventive care • Primary care provider • Specialist	 • $20 copayment • $40 copayment	 • Benefits not available • Benefits not available
Includes routine physical exams, well baby, well-child care, and immunizations. The following preventive care benefits are available out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests.		
Short-term rehabilitative therapies • Chiropractic services	 • $40 copayment • $20 copayment	 • 60% after deductible • 60% after deductible
Combined in- and out-of-network benefit period maximums apply to home, office and outpatient settings. 30 visits per benefit period for physical/occupational therapy, including chiropractic services. 30 visits per benefit period for speech therapy.		
Other therapies	• 100%	• 60% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See outpatient services for other therapies provided in an outpatient setting.		
Infertility and sexual dysfunction services • Primary care provider • Specialist	 • $20 copayment • $40 copayment	 • 60% after deductible • 60% after deductible
Combined in- and out-of-network lifetime maximum of $5,000 per member, provided in all places of service.		
Routine eye exam	• $25 copayment	• Benefits not available

State Health Plan SmartChoice℠
Benefits At A Glance
Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

Service Category	In-Network Member Liability	Out-of-Network Liability
Urgent care centers and emergency room		
• Urgent care centers	• $50 copayment	• $50 copayment
• Emergency room visit	• $200 copayment then 80% after deductible	• $200 copayment then 60% after deductible
If admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided. If the member is held for observation, outpatient benefits apply to all covered services provided. If the member is sent to the emergency room from an urgent care center, the member may be responsible for both the emergency room copayment and the urgent care copayment.		
Ambulatory surgical center	• 80% after deductible	• 60% after deductible
Outpatient clinic or hospital services		
• Physician services	• 80% after deductible	• 60% after deductible
• Hospital and hospital-based services	• 80% after deductible	• 60% after deductible
• Outpatient clinic services	• 80% after deductible	• 60% after deductible
Outpatient diagnostic services		
• Outpatient lab tests and mammography, when performed alone	• 100%	• 60% after deductible
• Outpatient lab tests and mammography, when performed with another service	• 80% after deductible	• 60% after deductible
• Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	• 80% after deductible	• 60% after deductible
• CT scans, MRIs, MRAs and PET scans received in any location, including in a physician's office	• 80% after deductible	• 60% after deductible

State Health Plan SmartChoice℠
Benefits At A Glance
Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

Service Category	In-Network Member Liability	Out-of-Network Liability
Therapy services	• 80% after deductible	• 60% after deductible
Includes short-term rehabilitative therapies and other therapies; see physician office services for visit maximums.		
Inpatient hospital services • Physician services • Hospital and hospital-based services	• 80% after deductible • $150 per admission copay then 80% after *deductible*	• 60% after deductible • $150 per admission copay then 60% after *deductible*
Includes maternity delivery, prenatal and post-delivery care.		
Skilled nursing facility	• 80% after deductible	• 60% after deductible
Combined in- and out-of-network maximum of 100 days per benefit period. Services applied to the deductible count towards this day maximum.		
Other services	• 80% after deductible	• 60% after deductible
Includes ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices – correction of positional plagiocephaly limited to a lifetime maximum of $600 and prosthetic appliances.		
Lifetime maximum, deductible, and coinsurance maximum The following deductibles and maximums apply to the services listed above in the summary of benefits unless otherwise noted.		
Lifetime maximum	• Unlimited	• Unlimited
Unlimited for all services, except orthotic devices for positional plagiocephaly, infertility and sexual dysfunction, infertility drugs and substance abuse.		
Deductible • Individual, per benefit period • Family, per benefit period	 • $300 • $900	 • $600 • $1,800
Charges for the following do not apply to the benefit period deductible: • Inpatient newborn care for well baby • Mental health and substance abuse services • Prescription drugs		

State Health Plan SmartChoice℠
Benefits At A Glance
Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

Service Category	In-Network Member Liability	Out-of-Network Liability
Coinsurance maximum • Individual, per benefit period • Family, per benefit period	• $1,750 • $5,250	• $3,500 • $10,500
Charges for the following do not apply to the benefit period coinsurance maximum: • Mental health and substance abuse services • Prescription drugs		
Certification penalty If certification is not obtained for covered out-of-network inpatient admissions, allowed charges will be reduced by 25% then deductible and coinsurance will be applied.		
Prescription drugs • Generic drugs • Preferred *(no generic equivalent available)* • Preferred *(generic equivalent available)* • Non-preferred drugs	• $10 copayment • $25 copayment • $40 copayment • $50 copayment	• $10 copayment • $25 copayment • $40 copayment • $50 copayment
One copayment for up to a 34-day supply. 35-68-day supply is two copayments, and 69-102-day supply is three copayments.		
Mental health and substance abuse services All inpatient and outpatient mental health and substance abuse services must be certified in advance by Value Options. Office visits do not require certification.		
Mental health office services • Combined in- and out-of-network limit of: 30 office visits per benefit period.	• $40 copayment	• 60% after deductible
Mental health inpatient/ outpatient services • Combined in- and out-of-network limit of 30 days per benefit period.	• 80% after deductible	• 60% after deductible

State Health Plan SmartChoice℠ Benefits At A Glance Benefit Period – October 1, 2006 through June 30, 2007 Benefit payments are based on where the services are received and how the services are billed.		
Service Category	**In-Network Member Liability**	**Out-of-Network Liability**
Substance abuse office services	• $40 copayment	• 60% after deductible
Substance abuse inpatient/ outpatient services	• 80% after deductible	• 60% after deductible
Substance abuse benefit period maximum **Substance abuse lifetime maximum**	• $8,000 • $16,000 *(combined in and out-of-network)*	
Complete benefit booklets are available on the Web: ***http://statehealthplan.state.nc.us/smartchoice-ppo.html***		

State Health Plan SmartChoice℠ Plus

Benefits At A Glance

Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

Service Category	In-Network Member Liability	Out-of-Network Liability
Office visit • Primary care provider • Specialist Includes office surgery, x-rays and lab tests.	 • $15 copayment • $30 copayment	 • 70% after deductible • 70% after deductible
See outpatient services for outpatient clinic or hospital-based services. Office visits for the evaluation and treatment of obesity are limited to a combined in- and out-of-network maximum of four visits per benefit period.		
Preventive care • Primary care provider • Specialist	 • $15 copayment • $30 copayment	 • Benefits not available • Benefits not available
Includes routine physical exams, well baby, well-child care, and immunizations. The following preventive care benefits are available out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests.		
Short-term rehabilitative therapies • Chiropractic services	 • $30 copayment • $15 copayment	 • 70% after deductible • 70% after deductible
Combined in- and out-of-network benefit period maximums apply to home, office and outpatient settings. 30 visits per benefit period for physical/occupational therapy, including chiropractic services. 30 visits per benefit period for speech therapy.		
Other therapies	• 100%	• 70% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See outpatient services for other therapies provided in an outpatient setting.		
Infertility and sexual dysfunction services • Primary care provider • Specialist	 • $15 copayment • $30 copayment	 • 70% after deductible • 70% after deductible
Combined in- and out-of-network lifetime maximum of $5,000 per member, provided in all places of service.		
Routine eye exam	• $15 copayment	• Benefits not available

State Health Plan SmartChoice℠ Plus

Benefits At A Glance

Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

Service Category	In-Network Member Liability	Out-of-Network Liability
Urgent care centers and emergency room		
• Urgent care centers	• $50 copayment	• $50 copayment
• Emergency room visit	• $150 copayment then 90% after deductible	• $150 copayment then 70% after deductible
If admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided. If the member is held for observation, outpatient benefits apply to all covered services provided. If the member is sent to the emergency room from an urgent care center, the member may be responsible for both the emergency room copayment and the urgent care copayment.		
Ambulatory surgical center	• 90% after deductible	• 70% after deductible
Outpatient clinic or hospital services		
• Physician services	• 90% after deductible	• 70% after deductible
• Hospital and hospital-based services	• 90% after deductible	• 70% after deductible
• Outpatient clinic services	• 90% after deductible	• 70% after deductible
Outpatient diagnostic services		
• Outpatient lab tests and mammography, when performed alone	• 100%	• 70% after deductible
• Outpatient lab tests and mammography, when performed with another service	• 90% after deductible	• 70% after deductible
• Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	• 90% after deductible	• 70% after deductible
• CT scans, MRIs, MRAs and PET scans received in any location, including in a physician's office	• 90% after deductible	• 70% after deductible

State Health Plan SmartChoice℠ Plus

Benefits At A Glance

Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

Service Category	In-Network Member Liability	Out-of-Network Liability
Therapy services	• 90% after deductible	• 70% after deductible
Includes short-term rehabilitative therapies and other therapies; see physician office services for visit maximums.		
Inpatient hospital services • Physician services • Hospital and hospital-based services	• 90% after deductible • $100 per admission copay then 90% after *deductible*	• 70% after deductible • $100 per admission copay then 70% after *deductible*
Includes maternity delivery, prenatal and post-delivery care.		
Skilled nursing facility	• 90% after deductible	• 70% after deductible
Combined in- and out-of-network maximum of 100 days per benefit period. Services applied to the deductible count towards this day maximum.		
Other services	• 90% after deductible	• 70% after deductible
Includes ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices – correction of positional plagiocephaly limited to a lifetime maximum of $600 and prosthetic appliances.		
Lifetime maximum, deductible, and coinsurance maximum The following deductibles and maximums apply to the services listed above in the summary of benefits unless otherwise noted.		
Lifetime maximum	• Unlimited	• Unlimited
Unlimited for all services, except orthotic devices for positional plagiocephaly, infertility and sexual dysfunction, infertility drugs and substance abuse.		
Deductible • Individual, per benefit period • Family, per benefit period	 • $150 • $450	 • $300 • $900
Charges for the following do not apply to the benefit period deductible: • Inpatient newborn care for well baby • Mental health and substance abuse services • Prescription drugs		

State Health Plan SmartChoice℠ Plus

Benefits At A Glance

Benefit Period – October 1, 2006 through June 30, 2007

Benefit payments are based on where the services are received and how the services are billed.

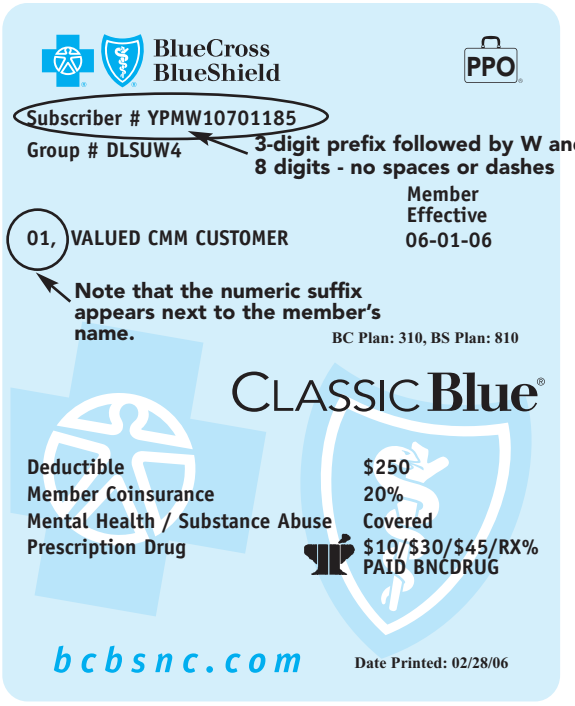
Service Category	In-Network Member Liability	Out-of-Network Liability
Coinsurance maximum • Individual, per benefit period • Family, per benefit period	 • $1,000 • $3,000	 • $2,000 • $6,000
Charges for the following do not apply to the benefit period coinsurance maximum: • Mental health and substance abuse services • Prescription drugs		
Certification penalty If certification is not obtained for covered out-of-network inpatient admissions, allowed charges will be reduced by 25% then deductible and coinsurance will be applied.		
Prescription drugs • Generic drugs • Preferred *(no generic equivalent available)* • Preferred *(generic equivalent available)* • Non-preferred drugs	 • $10 copayment • $25 copayment • $40 copayment • $50 copayment	 • $10 copayment • $25 copayment • $40 copayment • $50 copayment
One copayment for up to a 34-day supply. 35-68-day supply is two copayments, and 69-102-day supply is three copayments.		
Mental health and substance abuse services All inpatient and outpatient mental health and substance abuse services must be certified in advance by Value Options. Office visits do not require certification.		
Mental health office services • Combined in- and out-of-network limit of: 30 office visits per benefit period.	• $30 copayment	• 70% after deductible
Mental health inpatient/ outpatient services • Combined in- and out-of-network limit of 30 days per benefit period.	• 90% after deductible	• 70% after deductible

State Health Plan SmartChoice℠ Plus Benefits At A Glance Benefit Period – October 1, 2006 through June 30, 2007		
Benefit payments are based on where the services are received and how the services are billed.		
Service Category	**In-Network Member Liability**	**Out-of-Network Liability**
Substance abuse office services	• $30 copayment	• 70% after deductible
Substance abuse inpatient/ outpatient services	• 90% after deductible	• 70% after deductible
Substance abuse benefit period maximum **Substance abuse lifetime maximum**	• $8,000 • $16,000 *(combined in and out-of-network)*	
Complete benefit booklets are available on the Web: ***http://statehealthplan.state.nc.us/smartchoice-ppo.html***		

3.16 Classic Blue®

Classic Blue® is an indemnity Comprehensive Major Medical "CMM" plan. A sample ID card and benefit summary follow.

3.16.1 Sample ID Card



Toll-free Customer Service:
Medical: Benefits & Claims **1-877-258-3334**
Mental Health / Substance Abuse **1-800-359-2422**
Magellan Behavioral Health: Certification for all mental health & substance abuse services, except office visits.

To find a participating provider outside of NC:
BlueCard® .....**1-800-810-BLUE (2583)**

bcbsnc.com
Provider Directory, Member Health Partnerships℠, My Member Services to review claim status, update contact information, request ID card, etc.
Blue Extras℠: discount programs, exercise incentives, and more

Physicians and other medical providers should file claims to the local Blue Cross and/or Blue Shield plan where services are rendered.
Send Medical Claims to:
Blue Cross and Blue Shield of North Carolina Claims Department
PO Box 35, Durham, NC 27702-0035
Certifications: Providers Call **1-800-214-4844**
All claims are subject to review under BCBSNC's health coaching and intervention programs. Participating providers are responsible for obtaining certification. If you are using a non-participating provider, and you have questions about your certification requirements, contact BCBSNC Customer Service.
Insured by Blue Cross and Blue Shield of North Carolina

This card issued by Blue Cross and Blue Shield of North Carolina, an independent licensee of the Blue Cross and Blue Shield Association.

- The full subscriber ID begins with YPMW followed by a total of 11 digits, including the two digits that are displayed to the left of the subscriber's or dependent's name.

3.16.2 Health Benefit Summary

- Classic Blue® is a comprehensive major medical plan. Benefits are available for services received from any eligible physician or provider. Classic Blue® includes benefits for Blue Assurance®, CMM Conversion, Access℠ and Short Term Health Care.
- Participating providers cannot balance bill members.
- Summary of benefits offered as an example of member's benefit options; however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Classic Blue® Typical Coverage for Services Provided in an Office	
Service Category	**Member Liability**
Office visits • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Infertility services	• Deductible and coinsurance
Preventive care • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears • Immunizations • Screening mammograms • Prostate Specific Antigen "PSA" tests • Colorectal screening	• Deductible and coinsurance
Maternity • Prenatal • Post-delivery	• Deductible and coinsurance
Short-term rehabilitative therapy • Occupational therapy/physical therapy *(including chiropractic services)* • Speech therapy	• Deductible and coinsurance • On most Classic Blue® plans, short-term rehabilitative therapies are limited to a maximum of 30 visits per benefit period per therapy combination *(i.e., occupational and physical therapies are combined)*
Other therapies • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy	• Deductible and coinsurance
Urgent care	• Deductible and coinsurance

Classic Blue® Typical Coverage for Services Provided in an Office		
Service Category	**In-Network Member Liability**	**Out-Of-Network Member Liability**
Prescription drugs	• On most Classic Blue® plans, prescription drugs are covered under a three-tier copayment design. The copayments are listed on the ID card *(see chapter 19, Specialty Networks)* • Standard drug plans include a brand penalty. This penalty will not apply when the brand is determined to be necessary by the provider and dispense as written "DAW" is included on the prescription.	• Members will be required to pay the bill in full at the time of service and file a claim with BCBSNC
Mental health and substance abuse	• Deductible and MH/SA coinsurance • Effective on New Blue, where ID card prefix is YPM, pre-approval is not required	• Deductible and MH/SA coinsurance • Effective on New Blue, where ID card prefix is YPM, pre-approval is not required

Classic Blue® Typical Coverage for Services Provided in a Facility Depends on the Network Status of the Facility	
Service Category	**Member Liability**
Inpatient services	• Deductible and coinsurance
Skilled nursing facilities	• Deductible and coinsurance • Limited to 60 days per benefit period
Inpatient and outpatient services for mental health and substance abuse *(Outpatient services do not include office visits)*	• Mental health and substance abuse services are subject to deductible and coinsurance • Inpatient mental health days are subject to a day limit *(usually 30 days)* per benefit period • For Classic Blue® benefits, substance abuse benefits are limited to a benefit period dollar maximum *(usually $8,000)* and a lifetime dollar maximum *(usually $16,000)* • Blue Assurance℠, CMM Conversion and Access℠, all mental health and substance abuse benefits are limited to a combined benefit period dollar maximum and a combined $10,000 lifetime dollar maximum

Classic Blue® Typical Coverage for Services Provided by an Ancillary Provider	
Service Category	**Member Liability**
Home health care	• Deductible and coinsurance
Hospice care	• Deductible and coinsurance
Private duty nursing	• Deductible and coinsurance
Home infusion	• Deductible and coinsurance

Classic Blue® Optional Benefits	
Service Category	**Member Liability**
Home short term therapy	• Deductible and coinsurance
Dialysis	• Deductible and coinsurance

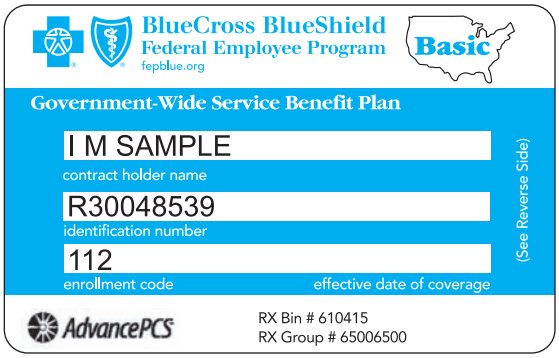
Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan

4. Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan

The Federal Employee Program is also known as the Blue Cross and Blue Shield Service Benefit Plan. The Blue Cross and Blue Shield Association contracts with the United States Office of Personnel Management on behalf of the 47 independent Blue Cross and Blue Shield Plans to provide health care coverage to federal employees, postal employees and retirees who choose to enroll in this plan. Federal employees, postal employees and retirees in North Carolina have the option to choose from either the service benefit plan or 6 union sponsored plans. The service benefit plan is a Preferred Provider Organization "PPO" plan. The plan has two options - standard option and basic option.

The following information is only applicable to those members enrolled in the Federal Employee Program.

4.1 Identification Cards



Enrollment codes are:

- **104** - Standard Option - Self Only
- **105** - Standard Option - Self and Family
- **111** - Basic Option - Self Only
- **112** - Basic Option - Self and Family

Important telephone numbers are located on the back of each card.

4.2 BCBSNC Federal Employee Program Contact Information

BCBSNC FEP Customer Service 1-800-222-4739

- The Provider Blue Line℠ offers health care providers a choice when calling for customer service assistance. Providers can call the BCBSNC FEP customer service department directly at **1-800-222-4739**, or use the Provider Blue Line℠ by calling **1-800-214-4844**, and follow the prompts to be connected.

Health Coaching and Intervention FEP 1-800-672-7897

Providers arranging services for FEP members should call **1-800-672-7897** for the following:

- Certification *(precertification and prior review [except outpatient mental health and substance abuse])*
- Home hospice care
- Organ and tissue transplants **1-800-672-7897**
  - Clinical trials for certain organ and tissue transplants **1-800-225-2268**

Additional Important Numbers	
FEP health management *(case management)*	**1-888-234-2415**
FEP Healthy Endeavors *(disease management)*	**1-888-392-3506**
Mental health/substance abuse benefits	**1-800-222-4739**
Magellan: mental health/substance abuse visit approvals	**1-800-288-3976**
Retail pharmacy information	**1-800-624-5060**
Mail service pharmacy information	**1-800-262-7890**
Blue health connection information	**1-888-258-3432**
Mailing Addresses	
Claims processing	BCBSNC P.O. Box 35 Durham, NC 27702
Claims reconsideration review	BCBSNC Customer Service P.O. Box 2291 Durham, NC 27702-2291
Review of disputed claims/reconsideration review/ Office of Personnel Management "OPM" appeal	United States Office of Personnel Management Insurance Services Programs Health Insurance Group I 1900 East Street, NW Washington, DC 20415-3610
For fastest claims processing, file electronically! Visit BCBSNC Electronic Solutions on the Web at: ***http://www.bcbsnc.com/providers/edi/***	***Blue e***^{SM}

Visit us on the Web at ***www.fepblue.org***.

4.3 Certification for the Federal Employee Program

4.3.1 Inpatient Precertification for the Federal Employee Program

The member is responsible for ensuring that all elective inpatient hospital admissions have been certified prior to the admission. The following are exceptions to the precertification requirement:

1. Routine maternity admissions
2. The facility is outside the United States
3. The Federal Employee Program is the secondary payer, including Medicare A *(except for major organ transplantation)*

Either the member, a representative of the member, the member's physician, or the hospital may precertify the hospital stay utilizing one of the following methods:

1. Rightfax at **919-765-2081**
2. Calling BCBSNC FEP at **800-672-7897**
3. Provider Blue Link℠
4. ***Blue e***℠

4.3.2 Flexible Benefits Option

BCBSNC has the authority to determine the most effective way to provide services. BCBSNC may identify medically appropriate alternatives to traditional care and coordinate providing Plan benefits as a less costly alternative benefit. These alternative benefits are subject to ongoing review and the Plan may decide to resume regular contract benefits at its sole discretion. Call **1-888-234-2415**, for information.

4.3.3 Prior Approval

The following services require prior approval before they are rendered:

4.3.3.1 Home Hospice Care

Providers should contact us at **1-800-672-7897**. The medical information necessary to make a coverage decision will be requested by BCBSNC.

4.3.3.2 Organ and Tissue Transplants

Providers should contact us at **1-800-672-7897**. BCBSNC will request the necessary medical information to make the appropriate medical decision. Both the facility and the procedure require prior approval. BCBSNC will also make sure the patient meets the criteria for transplant as established by the facility.

4.3.3.3 Clinical Trials for Certain Organ and Tissue Transplants

Members should contact our Transplant Clinical Trials Information Unit at **1-800-225-2268**. We will request the records needed to make a coverage determination. Transplants are currently covered only for the following conditions:

- Allogenic blood or marrow stem cell transplants for chronic lymphocytic leukemia; early stage *(indolent or non-advanced)* small cell lymphocytic lymphoma; multiple myeloma

- Nonmyeloablative allogeneic blood or marrow stem cell transplants for acute lymphocytic or non-lymphocoytic *(i.e. myelogenous)* leukemia; advanced forms of myelodysplastic syndoromes; advanced Hodgkin's lymphoma; chronic lympocytic leukemia; chronic myelogenous leukemia; early stage *(indolent or non-advanced)* small cell lymphocytic lymphoma; multiple myeloma; myeloproliferative disorders; renal cell carcinoma; advanced non-Hodgkin's lymphoma; breast cancer; colon cancer; non-small cell lung cancer; ovarian cancer; prostate cancer; sarcoma
- Autologous blood or marrow stem cell transplants for: breast cancer; chronic lymphocytic leukemia; early stage (indolent or non-advanced) small cell lymphocytic lymphoma; epithelial ovarian cancer; chronic myelogenous leukemia
- Autologous blood or stem cell transplants for the following autoimmune diseases; multiple sclerosis; systemic lupus erythematosis; systemic sclerosis

4.3.3.4 Partial Hospitalization or Intensive Outpatient Treatment for Mental Health/ Substance Abuse

The member or someone acting on their behalf must contact BCBSNC at **1-800-222-4739** to verify benefits prior to obtaining services for intensive outpatient treatment or partial hospitalization. The provider must obtain prior authorization through Magellan at **1-800-288-3976**.

4.3.3.5 Outpatient Mental Health and Substance Abuse Treatment – Standard Option

The member or someone acting on their behalf must contact BCBSNC at **1-800-222-4739** to verify benefits for outpatient visits. The provider must contact Magellan at **1-800-288-3976** prior to the ninth outpatient visit. When Magellan approves the plan of care, the provider will be given authorization for additional visits. The number of visits will depend on the treatment plan. If the provider fails to contact Magellan, the Plan will provide only non-preferred *(out-of-network)* benefits. If the member changes providers, Magellan must be contacted for approval of visits.

4.3.3.6 Outpatient Mental Health and Substance Abuse Treatment – Basic Option

The member or someone acting on their behalf should contact BCBSNC at **1-800-222-4739** to verify benefits for outpatient visits. The provider must contact Magellan at **1-800-288-3976** prior to services being rendered to obtain prior approval. When Magellan approves the plan of care, the provider will be given authorization for visits. The number of visits will depend on the treatment plan.

4.3.3.7 Prescription Drugs and Supplies

Prior approval is needed for certain drugs and supplies. The retail pharmacy program will request the medical evidence necessary to make a coverage determination.

4.4 Review of Disputed Claims / Reconsideration Review / Office of Personnel Management "OPM" Appeal

4.4.1 Disputed Claims

There are specific procedures for the review of disputed claims. The service benefit plan has two steps, starting with an informal review by BCBSNC which may lead to a review by OPM *(OPM appeal)*.

4.4.2 Reconsideration Review

The Plan will review the determination of benefits upon receiving a written request from the member for review or requesting additional information necessary to make a benefit determination, within 30 days of receiving the request for review.

4.4.3 OPM Appeal

When the Plan affirms its denial of benefits, the contract holder or member may send a written request to OPM for review to determine if the carrier has acted in accordance with the FEP contract. All requests for review must be sent to OPM within 90 days of the date of the Plan's letter affirming its denial.

OPM appeals should be addressed to:

United States Office of Personnel Management
Insurance Services Programs
Health Insurance Group I
1900 E. Street, NW
Washington, DC 20415-3610

OPM will accept a request for review from a contract holder or member as an appeal if the Plan fails to respond to the member's request for review within 30 days of the date of the request.

4.5 Federal Employee Program Covered Professional Providers

The following are considered to be covered professionals when they perform services within the scope of their license or certification:

4.5.1 Physician

Doctors of Medicine "M.D."; Osteopathy "D.O."; Dental Surgery "D.D.S."; Medical Dentistry "D.M.D."; Podiatric Medicine "D.P.M."; and Optometry "O.D."; and Chiropractic "D.C."

4.5.2 Physician Assistant

A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified or registered as a physician assistant where the services are performed.

4.5.3 Independent Laboratory

A laboratory that is licensed under State law or, where no licensing requirement exists, that is approved by the Plan.

4.5.4 Clinical Psychologist

A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology or is approved by the Plan; and (3) has met the clinical psychological experience requirements of the Individual State Licensing Board.

4.5.5 Nurse Midwife

A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.

4.5.6 Nurse Practitioner/Clinical Specialist

A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.

4.5.7 Clinical Social Worker

A social worker who (1) has a master's or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified or registered as a social worker where the services are performed.

4.5.8 Physical, Speech and Occupational Therapist

A professional who is licensed where the services are performed or meets the requirements of the Plan to provide physical, speech or occupational therapy services.

4.5.9 Nursing School Administered Clinic

A clinic that (1) is licensed or certified in the state where the services are performed; and (2) provides ambulatory care in an outpatient setting - primarily in rural or inner-city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient office charges rather than facility charges.

4.5.10 Audiologist

A professional who, if the state requires it, is licensed, certified or registered as an audiologist where the services are performed.

4.5.11 Dietitian

A professional who, if the state requires it, is licensed, certified or registered as a dietitian where the services are performed.

4.5.12 Diabetic Educator

A professional who, if the state requires it, is licensed, certified or registered as a diabetic educator where the services are performed.

4.5.13 Nutritionist

A professional who, if the state requires it, is licensed, certified or registered as a nutritionist where the services are performed.

4.6 Health Benefit Highlights – Standard and Basic Options

Please note: This is a summary of the features of the Blue Cross and Blue Shield service benefit plan. All benefits are subject to the definition, limitations and exclusions set forth in the federal brochure. For a contractual and complete description of the benefits available under the service benefit plan, please refer to the Blue Cross and Blue Shield service benefit plan brochure *(RI 71-005)*.

STANDARD OPTION	BASIC OPTION
• Standard Option has a calendar year deductible. It is as follows: - $250.00 per person - $500.00 per family *(aggregate)* • Benefits are available to out-of-state members seeking treatment. Claims should be filed with the state rendering the service. • Benefits are available for services received from PPO *Select* network physicians or providers called preferred provider in member materials. • Benefits from non-preferred physicians and providers are paid at a lower level. Members are responsible for any deductible and coinsurance amounts as well as the difference between the providers charge and BCBS's payment.	• Under Basic Option, members must use preferred providers for all medical care. Benefits are only available for care provided by non-preferred providers in certain situations, such as: - Initial medical emergency or accidental injury care in a hospital emergency room and related ambulance transport - Professional care provided by certain non-preferred providers *(radiologists, emergency room physicians and assistant surgeons)* at preferred facilities - Laboratory and pathology services, x-rays and diagnostic tests billed by non-preferred laboratories, radiologists and outpatient facilities - Services of assistant surgeons - Special provider access situations - Care received outside the United States and Puerto Rico • When services of non-preferred providers are covered in a special exception, benefits will be provided based on the Plan's allowance. The member is responsible for the applicable copayment, and may also be responsible for any difference between the Plan's allowance and the billed amount. • For Basic Option, the term primary care provider includes family practitioners, general practitioners, medical internists, pediatricians and obstetricians/gynecologists.
• If a member has Standard Option and Medicare Part A and Part B as the primary payer, the calendar year deductible, coinsurance amounts, copayment amounts for inpatient and outpatient hospital care, physician care, medical supplies and other covered services are waived.	• The Federal Employee Program encourages physicians to prescribe a brand-name drug from the formulary list when there is no generic equivalent available. The drug cost for non-formulary drugs will be higher. A formulary listing can be viewed on our Web site at ***fepblue.org*** or request a copy by calling **1-800-624-5060**. • Benefits are nationwide and are available to out-of-state members seeking treatment. Claims should be filed with the state rendering the service. Benefits are available for services received from PPO *Select* network physicians or providers called preferred provider in member materials. • If a member has Basic Option and Medicare Part A and Part B as the primary payer, the inpatient and outpatient hospital copayments, preferred physician copayments, copayments of other preferred health care professionals are waived.

Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan Standard Option and Basic Option Typical Coverage for Services		
Service Category	**In-Network Member Liability STANDARD OPTION**	**In-Network Member Liability BASIC OPTION**
Office visits • Home and office visits • Second surgical opinions • Outpatient consultation • Pharmacotherapy for prescription drug coverage	• $15 office visit copayment • No deductible	• $20 office visit copayment for primary care provider • $30 office visit copayment for specialists
Preventive care screenings • History and risk assessment • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile *(total cholesterol, LDL, HDL, and/or triglycerides)* when performed by a Preferred provider or any independent laboratory • Chlamydia infection test	• $15 office visit copay • No deductible or coinsurance for covered preventive screenings	• $20 office visit copay for primary care provider • $30 office visit copay for specialists • Nothing for covered preventive screenings billed by the provider • Note: 30% prior review for drugs and supplies
Preventive cancer screenings and diagnostic tests • Colorectal cancer tests, including: - Fecal occult blood test Colonoscopy - Sigmoidoscopy - Double contrast barium enema • Prostate cancer test – Prostate Specific Antigen "PSA" test • Cervical cancer test *(including Pap tests)*	• $15 office visit copay • No deductible or coinsurance for covered preventive screenings	• $20 office visit copay for primary care provider • $30 office visit copay for specialists • Nothing for covered preventive screenings billed by the provider Note: 30% prior review for drugs and supplies

Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan Standard Option and Basic Option Typical Coverage for Services		
Service Category	**In-Network Member Liability STANDARD OPTION**	**In-Network Member Liability BASIC OPTION**
Preventive cancer screenings and diagnostic tests *(continued)* • Breast cancer tests *(routine or non-routine mammograms)* • Ultrasound for aortic abdominal aneurysm	Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	*(see preceding page for this information)*
Preventive care children • All healthy newborn visits including routine screening *(inpatient or outpatient)* • Routine physical examinations • Human Papillomavirus "HPV" vaccines • Rotavirus vaccines • Routine hearing tests • Laboratory tests • Immunizations • Meningococcal vaccine • Related office visits	• No expenses for covered services Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	• No expenses for covered services Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.
Routine immunizations without regard to age, limited to: • Hepatitis immunizations *(Types A & B)* for patients with increased risk or family history • Influenza and pneumococcal vaccines, annually • Tetanus – diphtheria "Td" booster – once every 10 years • Herpes Zoster *(shingles)* vaccines • Human Papillomavirus "HPV" vaccines	• $15 office visit copay, no deductible • Nothing for immunizations	• $20 office visit copay for primary care provider • $30 office visit copay for specialists • Nothing for immunizations

Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan Standard Option and Basic Option Typical Coverage for Services		
Service Category	**In-Network Member Liability STANDARD OPTION**	**In-Network Member Liability BASIC OPTION**
Accidental injury/ emergency care • Accidental injury care, physician and facility care • Related ambulance services	• No expenses for covered services Note: These benefit levels apply for care rendered with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply.	• $50 copayment
• Medical emergency care – physician and facility	• $250 calendar year deductible • 10% prior review*	• $50 copayment
Professional care • Inpatient care *(surgical and medical)* • Outpatient surgery and related diagnostic tests such as x-rays, laboratory tests and machine diagnostic tests	• $250 calendar year deductible • 10% prior review*	• $100 copayment per surgeon or by preferred independent laboratories
Maternity care • Inpatient hospital care – precertification is not required unless stay is in excess of 48/96 hours for a vaginal/cesarean delivery	• No deductible or coinsurance	• The member pays nothing for the delivery • $100 per admission copay
• Physician care including delivery and pre- and post-natal care	• No deductible or coinsurance	• No expenses for pre- or post-natal care and delivery
• Tocolytic therapy and related services *(when provided and billed by a home infusion therapy company or a home health care agency)*	• No deductible or coinsurance	• No expenses for pre- or post-natal care

Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan Standard Option and Basic Option Typical Coverage for Services		
Service Category	**In-Network Member Liability STANDARD OPTION**	**In-Network Member Liability BASIC OPTION**
Hospital / facility care • Hospital inpatient *(Precertification required)*	• Unlimited days • $100 per admission copayment	• Unlimited days • $100 per day up to $500
Professional inpatient treatment therapies *(chemotherapy, radiation therapy, renal dialysis, pharmacotherapy)*	• $250 calendar year deductible • 10% prior review*	• No expenses for covered services
Outpatient surgery *(facility)*	• 10% prior review* • No deductible	• $40 copayment per facility
Outpatient professional medical services *(including medical, emergency care and diagnostic tests)*	• $250 calendar year deductible, then 10% prior review	• $40 per day facility copay *(except for diagnostics)* • $20 office visit copay for primary care providers • $30 office visit copay for specialists Note: 50 combined visits for physical, occupational and speech therapy.
Extended care benefits / nursing care facility benefits Limited to the following benefits for Medicare Part A copayments: • When Medicare Part A is the primary payer and has made payment, limited secondary benefits are provided • The plan pays the applicable Medicare Part A copayments incurred in full during the first through the 30th day of confinement for each benefit period in a qualified nursing facility**	• No out-of-pocket expenses for covered services	• All charges

Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan Standard Option and Basic Option Typical Coverage for Services		
Service Category	**In-Network Member Liability STANDARD OPTION**	**In-Network Member Liability BASIC OPTION**
• If Medicare pays the first 20 days in full, plan benefits will begin on the 21st day and will end on the 30th day Note: If the patient does not have Medicare Part A, no benefits are provided for skilled nursing facility care	Note: The member pays all charges not paid by Medicare after the 30th day.	
Prescriptions • Retail pharmacy *(up to a 90-day supply)*	• 25% prior review*	• Up to an initial 34-day supply • $10 copay for generic drugs • $30 copay for formulary brand name drugs • 50% coinsurance of $35 minimum for non-formulary brand name drugs
• Mail-service pharmacy *(up to a 90-day supply)*	• $10 copay for generic • $35 copay for brand name	• No benefit available
Hospice care • Outpatient – prior review required	• No expenses for covered services	• No expenses for covered charges
• Inpatient – certification required	• $100 per admission copay	• $100 per day copay up to $500 per admission
Home nursing services • Two hours per day, up to 25 visits per calendar year • When ordered by a physician and services rendered by an RN or LPN	• $250 calendar year deductible • 10% prior review*	• $20 copayment per visit
Ambulance	• 10% prior review*	• $50 copayment per trip
Durable medical equipment and medical supplies	• $250 calendar year deductible • 10% prior review*	• 30% plan allowance

Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan Standard Option and Basic Option Typical Coverage for Services		
Service Category	**In-Network Member Liability STANDARD OPTION**	**In-Network Member Liability BASIC OPTION**
Chiropractic care • Spinal manipulations • Initial office visit • Initial set of x-rays	• $15 copay • No deductible • 12 manipulations per year	• Up to 20 spinal manipulations per year • $20 office visit copayment for primary care provider
Nutritional counseling	• $250 calendar year deductible, then 10% prior review Note: Limit of 4 visits per year, unless rendered for the treatment of anorexia or bulimia	• $20 office visit copay for a primary care physician • $30 office visit copay for a specialist

** A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases.

4.7 Home Health Services

Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when:

- A registered nurse "R.N." or licensed practical nurse "L.P.N." provides the services
- A physician orders the care

4.8 Medical Supplies

Medical supplies such as:

- Medical foods for children with inborn error of amino acid metabolism
- Medical foods and nutritional supplements when administered by catheter or nasogastric tubes
- Ostomy and catheter supplies
- Oxygen, regardless of the provider
- Blood and blood plasma except when donated or replaced, and blood plasma expanders

4.9 Orthopedic and Prosthetic Devices

Orthopedic braces and prosthetic appliances such as:

- Artificial limbs and eyes

- Functional foot orthotics when prescribed by a physician
- Rigid devices attached to the foot or a brace, or placed in a shoe
- Replacement, repair and adjustment of covered devices
- Following a mastectomy, breast prostheses and surgical bras, including necessary replacements
- Surgically implanted penile prostheses to treat erectile dysfunction

4.10 Durable Medical Equipment "DME"

Claims for DME rentals or purchases must be billed with the appropriate RR *(rental)* or NU *(purchase)* modifier. A copy of the Certificate of Medical Necessity "CMN" must accompany the first claim.

Durable Medical Equipment "DME" is equipment and supplies that:

- Are prescribed by the attending physician *(i.e., the physician who is treating the illness or injury)*
- Are medically necessary
- Are primarily and customarily used only for a medical purpose
- Are generally useful only to a person with an illness or injury
- Are designed for prolonged use
- Serve a specific therapeutic purpose in the treatment of an illness or injury

We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment. Under this benefit, we cover:

- Home dialysis equipment
- Oxygen equipment
- Hospital beds
- Wheelchairs
- Crutches
- Walkers
- Continuous Passive Motion "CPM" devices and Dynamic Orthotic Cranioplasty "DOC" devices
- Other items that we determine to be DME, such as compression stockings

4.11 Claims Billing Tips

4.11.1 Venipuncture

Effective for claims processed on or after 03/01/07, FEP will not pay a separate allowance for a venipuncture charge when billed with medical or surgical care on the same claim for preferred or participating providers. The venipuncture charge will be bundled with the medical or surgical care for payment. Please note the charges are not billable to members for preferred or participating providers.

4.11.2 Preventive Care Children

Preventive care benefits for children are available under both Basic and Standard options for covered children up to age 22. Basic Option members must use preferred providers in order to receive benefits.

4.11.3 Immunizations

Claims for immunizations should be filed as follows:

- Each immunization must be filed on a single line on the CMS-1500 *(version 08-05)* claim form with its specific CPT code.
- For state-supplied vaccines, the modifier (52) for reduced service must be appended to the specific CPT code. This modifier indicates that the provider is only requesting payment for administering the vaccine.
- For immunizations that are not supplied by the State, the CPT code without the reduced service modifier must be used to indicate that the provider is requesting payment for the serum as well as the administration fee.

4.11.4 Timely Filing

For FEP all claims must be submitted no later than December 31 of the calendar year after the one in which the covered care or service was provided in order to be considered timely filed.

Examples:	Date of service:	12/15/2006
	Must be filed by:	12/31/2007
	Date of service:	01/15/2007
	Must be filed by:	12/31/2008

4.11.5 Do Not File The Same Claim Multiple Times

Do not file the same claim multiple times. Instead of speeding up the processing of your claim, this in fact slows claims processing. If the FEP has not paid a claim within 30 to 45 days, then you may contact us to find out the status of the claim.

4.11.6 Avoiding Claims Mailback

The single most common reason for having a claim mailed back to you is that the FEP member number that starts with R is incorrect or missing *(must be R plus 8 digits)*. This is a critical piece of information for the claim to be processed correctly. An extra quality step to recheck the member number before filing the claim could avoid many claim mailbacks and double work for both you and the FEP department. Other common reasons for mailbacks are:

- Invalid or missing provider number
- Missing primary payer's Explanation of Benefits "EOB"
- Missing dates and/or diagnosis code

4.12 Care Coordination Processes

4.12.1 Medical Review

- A Certified or Letter of Medical Necessity "CMN" or "LMN" must be submitted for all DME requests. A prescription signed by a physician is not a substitute for this requirement.
- Many DME items require submission of supporting documentation to substantiate medical necessity. Guidelines for required documentation can be viewed online at ***www.bcbsnc.com/services/medical-policy***.
- DME commonly requiring additional documentation includes, but is not limited to, the following:
  - Electric wheelchairs
  - Scooters
  - Hospital beds
  - Oxygen
  - CPAP or BiPAP
- Claims for certain procedures will also be reviewed for medical necessity. Courtesy pre-determinations are not available. These services include, but are not limited to, the following:
  - Intra-articular hyaluronan injections
  - Rhinoplasty
  - Reduction mammoplasty
  - Extracorporeal shockwave therapy for musculoskeletal conditions
  - Botulinum toxin injections
  - Blepharoplasty
  - Treatments for venous insufficiency

4.12.2 Case Management

The case management program is a voluntary program, free of charge, which may be available to members that are not Medicare primary. Members with catastrophic or life-threatening illness or chronic and complex medical conditions may benefit from case management services. Many case management referrals come from the member's physician. You may refer a member by calling **1-888-234-2415**.

4.12.3 Healthy Endeavors

Healthy Endeavors is a disease management program for non-Medicare primary members. Members will receive educational material and may work with a health professional *(nurse or dietician)* to improve their understanding and management of chronic illness. Many Healthy Endeavors referrals come from the member's physician. You may refer a member by calling **1-888-392-3506**.

4.13 Blue Health Connection - 24-Hour Nurse Telephone Service

Blue Health connection features health advice, health information and counseling by registered nurses. Also available is the AudioHealth library with hundreds of tapes, ranging from first aid to infectious diseases to general health issues. Members can also get information about health care resources to help them find doctors, hospitals or other health care services affiliated with the Blue Cross and Blue Shield service benefit plan. Help with health concerns is available 24 hours a day, 365 days a year by calling a toll-free number **1-888-258-3432** or accessing ***fepblue.org*** online.

4.14 Complementary and Alternative Medicine Program

Members enrolled in the service benefit plan have access to a number of services.

Members may purchase health and wellness products at discounted prices. These include vitamins, minerals, herbal supplements, homeopathic remedies, sports nutrition products, books, videotapes and skin care products. Products can be ordered online at ***fepblue.org***.

4.15 Other Important Numbers and Addresses

Affinity Programs

- David Vision **1-800-551-3337**
- U S Laser Network **1-877-552-7376**
- American Specialty Health **1-877-258-7283**

FEP Web site Address

- ***fepblue.org***

Address for Claims

P.O. Box 35 • Durham, NC 27702

North Carolina State Health Plan Teachers' and State Employees' Comprehensive Major Medical "CMM" *(Indemnity)* Plan and North Carolina Health Choice

5. North Carolina State Health Plan Teachers' and State Employees' Comprehensive Major Medical "CMM" *(Indemnity)* Plan and North Carolina Health Choice

The State of North Carolina has contracted with BCBSNC to administer its traditional health plan for state employees, teachers and retirees through a plan called the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan "CMM" and NC Health Choice *(or as more commonly referred to the [State Health Plan] or [the Plan])*. The State Health Plan and NC Health Choice have unique health coaching and intervention programs, mental health care management, and Member Health Partnerships℠ programs that are described in this chapter. The following information applies to State Health Plan CMM *(indemnity)* and NC Health Choice members only and is distinct from other information contained within this manual. Information contained in this chapter *(chapter five)* is the information needed for you and your office staff to effectively administer the State's CMM *(indemnity)* health plan and NC Health Choice. Unless otherwise noted, this chapter *(chapter five)* of this manual applies specifically to State CMM *(indemnity)* membership enrolled in the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan "CMM" and NC Health Choice, and does not apply to the State's NC Smart*Choice*℠ PPO benefit plans.

NC Smart*Choice*℠ PPO is administered by BCBSNC under the Blue Options℠ product. The State Health Plan "the Plan" includes three BCBSNC Blue Options℠ Preferred Provider Organization, "PPO" plans, in addition to the Comprehensive Major Medical, "CMM" *(indemnity)* plan. General benefits information for members enrolled in the State's NC Smart*Choice*℠ PPO plans can be found in chapter three of this manual and on the State Health Plan Web site at ***www.shpnc.org***. Unless otherwise noted, information contained in this manual *(excluding information contained within this chapter [chapter five])* is the information needed for you and your office staff to effectively administer the NC Smart*Choice*℠ PPO products.

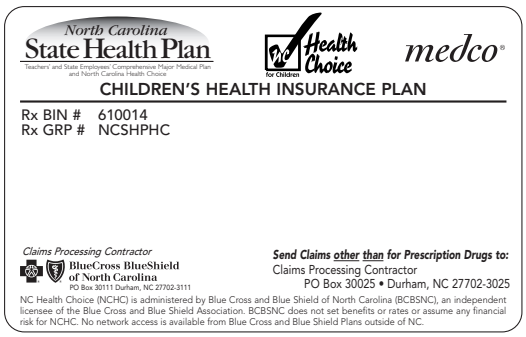
5.1 Sample Identification Cards for the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan "CMM" *(Indemnity)* and NC Health Choice

The full subscriber ID for State Health Plan members begins with a W and is followed by ten randomly assigned numbers:

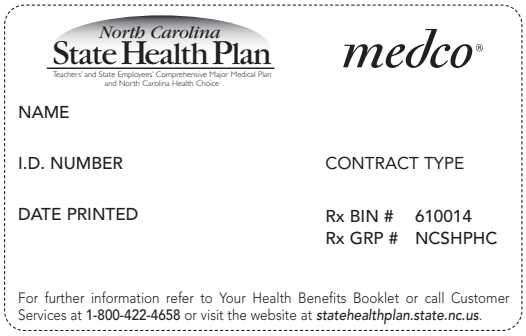
- W1234567890 – State Health Plan
  - State Health Plan member identification numbers do not include a three letter alpha prefix.

The full subscriber ID for NC Health Choice members begins with YPCW and is followed by ten randomly assigned numbers:

- YPCW1234567890 – NC Health Choice


North Carolina State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan and North Carolina Health Choice
Health Choice for Children
medco
CHILDREN'S HEALTH INSURANCE PLAN
Rx BIN # 610014
Rx GRP # NCSHPHC
Claims Processing Contractor
BlueCross BlueShield of North Carolina
PO Box 30111 Durham, NC 27702-3111
Send Claims other than for Prescription Drugs to:
Claims Processing Contractor
PO Box 30025 • Durham, NC 27702-3025
NC Health Choice (NCHC) is administered by Blue Cross and Blue Shield of North Carolina (BCBSNC), an independent licensee of the Blue Cross and Blue Shield Association. BCBSNC does not set benefits or rates or assume any financial risk for NCHC. No network access is available from Blue Cross and Blue Shield Plans outside of NC.

- For further information refer to your NC Health Choice Handbook or call **Customer Services** at **1-800-422-4658**.
- **Mental Health and Chemical Dependency Services** must be precertified by calling **1-800-753-3224**, 24 hours a day, 7 days a week.
- **Hospital Admissions** other than for mental health or chemical dependency must be precertified by calling **1-800-672-7897**, M - F, 8 a.m. to 5 p.m., *(after hours leave message)*.
- Physicians and other medical providers should file claims to the local Blue Cross and/or Blue Shield plan where services are rendered.
- **Pharmacy Customer Service: 1-800-336-5933**
- **Pharmacy Services Help Desk: 1-800-922-1557**


North Carolina State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan and North Carolina Health Choice
medco
NAME
I.D. NUMBER
CONTRACT TYPE
DATE PRINTED
Rx BIN # 610014
Rx GRP # NCSHPHC
For further information refer to Your Health Benefits Booklet or call Customer Services at 1-800-422-4658 or visit the website at *statehealthplan.state.nc.us*.

- **Mental Health and Chemical Dependency Services** must be precertified by calling **1-800-367-6143**, 24 hours a day, 7 days a week.
- **Hospital Admissions** other than for mental health or chemical dependency must be precertified by calling **1-800-672-7897**, M - F, 8 a.m. to 5 p.m.
- **Pharmacy Customer Service: 1-800-336-5933**
- **Pharmacy Services Help Desk: 1-800-922-1557**

Send claims for medical services rendered in NC to:
Claims Processing Contractor
PO Box 30025
Durham, NC 27702-3025

Send claims for medical services rendered outside NC to:
PHCS PRIVATE HEALTHCARE SYSTEMS
MD Plan
Claims Processing Contractor
PO Box 3823
Durham, NC 27702-3823
Call **1-800-355-7610** to locate a participating PHCS provider outside NC.

Always remember to make a copy of the front and back of the member's identification card and place that copy in the member's file for your records. Please also ensure that any discarded copies are properly destroyed to help protect the patient's identity.

5.2 Determining Eligibility

Providers are encouraged to always verify a member's benefits and eligibility prior to providing services, and providers using ***Blue e***℠ have the fastest and easiest way to obtain a member's eligibility and benefits information. With ***Blue e***℠, you only need to access the ***Blue e***℠ member name search and/or member health eligibility search – and in real-time you can view the member's information from your own computer screen. If your organization does not yet have access to ***Blue e***℠, find out more by visiting BCBSNC electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/***, or refer to the section on Electronic Solutions in this manual.

Blue e℠ and State Health Plan and NC Health Choice Customer Service are the most accurate and up-to-date sources for verifying State CMM member eligibility. If you have not yet signed up for the convenience of ***Blue e***℠, you can still verify member's benefits and eligibility by calling State Health Plan and NC Health Choice Customer Service at **1-800-422-4658**. When calling, please have information from the patient's membership identification card available.

5.3 NC Health Choice Allowable Rates

Session Law 2005-276 mandates that the NC Health Choice program limits participation to eligible children ages 6 through 18. Session Law 2005-276 also mandates that the Medicaid program extends coverage to children from birth through age five, with family incomes that equal or are less than 200 percent of the federal poverty level.

Senate Bill 622, the 2005 Appropriations Bill, made changes in the NC Health Choice program's reimbursement for professional and institutional claims. Effective January 1, 2006, the NC Health

Choice allowable rate for professional services was 115% of the Medicaid rates. The rate remained in effect until June 30, 2006. As of July 1, 2007, the allowable rates for professional services changed to 100% of the Medicaid rates. Institutional reimbursement, including DRG, non-DRG and ancillary, varies based on the services provided.

5.4 Contact Information for Providers Calling About State Health Plan and NC Health Choice Members

The State Health Plan (PPO) offers to NC teachers, state employees and state retirees, benefit plan choices that include a comprehensive major medical "CMM" plan or enrollment in the NC Smart*Choice*SM PPO plan. Therefore, when calling about a patient that is employed by, or retired from the State, the phone number needed can vary as depicted in the below chart:

When Calling About	State Member Enrolled In CMM Plan	State Member Enrolled In a PPO Plan
Eligibility and claim status	***Blue e***SM	***Blue e***SM
Provider customer service, including eligibility and claim status	State Health Plan **1-800-422-4658**	Provider Blue Line℠ **1-800-214-4844**
Prior review	State Health Plan Prior Review **1-800-422-1582** **1-919-765-4890** *(fax)*	State PPO Prior Authorization **1-800-672-7897**
Certification of medical inpatient admissions *(except mental health and substance abuse services)*	Preadmission Certification **1-800-372-7897** *(select prompt one)* **1-919-765-4891** *(fax)*	Preadmission Certification **1-800-372-7897** *(select prompt two)* Regional fax numbers can be found in chapter eight of this manual, "Health Coaching and Intervention."
Certification of mental health and substance abuse services *(except for NC Health Choice members)*	Value Options **1-800-367-6143**	Value Options **1-800-367-6143**
Certification of mental health and substance abuse services *(for NC Health Choice members)*	Mental Health Case Management for NC Health Choice **1-800-753-3224**	N/A
Disease management and case management *(except transplants)*	Health Coaching and Intervention **1-800-672-7897**	Health Coaching and Intervention **1-800-672-7897**

When Calling About	State Member Enrolled In CMM Plan	State Member Enrolled In a PPO Plan
Transplants	State Health Plan **1-800-422-1582**	Health Coaching and Intervention **1-800-672-7897**
NC *HealthSmart* programs	Health Dialog **1-877-277-5900**	Health Dialog **1-877-277-5900**
Chronic case management	Status One **1-888-607-9594**	Status One **1-888-607-9594**
End-state renal disease / chronic kidney disease	Renaissance Health Care **1-888-877-3625**	Renaissance Health Care **1-888-877-3625**

5.5 Mailing Addresses for the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan "CMM" and NC Health Choice Members

Please note that mailing information for State PPO members enrolled in NC Smart*Choice*SM is located in chapter two of this manual. Please only use the below chart if mailing on behalf of State CMM members.

State Health Plan CMM Mailing Addresses:	
Appeals/Grievances	Claims Processing Contractor P.O. Box 30025 Durham, NC 27702
Certifications	State Health Plan and NC Health Choice Medical Review P.O. Box 30111 Durham, NC 27702-3111
Overpayments	BCBSNC State Corporate Cashiers P.O. Box 30111 Durham, NC 27702-3111
Subrogation refunds	Public Consulting Group State Health Plan P.O. Box 20733 Raleigh, NC 27619
Inquiries	State Customer Services P.O. Box 30111 Durham, NC 27702-3111

State Health Plan CMM Mailing Addresses:	
Appeals/Grievances	State Health Plan and NC Health Choice for Children P.O. Box 3869 Durham, NC 27702-3869
Mental health and substance abuse appeals	Mental Health Case Manager P.O. Box 12438 Research Triangle Park, NC 27709-2438
For fastest claims processing, file electronically! **Visit BCBSNC Electronic Solutions on the Web at** ***http://www.bcbsnc.com/providers/edi/***	***Blue e℠***

Visit us on the Web at ***www.shpnc.org***.

5.6 Billing Guidelines and Claim Submission Requirements

State Health Plan billing and claim submission requirements closely adhere to BCBSNC requirements; however, some State Health Plan specific requirements do apply as described within this chapter *(chapter five)* of the manual. Except where otherwise specified within chapter five, providers should reference chapter ten, Claims – Billing and Reimbursement of this manual, for State Health Plan CMM and NC Health Choice billing and claim filing instructions.

5.7 Immunizations

The Plan provides benefits for immunizations for the prevention of contagious diseases. These benefits are not subject to the Plan year deductible and coinsurance requirements and are paid at 100% of UCR. Claims for immunizations should be filed as follows:

- Each immunization must be filed on a single line on the CMS-1500 claim form with its specific CPT code.
- For state-supplied vaccines, the modifier (52) for reduced service must be appended to the specific CPT code. This modifier signifies that the provider is only requesting payment for administering the vaccine.
- For state-supplied vaccines, the single fee is $13.71. For multiple vaccines, the fee is $27.42 divided by the number of injections.
- For immunizations that are not supplied by the state, the CPT code without the reduced service modifier must be used to signify that the provider is requesting payment for the serum as well as the administration fee.

The Plan also allows benefits for vaccine administration codes 90471 and 90472 when a patient receives a vaccine purchased by the provider.

- The allowance for codes 90471 and 90472 will be $13.71 each.
- The maximum reimbursement allowed per day will be $27.42 regardless of the number of units billed.

- If a patient receives a state-supplied vaccine, the provider should file the claim with the specific procedure code and append a modifier 52. This modifier indicates that the provider is only requesting payment for administering the vaccine.
- If a provider administers state-supplied vaccines and purchased vaccines on the same day, **the vaccines that were purchased by the provider must be listed on the claim first, or codes 90471 and 90472 will be denied**.

5.8 Acupuncture and Biofeedback

- Benefits for acupuncture will be allowed for nausea and vomiting related to pregnancy, chemotherapy, or recent post-op surgery.
- Acupuncture for any other indication, will be denied.
- A denied claim will be reviewed, only if a request is made by the provider and medical records submitted.
- All claims for biofeedback will be reviewed for medical necessity.

Note: Prior approval is not required for acupuncture or biofeedback; however, providers can submit medical records for a courtesy review.

5.9 Filing Newborn Baby Claims

Maternity benefits are provided to enrolled female employees and enrolled female spouses. The mother must be enrolled in the Plan in order to receive newborn well-baby benefits. Coverage for newborn care in the hospital *(including well-baby pediatrician, well-baby nursery charges and circumcision)* is a maternity benefit. When a newborn requires special care as a sick baby, the care is no longer considered a maternity benefit. For benefits to be provided, the newborn must be enrolled in the Plan effective the first day of the birth month. To correctly file a claim for a newborn baby, the provider should put the newborn's name and date of birth on the claim and use the ID number of the mother's policy. Once we receive the claim, we will transfer the charges to the mother's name if the newborn is determined to be a well baby. The charges will be posted under the mother's name on the notification of payment. Preadmission certification "PAC" is required if the mother's hospital stay is longer than 48 hours for vaginal delivery or longer than 96 hours for a cesarean section. PAC is also required when the newborn requires special care.

Maternity and maternity-related benefits are not provided under NC Health Choice.

Benefits are not provided for maternity care or complications from pregnancy for enrolled dependent children.

5.10 Multiple Surgical Procedures

The State Health Plan pays a surgeon's services differently when two or more surgical procedures are performed at the same time.

When two or more covered surgical procedures are performed by the same surgeon through separate incisions or operative approaches during the same operative session, the surgical benefits are limited to 100% UCR allowance for the one procedure which has the higher UCR allowance. The remaining covered surgical procedure(s) are limited to 50% UCR allowance.

When two or more covered surgical procedures are performed by the same surgeon through the same incision or operative approach during the same operative session, the surgical benefits are limited to 100% UCR for the one procedure with the higher UCR allowance. No additional benefits are allowed for the remaining surgical procedure(s).

Unless otherwise provided, covered surgical procedure performed in two or more stages are paid as if the surgical procedure had been performed in one stage.

5.11 Modifiers 25 and 57

The State Health Plan recognizes modifier 25 and 57 only on limited observation and inpatient evaluation and management "E&M" codes. Please note that the Plan does not recognize modifier 57 if it is filed with any outpatient, emergency room, or office visit E&M codes.

The State Health Plan recognizes modifier 25 when filed with the following codes:

99214 to 99263	Consultations
99201 to 99215	Office/outpatient visit
99281 to 99285	Emergency room visit
99341 to 99350	Home care
99291, 99292	Critical care

The State Health Plan recognizes modifier 57 when filed with the following codes:

99218, 99219, 99220	Observation
99221 to 99223	Initial hospital care
99231 to 99233	Subsequent hospital care
99251 to 99255	Initial inpatient consultations
99261 to 99263	Follow-up inpatient consultations
99271 to 99275	Confirmatory consultations

5.12 Durable Medical Equipment "DME"

The State Health Plan provides benefits for certain types of durable medical equipment "DME." Benefits are subject to the plan year deductible and coinsurance requirements, and reimbursement is considered based on usual, customary and reasonable "UCR." This includes prosthetic, orthopedic and orthotic appliances.

The provider must request prior approval from the State Health Plan for:

- All DME rentals with a purchase price greater than $1,000
- DME purchases when the reimbursement is greater than $1,000
- Expenses in excess of $1,000 for the repair of previously approved DME.

Note: Prior approval is not required when Medicare is the primary coverage and the durable medical equipment being rented, purchased, repaired, or maintained is covered by Medicare, regardless of the cost.

5.13 Chiropractic Benefits

State Health Plan chiropractic benefits are limited to x-rays, manipulation, and modalities of the spine, back and neck region. Benefits are limited to $2,000 per fiscal year and to no more than one hour per day. Services are subject to the Plan year deductible and payable at 80% after a professional services copayment per date of service. Supplies, drugs, creams, foot orthotics, acupuncture or durable medical equipment provided by a chiropractor are not covered.

5.14 Therapy Services

- Physical therapy/occupational therapy – benefits are allowed for physical therapy and occupational therapy rendered on the same day if the services are rendered by a licensed physical therapist/certified physical therapy assistant and a licensed occupational therapist. Benefits are limited to one (1) hour per day for each therapy.

  Please note that all PT and OT services provided in the home setting require prior approval by the Plan, in advance of service.

- Speech therapy – prior approval is required for speech therapy benefits. The initial evaluation for speech therapy does not require prior approval.

5.15 Surgical Procedure Codes Ending in NOS

Claims submitted to the State Health Plan with a surgical procedure code ending in NOS *(not otherwise specified)* cannot be processed, and will be mailed back to the provider. These claims must be submitted with more specified code. The State Health Plan uses 3M's AP DRG, Version 23, to process inpatient hospital claims. The 3M Clinical Claims Editor "CCE" software includes a software package, the Medicare Code Editor "MCE" that provides additional information to the all-patient grouper. Surgical procedure codes described as *Not Otherwise Specified "NOS"* are identified by the MCE software as non-specific. A business decision was made by the State Health Plan to accept the Medicare edits "MCE" when AP DRG was implemented.

5.16 Certified Registered Nurse Anesthetist "CRNA"

Effective September 1, 2007, Certified Registered Nurse Anesthetist "CRNA" services will be covered for all State Indemnity and NC Health Choice members. In the past, the State Health Plan provided coverage for CRNA services only when Medicare was the primary carrier. The revised policy is now on the State Health Plan Web site at: ***http://statehealthplan.nc.us/pdf/SU0025.pdf***.

5.17 Ambulance Claims

All ambulance claims must be filed with the mileage, appropriate HCPCS code, and modifier. All air ambulance and any licensed land ambulance service over 50 miles requires prior approval. Claims that are submitted with any of this information missing will be mailed back to the provider.

5.18 Coordination of Benefits "COB"

When the State Health Plan CMM is the secondary insurance carrier, coordination of benefits applies to all inpatient and outpatient claims. The State Health Plan will coordinate benefits only up to the State Health Plan UCR charge allowance.

COB claims should be submitted first to the health care plan that provides the patients primary health care benefits. When a patient has coverage with both the State Health Plan CMM and BCBSNC, and the State Health Plan CMM is the patient's primary coverage plan, providers are required to file a claim first to the State Health Plan for processing of the member's primary benefits. Providers are requested to please wait for receipt of the primary EOB from the State Health Plan before filing a claim to BCBSNC for the member's secondary benefits. BCBSNC cannot process the member's secondary benefits unless you have provided the primary EOB information with the claim.

When the State Health Plan CMM is the secondary coverage plan, providers should upon receipt of the primary payment, submit a claim with the primary carrier's EOB to the State Health Plan for processing of applicable secondary benefits. Secondary claims received without the EOB will be denied. When filing secondary claims, document on the EOB or claim any write-off or discounts for which the patient is not held responsible, as this will help us coordinate the claim correctly on the first submission.

Please note that the other carrier field on the UB-04 should not be used unless the patient has other health care coverage. Data placed in the other carrier field when the patient does not have other coverage will delay processing of the claim.

5.19 The State Health Plan Fiscal Year *(July 1 to June 30)*

Claims spanning the end of the State Health Plan fiscal year cannot be processed for payment and will be denied. Services must be split and separate claims submitted.

The exceptions are:

- Medicare Part A claims
- Claims reimbursed based on DRG methodology

5.20 State Health Plan Coverage and Medicare Part B *(Medical)*

When a SHP indemnity member is eligible for Medicare Part B *(medical)* due to disability, End Stage Renal Disease "ESRD," or reaching age 65, it is recommended that the member enroll. If a member chooses not to enroll in Medicare Part B, the Plan estimates the amount that Medicare would have paid for covered services and considers for SHP indemnity payment only the remaining balance just as if Medicare had paid.

5.21 Utilization Review/Medical Review

The SHP utilizes the BCBSNC utilization/medical review process to ensure SHP Indemnity members have access to timely, appropriate, and cost-effective health care. The utilization/medical review process requires that certain health care services be approved by the State Health Plan's Claims Processing Contractor, BCBSNC. BCBSNC looks at whether health care services are medically necessary, provided in the proper setting, and provided for a reasonable length of time. If the member's claim(s) information is insufficient to make a determination, it may be necessary for BCBSNC to request additional relevant medical information from you as the provider. In the event that BCBSNC does not receive sufficient information to approve coverage for a health care service, BCBSNC will send a letter stating the denial of benefit coverage. If, after receiving the letter, the member or provider thinks additional information may change the outcome of the decision, you have the right to submit the information. Follow the instructions in the letter from BCBSNC for directions about how to submit additional information.

Please note that the mental health case manager provides prior approval of mental health and chemical dependency benefits. Approval in advance *(precertification)* is required prior to admission or start of treatment for inpatient care, residential treatment, partial hospitalization, treatment in an intensive outpatient program, and for crisis evaluation/stabilization. In addition, certain documentation must be submitted for approval to the mental health case manager prior to visit 27 of each plan year. Contact the mental health case manager by calling **1-800-367-6143**.

5.22 Prior Approval for Services

The Plan requires prior approval for certain services, equipment and supplies before services are rendered. The fact that a doctor orders services, equipment or supplies does not in itself constitute justification. Prior approval determinations are based on appropriateness and medical necessity determinations. The medical policies used for medical necessity determinations are available on the State Health Plan's Web site at ***www.shpnc.org***.

Of course, prior approval is not valid if, at the time the services are received, benefits have been exhausted or there is no coverage. The member is always responsible for the plan year deductible, coinsurance amounts, copayment, and charges for non-covered services.

If you do not obtain approval before services are rendered, you may request retrospective review. If the member has received all of the requested health care services, the medical necessity review is considered retrospective. To be considered for retrospective review, requests must be received within six months *(180 days)* of the end date of service. Requests for retrospective reviews that are received after 180 days of the end date of service will not be considered even if the services were provided in the appropriate setting and met medical necessity criteria.

The State Health Plan will not pay claims for services when the claim is received after the 18-month filing period, which begins at the date of service.

You should send medical records and a letter of medical necessity explaining the need for the services requiring prior approval to:

Medical Review
P.O. Box 30111 • Durham, NC 27702-3111
Fax: 1-919-765-4890 • Phone 1-800-422-1582

Although you may receive prior approval, it does not guarantee that benefits will be paid. Benefits are subject to all other terms and conditions of the Plan.

5.22.1 Services That Require Prior Approval

The following services require prior approval by the State Health Plan:

- Durable Medical Equipment – all purchases, rental or repair, when the total allowed reimbursement is over $1,000
- Licensed land ambulance over 50 miles
- Air ambulance
- Any service provided in the home
- Hospice care
- Private duty nursing
- Skilled Nursing Facility "SNF" care
- Speech therapy *(except inpatient hospital)*
- Subcutaneous injection – filling material injected into tissue, such as silicone
- Temporomandibular Joint "TMJ" dysfunction appliance/splint therapy

5.22.2 Surgical Procedures That Require Prior Approval

- Abdominoplasty
- Blepharoplasty
- Cochlear implants
- Excision of gynecomastia
- Fimbrioplasty
- Gastric surgery
- Hermaphroditism correction
- Keloid excision
- Nasal structure revision
- Oral surgery
- Orthognathic surgery
- Penile prosthesis
- Reduction mammoplasty
- Suction lipectomy
- Temporomandibular Joint "TMJ" dysfunction surgery

5.22.3 Requesting Prior Approval:

When requesting prior approval, providers should do the following:

- Prior approval must be obtained prior to rendering services
- Fax or write State medical review department for certifications and include the following information:
  - Patient's name
  - Member identification number
  - Patient's date of birth
  - Letter of medical necessity or referral and treatment signed by a physician.
- For urgent prior approval requests, call State Medical Review Department at **1-800-422-1582**.
- Providers should not bill for services until written confirmation of approval is received from the State Health Plan and NC Health Choice.
- Providers may render services after requesting prior approval. However, services will be subject to medical necessity review.
- By authorizing a service, the State Health Plan provides approval in advance to render a service that is medically necessary and appropriate. This determination does not guarantee payment as benefit coverage will be determined upon receipt of the claim. Providers may call the customer service phone number on the member identification card for benefit information.
- Claims submitted without appropriate certification will be denied.
- You may not seek payment from the State Health Plan or its members if a proper claim is not submitted to us within 18 months from the date of service.
- Contracting providers can bill members for amounts denied due to failure to obtain prior approval. Providers may also bill Plan members for noncovered services.

5.23 About Home Health Care Benefits:

- Patients must be homebound to be eligible for home health care benefits. A patient is homebound if:
  - He/she has a condition or injury restricting the ability to leave home;
  - He/she has a condition for which leaving home is medically contraindicated; and/or
  - Physical assistance and significant supervision by another person is required in order to leave home
- All home health and private duty nursing services require prior review
- All home care services must be ordered by the member's physician.
- All services must be skilled. Skilled nursing visits must be done by a RN and should never be longer than one hour.

- All home health care benefits are limited to 60 days each plan year, but may be extended on an individual basis.
- Home health care benefits are not an entitlement. Home health care benefits are short-term benefits. They are not meant to be long term.

5.23.1 Covered Home Health Care Services:

- Registered Nurse "RN" services
- Licensed Practical Nursing "LPN" services under RN supervision
- Home care aides under RN supervision *(limited to a maximum of four hours per day)*
- Therapy services rendered by a qualified therapist
  - Occupational therapy for restoration of bodily function
  - Physical therapy *(no approval unless rendered in the home)*
  - Speech therapy *(patient must be expected to make reasonable progress and approvals are short term)*

Please note that the services of the home care aide are to be considered as part of the overall treatment plan, as an adjunct to or extension of concurrent medically necessary skilled services.

5.23.2 Non-Covered Home Care Services:

- Services when patient is not homebound
- Sitters
- Services rendered to a hospice patient
- Oral Rx drugs
- Aerosolized drugs
- Blood draw nursing visits for home infusion patients
- Concurrent care *(private duty nursing and home care aide)*
- EKGs
- Holter monitoring
- Psychiatric services

Please note that the above listing is not all inclusive.

5.24 Skilled Nursing Facility "SNF" Benefits:

- Provided to help in the transition from hospital to home.
- Care may also serve to help medically stabilize the patient.
- Once the patient is stable and longer in need of acute medical care, eligibility for skilled nursing facility benefits will be terminated.
- Prior approval is required upon admission in a SNF. Benefits are limited to a maximum of 100 days per plan year for the same reason.

5.24.1 Skilled Nursing Facility Requirements:

- Must be hospitalized for at least 3 days for the same condition treated in the SNF
- Must be admitted to a SNF within 14 days after discharge from a hospital
- Must be referred to a SNF that is licensed to deliver services
- Must be referred to a SNF by a doctor
- Must be under the continuous care of a doctor
- Must require and receive skilled services on a continuous daily basis
- The medical condition must be such that an inpatient hospital stay would otherwise be required.

5.24.2 Non-Covered Skilled Nursing Facility Services:

- Intermediate, custodial or domiciliary care
- Care when, in the opinion of the Plan, the patient's medical condition is stable or does not require skilled medical services on a continuous daily basis
- Care when the patient's rehabilitation has been met in the opinion of the Plan
- Personal items *(television, hair salon, etc.)*

Please note that the above listing is not all inclusive.

5.25 Medical Records

If you receive an NOP and the claim has denied with code 233, that is your request for medical records. The claim will remain denied until the records are received. When submitting medical records, we must have the patient's name and ID number, your name, phone number and fax number. If we receive incomplete medical records, we will send a request form to obtain the additional records.

If a review of the medical records results in a reversal of our original benefit determination, the claim will be adjusted.

5.26 NC Health*Smart*

The North Carolina State Health Plan offers NC Health*Smart*, an initiative designed to help eligible members* stay healthy and to support physicians as they care for members with chronic medical conditions. One of NC Health*Smart*'s goals is to link members more closely with their physicians, thus supporting the Medical Home concept.

NC Health*Smart* provides broad health and wellness supports for members, particularly those who have diabetes, asthma, coronary heart disease, heart failure and chronic obstructive pulmonary disease. All members with these diseases receive mailed educational information and are encouraged to call Health Coaches 24/7 for health care information or support.

In addition to working with members, the NC Health*Smart* initiative supports physician practices. A practice support tool, the SMART® Registry, offered twice a year, is designed to assist physicians in providing high-quality, evidence-based care to NC Health*Smart* eligible patients with chronic illnesses. The SMART® Registry offers practical, relevant information about the physician's patients in an easy-to-use format. This tool enables physicians to identify State Health

Plan members who have targeted chronic illnesses and helps physicians more easily monitor the member's care plans.

The NC Health*Smart* initiative also supports physician practices with access to Provider Service Specialists, clinicians who are knowledgeable about NC Health*Smart*. Provider Service Specialists are available to meet with physicians and their office staff to provide additional program information and practical patient education and management tools.

Physicians can request information, refer a member for health coaching, or provide program feedback by calling the NC Health*Smart* Provider Support Line at **1-800-819-7075**.

Link to: **NC Health*Smart*: *http://www.shpnc.org/nc-healthsmart.html***.

* Members eligible for NC Health*Smart* services are members whose primary health insurance is through the NC State Health Plan, and who are not on COBRA. SMART® is a registered trademark of Health Dialog Services Corporation.

5.27 Specialty Drug Program

The State Health Plan *(Indemnity)* is pleased to announce the launch of the specialty drug program in conjunction with the preferred vendor Medco special care pharmacy. The new program will provide a fast, easy, and convenient way for providers to obtain a broad selection of specialty medications for State Health Plan members. The Medco special care pharmacy will provide comprehensive, high quality pharmacy care management, service and support to providers and patients.

For providers:

- Refill reminders and coordination with your office for medication delivery
- Inventory management
- Comprehensive coordination of care, compliance monitoring, adherence counseling and clinical follow-up

For patients:

- A staff of pharmacists, nurses and care coordinators specifically trained in disease support
- Delivery of self-injected medications to your patient's homes or other designated location, including supplies such as syringes and needles at no additional cost
- Access to pharmacists – 24 hours a day, 7 days a week

If you have any questions or wish to place an order, please call Medco special care pharmacy at **1-800-987-4904** or visit the State Health Plan Web site at ***www.shpnc.org*** to obtain an order form.

5.28 Claims Filing Reminders

- Claims for supplies, miscellaneous and unlisted services require a description.
- Do not file multiple claims as this slows claims processing. If the claim has not been paid by the Plan within 30 to 45 days, then you can re-file the claim.
- The Plan prefers to have claims submitted electronically. Paper claim submissions are slower and more labor intensive.
- Claims for covered services must be filed within 18 months from the date of service.

5.29 Correcting a Claim

A corrected claim should only be submitted for a claim that has been paid, applied to the patient's deductible/copayment, or denied by the Plan, and you need to correct information submitted on the original claim. A claim that has been mailed back should not be resubmitted as a corrected claim. Submitting a corrected claim does not always result in additional payment.

Do not attach a provider inquiry form to a corrected claims as this delays processing.

5.30 Courtesy Review

If you disagree with the way the SHP processed your claim, you should contact customer services and request a courtesy review. Most problems and concerns can be resolved by customer services without going through the formal appeals process. If you disagree with the outcome of the courtesy review, then the member can initiate the formal appeals process.

5.31 Using the Document Control Number "DCN" to Check the Status of Inpatient Hospital Claims

When an electronically transmitted claim is received by Blue Cross and Blue Shield of North Carolina, the claim is imaged and assigned a document control number "DCN," if it is essentially clean and passes all front end edits. However, at this point, an inpatient hospital claim has not yet been reviewed for room accommodation rate validation. Once a claim is routed to the appropriate line of business, the room accommodation rate is verified, and if correct, a claim is entered into the system for benefit determination. However, an inpatient hospital claim filed with an incorrect room accommodation rate will be deleted and mailed back to the submitting facility for correction.

The DCN assigned image may provide proof that a particular claim has been filed and may assist in verification of claim status; however, a DCN image may not be used to initiate a request for the re-keying of an inpatient hospital claim. The re-keying of an inpatient hospital claim from its original DCN image will only result in the same – deletion and mail back. There are a few other reasons why a claim may be deleted and mailed back, however; invalid room accommodation rate is the number one reason for return of an inpatient hospital claim.

When calling our customer service specialists to request retrieval of a DCN image of an inpatient hospital claim for re-entering onto our claims processing system, you will be asked to do the following:

- Verify your Statement of Accommodation "SOA" – verify the revenue code and the accommodation rate submitted on the original claim match your contractual SOA.
- Verify the bill type is accurate as billed.

Check ***Blue e***℠, RealMed, or use the HIPAA 276 inquiring the claim status or re-contact Customer Services during the next 2-3 business days. At that time there would be record of a claim either as paid, denied, or pending.

5.32 Refund Request

The State Health Plan no longer pursues any overpayments that exceed two (2) years, unless a refund is deemed appropriate by the claims processing contractor or the executive administrator. The two year time frame is calculated by date of identification to date of payment, and applies to standard refund request only.

Please note that if the State Health Plan or the CPC identifies fraudulent reporting of claims, the CPC will pursue overpayments beyond the two year time frame.

If we discover an overpayment, we will send a letter to you requesting payment within 30 days. If payment is not received after 45 days of our notification to you, we will deduct the amount owed from future payments to you. To avoid voucher deductions, overpayments should be sent to us as soon as the refund request letter is received.

5.33 Mailbacks

If your claim is returned with a mailback form, make the necessary changes and re-file the claim. If you file electronically, make the corrections in the HIPAA 837 correction claim format and resubmit the claim electronically. You do not have to drop the claim to paper. This resubmission is still considered to be a new claim. Update your system so the error will not be repeated on future submissions. We cannot add any missing information to your claim.

5.34 How to Avoid Claim Mailbacks

When filing claims to the State Health Plan, make sure the information on your claims is complete and accurate. Doing this eliminates the mutual inconvenience of having claims mailed back to you for correction. The top reasons claims are mailed back are listed below:

- Invalid or missing BCBSNC individual or group provider number
- Invalid, incomplete or missing member ID number
- Invalid place of service
- Missing or incorrect number of units
- Missing patient's date of birth
- Missing onset date of symptoms
- Missing or incomplete diagnosis
- Missing or incomplete specific diagnosis
- Missing primary payer's Explanation of Benefits "EOB"
- Missing admission and discharge dates for inpatient claims

If you receive a claim mailback with your returned claims, please do not provide the missing information on a mailback form. Please correct the claim and resubmit to the State Health Plan.

5.35 Subrogation

The State Health Plan has contracted with Public Consulting Group, Inc. "PCG" to assist the Plan to pursue third party recoveries for automobile, trauma related accidents. The Plan intends to exercise its broad rights of recovery as described in North Carolina General Statute §135.40.13 (g) and to pursue subrogation rights codified by North Carolina General Statute §135.40.13. The Plan may subrogate on any claims that were filed on or after January 22, 2004, but may exercise its right of recovery on all claims.

NC Health Choice does not subrogate, but the program has the right of recovery pursuant to North Carolina General Statute §135.40.13(g).

Questions concerning subrogation should be directed to PCG at **1-800-294-2757**.

5.36 Prompt Payment

The State Health Plan is required to take one of six actions within 30 days of receiving a claim from a health care provider or facility:

- Pay the claim
- Deny the claim
- Notify the claimant there is insufficient information to process the claim
- Notify the claimant the claim was not submitted on the appropriate form
- Notify the claimant that coordination of benefits is needed to pay the claim
- Notify the claimant the claim cannot be processed due to non-payment of fees by the patient's employer

Claims adjudicated after the statutory limit *(30 days)* will be subject to an 18% annual interest rate. The State Health Plan must inform the insured of the claim status if it remains unpaid after 60 days and send a status report to the insured and the claimant every 30 days thereafter until the claim is resolved.

5.37 State Health Plan Appeals and Grievances

Most appeals and grievances can be avoided. Please contact State Customer Services by calling **1-800-442-4658** or by writing to:

State Customer Services
P.O. Box 30111
Durham, NC 27702-3111

to inquire about the benefit decision or denial in question. Benefit and medical policy information is available to each member through the benefit booklet and the State Health Plan *(the Plan)* Web site at ***www.shpnc.org*** and North Carolina Health Choice for Children "NCHC" Web site at ***dhhs.state.nc.us/dma***. While benefits are the members' responsibility, providers are encouraged to use these Web sites.

If a service is specifically excluded in the benefit booklet, it is deemed a benefit exclusion and is not eligible for appeal or grievance.

The appeal and grievance process is reserved for the member and his or her authorized representative. The member must complete an authorization form if anyone other than the member wants to appeal. *Remember,* all appeals and grievances must be submitted in writing within 60 days of the original benefit decision or denial.

- An appeal is a written request from a member or an authorized representative of the member to review a medical non-certification *(denial)* determination.
- A grievance is a written request submitted by a member or an authorized representative about decisions, policies, or actions related to availability, delivery or quality of health care services; claims payments or handling or reimbursement for services; the contractual relationship between the member and the CPC; or the outcome of an appeal of a non-certification.

Below are the different consecutive levels available for appeal and grievance through the Claims Processing Contractor "CPC":

- Level one appeal or level one grievance
- Level two grievance
- External review by an Independent Review Organization "IRO"

Please note: Only medical non-certifications are eligible for IRO review.

Expedited appeals can be requested if a standard appeal would reasonably appear to seriously jeopardize the life or health of the member, or jeopardize the member's ability to regain maximum function. The member, or an authorized representative of the member may request an expedited appeal by submitting a written request by fax to **1-919-765-2923** or by mail to:

State Appeals
P.O. Box 3869
Durham, NC 27702-3869

Retrospective reviews are not considered eligible for an expedited appeal.

5.37.1 Sample Member/Dependent Authorization Request Form

North Carolina State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan and North Carolina Health Choice

INSTRUCTIONS FOR FILLING OUT THE AUTHORIZATION REQUEST FORM

- **SUBMITTING THIS AUTHORIZATION FORM IS OPTIONAL.** You do not need to send it unless you want someone else to have access to your Protected Health Information (PHI) such as your spouse, a family member or friend. This is your choice. Also, you do not need to submit an authorization form in order for the State Health Plan (Plan) to pay your claims. Submitting this authorization form will not affect your coverage.
- **ONLY ONE PERSON PER FORM.** Only one person may give their authorization per form. Also, only one person may be authorized per form to receive PHI.
- **YOU MUST FILL IN THE FOLLOWING INFORMATION** on the form; otherwise, the Plan **cannot** accept your authorization request.

    1. **Your Name** must be filled in the "Member/Dependent Name" blank.
    2. **Your Date of Birth** must be filled in the "Member/Dependent Date of Birth" blank.
    3. **Your Member ID Number** must be filled in the "Member ID Number" blank. This is on your member ID card.
    4. **Your Entire Address** currently on record must be filled in the "Member/Dependent Address on Record" blank.
    5. **Name of Person or Entity You are Authorizing** to receive your PHI must be filled in the blank for "Name" which is immediately below the statement "At my request, I authorize the SHP/NCHC and their business associates to disclose my PHI to..."
    6. **Relationship.** The authorized person's or entity's relationship to you must be filled in the blank "Relationship to Member/Dependent".
    7. **The Type of PHI** you are authorizing this person or entity to receive must be checked in the boxes provided, which are underneath the statement "I authorize the SHP/NCHC and their business associates to disclose the following PHI..." If you check the box for "Any information requested," this means that the person you are authorizing may receive any of your PHI that they request.
    8. **When This Authorization Expires** should be filled in the blank after the statement "I would like this authorization to expire on..." **Or,** you may check the box "when my coverage expires".
    9. **Your Signature.** You must sign your own authorization form unless you are the legal personal representative *(see below)* or the parent of a minor child who is giving the authorization.
    10. **Date.** The date you signed the authorization form must be filled in the blank next to your signature.

- **PERSONAL REPRESENTATIVES.** A personal representative is a person who has legal authority to make decisions for the member/dependent. If a personal representative is signing for the member/dependent, the personal representative must state their authority to sign in the blank spaces below the signature line. If the personal representative is not a parent, then the document(s) giving the personal representative legal authority to sign must be on file with the State Health Plan or its Claims Processor, Blue Cross and Blue Shield of North Carolina, for the Plan to accept the request *(if already submitted and valid, you do not need to submit new forms)*.

For more information, please visit our website http://statehealthplan.state.nc.us/ and click on "HIPAA FAQs".

North Carolina State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan and North Carolina Health Choice

MEMBER/DEPENDENT AUTHORIZATION REQUEST FORM

You may give the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and NC Health Choice "SHP/ NCHC" written authorization to disclose your Protected Health Information "PHI" to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that the SHP/NCHC communicates with members or dependents.** ***For example, we will still send Explanation of Benefits "EOB" statements to the member.***

MEMBER/DEPENDENT NAME	MEMBER/DEPENDENT DATE OF BIRTH *(month, day, year)*

MEMBER ID NUMBER	MEMBER/DEPENDENT ADDRESS ON RECORD

At my request, I authorize the SHP/NCHC and their business associates to disclose my PHI to ***(enter name of person/entity who will receive your PHI)*****:**

NAME _____ RELATIONSHIP TO MEMBER/DEPENDENT) _____

I authorize the SHP/NCHC and their business associates to disclose the following PHI to the person/entity listed above:

- ☐ Enrollment Information
- ☐ Premium Payment Information
- ☐ All Claims Information
- ☐ Benefit Information
- ☐ Explanation of Benefits (EOB) Information
- ☐ Any Information Requested
- ☐ All services from a specific health care provider *(list provider's name)*: _____
- ☐ Other *(please list specific PHI)*: _____

I would like this authorization to expire on:

☐☐/☐☐/☐☐☐☐ (MONTH / DAY / YEAR)

OR ☐ **When my coverage expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving the SHP/NCHC written notice mailed to the address at the bottom of this form. I also understand that revocation *will not* affect any action the SHP/NCHC and their business associates took in reliance upon this authorization before receiving my written notice of revocation.

I also understand that the SHP/NCHC *will not* condition the provision of health plan benefits on this authorization.

I further understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act "HIPAA" or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

I also release and discharge the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and North Carolina Health Choice for Children and their business associates, including Blue Cross and Blue Shield of North Carolina, from any and all liability, cost and claims of whatsoever kind and nature arising from the release of this information.

Signature _____ **Date** _____

If signed by a personal representative:

Print your full name: _____

Describe your authority to act for the member (e.g., power of attorney, administrator, parent of minor child, executor of estate, etc.):

_____

NOTE: The SHP/NCHC will consider the effective date of this authorization to be the date the Claims Processing Contractor enters this authorization into its system, typically five days following receipt. If you would like this authorization to become effective on a date after the Claims Processing Contractor enters the authorization into its system, please insert the date here: ☐☐/☐☐/☐☐☐☐ (MONTH / DAY / YEAR)

RETURN THIS AUTHORIZATION TO: **ATTN: AUTHORIZATION DEPARTMENT**
NC TEACHERS' AND STATE EMPLOYEES'
COMPREHENSIVE MAJOR MEDICAL PLAN AND NC HEALTH CHOICE
P.O. BOX 30111 • DURHAM, NC 27702-3111

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (1) your name, (2) your member ID number, (3) your date of birth, (4) your address on record, and (5) the type of PHI you have authorized to be released.

C273, 4/06

5.38 State Health Plan Benefits at a Glance

This is only a summary of State Health Plan member benefits. Although a service may be covered, there may be limitations. If you do not see a service listed, please do not assume that it is covered. Unless otherwise noted, all covered services are subject to the member's deductible, coinsurance, and copayment requirements and are paid based on Usual, Customary and Reasonable "UCR" allowances. Please always verify a member's benefits and eligibility in advance of providing service.

State Health Plan Benefits at a Glance	
Benefit	**Coverage**
Maximum benefit	$5 million lifetime
Plan year	July 1 through June 30 *(fiscal year)*
Deductible	$450 per plan year with $1,350 limit for each employee and child(ren) or employee and family contract per plan year
Coinsurance	Member pays 20% up to $2,000 maximum each plan year; up to $6,000 maximum for each employee and child(ren) or employee and family contract per plan year
Prescription drugs *(Not subject to deductible and coinsurance)*	Copayments for each 34-day supply • $10 Generic • $30 Preferred brand without generic • $40 Preferred brand with generic • $50 Non-preferred brand Copayment limit of $2,500 per person per plan year. For prescription drug benefits call pharmacy benefit manager "Medco" at **1-800-336-5933**.
Medical supplies	Colostomy bags, catheters, dressings, oxygen, syringes and needles, and other similar supplies are covered
Physician services • **Office visits** • **Surgery** • **Inpatient care** • **X-ray, lab, radiation therapy**	 $25 copayment per visit per provider covered; some surgeries require prior approval Covered under most circumstances Covered when medically necessary

State Health Plan – Indemnity Plan
Benefits at a Glance *(continued)*

Benefit	Coverage
Wellness benefits • **Routine examinations**	$150 each plan year is not subject to deductible or coinsurance. Charges beyond the $150 are subject to deductible and coinsurance. $25 copayment is required for routine examination.
• **Mammograms, prostate exams, electrocardiograms, hearing tests, occult blood tests, chest x-rays, thyroid studies, tuberculin tine tests, blood pressure checks, VDRL tests, etc.**	For screening procedures: • no limit for well baby visits for children younger than age 1 • three well visits a year between the ages 1 and 2 • one well visit a year for ages 2 through 6 • once every 3 years for ages 7 through 39 • once every 2 years between ages 40 and 49 • once every year over age 50
• **Pap smears**	Pap smears are allowed each year for female members of any age as part of the wellness benefit.
• **Screening Mammograms**	Screening mammograms are allowed once a year for members 40 years of age and older.
• **Immunizations**	Immunizations are not subject to deductible and coinsurance.
Therapy services	$25 copayment per visit. Physical, occupational and inhalation therapies are covered and require prior approval if rendered at home. Speech therapy is covered and requires prior approval.
Chiropractic services	$25 copayment per visit. Covered up to $2,000 each plan year with limitations.
Outpatient hospital and ambulatory surgical facility	$75 copayment for outpatient hospital and ambulatory surgical facility services over $500 per episode of care. Readmission within 30 days after discharge for same reason is considered the same episode of care.
Emergency room	$200 copayment for each visit unless patient is admitted, or if patient is in an observation unit *(not to exceed 23 hours)*.
Inpatient hospital care • **Room and board** • **Other hospital services – intensive**	$150 inpatient admission copayment. All admissions require pre-admission certification. Semi-private room rate covered For pre-admission certification call **1-800-672-7897**.

State Health Plan – Indemnity Plan Benefits at a Glance *(continued)*	
Benefit	**Coverage**
Multiple surgical procedures	Covered – When two or more covered surgical procedures are performed by the same surgeon through separate incisions or operative approaches during the same session, the surgical benefits are limited to 100% UCR for the one procedure which has the higher UCR allowance and 50% for the remaining covered surgical procedure(s). Multiple surgical procedures performed through the same surgical incision or operative approach are paid based on the one procedure that has the higher UCR.
Out of state network	Out of state participating providers, call PHCS at **1-866-680-7427** or visit our Web site at ***www.shpnc.org***
Organ transplants	Require prior approval – with limitations.
Durable medical equipment, prosthetic and orthopedic appliances	Rental and purchases over $1,000 require prior approval.
Home care	Requires prior approval – with limitations
Private duty nursing	Requires prior approval – with limitations
Skilled nursing facility	Requires prior approval – with limitations
Mental health/chemical dependency • **Inpatient care** • **23 hour crisis evaluation and stabilization** • **Partial hospitalization** • **Treatment in an intensive outpatient program**	No benefits are provided, except as noted below, unless the mental health case manager approves services in advance. All services must be rendered by an eligible provider and are subject to deductible and coinsurance. $150 inpatient admission copayment; requires approval in advance Requires approval in advance Requires approval in advance Requires approval in advance

State Health Plan – Indemnity Plan Benefits at a Glance *(continued)*	
Benefit	**Coverage**
Mental health/chemical dependency *(continued)* • **Treatment in a Plan-approved residential treatment center** • **Outpatient treatment**	$150 inpatient admission copayment; requires approval in advance $15 copayment per visit Note: First 26 combined mental health and chemical dependency visits each plan year do not require precertification by the mental health case manager. Visits 27 and beyond each plan year DO require advance approval. Mental Health Case Manager **1-800-367-6143**.
Ambulance services	Any land transport over 50 miles and all air ambulance transport require prior approval.
Cardiac rehabilitation	Covered with limitations.
Dental services	$25 copayment per visit for accident related services. Routine dental care is not covered.
Diabetes self-care program	Covered up to $300 each Plan year with limitations.
Maternity care	Covered if the mother is enrolled as either the employee or spouse
Vision care	$25 copayment per medical eye exam. Routine eye exams, lenses, frames and contact lenses are not covered.

Benefits for the North Carolina Teachers' and State Employees' Comprehensive Major Medical *(Indemnity)* Plan are based upon legislation enacted by the North Carolina General Assembly, as well as a comprehensive medical policy approved by the executive administrator and board of trustees.

This is only a summary of member's benefits. Although a service may be covered, there may be limitations. If you do not see a service listed, do not assume that it is covered.

5.39 NC Health Choice for Children Coverage at a Glance Coverage Explanation

This is only a summary of the NC Health Choice benefits. Although a service may be covered, there may be limitations. If you do not see a service listed, do not assume that it is covered.

NC Health Choice for Children Coverage at a Glance	
Coverage	**Explanation**
Copay	Member may have to pay the first few dollars of a charge: • $5 office/outpatient copay If the child's ID card states $0 copay, the member does not have to pay
Prescription drugs	$1, $3, or $10 prescription drug copay
Surgery	Covered – some surgeries need prior approval
Multiple surgical procedures	Covered – When two or more covered surgical procedures are performed by the same surgeon through separate incisions or operative approaches during the same session, the surgical benefits are limited to 100% UCR for the one procedure which has the higher UCR allowance and 50% for the remaining covered surgical procedure(s). Multiple surgical procedures performed through the same surgical incision or operative approach are paid based on the one procedure that has the higher UCR.
Inpatient care	Covered. Needs preadmission certification and length-of-stay approval.
Emergency room	Covered – may have $20 ER copay
Ambulance services	Any land transport over 50 miles and all air ambulance transport require prior approval.
Hospital care • **Room and board** • **Other hospital services** *(intensive care, x-rays, drugs)*	Covered – must get preadmission certification and length-of-stay approval before being admitted. Covered – semi-private room rate Covered
Outpatient surgery	Covered – some surgeries need prior approval

NC Health Choice for Children
Coverage at a Glance *(continued)*

Coverage	Explanation
X-ray, lab and radiation therapy	Covered
Therapy services	Physical, occupational and respiratory therapies are covered but need prior approval when given in the home. Speech therapy is covered and needs prior approval when given at home or in the office *(May have a $5 office/outpatient copayment)*.
Organ transplants	Covered for corneal, bone marrow, kidney, liver, heart, lung, heart-lung and pancreas. Needs prior approval and cannot be experimental or investigational.
Mental health, alcohol and drug treatment • **Outpatient treatment**	Call the mental health case manager before starting treatment and again at the 18th visit to get approval for more than 26 visits. Up to 26 visits are covered in a fiscal year without prior approval.
• **Inpatient treatment**	Call the mental health case manager before admittance – inpatient and partial hospitalization, residential treatment and intensive outpatient care are covered.
• **Treatment in higher levels of care**	Covered. Inpatient and partial hospitalization, residential treatment, and care in a structured/intensive outpatient program. Preadmission certification is required from the mental health case manager before being admitted to any of these types of care.
Durable medical equipment	Covered. Must be medically necessary and a covered item. Needs prior approval for all purchases, rentals, and repairs over $1000.
Dental care • **Diagnostic, preventive and maintenance**	Covered for routine cleaning, polishing, exams and fluoride treatments once every 6 months, silver and tooth colored fillings, sealants for children ages 6-14 years old, simple tooth pulling only *(pulling impacted teeth is not covered)*, the removal of part of a tooth nerve *(pulpotomy)* and stainless-steel crowns
• **Oral surgery**	Covered. Needs prior approval.
• **Accidental injury**	Covered after review. Repairs the mouth and teeth to the way they were before the accident if child is covered on the date of the accident.

NC Health Choice for Children Coverage at a Glance *(continued)*	
Coverage	**Explanation**
TMJ ***(temporomandibular joint dysfunction)*** **treatment**	Covered. *(May have a $5 office/outpatient copay.)* Limited to office visits and tests to diagnosis TMJ. Appliance or splint therapy and surgery are covered only after an accident when the child was covered on the date of the accident and treatment began within 18 months following the accident. Surgery and appliance therapy need prior approval.
Hearing care	Covered. *(May have a $5 office/outpatient copay.)* Services may include exams, hearing aids, repairs, ear molds, loaners and rentals. Need prior approval.
Vision care • **Eye exam** • **Lenses** • **Frames**	Covered. *(May have a $5 office/outpatient copay.)* Covered. Once every 12 months. Covered. Only one set of glasses or contacts every 12 months. Covered. Only one set of frames every 24 months.
Maximum coverage	$5 million lifetime

5.40 State of North Carolina Teachers' and Employees' Comprehensive Major Medical Wellness Program

North Carolina State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan and North Carolina Health Choice

STATE OF NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL WELLNESS PROGRAM

Wellness and preventive care benefits for the State Health Plan include routine physical and screening procedures performed for periodic health assessments in the absence of illness or symptoms. Wellness benefits for the State Health Plan include:

- $150 for covered charges submitted each fiscal year for routine screenings are payable at 100% of our usual, customary and reasonable "UCR" allowance after subtracting any physician office visit co-payments.
- Charges for routine physicals and screenings beyond $150 are subject to the fiscal year deductible and coinsurance requirements.
- Immunization charges are payable at 100% of our UCR allowance. Immunizations are not included in the wellness benefits and are not subject to the $150 fiscal year limit.
- Female members of any age group may receive a pap smear each year as part of the $150 wellness and preventive care benefits not subject to deductible and coinsurance.
- Female members age 40 years old and older may receive a screening mammogram each year as part of the $150 wellness and preventive care benefits not subject to deductible and coinsurance.

The specific time limitations for similar wellness services are determined by a patient's age are still in effect. Benefits are similar wellness services are limited to:

- No limit for well baby visits for participants younger than one year of age
- Three well visits each year for participants ages one and two
- Once every year for participants ages three through six
- Once every three years for participants ages 7 through 39
- Once every two years for participants ages 40 through 49
- Once every year for participants ages 50 or older

Diagnoses of family history *(V16-V19.8)* will be allowed once each year regardless of age.

Appropriate procedure codes for the wellness program include:

76092	99385	99394	G0103	G0122	45.24
90755	99386	99395	G0104	G0202	48.23
99381	99387	99396	G0105	45300	REV 403
99382	99391	99397	G0106	45330	REV 770
99383	99392	G0101	G0120	45378	REV 779
99384	99393	G0102	G0121	45.23	REV 923

Appropriate diagnosis codes for the the wellness program include:

V16 - V16.9	V20.2	V70.0	V73.9	V76.8	V82.8
V17 - V17.8	V21 - V21.3	V70.9	V74 - V74.6	V76.9	
V18 - V18.8	V26.4	V72	V74.8	V77 - V77.9	
V19 - V19.8	V26.8	V72.3	V74.9	V78 - V78.3	
V20	V26.9	V73 - V73.6	V75 - V75.9	V78.8	
V20.1	V70	V73.8	V76 - V76.5	V78.9	

This information applies exclusively to the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan

revised July 2005

5.41 NC Health Choice for Children Wellness Program

North Carolina State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan and North Carolina Health Choice

NC HEALTH CHOICE FOR CHILDREN
WELLNESS PROGRAM

Wellness and preventive care benefits for NC Health Choice for Children include routine physical and screening procedures performed for periodic health assessments in the absence of illness or symptoms. Wellness benefits for NC Health Choice include:

- Covered charges submitted each fiscal year for routine screenings are payable at 100% of our usual, customary and reasonable "UCR" allowance.
- Female members may receive a pap smear every year.
- Immunization charges are payable at 100% of our UCR allowance.

The specific time limitations for wellness services are determined by a patient's age. Benefits for wellness services are limited to:

- NC Health Choice covers eligible wellness checkups as follows:
- 1 visit between 6 and 7 years of age
- 1 visit every 3 years from 7 through 18 years of age

Routine shots *(immunizations)* to prevent such diseases as measles or mumps

Diagnoses of family history *(V16-V19.8)* will be allowed once each year regardless of age.

Appropriate procedure codes for the wellness program are:

90755	99386	99395	REV 923
99381	99387	99396	
99382	99391	99397	
99383	99392	G0101	
99384	99393	REV 770	
99385	99394	REV 779	

Appropriate diagnosis codes for the the wellness program are:

V16 - V16.9	V20.2	V70.0	V73.9	V76.8	V82.8
V17 - V17.8	V21 - V21.3	V70.9	V74 - V74.6	V76.9	
V18 - V18.8	V26.4	V72	V74.8	V77 - V77.9	
V19 - V19.8	V26.8	V72.3	V74.9	V78 - V78.3	
V20	V26.9	V73 - V73.6	V75 - V75.9	V78.8	
V20.1	V70	V73.8	V76 - V76.5	V78.9	

This information applies exclusively to NC Health Choice for Children.

revised February 2007

Inter-Plan Programs

BlueCard®

National Accounts

6. Inter-Plan Programs

6.1 Inter-Plan Programs

At BCBSNC the inter-plan programs department is responsible for all inter-plan operations, which includes BlueCard® and other national accounts. The inter-plan programs department is available to assist you with all your out of state Blue Plan member claims and claims questions by calling **1-800-487-5522**. However, please note that if your question(s) pertain to an out of state member's eligibility or benefits, the number to call is BlueCard® Eligibility at **1-800-676-BLUE (2583)**.

Just a reminder, providers with ***Blue e***℠ can verify eligibility, benefits and claim status, immediately, and from the convenience of their desktop computer. To find out more about signing up for ***Blue e***℠, visit BCBSNC electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/***, or refer to chapter 13 of this manual.

6.2 Overview of National Programs

As a part of the Blue Cross and Blue Shield Association, BCBSNC is able to participate in a variety of programs that make health care services available to BCBS members nationally and internationally. BCBSNC members in CMM, PPO and HMO products can access care while traveling or living outside of their home state through the BlueCard® program. Many hospitals and doctors participate in their local Blue Cross or Blue Shield Plan's designated networks. BlueCard® Worldwide provides access to services for BCBS members traveling or living outside of the United States.

In addition, Blue Care℠ members who are traveling can access urgent care services through the BlueCard® program. For members temporarily residing outside of North Carolina, such as students or workers on a temporary assignment, a program called guest membership is available.

Participating providers can be found by calling toll free **1-800-810-2583 (BLUE)** or online at ***www.bcbs.com***.

6.3 BlueCard® Program

The BlueCard® program is a national program that enables members obtaining health care services while traveling or living in another Blue Cross and Blue Shield "BCBS" Plan's area to receive all the same benefits of their contracting BCBS Plan and access to providers and savings. The program links participating health care providers and the independent BCBS Plans across the country and around the world through a single electronic network for claims processing and reimbursement.

With the BlueCard® program, claims for most out-of-state and international BCBS patients receiving care in North Carolina are submitted directly to Blue Cross and Blue Shield of North Carolina "BCBSNC." BCBSNC is the first line of contact for claims processing, payments, adjustments and inquiries for our contracted providers *(Please note: Due to HIPAA privacy regulations members must contact their home plan for all inquiries and related issues)*. All claims should be billed to BCBSNC unless otherwise noted on the back of the member's identification card.

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With the BlueCard® program, claims for most out-of-state and international BCBS patients receiving care in North Carolina are submitted directly to Blue Cross and Blue Shield of North Carolina "BCBSNC." BCBSNC is the first line of contact for claims processing, payments, adjustments and inquiries for our contracted providers *(Please note: Due to HIPAA privacy regulations members must contact their home plan for all inquiries and related issues).* All claims should be billed to BCBSNC unless otherwise noted on the back of the member's identification card.

The BlueCard® program applies to all inpatient, outpatient and professional claims except for:

- Prescription drugs
- Non-medical dental
- Federal Employee Program "FEP" *(please use Follow Your FEP Billing Guidelines)*

Claims for these services should be filed to the address on the member's identification card.

Medicare supplemental plans – all Medicare Supplement and Medicare Choice/Plus go through the BlueCard® program.

Vision and hearing services are covered under BlueCard®.

Medicare Advantage claims for members living in NC should be filed to BCBSNC.

6.3.1 Products Included in the BlueCard® Program

Currently three types of products are administered through the BlueCard® Program:

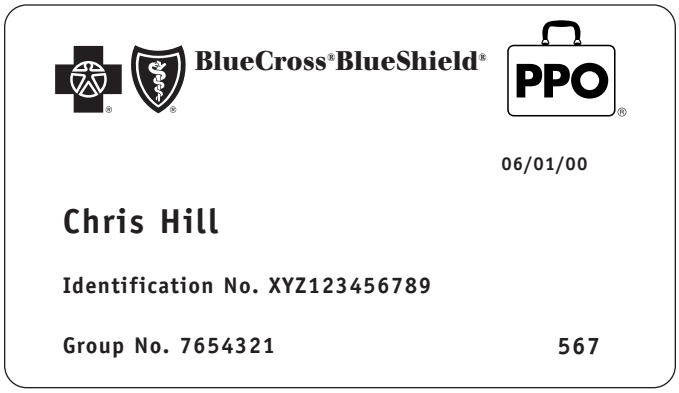
- **BlueCard® Traditional** - offers these members the traditional or indemnity level of benefits when they obtain services from a physician or hospital outside their Blue Plan's service area. In North Carolina, the providers' CostWise contract is applicable.
- **BlueCard® PPO** - offers members the highest level of PPO benefits when they obtain services from a participating provider outside of their Blue Plan's service area. In North Carolina, the providers' PPO *Select* contract is applicable.
- **BlueCard® HMO** - Occasionally, BCBS HMO members affiliated with other BCBS Plans will seek care at your office or facility. You should handle claims for these members the same way as you do BCBSNC members and BCBS traditional and PPO patients from other Blue Plans – by submitting them through the BlueCard® program.

6.3.2 Identifying BlueCard® Members

When members from other BCBS Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. Specific elements of the member ID card identify BlueCard® members.

It is very important to capture all ID card data at the time of service. This is critical for verifying membership and coverage. We suggest that you make copies of the front and back of the ID card and pass this key information on to your billing staff.

Do not make up alpha prefixes or add additional digits to the ID number. As BCBS Plans move away from using social security numbers, please be aware they may be using alphas in addition to numbers as part of the ID number and numbers can be as few as five.



"PPO in a suitcase" PPO **Logo**

BlueCard® PPO members are uniquely identified by their BCBS identification card with the PPO in a suitcase logo. Members traveling or living outside their Plan's service area receive PPO level benefits when they obtain services from preferred providers. It is important to remember that not all BCBS PPO members are BlueCard® PPO members, only those whose identification cards carry this logo.

CMM and HMO members will not have a PPO in a suitcase logo on their cards. All BlueCard® members will have a three letter alpha prefix on their card. Out of state members that do not have an alpha prefix should be billed to the address on the member's identification card.

If you are a non-PPO *(CMM)* provider and are presented with an identification card with the PPO in a suitcase logo on it, you should still accept the card and file with your local Blue Cross and Blue Shield Plan. You will still be given the appropriate traditional pricing.

6.3.2.1 Exceptions to BlueCard® Claims Submissions

Occasionally, exceptions may arise in which BCBSNC will *require* you to file the claim directly with the member's Blue Plan. Here are some of those exceptions:

- You contract with the member's Blue Plan *(for example, in contiguous county or overlapping service area situations)*.
- The ID card does not include an alpha prefix.

6.3.2.2 Durable Medical Equipment Providers Contracting With Multiple Blue Plans

Participating durable medical equipment providers having direct contracts with more than one Blue Plan should follow the following protocol:

- If you have a direct contract in place with the Plan in whose service area the equipment or supply was shipped, you should file to that Plan.

- If you do not have a direct contract in place *(i.e., do not have a contact with the plan in whose service area the equipment or supply was shipped)*, you should file to BCBSNC the local plan as done today.

6.3.2.3 Claims for Accounts Exempt from the BlueCard® Program

When a member belongs to an account that is exempt from the BlueCard® program, BCBSNC will electronically forward your claims to the member's Blue Plan. That means you will no longer need to send paper claims directly to the member's Blue Plan. Instead, you will submit these claims to BCBSNC through your normal claims filing process. See below for further instructions concerning Medicare supplemental *(Medigap)* and other COB claims.

How the exempt account claim process works:

- You will submit these claims with alpha prefixes exempt from BlueCard® directly to BCBSNC, we will forward the claims to the member's plan for you.
  - It is important for you to correctly capture on the claim the member's complete identification number, including the three-character alpha prefix at the beginning. If you don't include this information, BCBSNC may return the claim to you and this will delay claims resolution and your payment.
  - It is also important for you to call BlueCard® eligibility at **1-800-676-BLUE** to verify the member's eligibility and coverage or submit an electronic eligibility request (270).

6.3.2.4 Coordination of Benefits "COB" Claims

Coordination of Benefits "COB" refers to how we make sure people receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment. See section 6.3.9 for further instructions.

Tip: When the patient first arrives for service, always ask if they have other health insurance in addition to their Blue Cross and/or Blue Shield coverage. If the patient does have more than one health care coverage, please be sure to make a photocopy of all their health insurance cards.

If after calling **1-800-676-BLUE** or through other means you discover the member has a COB provision in their benefit plan, and BCBSNC is the primary payer, submit the claim along with information regarding COB to BCBSNC. If you do not include the COB information with the claim, the member's Blue Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

6.3.2.5 Medicare Supplemental *(Medigap)* Claims

For Medicare supplemental claims, always file with the Medicare contractor first. Always include the complete Health Insurance Claim Number "HICN"; the patient's complete Blue Cross Blue Shield Plan identification number, including the three-character alpha prefix; and the Blue Cross Blue Shield Plan name as it appears on the patient's ID card, for supplemental insurance. This will ensure cross-over claims are forwarded appropriately.

There is a basic rule when it comes to Medicare primary coverage and BlueCard®, which is – always file to the Medicare contractor first. Follow this rule by never filing to both the Medicare contractor and BCBSNC at the same time, instead wait until the claim has processed and

Medicare has provided you with a Explanation of Benefits "EOB" or a payment advice. The reasoning behind this rule is simple; the member's benefits cannot be determined by the member's Plan without knowing what Medicare has allowed.

Do not file with BCBSNC and Medicare simultaneously. Wait until you receive the Explanation of Medical Benefits "EOMB" or payment advice from Medicare. After you receive the Medicare payment advice/EOMB, determine if the claim was automatically crossed over to the supplemental insurer. See section 6.3.9, Coordination of Benefits and Where to File Secondary Claims to Medicare and Other Insurance for correct filing procedures.

Cross-Over Claims: If the claim was crossed over, the payment advice/EOMB should typically have Remark Code MA 18 printed on it, which states The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them. The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

Claim Not Crossed Over: If the payment advice/EOMB does not indicate the claim was crossed over and you accepted Medicare assignment, file the claim to BCBSNC if the claim has a prefix. If no prefix, file the claim to the address on the back of the card. BCBSNC or the member's BCBS Plan will pay you the Medicare supplemental benefits. If you did not accept assignment, the member will be paid and you will need to bill the member. See section 6.3.9, Coordination of Benefits and Where to File Secondary Claims to Medicare and Other Insurance for correct filing procedures.

6.3.2.6 How to Handle Calls from Members and Others with Claims Questions

If members contact you, tell them to contact their Blue Cross and Blue Shield Plan. Refer them to the front or back of their ID card for a customer service number. The member's Plan should not be contacting you directly, unless you filed a paper claim directly with that Plan. If the member's Plan contacts you, to send them another copy of the member's claim, and you originally filed with BCBSNC, refer them to BCBSNC.

6.3.2.7 Where to Find More Information About the BlueCard® Program

For more information about the BlueCard® program, call BCBSNC at **1-800-487-5522** or visit the Blue Cross and Blue Shield or North Carolina Web site at ***bcbsnc.com***.

6.3.2.8 Alpha Prefix

The three character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Cross and Blue Shield Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage.

There are two types of alpha prefixes: Plan-specific and Account-specific.

- **Plan-specific alpha prefixes** are assigned to every Plan and start with X, Y, Z or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.
- **Account-specific alpha prefixes** are assigned to centrally processed national accounts. National accounts are employer groups that have offices or branches in more than one area, but offer uniform benefits coverage to all employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically, a national account alpha prefix will relate

to the name of the group. All three positions are used to identify the national account.

Occasionally, you may see identification cards from foreign BCBS Plan members. These ID cards will also contain three character alpha prefixes. Please treat these members the same as domestic BCBS Plan members.

Identification cards that do not have an alpha prefix indicate that claims are handled outside the BlueCard® program. Look for instructions or a telephone number on the back of the member's ID card for how to file these claims.

Alpha Prefix Helpful Hints

- The alpha prefix will always be the 1st three digits of the member's ID.
- Following the three-character alpha prefix, the ID card may include any combination of alpha/numeric characters *(letters or numbers)* for a maximum length of 17 characters total *(3 character alpha prefix + up to 14 alpha/numeric characters)*. You may see cards with ID numbers that are fewer than 17 characters in total. Remember member ID numbers must not be changed or altered.
- Always make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- To ensure that the member gives you the most current ID card, you may want to request the card at every visit.
- Whether the most current ID card contains the social security number or an alternate unique identification number, please enter the identification number exactly as it appears on the member's card, including the alpha prefix, and pass this key information to your billing staff.
- Please use ***Blue e***℠ to verify membership and coverage for members covered by Blue Cross and Blue Shield plans outside of North Carolina. See chapter 12, Electronic Solutions.

6.3.3 How to Verify Membership and Coverage

Once you've identified the alpha prefix:

- Use ***Blue e***℠ to verify membership and coverage for members covered by Blue Cross and Blue Shield Plans outside North Carolina or
- Have the member's ID card ready when calling and call the BlueCard® eligibility line at **1-800-676-BLUE**

Operators are available to assist you weekdays during regular business hours *(7am - 10pm EST)*. They will ask for the alpha prefix shown on the patient's ID card and will connect you directly to the appropriate membership and coverage unit at the member's Blue Cross Blue Shield Plan. If you call after hours, you will get a recorded message stating the business hours. Keep in mind BCBS Plans are located throughout the country and may operate on a different time schedule than Blue Cross and Blue Shield of North Carolina. It is possible you will be transferred to a voice response system linked to customer enrollment and benefits or you may need to call back at a later time.

6.3.4 Prior Review and Certification

Out-of-area CMM, PPO and HMO members are responsible for obtaining pre-admission certification or authorization from their home Plan in order to ensure there is no delay in your payment. You may choose to contact the member's home Plan on behalf of the patient to obtain authorization. Refer to the phone number on the back of the member's ID card or call BlueCard® eligibility at **1-800-676-BLUE** and ask to be directed to the utilization review area.

Blue e℠ also enables users to notify home plans to obtain certification for out-of-state members. If you do not have ***Blue e***℠, refer to chapter 12, Electronic Solutions.

Disease Management - You may be contacted by another plan to assist them in disease management of an out-of-state member.

- The participating provider contacts BCBSNC when prior review or certification is required *(see chapter 8, Health Coaching and Intervention, for a description of procedures).*
- For BlueCard® members, mental health and substance abuse services are coordinated by the home BCBS Plan. For information on these services or to obtain certification, call the number on the back of the member's ID card.

6.3.5 Claims Submission

Submit BlueCard® claims to BCBSNC using your normal claims billing process. Be sure to always include the alpha prefix and the member's complete identification number when you submit the claim. Do not make up alpha prefixes. Incorrect or missing alpha prefixes and incorrect member identification numbers delay claims processing. Claims will be returned or denied if subscriber information is incorrect or invalid.

Once we receive a claim, we will electronically route the claim to the member's BCBS Plan. To help ensure that claims are routed accurately and that the member's Plan has all of the information needed to appropriately apply benefits, BCBSNC forwards to the member's home Plan a complete record of the information reported on the claim form from the provider of service, i.e. member/patient demographics, provider demographics including tax identification, member/patient services and medical conditions. The member's Plan then processes the claim, applies benefits and approves or denies payment. BCBSNC will process your claim and will pay you. Generally, this process for claims submission takes 14 days for turnaround from the home plan.

When in doubt, please send the claim to BCBSNC and we will handle the claim for you.

6.3.6 International Claims

The claim submission process for international Blue Cross and Blue Shield Plan members is the same as for domestic Blue Cross and Blue Shield Plan members. You should submit the claim directly to BCBSNC.

6.3.7 Verifying Claim Status and Resolving Other Claims Issues

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

- Utilizing ***Blue e***℠ to check claim status inquiries directly from the member's home plan. Replies from Home Plans are generally received in less than one minute.
- Call the BlueCard® dedicated provider customer service department at **1-800-487-5522**.

- Complete a provider claim inquiry form found in chapter 23, Forms and mail to:

Blue Cross and Blue Shield of North Carolina
BlueCard® Department
P.O. Box 2291
Durham, NC 27702-2291

6.3.8 When to Contact the Home Plan and the Host Plan

- Claim status – always call local plan *(BCBSNC)* or use ***Blue e***℠
- Eligibility/precertification – call the number on the card or **1-800-676-BLUE** or use ***Blue e***℠
- Questions about:
  - EOB received from home Plan – call the home Plan
  - EOB received from NC – always call NC **1-800-487-5522**

6.3.9 Provider-Initiated Refunds for Out-of-Area Members

When we receive non-requested refunds for out-of-area Blue Plan members, both BCBSNC and the member's home Plan are involved in the transaction. Because of this coordination with other Blue Plans, it is critical that we receive accurate information whenever you send us a refund for out-of-area members.

BCBSNC's goal is to minimize the occurrence of returned payments. However, if you do return a payment to us, the inter-plan programs' team will work with both you and the member's home Plan to process the returned payment and it's associated claim, in an accurate and timely manner.

So that we can effectively represent your interest when contacting the home Plan about refund, we need sufficient documentation to link a particular refund to a specific claim. When sending provider-initiated refunds to BCBSNC, please use the following checklist to help ensure that all necessary information is provided:

- All explanation of benefits pertaining to the claim
- Patients name and ID number including the alpha prefix
- Provider name, ID number and mailing address
- The specific reason why the refund is being returned such as; duplicate payment, workman's compensation, Medicare payment is primary, other carrier paid primary, corrected claim, billing error, etc.

To assist in this process we have developed inter-plan programs par/host plan form, which contains a checklist of the information we will need to process your request. This form can be printed from our Web site at ***http://www.bcbsnc.com/providers/*** or copied from page 15 in the forms chapter of this manual.

Unfortunately, if we cannot accurately associate your returned payment amount to the appropriate claim, BCBSNC must return the payment to you. Submitting the above information will help ensure that you're returned payment is processed appropriately.

6.3.10 Coordination of Benefits and Where to File Secondary Claims to Medicare and Other Insurance

Effective April 2003, BCBSNC along with all BlueCard® Plans across the nation implemented HIPAA compliant software to more efficiently process provider claims. This software update allows Plans to process all Coordination of Benefit "COB" claims through the BlueCard® ITS system. This should lessen the occurrences of the home Plan paying the patient instead of the participating provider for COB claims. Providers should now expect payment through the BlueCard® program.

Listed below are the instructions for the electronic submission of BCBSNC secondary to Medicare claims via 837 *(HIPAA compliant software)*. When filing claims electronically via 837 for UB-04 hospital claims the provider should file the Medicare COB data as follows:

- Medicare allowed amount should be filed using an AMT segment in the 2320 loop with a "B6" qualifier and the corresponding $ amount.
- Medicare paid amount should be filed using an AMT segment in the 2320 loop with a "C4" qualifier and the corresponding $ amount.
- The contractual adjustment should be filed using the CAS segment in the 2320 loop using a claim adjustment group code of "PR," claim adjustment reason code "45" and the corresponding claim adjustment $ amount.
- The claim level deductible amounts should be filed using the CAS segment in the 2320 loop using a claim adjustment group code of "PR," claim adjustment reason code "1" and the corresponding claim adjustment $ amount.
- The claim level coinsurance amounts should be filed using the CAS segment in the 2320 loop using a claim adjustment group code of "PR," claim adjustment reason code "2" and the corresponding claim adjustment $ amount.
- Please do not use the value codes of A1 and/or A2 on the 837 for deductible and coinsurance when filing an 837 institutional BlueCard® claim, please use the CAS code segments as indicated above.

If you have questions, please contact EDI Services at **1-888-333-8594**.

6.3.11 Medical Records

Do not send medical records until BCBSNC requests the records from you. Upon receipt of the medical records, BCBSNC will forward the records to the member's home Plan. Do not send medical records to the member's home Plan.

6.3.12 How Your Patients Can Receive Care Through BlueCard® When Traveling

Your patients that are BCBSNC CMM, PPO and HMO members can receive services while traveling out-of-state through the BlueCard® program. Many hospitals and doctors participate in their local plan's networks. Participating providers can be found by calling **1-800-810-2583** or through ***bcbs.com***. Provider link is an electronic method of requesting and sending medical records. If you use provider link, a medical request is submitted to you through provider link, the request should be returned through provider link.

6.4 Payment for BlueCard® Claims

If you haven't received payment within 30 days of the claim submission, do not resubmit the claim. If you do, the claim will be denied as a duplicate. You will also confuse the member because he or she will receive another EOB and will need to call customer service.

The next time you don't receive your payment or a response regarding your payment, please call our customer service department at **1-800-487-5522**. Please wait 30 days from BCBSNC receipt of your claim before checking claim status. You may also check claim status through ***Blue e***[SM].

In some cases, a member's Blue Cross and Blue Shield Plan may suspend a claim because medical review or additional information is necessary. When resolution of claim suspensions requires additional information from you, *we* may either ask you for the information or give the member's Plan permission to contact you directly.

6.5 BlueCard® Members and Health Care Debit Card

Some Blue members have a Blue Cross and/or Blue Shield health care debit card - a card with value-added features to assist providers to collect member cost-sharing amount.

Using the new cards can help you simplify your administration process and can help you:

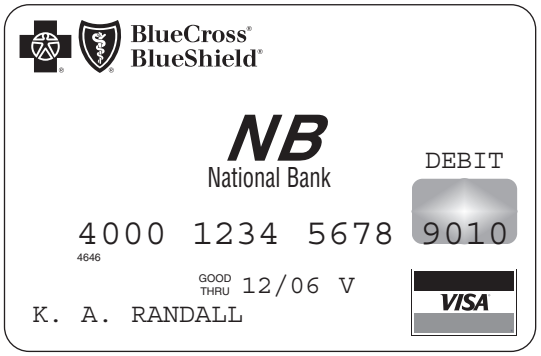
- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

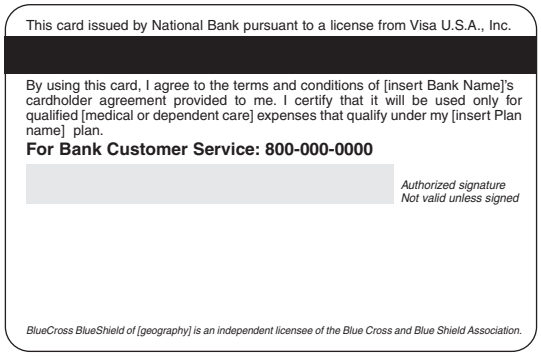
The card allows members to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement "HRA," Health Savings Account "HSA" or Flexible Spending Account "FSA." Some cards are stand-alone debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number.

It's easy to recognize - just look for the familiar logos.

The card will have the nationally recognized Blue Cross and/or Blue Shield logos, along with the logo from a major debit card logo such as MasterCard® or Visa®.

Sample Stand-Alone Debit Cards





It's easy to use - simply swipe the card like an ordinary debit card.

The cards include a magnetic strip so providers can swipe the card at the point of service to collect. With the health debit cards members can pay out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

It saves time and money.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities. If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit card.

Helpful Tips

- Ask members for their current member ID card and regularly obtain new photocopies *(front and back)* of the member ID card. Having the current card will enable you to submit claims with the appropriate member information *(including alpha prefix)* and avoid unnecessary claims payment delays.
- Check eligibility and benefits by using ***Blue e***℠ or calling **1-800-676-BLUE (2583)** and provide the alpha prefix, or use electronic capabilities.
- If the member presents a debit card *(stand-alone or combined)*, be sure to verify what the member will owe before processing payment. Select "debit" when running the card through for payment. No PIN is required for use.
- Please do not use the card to process full payment up front. Applicable coinsurance and deductible amounts may be billed to BCBSNC members only after provider has received the notification of payment or explanation of payment. Emergency room copayments may be collected at the time service is rendered. Any amounts collected erroneously by you from a Member for any reason will be refunded to the Member within forty-five (45) days of your receipt of notification or your discovery of such error. If you have any questions about the member's benefits, please contact **1-800-676-BLUE (2583)**. For questions about the debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

6.6 Blue Cross and Blue Shield National Directory

Please Note: This publication is designed to offer basic information to the provider. Though all of the information has been carefully researched and checked for accuracy and completeness, information can change periodically. For the most up-to-date information, please contact the BlueCard® Eligibility Line at **1-800-676-BLUE (2583)**. Please be prepared to give the operator the member's three-digit alpha prefix.

- Please note that updated plan contact information can be obtained by accessing ***bcbsnc.com***.

Alabama

Blue Cross and Blue Shield of Alabama
405 Riverchase Parkway East
Birmingham, AL 35244

P.O. Box 995
Birmingham, AL 35298

Customer Service **1-800-517-6425**
Provider Service **1-205-988-2534**

Alaska

Serviced by Blue Cross Blue Shield of Alaska in Seattle, Washington

Arizona

Blue Cross and Blue Shield of Arizona, Inc.
2444 West Las Palmaritas Drive
Phoenix, AZ 85021

P.O. Box 13466
Phoenix, AZ 85002-3466

Main Phone **1-602-864-4100**
Customer Service **1-800-232-2345**

Arkansas

Arkansas Blue Cross and Blue Shield
(A Mutual Insurance Company)
601 Gaines Street
Little Rock, AR 72201

P.O. Box 2181
Little Rock, AR 72203

Customer Service **1-501-378-2010**
Provider Service **1-800-827-4814**

California

Blue Shield of California
(California Physicians' Service)
50 Beale Street
San Francisco, CA 94105

P.O. Box 7168
San Francisco, CA 94120

Main Phone **1-415-229-5000**
Provider Services **1-800-258-3091**

California

Blue Cross of California
21555 Oxnard Street
Woodland Hills, CA 91367

P.O. Box 70000 *(mailing address)*
Van Nuys, CA 91470

Main Phone **1-818-703-2345**
Customer Service **1-800-444-2726**

Colorado

Blue Cross and Blue Shield of Colorado
(Rocky Mountain Hospital and Medical Service)
700 Broadway
Denver, CO 80273

Main Phone **1-303-831-2131**
Customer Service **1-800-433-5447**

Connecticut

Anthem Blue Cross and Blue Shield of Connecticut
(Anthem Health Plans, Inc.)
370 Bassett Road
North Haven, CT 06473

Customer Service **1-800-545-0948**
Provider Service **1-800-895-9915**

Delaware

Blue Cross Blue Shield of Delaware
(Blue Cross Blue Shield of Delaware, Inc.)
One Brandywine Gateway
Wilmington, DE 19899

P.O. Box 1991 (all correspondence)
P.O. Box 8820 (all claims)
Wilmington, DE 19899

Main Phone	**1-302-421-3000**
Customer Service	**1-800-633-2563**

District of Columbia

CareFirst BlueCross BlueShield
(Group Hospitalization and Medical Services, Inc.)
550 12th Street, S.W.
Washington, DC 20065

Main Phone	**1-202-479-8000**
Customer Service	**1-202-479-7727**

Florida

Blue Cross and Blue Shield of Florida
(Blue Cross and Blue Shield of Florida, Inc.)
4800 Deerwood Campus Parkway
Jacksonville, FL 32231-0014

Customer Service	**1-800-727-2227**
Provider Service	**1-800-888-6758**

Georgia

Blue Cross and Blue Shield of Georgia
(Blue Cross and Blue Shield of Georgia, Inc.)
Capital City Plaza
3350 Peachtree Road, N.E.
Atlanta, GA 30326

P.O. Box 4445
Atlanta, GA 30302-4445

Main Phone	**1-404-842-8000**
Customer Service	**1-800-441-2273**

Hawaii

Blue Cross and Blue Shield of Hawaii
(Hawaii Medical Service Association)
818 Keeaumoku Street
Honolulu, HI 96814

P.O. Box 860
Honolulu, HI 96808-0860

Main Phone	**1-808-948-5110**
Customer Service	**1-800-776-4672**

Idaho

Blue Cross of Idaho Health Service
(Blue Cross of Idaho Health Service, Inc.)
3000 E. Pine Avenue
Meridian, ID 83642-5995

P.O. Box 7408
Boise, ID 83707

Main Phone	**1-208-345-4550**
Customer Service	**1-800-627-1188**

Idaho

Regence BlueShield of Idaho
1602 21st Avenue
Lewiston, ID 83501

P.O. Box 1106
Lewiston, ID 83501

Main Phone	**1-208-746-2671**
Customer Service	**1-800-632-2022, x6264**

Illinois

Blue Cross and Blue Shield of Illinois
300 E. Randolph Street
Chicago, IL 60601-5099

P.O. Box 1364
Chicago, IL 60690

Main Phone	**1-312-938-6000**
Customer Service	**1-800-313-4217**

Indiana

Anthem Insurance Companies, Inc.
(Anthem Blue Cross and Blue Shield)
120 Monument Circle
Indianapolis, IN 46290

Main Phone **1-317-488-6000**
Customer Service **1-800-428-0667**

Iowa

WellMark Blue Cross and Blue Shield of Iowa
(Wellmark, Inc.)
(Affiliated with Wellmark Blue Cross and Blue Shield of South Dakota)
636 Grand Avenue
Des Moines, IA 50309

Main Phone **1-515-245-4500**
Customer Service **1-800-362-2218**

Kansas

Blue Cross and Blue Shield of Kansas
(Blue Cross and Blue Shield of Kansas, Inc.)
1133 Topeka Boulevard
Topeka, KS 66629-0001

P.O. Box 239
Topeka, KS 66601-0239

Main Phone **1-785-291-7000**
Customer Service **1-800-432-3990**

Kentucky

Anthem Blue Cross and Blue Shield - Kentucky
9901 Linn Station Road
Louisville, KY 40223

Main Phone **1-502-423-2011**

Louisiana

Blue Cross and Blue Shield of Louisiana
(Louisiana Health Services & Indemnity Company)
5525 Reitz Avenue
Baton Rouge, LA 70809-3802

P.O. Box 98029
Baton Rouge, LA 70898-9029

Main Phone **1-225-295-3307**
Customer Service **1-800-599-2583**

Maine

Blue Cross and Blue Shield of Maine
(Associated Hospital Service of Maine)
2 Gannett Drive
South Portland, ME 04106-6911

Main Phone **1-207-822-7000**
Customer Service **1-800-822-8962**

Maryland

CareFirst BlueCross BlueShield
(CareFirst of Maryland, Inc.)
10455 Mill Run Circle
Owings Mills, MD 21117

Main Phone **1-410-581-3000**
Customer Service **1-410-581-3000**

Massachusetts

Blue Cross and Blue Shield of Massachusetts
(Blue Cross and Blue Shield of Massachusetts, Inc.)
100 Summer Street
Boston, MA 02110

Main Phone **1-617-832-5000**
Customer Service **1-800-413-4123**

Michigan

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, MI 48226-2998

Main Phone **1-313-225-9000**
Customer Service **1-313-225-8000**

Minnesota

Blue Cross and Blue Shield of Minnesota
(Blue Cross and Blue Shield of Minnesota, Inc.)
3535 Blue Cross Road
St. Paul, MN 55122-1154

P.O. Box 64560
St. Paul, MN 55164-0560

Main Phone **1-651-662-8000**
Customer Service **1-612-662-8000**

Mississippi

Blue Cross and Blue Shield of Mississippi
(Blue Cross and Blue Shield of Mississippi, A Mutual Insurance Company)
3545 Lakeland Drive
Jackson, MS 39208-9799

P.O. Box 1043
Jackson, MS 39215-1043

Main Phone **1-601-932-3704**
Customer Service **1-800-810-2583**

Missouri

Blue Cross and Blue Shield of Kansas City
2301 Main
Kansas City, MO 64108

P.O. Box 419169
Kansas City, MO 64141-6169

Main Phone **1-816-395-2222**
Main Fax **1-816-395-2035**

Missouri

Alliance Blue Cross Blue Shield
(RightCHOICE Managed Care, Inc.)
1831 Chestnut Street
St. Louis, MO 63103-2275

Main Phone **1-314-923-4444**
Main Fax **1-314-923-5002**

Montana

Blue Cross and Blue Shield of Montana
(Blue Cross and Blue Shield of Montana, Inc.)
560 North Park Avenue
Helena, MT 59601

P.O. Box 4309
Helena, MT 59604-4309

Main Phone **1-406-444-8200**
Customer Service **1-800-447-7828**

Nebraska

Blue Cross and Blue Shield of Nebraska
7261 Mercy Road
Omaha, NE 68180-0001

P.O. Box 3248, Main PO Station
Omaha, NE 68180-0001

Main Phone **1-402-390-1800**
Customer Service **1-402-390-1820**

Nevada

Blue Cross and Blue Shield of Nevada
(Rocky Mountain Hospital and Medical Service)
5250 South Virginia Street
Reno, NV 89502

Main Phone **1-775-448-4000**
Customer Service **1-800-992-6907**

New Hampshire

Blue Cross and Blue Shield of New Hampshire
(New Hampshire-Vermont Health Service)
3000 Goffs Falls Road
Manchester, NH 03111-0001

Main Phone	**1-603-695-7000**
Customer Service	**1-800-438-9672**

New Jersey

Blue Cross and Blue Shield of New Jersey, Inc.
(Horizon Healthcare Services, Inc.)
3 Penn Plaza East
Newark, NJ 07105

Main Phone	**1-973-466-4000**
Provider Service	**1-800-355-2583**

New Mexico

Blue Cross and Blue Shield of New Mexico
(New Mexico Blue Cross & Blue Shield, Inc.)
12800 Indian School Road, N.E.
Albuquerque, NM 87112

P.O. Box 27603 *(all correspondence)*
Albuquerque, NM 87125-7630

Main Phone	**1-505-291-3500**
Customer Service	**1-800-432-0750**

New York

Blue Cross and Blue Shield of Western New York
(HealthNow New York, Inc.)
1901 Main Street
Buffalo, NY 14208

P.O. Box 80
Buffalo, NY 14240-0080

Main Phone	**1-716-887-6900**
Customer Service	**1-800-444-2012**

New York

Blue Shield of Northeastern New York
(HealthNow New York, Inc.)
187 Wolf Road
Albany, NY 12205

P.O. Box 15013
Albany, NY 12212

Main Phone	**1-518-453-5700**
Main Fax	**1-518-438-1837**

New York

Empire Blue Cross and Blue Shield
P.O. Box 1407, Church St. Station
New York, NY 10227-2401

Main Phone	**1-212-476-1000**
Customer Service	**1-800-261-5962**

New York

BlueCross BlueShield of the Rochester Area
165 Court Street
Rochester, NY 14647

Main Phone	**1-716-454-1700**
Customer Service	**1-716-325-3630**

New York

Blue Cross and Blue Shield of Central New York
344 South Warren Street
Syracuse, NY 13202

P.O. Box 4809
Syracuse, NY 13221-4809

Main Phone	**1-315-448-3700**
Customer Service	**1-315-448-3801**

New York

Blue Cross and Blue Shield of Utica Watertown
Utica Business Park
12 Rhoads Drive
Utica, NY 13502-6398

Main Phone	**1-315-798-4200**
Customer Service	**1-315-798-4238**

North Carolina

Blue Cross and Blue Shield of North Carolina
5901 Chapel Hill Road
Durham, NC 27707

P.O. Box 2291 *(all correspondence)*
Durham, NC 27702-2291

Main Phone	**1-919-489-7431**
Provider Blue Line℠ "VRU"	**1-800-214-4844**
BlueCard® Dedicated Customer Service	**1-800-487-5522**

North Dakota

Blue Cross Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, ND 58121-0001

Main Phone	**1-701-282-1100**
Customer Service	**1-800-342-4718**

Ohio

(Community Insurance Company)
(Anthem Insurance Companies, Inc.)
4361 Irwin Simpson Road
Mason, OH 45040

Main Phone	**1-513-872-8100**
Main Fax	**1-513-336-4400**

Oklahoma

Blue Cross and Blue Shield of Oklahoma
(Group Health Service of Oklahoma, Inc.)
1215 South Boulder Avenue
Tulsa, OK 74119-2800

P.O. Box 3283
Tulsa, OK 74102-3283

Main Phone	**1-918-560-3500**
Customer Service	**1-800-722-3130**

Oregon

Regence BlueCross BlueShield of Oregon
100 S.W. Market Street
Portland, OR 97201

P.O. Box 1271
Portland, OR 97207-1271

Main Phone	**1-503-225-5221**
Customer Service	**1-800-452-7390**

Pennsylvania

Capital Administrative Services, Inc.
NCAS Pennsylvania Department 778974
PA 17177-8974

Main Phone	**1-717-541-3800**

Pennsylvania

Capital Blue Cross – Harrisburg
2500 Elmerton Avenue
Harrisburg, PA 17177

Main Phone	**1-717-541-7000**

Pennsylvania

First Priority Health
19 North Main Street
PA 18711

Main Phone	**1-570-200-4300**

Pennsylvania

Highmark Blue Cross and Blue Shield
120 Fifth Avenue
Pittsburgh, PA 15222-3099

Main Phone **1-412-544-7000**

Pennsylvania

Highmark Blue Shield
(formerly Pennsylvania Blue Shield)

(Medical Service Association of Pennsylvania)
1800 Center Street
Camp Hill, PA 17011

P.O. Box 890089 *(mailing address)*
Camp Hill, PA 17089-0009

Main Phone **1-717-302-5101**

Pennsylvania

Independence BC and Pennsylvania BS
Caring Foundation for Children – Highmark
1901 Market Street 38th Floor
Philadelphia, PA 19103

Main Phone **1-215-241-2400**

Pennsylvania

Independence BC and Pennsylvania BS Caring
Foundation for Children – Philadelphia
1901 Market Street 38th Floor
Philadelphia, PA 19103

Main Phone **1-800-464-5437**

Pennsylvania

Independence Blue Cross – Philadelphia
1901 Market Street 38th Floor
Philadelphia, PA 19103

Main Phone **1-215-241-2400**

Pennsylvania

Keystone Health Plan Central, Inc. – Harrisburg
300 Corporate Center #602
Camp Hill, PA 17089

Main Phone **1-717-302-0200**

Pennsylvania

Keystone Health Plan Central, Inc. – Highmark
300 Corporate Center Drive, 6th Floor #602
Camp Hill, PA 17089-8812

Main Phone **1-717-763-3458**

Pennsylvania

Keystone Health Plan East, Inc.
1901 Market Street
Philadelphia, PA 19103

Main Phone **1-215-241-2001**

Pennsylvania

Keystone Health Plan West, Inc.
120 Fifth Avenue
PA 15222-3099

Main Phone **1-412-544-7000**

Pennsylvania

Pennsylvania Blue Shield
1800 Center Street
Camp Hill, PA 17089

Main Phone **1-717-763-3151**

Pennsylvania

The Caring Foundation of Central
Pennsylvania – Harrisburg
Department 777014
PA 17177-7014

Main Phone **1-800-543-7101**

Pennsylvania

The Caring Foundation of Central
Pennsylvania – Highmark
Department 777014
PA 17177-7014

Main Phone **1-800-543-7101**

Pennsylvania

The Caring Foundation of Northeastern
Pennsylvania – Highmark)
70 North Main Street
PA 18711

Main Phone **1-800-543-7199**

Pennsylvania

The Caring Foundation of Northeastern
Pennsylvania – Wilkes-Barre)
19 North Main Street
Wilkes-Barre, PA 18711

Main Phone **1-570-200-4300**

Pennsylvania

Western Pennsylvania Caring
Foundation for Children
Fifth Avenue Place
120 Fifth Avenue
PA, 15222

Main Phone **1-800-543-7106**

Pennsylvania

Pennsylvania,
Blue Cross of Northeastern
19 North Main Street
Wilkes-Barre, PA 18711

Main Phone **1-570-200-4300**

Puerto Rico

Triple-S, Inc.
Ave. F.D. Roosevelt 1441
Caparra, PR 00920

P.O. Box 363628
San Juan, PR 00936-3628

Main Phone **1-787-749-4949**
Customer Service **1-787-749-4777**

Puerto Rico

La Cruz Azul de Puerto Rico
(Blue Cross of Puerto Rico)
Carr. 1 Km. 17.3
Rio Piedras, PR 00927

P.O. Box 366068 *(mailing address)*
San Juan, PR 00936-6068

Main Phone **1-787-272-9898**
Main Fax **1-787-272-7867**

Rhode Island

Blue Cross and Blue Shield of Rhode Island
444 Westminster Street
Providence, RI 02903-3279

Main Phone **1-401-459-1000**
Customer Service **1-401-831-7300**

South Carolina

Blue Cross and Blue Shield of South Carolina
I-20 East at Alpine Road
Columbia, SC 29219

Main Phone **1-803-788-3860**
Main Fax **1-803-736-3420**

South Dakota

Wellmark Blue Cross and Blue Shield of South Dakota
(Wellmark of South Dakota, Inc.)
1601 West Madison Street
Sioux Falls, SD 57104

Main Phone	**1-605-361-5800**
Customer Service	**1-800-722-1631**

Tennessee

Blue Cross and Blue Shield of Tennessee - Chattanooga
(Chattanooga Hospital & Medical Association, Inc.)
801 Pine Street
Chattanooga, TN 37402

Main Phone	**1-423-755-5600**
Customer Service	**1-800-667-1678**

Texas

Blue Cross and Blue Shield of Texas, Inc.
(A Division of Health Care Service Corporation, A Mutual Legal Reserve Company)
901 S. Central Expressway
Richardson, TX 75265-5730

P.O. Box 655730
Dallas, TX 75265-5730

Main Phone	**1-972-766-6900**
Customer Service	**1-972-669-3900**

Utah

Regence Blue Cross and Blue Shield of Utah
2890 East Cottenwood Parkway
Salt Lake City, UT 84130-0270

P.O. Box 30270
Salt Lake City, UT 84130-0270

Main Phone	**(801) 333-2000**
Customer Service	**(801) 333-2100**

Vermont

Blue Cross and Blue Shield of Vermont
445 Industrial Lane
Berlin, VT 05602

P.O. Box 186
Montpelier, VT 05601

Main Phone	**1-802-223-6131**
Customer Service	**1-802-223-3494**

Virginia

Trigon Blue Cross Blue Shield
(Trigon Insurance Company)
2015 Staples Mill Road
Richmond, VA 23230

P.O. Box 27401
Richmond, VA 23279

Main Phone	**1-804-354-7000**
Customer Service	**1-804-358-1551**
Provider Services	**1-800-533-1120** (Group)
Provider Services	**1-800-321-8318** (Non-Group)

Washington

Premera Blue Cross
Blue Cross Blue Shield of Alaska
7001 220th Street, S.W.
Mountlake Terrace, WA 98043-2124

P.O. Box 327
Seattle, WA 98111-0327

Main Phone	**1-425-670-4000**
Main Fax	**1-425-670-4900**
Customer Service	**1-425-670-5900**

Washington

Regence Blue Shield
1800 Ninth Avenue
Seattle, WA 98101-1322

P.O. Box 21267
Seattle, WA 98111-3267

Main Phone	**1-206-464-3600**
Customer Service	**1-206-464-3680**

West Virginia

Mountain State Blue Cross & Blue Shield
(Mountain State Blue Cross & Blue Shield, Inc.)
700 Market Square
Parkersburg, WV 26101

P.O. Box 1948
Parkersburg, WV 26101

Main Phone	**1-304-424-7700**
Customer Service	**1-304-424-7701**

Wisconsin

Blue Cross and Blue Shield United of Wisconsin
(Blue Cross Blue Shield United of Wisconsin)
401 West Michigan Street
Milwaukee, WI 53203

P.O. Box 2025
Milwaukee, WI 53201-2025

Main Phone	**1-414-226-5000**
Customer Service	**1-414-224-6100**

Wyoming

Blue Cross and Blue Shield of Wyoming
4000 House Avenue
Cheyenne, WY 82001-2266

P.O. Box 2266
Cheyenne, WY 82003-2266

Main Phone	**1-307-634-1393**
Main Fax	**1-307-778-8582**

National Accounts

6.7 National Accounts *(National Alliance and* BlueCard® *Program)*

Blue Cross and Blue Shield of South Carolina's National Alliance is an organization dedicated to helping other Blue Plans with the service and support of large, national accounts. The Alliance team's collaboration with us is designed to present a seamless presentation to the client and consultants with Blue Cross and Blue Shield of North Carolina serving as the control plan *(and owner of the relationship)* and National Alliance providing operational services. The business that sits on the Alliance platform is referred to as surrogate business. This program supports BCBSNC with potential or existing control business with 700 or more enrolled employees in multi-state locations.

The Alliance program staff works diligently to provide appropriate health programs that improve quality of life for members while maintaining appropriate cost controls. This is accomplished through a member-centric integrated health management model with a full complement of services designed to proactively identify care improvement opportunities.

All medical management and claim processing activities are conducted onsite at the Blue Cross and Blue Shield of North Carolina service center. Normal hours of operation are from 8:00 am to 8:00 pm EST. Members are to refer to the toll-free number on the back of their identification card for assistance. Available also are a VRU and Web site which provide customer service functions and access to pre-certification information. In addition, ***MyInsuranceManager.com*** is a Web-based health content site that helps members build better health, provides state of the art health content including health risk assessments, health newsletters and enrollment in various health and prevention programs with personalized email correspondence, health education and chronic disease information.

National Alliance offers a wide variety of administrative services that include:

- Claims administration/member services *(medical and dental)*
- Health care services
- Enrollment and billing services
- Administrative solutions/flexible benefits service provider/COBRA administration
- Specific and aggregate stop loss protection
- HIPAA service
- Worker's compensation and subrogation

BlueCard® Preferred Provider Organization "PPO" medical plan is the standard benefit and delivery model administered by National Alliance. Location of providers, claims processing, identifying membership coverage, pre-admission certification, international claims filing and receiving services while traveling follows the same procedures as with the BlueCard® program.

Medicare / Medicare Supplement

7. Medicare / Medicare Supplement

7.1 What is Medicare?

For information on how to file claims with Medicare, refer to ***www.palmettogba.com***.

- Medicare is a federally-funded health insurance program.
- The Center of Medicare and Medicaid Services "CMS" of the Department of Health and Human Services administrates the Medicare program.
- The Social Security Administration enrolls eligible individuals. Their offices collect premiums, issue Medicare cards and answer general Medicare questions.
- CMS contracts with private insurance companies to process Medicare claims and to provide information about those claims to beneficiaries or medical providers.

7.2 Who is Eligible?

- People aged 65 and over
- Disabled individuals under age 65 who are determined to be disabled for more than 24 months. Either Social Security or the Railroad Retirement Board makes the determination.
- End-Stage Renal Disease "ESRD" patients
- Certain government employees and certain members of their families when they are disabled for more than 29 months.

7.3 Medicare Part A Office

Telephone number:

Beneficiaries: **1-800-633-4227** *(customer service)*
Providers: **1-877-567-9249**

7.4 Part A Deductible and Coinsurance Amounts

Inpatient Hospital		
Deductible	per benefit period in 2007	$992.00
Coinsurance	days 61-90 in year 2007	$248.00
Lifetime reserve days	days 91-150 in year 2007	$496.00
Skilled nursing facility	days 21-100 in year 2007	$124.00

7.5 How is the Program Set-Up?

There are two parts to Medicare - Part A and Part B

7.5.1 Medicare Part A

***Processes claims for:**

- Inpatient hospital
- Skilled nursing facilities
- Home health care
- Hospice

**In North Carolina, the Intermediary is Palmetto GBA.*

7.5.2 Medicare Part B**

Processes claims for:

- Physician charges
  Medical and surgical services, including anesthesia
  Treatment of mental illness
- Diagnostic test and procedures that are part of treatment
  radiology and pathology services *(inpatient and outpatient)*
- Ambulance services
- Ambulatory surgical centers

7.5.3 Other Services**

- X-rays
- Services of ancillary personnel
- Drugs and biologicals that cannot be self-administered
- Certain medical supplies
- Physical/occupational/speech pathology therapy and services

***In North Carolina, the carrier is CIGNA Health Care*

7.5.4 Medicare Part D Benefits

Processes claims for:

- Prescription drugs
- Vaccines *(not all vaccines are covered)*
- Insulin
- Certain medical supplies associated with the injection of insulin *(syringes, needles, alcohol swaps and gauze)*

7.6 Benefit Periods

Medicare hospital and skilled nursing facility benefits are paid on the basis of benefit periods. A benefit period begins the first day the patient receives a Medicare-covered service as an inpatient in a Medicare-certified hospital and ends when the patient has been out of the hospital or other facility that mainly provides skilled nursing or rehabilitation services for 60 days in a row. It also ends if the patient remains in a Medicare-certified facility *(other than a hospital)* that mainly provides skilled nursing or rehabilitation services, but the patient does not receive any skilled care there for 60 consecutive days.

If a patient is readmitted as a hospital inpatient after the 60 days, a new benefit period begins and the hospital and skilled nursing facility benefits are renewed. Beginning a new benefit period also requires the patient to pay another Part A inpatient hospital deductible. There is no limit to the number of Medicare benefit periods the patient can have for hospital and skilled nursing facility care.

7.7 Medicare Part A Benefits

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient hospital care and inpatient skilled nursing facility care. These benefits are paid on the basis of benefit periods.

7.7.1 Hospital

Basic days available for each benefit period:

- 60 days at 100% of all covered services except for the Medicare Part A inpatient hospital deductible of $952*
- 30 days at 100% of all covered services except for a coinsurance amount of $238* per day.

For hospital services after the 90 basic days available each benefit period, your patients are entitled to the following lifetime-reserve days. These benefits are not renewable with the beginning of a new benefit period. However, any lifetime reserve-days not used during an inpatient hospital stay will remain available for use at a later time.

- 60 days at 100% of all covered services except for a coinsurance amount of $476* per day.

7.7.2 Skilled Nursing Facility

Basic days available each benefit period:

- 20 days at 100% of all covered services
- 80 days at 100% of all covered services except for a coinsurance amount of $119* per day.

**These are the deductible and coinsurance rates applicable to calendar year 2006.*

7.8 Medicare Part B Benefits

Medicare Part B helps cover medical services that Part A does not cover. Part B benefits include:

- Doctors' services
- Outpatient hospital care

- Physical and occupational therapists
- Home health care

7.9 Medicare Part D Benefits

Medicare Part D covers prescription drugs at local pharmacies and through mail order. Part D processes claims for:

- Prescription drugs
- Vaccines *(not all vaccines are covered)*
- When a vaccine is considered a prescription drug benefit under Part D vs a medical benefit, eligible members are to obtain the vaccine from their health care provider. A member should never be sent to a pharmacy to obtain the vaccine as it is always to be received by the administering provider. Therefore, we are currently asking that members with Medicare Part D *(not BCBSNC commercial members)* pay at the provider's office for the vaccine and then file a member's claim form directly to BCBSNC for their charge. Please note that at the time of this publication BCBSNC is working with Medco, our pharmacy benefits manager, to develop an easier way for office-administered vaccines to be adjudicated under Medicare Part D. Please check our Web site and review the online version of the *Blue Book*℠ for an update to this process.
- Insulin
- Certain medical supplies associated with the injection of insulin *(syringes, needles, alcohol swabs and gauze)*

7.10 Appeals Process

7.10.1 Review

In the event that a provider or beneficiary disagrees with a reimbursement decision made by Medicare, the decision may be appealed by requesting a review. This request must be made in writing and within six months of the original decision. If the request is submitted after the six-month limit has expired, submission of an explanation is necessary. If the explanation is considered to be of good cause, the time limit for requesting an appeal may be extended. Additional documentation that would assist in the review determination should be included or attached to the review request.

The Appeals department reviews the original claim processing and decision. This process must be completed within 45 days of the date of receipt of the review request. If the reviewer makes a favorable decision for the requester, additional payment is automatically issued. When the reviewer upholds the original decision, a letter is sent to the appropriate party.

7.11 Medicare Secondary Payer "MSP"

MSP stands for Medicare Secondary Payer and refers to situations that Medicare acts as the secondary payer on health care claims. Mandates from the Center of Medicare and Medicaid Services "CMS" require that providers identify and report situations where Medicare should be the secondary payer.

Three categories of coverage that Medicare may be secondary to are listed as follows:

Employer Group Health Plans:

- Working-aged
- Disability
- End-Stage Renal Disease "ESRD"

Accident/Injury Related Insurance:

- No-fault
- Liability
- Worker's compensation

Other Government Sponsored Health Plans

- Veterans Administration "VA"
- Black lung

7.12 Fraud and Abuse

Any of the following should be reported to the carrier or intermediary immediately.

7.12.1 Violations Include a Provider Who:

- Performs an unnecessary or inappropriate service
- Bills a service that was not received or misrepresents a service
- Charges in excess of the limiting charge
- Violates the assignment agreement with Medicare
- Accepts referral fees *(i.e. kickbacks)*
- Misrepresents the reason for ambulance transportation
- Collects monies except for deductible amounts, coinsurance amounts and non-covered items

7.12.2 Violations Include a Beneficiary Who:

- Misrepresents a condition to get Medicare to pay for a service
- Misuses a Medicare card

7.13 Medicare Supplement

The Health Care Financing Administration has authorized the sale of 10 standard types of plans *(Plans A through J)* with which individuals with Medicare coverage may supplement their benefits. BCBSNC offers nine of the standardized plans: A, B, C, D, E, F, H, I and J. Benefits in these plans vary in their richness and their cost.

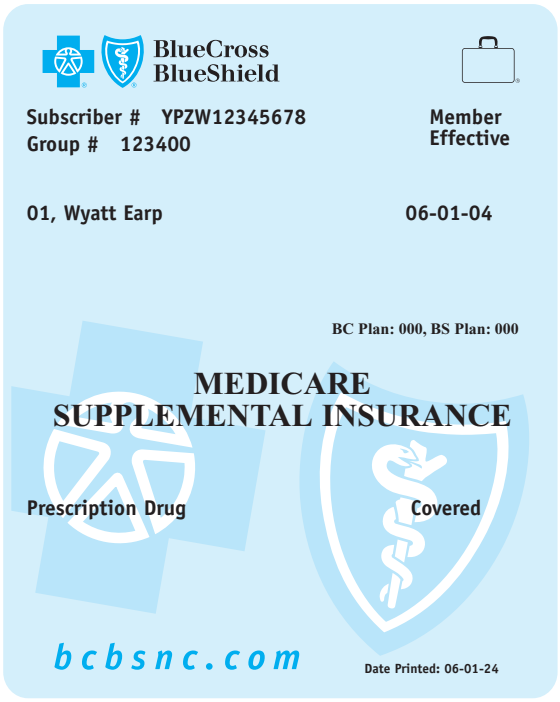
With reference to hospital benefits in particular, BCBSNC Medicare Supplement Plans are designed to fill in the gaps and pay the cost-sharing amounts not covered by Medicare. Additionally, covered individuals may choose to be treated in any facility approved by Medicare.

7.14 Alpha Prefix for Medicare Supplement

Medicare supplement member's identification numbers begin with the alpha prefix YPZ.

Filing paper and electronic claims with the correct and complete member identification number will ensure that your claims are not returned to you for correction and resubmission.

7.15 Sample ID Card



Toll-free Customer Service:

Medical: Benefits & Claims.....**1-800-672-6584**

To find a participating provider outside of NC:
BlueCard®.....**1-800-810-BLUE (2583)**

bcbsnc.com

- online Provider Directory
- e-Member Customer Service

Blue Values℠: discount programs, and more

Physicians and other medical providers should file claims to the local Blue Cross and/or Blue Shield plan where services are rendered.

Send Claims to:
Blue Cross and Blue Shield of North Carolina Claims Department
P.O. Box 35, Durham, NC 27702-0035

Insured by Blue Cross and Blue Shield of North Carolina

This card issued by Blue Cross and Blue Shield of North Carolina, an independent licensee of the Blue Cross and Blue Shield Association.

7.16 Ten Standard Plans

Basic Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan H	Plan I	Plan J
Part A hospital (days 61-90)	X	X	X	X	X	X	X	X	X
Lifetime reserve days (91-150)	X	X	X	X	X	X	X	X	X
365 life hospital days 100%	X	X	X	X	X	X	X	X	X
Parts A and B blood	X	X	X	X	X	X	X	X	X
Part B coinsurance 20%	X	X	X	X	X	X	X	X	X

Additional Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan H	Plan I	Plan J
Skilled nursing facility coinsurance days (21-100)			X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X
Part B deductible			X			X			X
Part B excess charges						100%		100%	100%
Foreign travel emergency			X	X	X	X	X	X	X
At home recovery*				X				X	X
Prescription drugs**							1	1	2
Preventive medical care					X				X

** Activities of Daily Living "ADL": bathing, dressing, personal hygiene*

***These plans must be available without prescription drug coverage on January 1, 2006, to comply with the Medicare Modernization Act.*

BCBSNC does not offer Plan G

7.16.1 Basic Benefits

Basic benefits cover Part A and Part B coinsurance and the first 3 pints of blood each year.

7.16.2 Two Prescription Drug Benefits

1. A basic benefit with a $250 annual deductible, 50% coinsurance and a $1,250 maximum annual benefit *(Plans H and I)*
2. An extended benefit *(Plan J)* with a $250 annual deductible, 50% coinsurance and a $3000 maximum annual benefit

Please note that not all drugs are covered as part of these prescription drug benefits; i.e.: drugs infused in the home, non-oral meds, etc. Please call customer service at **1-800-672-6584** for additional information. Please note that prescription drug benefits are no longer available for sale. Members who purchased these plans prior to 1/1/2006 may retain the prescription drug benefit.

7.16.3 The Four Most Popular Plans

Customers may choose from a variety of plans to help save from having to pay Medicare's unpaid bills. The four plans listed below are BCBSNC's most popular.

7.16.3.1 Plan B

This plan pays Part A hospital copayments of $238 a day for days 61 through 90 and $476 a day for days 91 through 150. When Medicare benefits stop after 150 days, Plan B goes on to cover 100% of Medicare allowable expenses for an additional 365 days. It pays the Medicare Part A deductible *($952)*. It generally pays the 20% of Medicare-approved Part B expenses that members would otherwise be required to pay.

7.16.3.2 Plan C

In addition to all the benefits of Plan B, Plan C pays the Medicare Part B deductible *($124)*.

Plan C also pays Medicare copayments for skilled nursing care for days 21 through 100. Medically necessary emergency care for members traveling out of the US is also covered.

7.16.3.3 Plan F

In addition to all of the benefits of Plan C, if members use a doctor who does not accept the Medicare-approved amount as payment in full for covered services and charges, Plan F will pay the difference. The member is covered for expenses in excess of the Medicare-approved amount for all covered Part B services and have no out-of-pocket expenses.

7.16.3.4 Plan J

In addition to all of the benefits of Plan F, Plan J covers at-home recovery benefits. Plan J also pays up to $120 per year for preventive health care including annual physical exams, mammograms, urinalysis, serum cholesterol screenings and more. For those members who enrolled prior to 1/1/2006, Plan J also covers 50% of outpatient prescription drug charges *(after a $250 calendar year deductible)* up to $3,000 a year.

Note: Deductibles/coinsurance as stated above are for calendar year 2006.

Benefits description offered as an example of member's benefit options, however, this is not a guarantee of benefits, eligibility or plan coverage. Please verify member's actual eligibility and benefits prior to providing services.

Health Coaching and Intervention

8. Health Coaching and Intervention

8.1 Overview

In an effort to work with physicians and members to facilitate the most medically appropriate, cost effective quality care, the health coaching and intervention department has designed comprehensive processes to administer BCBSNC benefit plans.

As your partner in managing care, BCBSNC is committed to focusing on our customers. We will attempt to simplify processes, assist when needed, and empower our customers with the knowledge they need.

The health coaching and intervention department administers the following processes:

- Prospective review
- Prior review
- Admission certification
- Discharge planning
- Case management
- Continuity of care

Contracted providers are responsible for complying with medical management policies and procedures, which utilize nationally accepted healthcare management guidelines. You are responsible for contacting BCBSNC to obtain all necessary certifications when a BCBSNC member seeks care from you.

Medical decisions are based on Milliman Care Guidelines™ and BCBSNC medical policy. You may request a copy of a specific criteria set or medical policy by calling the Health Coaching and Intervention Department at **1-800-672-7897**. Medical policy is also available on the BCBSNC Web site at ***bcbsnc.com***.

For information pertaining to health coaching and intervention for the Federal Employee Program "FEP," see chapter four.

For information pertaining to health coaching and intervention for the State Health Plan CMM *(indemnity)* product and NC Health Choice, see chapter five.

For information pertaining to health coaching and intervention for inter-plan programs, see chapter six, Inter-Plan Programs.

8.2 Contacting Health Coaching and Intervention

The health coaching and intervention department is available as follows:

- Monday through Friday, 8 a.m. - 5 p.m. by calling **1-800-672-7897**.
- You may also access the contacting health coaching and intervention functions via the Provider Blue Line℠ at **1-800-214-4844**.

- Health coaching and intervention may also be accessed via the ***Blue e***℠ electronic network. See chapter 12, Electronic Solutions for more detailed information.

Contact information for discharge services can be found in section 8.8 of this manual.

8.3 Services Not Requiring Prior Review

Emergency Services and Urgent Care

State law requires insurers to cover emergency services without prior review if a prudent lay person, acting reasonably, would have believed that an emergency medical condition existed. Members are advised that their primary care physician or Health Line Blue℠ *(the 24-hour health information line)* may provide guidance in an emergency or urgent situation. Health Line Blue℠ can be accessed at **1-877-477-2424**. Members are not required to obtain certification prior to an emergency room visit. Primary care physicians are not required to submit a referral to BCBSNC when they have referred a member to the emergency room. The primary care physician should coordinate continuing care that results from the emergency room or urgent care center and the member should contact their primary care physician as soon as possible after any emergent service. The primary care physician should obtain certification for any inpatient admission following an emergency service, but no later than two (2) business days following notification by the member *(see section 8.5.1.5, Certification List)*.

8.3.1 Observation

BCBSNC no longer requires notification for hospital observation for HMO, POS and PPO plans. BCBSNC encourages *(but does not require)* notification for hospital observation when the HMO, POS or PPO patient will have discharge needs.

Notification to BCBSNC will facilitate the coordination and authorization of discharge *(i.e., home health, home IV therapy, and DME services that require prior review for HMO, POS and PPO)*.

8.4 If Appropriate Participating Physician is Not Available

It is the policy of BCBSNC to provide members reasonable access to a network physician. If a specific service is not reasonably accessible within the network, the physician or member must contact BCBSNC to certify coverage for a non-participating provider before services are provided *(see section 8.5.1.5, Certification List)*. Reasonable access is defined by BCBSNC's access to care standards, which are available at ***bcbsnc.com*** or by contacting customer service.

The following standards apply to HMO, POS and PPO products:

- No benefits are available to HMO members for care from non-participating providers except in emergencies or with certification from BCBSNC. If an HMO member elects to receive non-emergency care from a non-participating provider without certification, the member is responsible for all charges incurred.
- POS and PPO members have the option of seeking care from participating or non-participating providers. If a POS or PPO member sees a non-participating provider, the care will be reimbursed at the lower benefit level, with the member having liability for a higher out-of-pocket expense.

- Non-participating providers may in certain instances provide care to members with special ongoing conditions who are in a continuity of care situation *(see section 8.12.3 of this chapter for more information about continuity of care).*

If you have a question about whether a provider participates in our HMO, POS or PPO networks, visit our Web site at ***bcbsnc.com*** or call the Provider Blue Line℠ at **1-800-214-4844** to speak to a representative.

To request certification for a referral to a non-participating provider, call Health Coaching and Intervention at **1-800-672-7897**.

8.5 Certification and Prior Review

8.5.1 Certification

Certification is the determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy our requirements for medically necessary services and supplies, appropriateness, health care setting, level of care and effectiveness.

Type of Certification:	Applies To:
Prior review approval	• HMO • POS • PPO • CMM (some large groups require prior review, verify member's benefit plan
Admission certification	• All products

The purpose of obtaining certification is to:

- Determine whether proposed care is a covered benefit and the setting is appropriate.
- Promptly advise the provider of the benefits available for selected services and/or procedures.

As part of the BCBSNC prospective review process, certification is required prior to delivery of certain outpatient services such as home health, home infusion therapy, private duty nursing and durable medical equipment. A list of services requiring certification has been included in this section for your convenience. This list is reviewed quarterly at that time. Please check at Web site ***bcbsnc.com*** for the current up-to-date list. This list is current as of the date of publication of this manual. For questions regarding this list, call the Provider Blue Line℠ at **1-800-214-4844**.

It is the physician's/provider's responsibility to request certification from BCBSNC. Failure to obtain certification for services will result in reduction or denial of payment for the charges both institutional and professional.

8.5.1.1 How to Request Certification

All certification requests for services, with the exception of mental health and substance abuse services, should be made directly to BCBSNC.

To request certification:

- Fax a completed BCBSNC certification request form to BCBSNC at the appropriate fax number listed in chapter 8.15, Regional Fax Numbers.

OR

- Call Health Coaching and Intervention at **1-800-672-7897**

OR

- Mail a completed BCBSNC certification request form to:

BCBSNC
Attn: Health Coaching and Intervention
P.O. Box 30007
Durham, NC 27702

Inpatient Admissions:

- Hospitals and facilities may notify BCBSNC via the admission notification application on ***Blue e***℠. If your organization does not have access to ***Blue e***℠, please refer to chapter 12, Electronic Solutions or visit our Web site at ***bcbsnc.com/providers/edi***.
- To request certification for mental health and/or substance abuse services for HMO, POS, PPO and CMM members, contact Magellan Behavioral Health at **1-800-359-2422**.
- To request certification for mental health and/or substance abuse services for State Health Plan PPO members or CMM *(indemnity)* members. Contact Value Options at **1-800-367-6143**.

Provide the following information when submitting a request:

- Practice name and BCBSNC provider number
- Contact name, phone number, and fax number
- Patient's name, BCBSNC member ID number, and date of birth
- Attending physician's name, BCBSNC provider number, and phone number
- Treatment setting - i.e. physician's/provider's office, home, inpatient, outpatient
- Facility name and number *(if applicable)*
- Expected dates of service
- Description of diagnosis and diagnosis codes
- Description of procedure and applicable codes
- Clinical information, including history and physical, treatment plan, and discharge needs
- If the service requested is part of a clinical trial, you will be asked to provide a copy of the signed informed consent and the clinical protocols.

You will be contacted if additional clinical information is required and will be notified of decisions within two (2) business days of our receipt of all necessary information.

8.5.1.2 Certification Decisions

We agree to use best efforts to notify you within two (2) business days of our receipt, of all necessary information, of our decisions regarding prior review and/or certification or non-certification of services, as set forth in our health coaching and intervention programs.

Certification is required for appropriate claims payment but does not guarantee claim payment. BCBSNC will honor a certification to cover medical services or supplies under a health benefit plan, except in the following instances:

- The member is not eligible for the services under his/her health benefit plan due to termination of coverage or non-payment of premiums
- The member's benefits are exhausted
- The certification was based on false or misleading information provided about a member's condition

A request for service that, based on the clinical information provided, does not meet the Milliman Care Guidelines™ and/or the corporate medical policy, is referred to the regional medical director. If benefit coverage for services is denied by the medical director, you will receive a letter from the medical director outlining the reason for the denial and information on the appeal process. BCBSNC will issue written notification of the decision within two business days of our receipt of all necessary information. If you feel a non-certification is in error, you may request a courtesy review *(see chapter 17, Appeal and Grievance Procedures)*.

If appropriate certification is not obtained, the claim will be denied or benefits will be reduced based on the product, and you cannot bill the member for charges denied or reduced due to failure to receive certification.

Retrospective certification requests may be considered in the following circumstances:

- Emergency and urgent care *(including out-of-area)*
- Issues regarding coordination of benefits
- Network gaps or transition of care
- Discharge services require notification by 12:00 p.m. on the next business day

8.5.1.3 Avoidable Days

- An avoidable day is a day the member is in an inpatient bed, awaiting needed services due to the unavailability of the physician or professional practitioner, or scheduling delays unrelated to the clinical condition of the member.
- Days determined by BCBSNC to be avoidable or not medically necessary will not be eligible for reimbursement to hospital.
- The hospital may not bill charges for those days to the member.

8.5.1.4 Non-Participating Providers for HMO, POS and PPO Members

- No benefits are available to HMO members for care from non-participating providers except in emergencies or with certification from BCBSNC. If an HMO member elects to receive non-emergency care from a non-participating provider without certification, the member is responsible for all charges incurred.
- POS members have the option of seeking care from participating or non-participating providers. If a POS member self-refers to a non-participating provider, the care will be reimbursed at the lower benefit level, with the member having liability for a higher out-of-pocket expense.

- In specific situations, BCBSNC may approve coverage for services received from non-participating physicians or providers. This includes situations where continuity of care or network adequacy issues dictate the use of a non-participating physician or provider *(see section 8.12.3, Continuity of Care in this manual)*.
- Services received from a non-participating physician or provider that are not urgent or emergent, and are not approved by BCBSNC in advance will not be paid at the in-network benefit level.
- If you have a question about participation in our HMO networks, visit our Web site at ***bcbsnc.com*** or call the Provider Blue Line℠ at **1-800-214-4844** to speak to a representative.
- To request certification for a non-participating provider, call Health Coaching and Interventions at **1-800-672-7897**.

8.5.1.5 Certification List

This list applies to BCBSNC products only and excludes the State Health Plan CMM *(indemnity)* and the Federal Employee Program.

Every quarter the prior review list is updated with new service codes, and/or service codes that are no longer effective. If changes are made to the prior review list, our Web site at ***bcbsnc.com*** will be updated by the 10th day of January, April, July and October. To access the prior review list, select the providers section and choose the prior authorization category. You can also contact Member Health Partnerships℠ Operations at **1-800-672-7897** for a list of services requiring prior approval. In addition, our internet-based application, ***Blue e℠*** will contain a notification whenever changes are made to the review list. ***Blue e℠*** is available to you free-of-charge for verification of membership eligibility, claims submission and inquiry.

BCBSNC requires certification for certain services, procedures, inpatient admissions and pharmaceuticals. If the process of obtaining certification changes, BCBSNC will notify you in accordance with your contract. The list of services, procedures and drugs requiring certifications is available on the Web or by contacting health care coaching and intervention at **1-800-672-7897**. For an up-to-date listing of the medications that may require certification or have quantity limitations please refer to our Web site, ***bcbsnc.com***. If the member's physician certifies in writing to health care coaching and intervention that the member has previously used an alternative drug(s) that was detrimental to the member's health, was ineffective in treating the same condition, and is likely to be ineffective or detrimental in treating the same condition again, drugs will be approved through the prior review process. A Yes indicates the following services, procedures, inpatient admissions and pharmaceuticals require certification, including prior review and admission certification. N/A is noted if certification is not required or is not applicable. Providers should verify benefits prior to providing services listed as N/A. PPO products have out-of-network benefits. Members should refer to their member guide for their responsibilities when seeking services from out-of-network providers.

Services/Procedures/Admissions	HMO	POS	PPO	CMM
Inpatient admissions • Scheduled *(elective)* admissions must be approved prior to admission *(including inpatient hospital, inpatient hospice, and skilled nursing facility admissions)*. • For urgent/emergency admissions, BCBSNC should be notified by the next business day or no later than the second business day after the admission. • For maternity admissions, certification is required for days beyond the first 48 hours after vaginal delivery or the first 96 hours after c-section. • Acute inpatient admission for rehabilitation.	Yes	Yes	Yes	Yes
Surgery and/or outpatient procedures, such as: • Morbid obesity surgery • UPPP, surgical management of obstructive sleep apnea • Orthotripsy • Vertebroplasty and Kyphoplasty • Percutaneous treatment of HNP	Yes[2]	Yes	Yes	N/A
Procedures potentially cosmetic, such as: • Abdominoplasty • Blepharoplasty • Breast surgeries including insertion and removal of silicone breast implants *(not resulting from mammoplasty)*, reduction mammoplasty, and gynecomastia • Orthognathic surgery	Yes[2]	Yes	Yes	N/A

Services/Procedures/Admissions	HMO	POS	PPO	CMM
Procedures potentially cosmetic, such as: • Reconstructive surgery, including but not limited to rhytidectomy, dermabrasion, and scar revision • Rhinoplasty • Therapy of superficial veins, such as varicose veins, telangiectasias	Yes[2]	Yes	Yes	N/A
Mental health and substance abuse treatment				
• Routine office visit	Yes[2]	Yes	N/A	N/A
• Outpatient mental health and substance abuse treatment, including partial day and intensive outpatient services	Yes[2]	Yes	Yes[1]	Yes[1]
• Inpatient treatment for mental health and substance abuse	Yes[3]	Yes	Yes[1]	Yes[1]
Ambulance-non-emergent air services	Yes	Yes	Yes	N/A
DME-rental or purchase of durable medical equipment	Yes,[2,4] but you must call	Yes, but you must call	Yes, but you must call	N/A
Private duty nursing	Yes[2]	Yes	Yes	Yes
Skilled nursing facility admissions	Yes[2]	Yes	Yes	Yes
Transplants	Yes[2]	Yes	Yes	Yes
Certain pharmaceuticals as indicated on our Web site, ***bcbsnc.com*** or by calling Health Coaching and Intervention at **1-800-672-7897**	Yes[2,3]	Yes	Yes	N/A

Services/Procedures/Admissions	HMO	POS	PPO	CMM
BCBSNC may authorize out-of-network/ non-participating services at the in-network benefit level if a service is not available in-network or if there is a continuity of care issue	Yes[2]	Yes	Yes	N/A
Certain non-emergency, outpatient, high-tech diagnostic imaging services, as defined by our diagnostic imaging management program. Please see section 8.10 for additional detail or visit our Web site at ***https://www.bcbsnc.com/services/medical-policy/dim-policies.cfm#DIM***				

1 Applies to Blue Options℠ and Classic Blue℠ only *(excludes* Blue Advantage®, Access℠, *CMM Conversion and* Blue Assurance℠*)*

2 Some large groups have special benefits. Please see member benefit booklet for some large groups. Please also reference benefit exclusions under, What is Not Covered.

3 RJ Reynolds has carved out pharmacy and mental health/substance abuse benefits. For inpatient mental health/substance abuse inpatient authorization contact BCBSNC at **1-800-672-7897**. Non-participating mental health/substance abuse may be referred only by Winston-Salem Health Care "WSHC" psychiatric department.

4 A referral is required for Blue HMO℠ members to go outside of WSHC to the Blue Care® Network. Home ST/OT/PT does not require prior review.

8.5.2 Prior Review

Prior review is the consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of medical necessity of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in certification or non-certification of benefits.

8.5.3 Guidelines for Obtaining Durable Medical Equipment and Home Health Services

Applies to HMO, PPO, and some CMM Plans

8.5.3.1 Durable Medical Equipment Services

- Prior review/authorization is required for specific DME codes *(whether purchased or rented)*. Refer to ***bcbsnc.com*** for most current DME service code list under prior review.
  - Only HDME suppliers that meet BCBSNC eligibility and/or credentialing requirements can request prior review for HDME equipment.
- All equipment services require a physician's order/prescription, or a certificate of medical necessity form *(see chapter 23, Forms)*.

8.5.3.2 Home Health Services

Home health services include skilled nursing visits, medical social services, non-routine medical supplies and home infusion therapy.

- Prior review/authorization is required for skilled nursing visits, medical social services and home infusion. Use the HCFA-285 *(Home Health Certification and Plan of Care)* and the HCFA-487 *(Addendum to Plan Of Treatment/Medical Update)* forms to communicate your orders to the health coaching and intervention department *(out-of-network)*.
- All home care services must be prescribed by a physician.
- The member must be homebound for home health services with the exception of home health infusion services. Refer to the medical policy on definition of home health homebound. Medical policies may be viewed on the Web site at ***bcbsnc.com***.

See chapter four, Federal Employee Program – Blue Cross and Blue Shield Service Benefit Plan for requirements for FEP members.

See chapter five, North Carolina State Health Plan Teachers' and State Employees' Comprehensive Major Medical "CMM" *(Indemnity)* Plan and North Carolina Health Choice for requirements for State Health Plan members.

8.5.4 Certification List for Ancillary Services

BCBSNC requires certification for certain services and procedures. The following chart indicates when certification is required.

Services/ Procedures/ Admissions	HMO	POS	PPO	CMM
Home health	Certification for RN/LPN only[2]	Certification for RN/LPN only[2]	Certification[1]	Not applicable
Home infusion therapy	Certification[2]	Certification[2]	Certification	Not applicable
Private duty nursing	Certification[2]	Certification[2]	Certification	Certification
Home durable medical equipment	Refer to specific DME service code list at ***bcbsnc.com*** under prior review[2]	Refer to specific DME service code list at ***bcbsnc.com*** under prior reveiw[2]	Refer to specific DME service code list at ***bcbsnc.com*** under prior reveiw[2]	Not applicable
Hospice - inpatient	Certification[2]	Certification	Certification	Certification
Hospice - outpatient	Not applicable[2]	Not applicable	Not applicable	Not applicable
Dialysis	Not applicable[2]	Not applicable	Not applicable	Not applicable

[1] Applies to Blue Options℠, NC Smart*Choice*℠, and Classic Blue® only *(excludes* Blue Advantage®*)*

[2] Some CMM plans require prior review for home health, home infusion, and home durable medical equipment. Verify member benefits.

- Certification can be requested by any participating physician or ancillary provider if the services have been ordered by the member's physician.
- Utilization program requirements must be requested and received prior to rendering services.
- POS members do not require certification for out-of-network services, *unless* it is an inpatient admission.
- A participating physician must request certification to refer to a non-participating provider.

8.5.5 Hospital Observation

(Applicable for all BCBSNC products and lines of business)

Observation services are defined as the use of a bed and periodic monitoring by hospital nursing or other staff. These services are considered reasonable and necessary to evaluate a patient's condition to assess the need for an inpatient admission.

Conditions that are usually appropriate for observation status include:

- Abdominal pain *(r/o appendicitis, renal colic, PID, UTI, gastritis, spastic colon)*
- Allergic reactions, immunization side effects
- Back pain
- Chest pain *(including rule out myocardial infarction)*
- Hypoglycemia
- Irritable bowel disease, mild diverticulitis, etc.
- Leg pain/swelling *(r/o DVT, phlebitis, cellulitis)*
- Nausea/vomiting/diarrhea/gastroenteritis/dehydration
- Syncope
- Transient Ischemic Attacks "TIA"

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, access to patient charts, and specification of discharge needs. During the course of an admission, BCBSNC should be notified of a change in clinical status or an anticipated change in clinical status so that we can review the original certification.

Medical Director's Responsibility

- The medical director will review all clinical information provided by the concurrent reviewer and document his or her determination. The continued stay may be approved based on the information provided, or the attending physician may be contacted for additional information.
- If the medical director concludes that there may be a medically appropriate alternative to continued hospital stay, coverage for continuing inpatient stay will be denied. The Health Coaching and Intervention coordinator will notify the requesting provider of the denial via telephone or fax within applicable regulatory timeframes.

- Written notice of the denial, including the appeals process, will be sent to the physician or provider, the facility, and the member within applicable regulatory timeframes.
- For information on appeals, refer to chapter 17, Appeal and Grievance Procedures.

8.6 Peer to Peer Review

BCBSNC medical directors are available to discuss clinical problems and benefit issues with network providers particularly where there are issues that complicate the management of the patient's condition.

- A peer to peer review is a clinical discussion between a requesting physician and a BCBSNC medical director.
- If you have questions about a certification request, you may request to speak directly to a medical director by calling **1-800-672-7897**, **x51019**.
- A peer to peer review may also be requested by a BCBSNC medical director in order to obtain more clinical information from an attending physician before making a final determination.
- The purpose of the peer to peer discussion is to give the requesting physicians an opportunity to discuss the clinical details of a requested service.

8.7 Discharge Services

The discharge services unit staff, in conjunction with concurrent review nurses, assist in facilitating transition to the most appropriate level of care, i.e., acute rehabilitation, Skilled Nursing Facility "SNF," inpatient hospice facility, outpatient services or home. Staff work frequently with the nurses in both the concurrent review and the case management departments, collaborating to maximize the member's benefits.

The discharge services staff is available to assist with discharge arrangements for BCBSNC members. Services include:

- DME - specific DME code listed at ***bcbsnc.com*** under prior review and/or prior plan approval
- Home health, including IV therapy
- Skilled Nursing Facility "SNF" placement
- Rehabilitative admissions

Requests for discharge services may be made to discharge services 24 hours a day, seven days a week by:

- Faxing a request to **1-800-228-0838** and including the provider's phone and fax numbers

OR

- Calling the voice mailbox at **1-800-672-7897**, **x51019** and leaving a message

All requests/messages should contain the following information:

- Physician's name and phone number, including area code
- BCBSNC provider number
- Subscriber's name and ID number
- Brief description of the needed services

8.8 Transfer to Long Term Acute Care Facilities

Requests for transfer to a Long-Term Acute Care "LTAC" hospital are not authorized if the necessary care can be provided in the acute care hospital where the patient is currently admitted. Additionally, because most North Carolina LTACs are not contracting providers with our health plans, some members *(e.g., HMO)* may not have a benefit for the LTAC. Other members in point of service or PPO plans may incur a significant financial obligation for care in these facilities that they would not if they received their care in-plan.

When Health Coaching and Intervention receives a request for a transfer from an acute care hospital to a LTAC hospital we ask for the following information:

1) What is the clinical reason for the transfer?
2) Are these services available at the current acute care hospital?
3) Does the patient/family know they may face significant financial responsibility if they choose to transfer to a LTAC hospital due to limited contracts for this type of facility *(e.g., the member may be responsible for up to 100% of charges)*?

While most of the requests for transfer to a LTAC will not meet the Plan's definition of medically necessary services, any non-certification of services on this basis must be made by a medical director. Physicians may avail themselves of a peer-to-peer consultation that is offered during the BCBSNC review process. A discussion between physicians may help clarify the situation and reach the best decision for the patient. A BCBSNC medical director is available during regular business hours and can be reached at **1-800-672-7987**, **x51019**.

- Consulting specialist
- Member or the member's family
- Employer

To refer a member to case management, call **1-800-672-7897**.

8.9 Diagnostic Imaging Management Program

BCBSNC implemented a diagnostic imaging management program in February 2007. American Imaging Management, Inc., "AIM" administers the program for BCBSNC for the management of outpatient, high-tech diagnostic imaging services.

For dates of service on or after February 15, 2007, prior review is required for the non-emergency, outpatient, diagnostic imaging services listed below – when they are performed in a physician's office, the outpatient department of a hospital, or a freestanding imaging center:

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

Ordering physicians must contact AIM via Web, phone, or fax to obtain a certification prior to scheduling an imaging exam for these outpatient diagnostic non-emergency services.

Servicing providers *(hospitals and freestanding imaging centers)* should confirm that certification was issued prior to scheduling the exam. Issuance of certification is not a guarantee of payment; claims will be processed in accordance with the terms of a subscriber's health benefit plan. Only ordering physicians can request prior review. Hospitals and freestanding imaging centers that perform the imaging services cannot obtain the certification.

Ordering physicians can obtain and confirm certification by contacting AIM in one of three ways:

1. By logging on to provider portal through ***Blue e***℠: seven days a week, 4 a.m. to 1 a.m., eastern time.
2. By calling AIM: **1-866-455-8414** *(toll free)*, Monday through Friday, 8 a.m. to 5 p.m. eastern time, or
3. By faxing AIM: **1-800-610-0050** *(toll free)*, using the designated fax form located on the providers page of Web site at ***https://providers.bcbsnc.com/providers/imaging.faces*** or by calling AIM at the number listed above.

Imaging service providers can also contact AIM, either through the provider portal or by phone, to ensure that a certification has been issued or to confirm that the certification information is correct. Imaging service providers can also call AIM to change the date of service on the certification, change the location of the service or request add-on procedures.

Neither AIM nor BCBSNC will issue retro-certification. However, if the requested scan is of an urgent nature, the ordering physician can request the certification within 48 hours of the procedure.

If you are not currently registered to use ***Blue e***℠, you will need to register online at ***https://www.bcbsnc.com/providers/edi/bluee.cfm***. BCBSNC provides ***Blue e***℠ to providers free-of-charge.

8.9.1 The Diagnostic Imaging Prior Review Code List

The diagnostic imaging prior review specific code list is available on the ***bcbsnc.com*** Web site at ***https://www.bcbsnc.com//pdfs/DIM-PPA-List.pdf***. This list is subject to change once per quarter. Changes will be posted to the BCBSNC Web site ***bcbsnc.com*** by the 10th day of January, April, July, and October. Diagnostic imaging management policies and medical policies are also available, located on the Web at ***https://www.bcbsnc.com/services/medical-policy/dim-policies.cfm#DIM***.

Please note that unlisted and miscellaneous health service codes should only be used if a specific code has not been established by the American Medical Association.

8.9.2 Diagnostic Imaging Physician Recognition Program "PRP"

The goal of the Diagnostic Imaging Management Program "PRP" is to simplify the authorization process for physicians who demonstrate appropriate utilization and the highest level of compliance with clinical practice guidelines. Physicians who qualify for the PRP will be subject to notification only (no medical necessity review) for the time period in which they qualify.

Physicians must have a regular ordering pattern with sufficient volume to demonstrate understanding of newer technologies and clinical practice guidelines. Physicians are evaluated against established PRP criteria every six months; those physicians who qualify for PRP status are evaluated against maintenance criteria once per calendar year. For specific criteria, physicians should contact their Network Management representative.

8.9.3 Diagnostic Imaging Employer Group Participation

Most BCBSNC employer groups are participating in the diagnostic imaging management program. However, not all employer groups are participating, so BCBSNC offers a Web-based employer group number search, available at ***https://providers.bcbsnc.com/providers/imaging.faces*** and on ***Blue e***℠. The employer group number search, allows providers to quickly determine whether an authorization is needed. BCBSNC will update this system as new employer groups enter the program, so it is important that you confirm participation in advance of providing services.

8.10 Health Coaching / Case Management

Health coaching and case management is a voluntary program. Health coaches and case managers are all licensed health care professionals who assist members with coordination of quality health care services to meet specific health care needs. Health coaching and case management goals include the coordination of care and enhancement of the member's quality of life. Case management proactively assists members and their families who are at risk of developing medical complications, or for whom a life altering incident has caused a need for rehabilitation or other health care support. Each member is individually screened for placement into the case management program.

8.10.1 About Health Coaches

A BCBSNC health coach is a health care professional whose role is to work with a member to set goals and develop a self care health plan that focuses on the individuals health care needs and treatment options. Health coaches will remain in contact with members via telephone to ensure follow through with their self-care goal plan, to identify and remove obstacles to care, and to provide education and guidance. They will utilize personalized mailings, identify local support services, educate and encourage members to use their BCBSNC benefits, incorporate and direct members to online decision support tools and initiate members into other MHP modules when appropriate.

When a patient is identified as a candidate for case management, a process begins which includes problem identification, intervention planning, monitoring, evaluation, and outcomes measurement. Throughout the case management process, the case manager considers all treatment alternatives and presents these alternatives to the member to ensure that the needs and goals of the member are incorporated into the treatment plan. This individualized plan is then reviewed with the physician and the member. Care is coordinated among multiple disciplines including the physician and provider in the implementation of this specific treatment plan. Case management by BCBSNC continues until the member's condition is stabilized, the need for care ends, or the member is no longer enrolled with BCBSNC.

Participants in the process may include but are not limited to:

- Physicians
- Physical therapists
- Pharmacists
- Social workers
- Home health agencies
- Available community resources
- DME providers

8.10.2 Referrals to Case Management

Members can be referred from the following sources:

- BCBSNC staff
- Health Line Blue℠ nurse *(24 hour health information line)*
- Hospital discharge planner or case manager

Members can be referred from the following sources:

- BCBSNC staff
- Health Line Blue℠ nurse *(24 hour health information line)*
- Hospital discharge planner or case manager
- Primary care physician

8.10.3 Transplant Management Program

Our transplant program includes preauthorization, a transplant network, and a case management component.

- Requires preauthorization for all lines of business.
- HMO and POS members must use participating providers in the BCBSNC transplant network.
- PPO and CMM members can maximize their benefits by using the BCBSNC transplant network, but may also access care outside the transplant network. If care is received at an in network facility, benefits will be applied at an in network level. If care is received at a non-participating facility, the lower out-of-network benefits will apply.

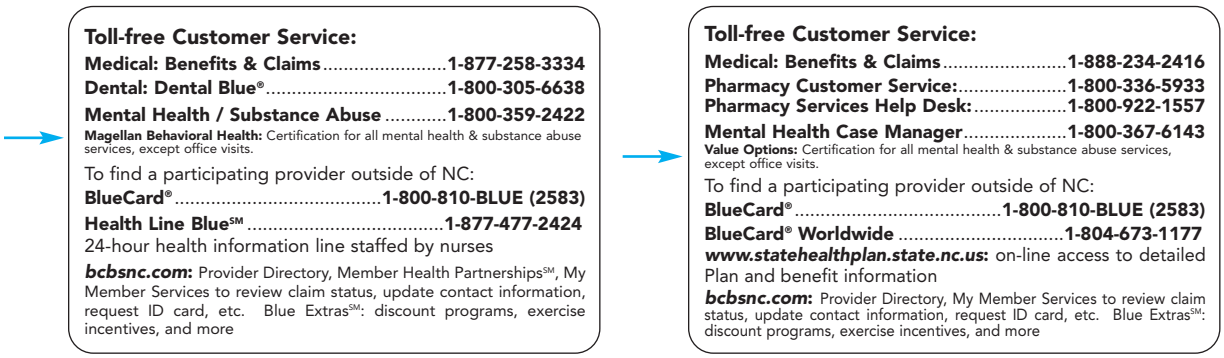
Case management for members requiring transplants includes addressing pre- and post-transplant needs. Special attention is given to assisting the member and provider with selection of the best transplant facility, coordinating travel and lodging, and resolving any organ/tissue procurement issues.

To refer a member to transplant management, contact our Health Coaching and Intervention Department at **1-800-672-7897**.

8.11 Mental Health and Substance Abuse Management Programs

BCBSNC delegates mental health and substance management and administration *(including certification, concurrent review, discharge planning and case management)* to Magellan Behavioral Health and Value Options. Depending on the member's plan type and/or employer group, mental health and substance management and administration may be handled by Magellan Behavioral Health, Value Options, or BCBSNC. The back of the member's identification card includes contact information when Magellan Behavioral Health or Value Options is providing the delegated services and is to be contacted.

Sample back view of a member identification card:



In most cases Magellan Behavioral Health will coordinate mental health and substance management and administration for HMO, POS, PPO and CMM members. Providers should contact Magellan Behavioral Health to conduct full health coaching and intervention for mental health and substance abuse services by calling **1-800-359-2422**. However, certain employer groups can elect to have BCBSNC handle services directly and some coverage plan types offer mental health and substance management and administration through either BCBSNC health coaching and intervention or Value Options, the most common of these are:

- Mental health and substance abuse services for members enrolled in Blue Advantage®, Access℠, and Blue Assurance℠ are handled by BCBSNC at **1-800-672-7897**.
- BCBSNC coordinates mental health and substance abuse services for members enrolled in Blue HMO℠. To arrange mental health and substance abuse services for Blue HMO℠ members, contact BCBSNC at **1-888-298-7575**.
- Mental health and substance abuse services for Federal Employee Program "FEP" members are handled by BCBSNC at **1-800-222-4739**. *(Additional information about the Federal Employee Program is located in chapter four of this manual.)*
- Mental health and substance abuse services for State Health Plan members enrolled in NC Smart*Choice*℠ PPO are coordinated by Value Options. Contact Value Options to conduct full health coaching and intervention for mental health and substance abuse services at **1-800-367-6143**.
  - Value Options also coordinates mental health and substance abuse management and administration for State Health Plan CMM *(indemnity)* members. *(Additional information about the State CMM [indemnity] plan is located in chapter five of this manual.)*

For more information about mental health and substance abuse delegated services, see chapter 19 of this manual and/or chapter two for contact information.

8.12 Third Party Health Coaching and Intervention Agreements

8.12.1 Delegation of Services

BCBSNC reserves the right to outsource additional health coaching and intervention services at its discretion.

8.12.2 Hold Harmless Agreement

Hold Harmless is a contractual agreement between BCBSNC and participating providers. This agreement states that the provider may not balance bill a member for services or supplies that were not prior authorized or certified in advance by BCBSNC and/or deemed not medically necessary by BCBSNC. Additional information about Hold Harmless is located in chapter ten of this manual *(see section 10.14 Hold Harmless Provision)*.

8.12.3 Continuity of Care

Continuity of care is a process that allows members with ongoing special conditions to continue receiving care from a provider who becomes an out-of-network provider, when the member's employer changes health benefit plans or when their provider is no longer HMO, POS, or PPO network participating. To be eligible for continuity of care, the member must be actively being seen by an out-of-network provider for an ongoing special condition and the provider must agree to abide by BCBSNC's requirements for continuity of care. Once written notification of a provider termination is received by BCBSNC, we are required to notify members by letter at least 30 days prior to the termination effective date. A new member has 45 days from their effective date to request a review for continuity of care. An ongoing special condition means:

- In the case of acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm;
- In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time;
- In the case of pregnancy, the second and third trimesters of pregnancy and postpartum care;
- In the case of a terminal illness, an individual has a medical prognosis that the member's life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, some exceptions may apply.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Continuity of care will not be provided when the provider's contract was terminated for reasons relating to quality of care or fraud.To request a continuity of care review call Health Coaching and Intervention at **1-800-672-7897**, with the exception of mental health and substance abuse services. To request a continuity of care review for services related to mental health and substance abuse contact Magellan Behavioral Health at **1-800-359-2422**, *(for State PPO members enrolled in* NC Smart*Choice*℠*, contact Value Options at* ***1-800-367-6143****)*.

8.13 Concurrent Review Documentation

BCBSNC has a business associate agreement with Provider Link, a Durham based health care technology company, to transfer media/documentation in a secure, internet-based format for concurrent review. For more information, visit the Provider Link Web site at ***www.providerlink.com*** or call **1-866-398-2804**.

8.14 ActiveHealth Management CareEngine Service Program

Some of the BCBSNC employer groups have elected to participate in the ActiveHealth Management CareEngine service program for patient health tracking. The program is also referred to as the clinical notification opportunities program. This program is aimed at providing you with helpful clinical information regarding your patients and their treatment regimens.

ActiveHealth management is a medical information technology company that aggregates and analyzes patient data. Specifically, ActiveHealth compiles all available patient claims, lab, and pharmacy data into a single patient file, and then uses a sophisticated computer software program to analyze this data employing a continually expanding set of clinical rules. Through this process, ActiveHealth uncovers potential discrepancies between the available patient data and the most recent evidence-based medical literature. ActiveHealth then communicates patient-specific information to the treating physicians. The communications are termed care considerations, and are delivered to the treating physician either through telephone, fax, or letter. When appropriate, ActiveHealth attaches the relevant patient data specific to each care consideration.

Please note that this is not a utilization review or pre-certification program, or a professional medical consultation. This information is being provided to assist you in offering health care to your patient, and should be considered according to your best independent medical judgment.

If you believe the information from ActiveHealth is inaccurate or incomplete, or if you are aware of extenuating circumstances, please use your medical judgment to determine the appropriateness of the care consideration(s).

For further information call the ActiveHealth management clinical information center's toll free number at **1-800-319-4454**.

8.15 Regional Fax Numbers

Regional Teams By County

REGION 1

Medical Director 1

Fax Number
1-800-459-1410

Team 1A[1]: Asheville	Team 1B: Charlotte
Alexander	Anson
Alleghany	Cabarrus
Ashe	Gaston
Avery	Lincoln
Buncombe	Mecklenburg
Burke	Montgomery
Caldwell	Richmond
Catawba	Rowan
Cherokee	Stanly
Clay	Union
Cleveland	
Graham	
Haywood	
Henderson	
Iredell	
Jackson	
Macon	
Madison	
Mitchell	
McDowell	
Polk	
Rutherford	
Swain	
Transylvania	
Watauga	
Wilkes	
Yancey	

REGION 2

Medical Director 2

Fax Number
1-800-571-7942
includes out of state requests

Team 2A[2]: Raleigh / Chapel Hill (partial)	Team 2B: Greenville
Alamance	Beaufort
Caswell	Bertie
Chatham	Camden
Durham	Carteret
Franklin	Chowan
Harnett	Craven
Johnston	Currituck
Lee	Dare
Moore	Edgecombe
Orange	Gates
Pitt	Greene
Wake	Halifax
Warren	Hertford
	Hyde
	Jones
	Lenoir
	Martin
	Nash
	Northampton
	Pamlico
	Pasquotank
	Perquimans
	Tyrrell
	Washington
	Wayne
	Wilson

REGION 3

Medical Director 3

Fax Number
1-800-672-6587

Team 3A: Raleigh/ Durham (partial)	Team 3B: Greensboro/ Winston-Salem
Granville	Davidson
Person	Davie
Vance	Forsyth
	Guilford
	Randolph
	Rockingham
	Stokes
	Surry
	Yadkin

Team 3C: Wilmington
Bladen
Brunswick
Columbus
Cumberland
Duplin
Hoke
New Hanover
Onslow
Pender
Robeson
Sampson
Scotland

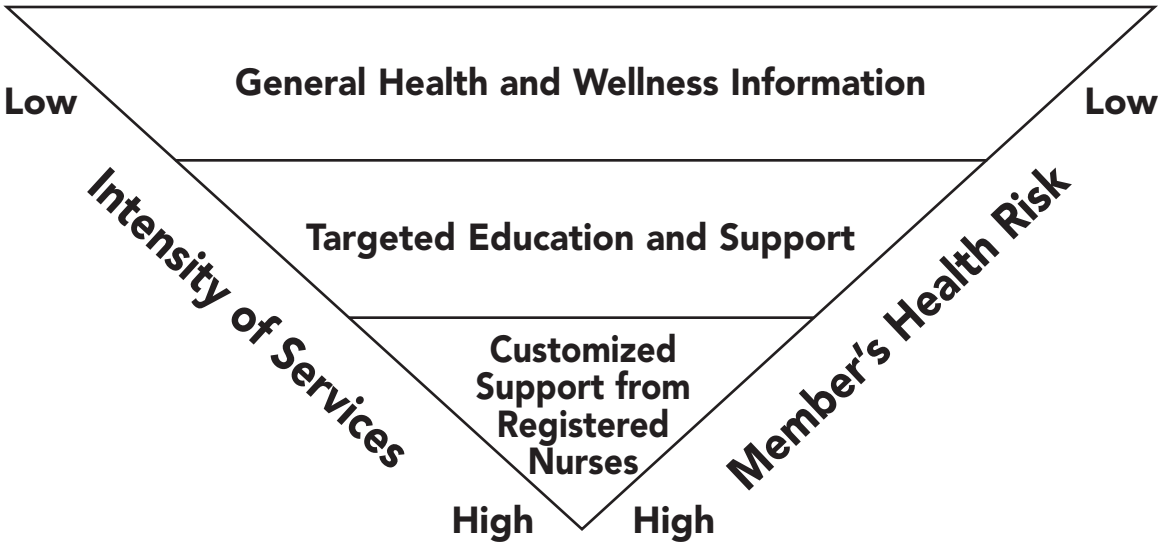
Discharge Services For All Regions 1-800-228-0838
State Health Plan PPO 1-866-225-5258
Pharmacy Quantity Limitations 1-800-795-9403

Care Management

9. Care Management

9.1 Care Management Overview

The goal of care management is to ensure that appropriate management interventions are offered to all members. This goal is accomplished by health risk stratification, so that appropriate case management, education and decision support can be provided for these members. For example, members with no current significant medical needs receive prevention and wellness information that enhances their ability to maintain or improve their health status. Members at higher risk receive interventions that improve their ability to manage their condition.



9.2 Case Management

Case management is an integral part of both health coaching and intervention and member health partnership programs. Case management seeks to ensure quality outcomes for our members who need intensive one-on-one assistance in managing their health condition(s).

More information about the case management process, including the transplant management program, can be found in chapter eight, Health Coaching and Intervention.

9.3 Member Health Partnerships℠ Program

BCBSNC offers free health management programs to members who have select health conditions. This confidential program is designed to provide members with targeted information and services, which can help them manage their specific health care needs. These programs are available to members enrolled in HMO and PPO products, including Blue Advantage®. The programs are also available to members enrolled in CDHP products, though benefits are not part of the first dollar preventive care and subject to deductible and coinsurance. Certain employer groups may choose not to offer this program to their employees.

Candidates for enrollment into the Member Health Partnership℠ program are identified based on medical and pharmaceutical claims data, physician or provider referrals, calls to Health Line Blue℠ and self-referrals via our toll-free number at **1-800-218-5295**. Members can also enroll through our Web site at ***bcbsnc.com***, or by sending an e-mail to ***partnerships@bcbsnc.com***.

These programs are designed to educate members about how to manage their health conditions in a way that will optimize their health status. Enrolled members receive:

- Comprehensive educational materials which are consistent with nationally-accepted evidence-based standards of medical care
- The opportunity to work with a registered nurse to learn more about their condition and how to manage it.
- Access to medical nutrition therapy from licensed, credentialed dietitians.

Conditions addressed include:

- Asthma
- Coronary heart disease
- Congestive heart failure
- Diabetes
- High blood pressure and high cholesterol
- Fibromyalgia
- Migraines
- Stress
- Tobacco cessation
- Achieving and maintaining a healthy weight

See below for information about our pregnancy and specialty care options.

Members actively participating in the MHP program will receive a health report offering personalized feedback based on responses to an initial health survey that they must complete to become actively enrolled. They also will receive a Member Health Partnerships℠ organizer to record results of medical tests and screenings, medical history, pharmacy history and office visits. Condition specific books and access to self-management tools are mailed to members to educate members on how to manage conditions, identify triggers of symptoms, and work with health care providers to treat appropriately. Members will also receive a semi-annual Member Health Partnerships℠ magazine, Blueprints to Health, containing strategies for better health.

Additional benefits and waivers include 6 visits for medical nutrition therapy, diabetes deductible waivers, and asthma copay reductions on select asthma medication are also available to actively enrolled members. Members will receive access to free and discounted medical supplies including asthma peak flow meters and spacers, diabetes testing supplies, blood pressure cuffs, and scales.

Lastly, members actively enrolled in Member Health Partnerships℠ will have access to one-on-one health coaching from a nurse if a member has questions about disease, medications or treatment plan, regardless of severity of illness.

Specialty Care:

In addition to the Member Health Partnerships℠ program, BCBSNC offers Member Health Partnerships℠ – Specialty Care that provides personalized support for 14 rare conditions. Members who have one of the following chronic, progressive diseases are eligible for the Member Health Partnerships℠ specialty care program.

- Amyotrophic Lateral Sclerosis "ALS"
- Chronic Inflammatory Demyelinating Polyneuropathy "CIDP"
- Cystic Fibrosis
- Dermatomyositis
- Hemophilia
- Myasthenia Gravis
- Multiple Sclerosis
- Gaucher Disease
- Parkinson's Disease
- Polymyositis
- Rheumatoid Arthritis
- Scleroderma
- Sickle Cell Disease
- Systemic Lupus Erythematosus

Program participants can benefit from customized educational materials, personalized health evaluations and education from registered nurses and other health care professions, and access to ***www.accordant.com***, a patient Web site featuring in depth, disease specific information, live interactive events and additional resources.

Pregnancy

Any member who is pregnant is eligible to have access to the Member Health Partnerships℠ – Pregnancy program. This program provides up-to-date information on pregnancy, labor and delivery options and costs, newborn care, and choosing a pediatrician, care seat and day-care with access to one-on-one health coaching from a pregnancy case manager.

9.4 Medical Nutrition Therapy Benefits

As of October 2005, Blue Cross and Blue Shield of North Carolina began covering medical nutrition therapy. The nutrition counseling benefit is available to members actively participating in the Member Health Partnerships program and who have Blue Care®, Blue Options℠ or Blue Advantage®. This benefit is not available to National Carolinas Program, PARTNERS Medicare products, or Comprehensive Major Medical "CMM" product lines. The State Health Plan does cover nutrition counseling for diabetics and the FEP provides some coverage. If a member is enrolled in the Blue Options HSA℠ plan, they may be subject to deductible and coinsurance. Benefits available through Member Health Partnerships℠ are subject to a member's current benefit plan and pre-existing waiting periods. Please note that some self-insured employer groups may choose to omit medical nutrition therapy from coverage for their employees. For this reason, it is always a good idea to verify a member's eligibility before the member's first visit.

Coverage Guidelines and Verifying Eligibility

Members enrolled in a BCBSNC Member Health Partnerships℠ program may have benefits for six medical nutritional therapy visits. Members with a diagnosis of diabetes may exceed six medical nutritional therapy visits per year. Please note that members diagnosed with diabetes, but not enrolled in a BCBSNC Member Health Partnerships℠ program, may be responsible for paying a copayment during the initial six visits. Visits exceeding the sixth visit may be subject to copayments even if the member is enrolled in a BCBSNC Member Health Partnerships℠ program. Please see the following charts for guidelines.

Guidelines for coverage of medical nutrition therapy per benefit period for state and commercial products *(assuming employer has not carved out and no pre-existing conditions).*

Plan	Non-Diabetics	Diabetics
State PPO	MNT not covered	Unlimited visits allowed with the first 6 visits copays waived. After the 6 visits, visits will be subject to copay or coinsurance and deductible.
Commercial products (Blue Care®, Blue Options℠, Blue Advantage®)	Member actively participating in MHP, 6 visits are covered with copay waived. Member not actively participating in MHP, no visits are covered.	Member actively participating in MHP, 6 visits are covered with copay waived. After the 6 visits, unlimited visits with applicable copay or coinsurance/deductible. Members not actively participating in MHP, unlimited visits covered, subject to copay or coinsurance and deductible.
HSA product	Member actively participating in MHP, 6 visits subject to coinsurance and deductible; not covered after 6. Member not actively participating in MHP, no visits are covered.	Member actively participating in MHP, 6 visits are subject to coinsurance and deductible; not covered after 6. Members not actively participating in MHP, unlimited visits covered, subject to copay or coinsurance and deductible.

9.5 Verifying Eligibility

Before seeing a Blue Cross and Blue Shield of North Carolina "BCBSNC" member, providers should first verify their benefits and eligibility by calling the Provider Blue Line℠ at **1-800-214-4844** or by using ***Blue e℠***. With ***Blue e℠*** providers can verify eligibility, benefits and claim status, immediately, and from the convenience of their desktop computer. To find out more about signing up for ***Blue e℠***, visit BCBSNC electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/***, or refer to chapter 13 of this manual.

Please verify that the member is actively enrolled in the Member Health Partnerships℠ program, that they member has no current pre-existing condition, and that the member's employer group has not carved out the benefit.

Copayments, coinsurance and deductible may apply to these visits. Contact the Federal Employee Program Customer Service at **1-800-222-4739** for more information and to verify benefits and coverage of services for members covered under the Federal Employee Program.

Members receiving nutritional counseling for the treatment of anorexia may not be eligible for benefits when provided by licensed, registered dietitians. Complex eating disorders are primarily considered part of a member's mental health benefit. In addition, BCBSNC currently does not have a Member Health Partnerships℠ program for GI conditions.

A medical nutritional therapy encounter may include one-on-one or group therapy.

9.6 Guidelines for Coverage of Medical Nutrition Therapy per Benefit Period for FEP

Nutritional counseling for the Federal Employee Program "FEP" for both standard and basic options has a visit limit of 4 visits per year, if the diagnosis is not anorexia or bulimia. If nutritional counseling is provided for the diagnosis of anorexia or bulimia there is no visit limitation. FEP benefits can be provided for nutritional counseling, as long as the member has a condition that may reasonably be expected to improve through nutritional counseling. This means that benefits can be provided for nutritional counseling given for obesity, weight control, or weight reduction. Providers such as covered dieticians and nutritionists - who bill independently for nutritional counseling - can bill for services to the plan. There has not been a change to the benefits from the 2006-year *(can be subject to change with quarterly updates)*.

Below is a chart of benefits nutritional counseling for both preferred providers and non-preferred providers.

Benefit Payment Levels for Nutritional Counseling 2006/2007 The Plan Pays:		
Provider	**Basic Option *(group codes 111/112)***	**Standard Option *(group codes 104/105)***
Preferred/In-network	Reimbursed at 100% of the plan allowance after the member pays a $20 copay licensed dietitian/ nutritionist, up to 4 visits per calendar year	Reimbursed at 90% of the plan allowance after the member meets their $250 deductible, up to 4 visits per calendar year
Non-preferred/ Out-of-network	No benefits	Reimbursed at 75% of the plan allowance after the member meets their $250 deductible. The member is also responsible for any difference between our allowance and the billed amount, up to 4 visits per calendar year

Contact the Federal Employee Program Customer Service **1-800-222-4739** for more information and to verify benefits and coverage of services for members covered under the Federal Employee Program.

Members receiving nutritional counseling for the treatment of anorexia may not be eligible for benefits when provided by licensed, registered dietitians. Complex eating disorders are primarily considered part of a member's mental health benefit. In addition, BCBSNC currently does not have a Member Health Partnerships℠ program for GI conditions.

A medical nutritional therapy encounter may include one-on-one or group therapy.

9.7 Health Line Blue℠ - 24 Hour Health Information Line

BCBSNC is proud to offer an innovative service to HMO and PPO members*. Health Line Blue℠ is an interactive health information and decision support resource designed to help patients make more informed medical decisions. Health Line Blue℠'s goal is to help members focus on the areas that concern them the most and prioritize their questions for discussion with their physician.

Members may talk confidentially with highly qualified nurses by phone or online about any health concern. Health Line Blue℠ nurses have access to evidence-based, up-to-date medical information, guidelines and studies. This information is also available to members in easy to understand videotapes, printed materials and online resources.

Health Line Blue℠ is backed by The Foundation for Informed Medical Decision Making, a not-for-profit organization founded by physicians, which provides objective, scientific information about medical concerns and treatment choices. Health Line Blue℠ nurses foster and facilitate a strong physician and patient relationship, and assist members with navigation through the health care

system. Health Line Blue℠ nurses do not recommend or discourage any particular medical treatment. They provide patients with unbiased, evidenced-based information and help them understand how their personal values and preferences might appropriately be incorporated into health care choices.

9.7.1 On the Phone – Toll Free at 1-877-477-2424

Members can call Health Line Blue 24 hours a day 7 days a week and can request to speak with the same nurse on an ongoing basis. Callers may also ask to have nurses follow up with them regarding a conversation or other health concern.

9.7.2 Online – *bcbsnc.com*

A comprehensive online resource, the Dialog Center℠1, is available to members. In the Dialog Center℠1, members can search the Healthwise® Knowledgebase library of current health information, send secure messages to nurses, track symptoms and medications and use tools that guide them through important health care decisions.

® Healthwise and Healthwise Knowledgebase are federally registered trademarks of Healthwise, Inc. used with permission

℠ Mark of Blue Cross and Blue Shield Association

℠1 Dialog Center is a service mark of Health Dialog Services Corporation used with permission

* Health Line Blue℠ is a service provided for members of Blue Care®, Blue Options℠ and Blue Advantage® plans.

Claims

Billing and Reimbursement

10. Claims – Billing and Reimbursement

10.1 Prompt Payment

The North Carolina General Assembly established legal requirements for the prompt payment of medical claims. These requirements are stated in North Carolina General Statute "NCGS" §58-3-225. The following offers some general information about the legislation:

A licensed insurer is required to take one of six actions within 30 days of receiving a claim from a health care provider or facility *(referred to as [the claimant])*:

1. Pay the claim.
2. Deny the claim.
3. Notify the claimant that there is insufficient information to process the claim *(the notice must include all reasons for why the claim has not been paid and an itemization of what information is needed to process the claim).*
4. Notify the claimant that the claim was not submitted on the appropriate form.
5. Notify the claimant that coordination of benefits information is needed to pay the claim.
6. Notify the claimant that the claim cannot be processed due to non-payment of fees or premium by either the patient or the patient's employer group.

Claims that are adjudicated after the statutory time limits are subject to 18% annual interest rate. Interest is not due for certain delays, such as when the carrier is waiting for additional information, or when claim payment is delayed due to non-payment of premium. If the insurer does require additional information, it has 30 days to process the claim once the requested information is received. If a claim is pending, the insurer shall deny the claim if the information is not received within 90 days. If a claim is denied because of missing information, it will be re-opened if the required information is submitted to the insurer within one year after the denial date.

A denied claim notice must include all specific denial reasons including, but not limited to, coordination of benefits, lack of eligibility or lack of coverage. If all or part of the claim is contested or cannot be paid because a specific health coaching and intervention or medical necessity standard is not satisfied, the notice must contain the decisions specific clinical rationale or refer to specific provisions in documents readily available through the insurer which provide the specific clinical rationale for that decision. However, if a notice of non-certification has already been provided under NC G.S. §58-50-61(h), then specific clinical rationale for the decision is not required.

The insurer must inform the insured of the claim status if it remains unpaid after 60 days. A status report must be sent to the insured and the claimant every 30 days thereafter until the claim is resolved.

This mandate does not apply to the following programs:

- ASO business *(self-funded groups)*, however, the mandate does apply to Multiple Employer Welfare Arrangement "MEWA" groups
- Medicare Supplement

- BlueCard®
- The Federal Employee Program "FEP"

If you are interested in learning more about the prompt payment mandate and how it affects you, please contact your local BCBSNC network management field office *(see chapter two, Quick Contact Information)*.

10.2 Medicaid Right of Assignment

A North Carolina law (NCGS §108A-55.4), effective January 1, 2007, assigns to Medicaid the rights of any other party *(including members and providers)* to reimbursement to the extent that Medicaid has already paid for a service. The law applies to insured plans, self-funded plans, and government plans for members of those plans who are also covered by Medicaid. When one of these members is treated by a provider and Medicaid pays as primary payor in error, BCBSNC must reimburse Medicaid the amount it would have paid to the provider up to the amount Medicaid paid.

Although the law assigns the provider's right to payment to Medicaid, it does not change the provider's contractual rights. If BCBSNC owes the provider a contracted amount that is more than Medicaid paid the provider, then the provider has the right to submit a claim for the service, and BCBSNC will reimburse the provider for the difference between BCBSNC's payment to Medicaid and the contracted amount, less member liabilities. If BCBSNC owes the provider less than the amount Medicaid paid the provider, then BCBSNC is obligated only to reimburse Medicaid for the amount that BCBSNC owes under the provider contract.

10.3 Disclosure of Claim Submission and Reimbursement Policies

North Carolina General Statute "NCGS" §58-3-227, requires health plans to disclose descriptions of their claim submission policies to participating *(contracting)* providers. This section serves as a resource tool to guide you and members of your office staff as to how you may obtain information regarding our claim submission policies as required under NCGS §58-3-227.

Scope of Disclosures

NCGS §58-3-227 applies only to insured business regulated by the State of North Carolina. The statute does not apply to the following: ASO *(self-funded group[s])* business, the Federal Employee Program "FEP," the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical "CMM" *(indemnity)* plan, inter-plan programs (BlueCard® *host)* or Medicare Supplement.

The provisions apply to the following lines of group business administered on BCBSNC's PowerMHS claims adjudication system:

- Blue Care®
- Blue HMO℠
- Blue Options℠
- NC Smart*Choice*℠
- Classic Blue®

In addition the provisions apply to our individual lines of business including:

- Blue Advantage®
- Blue Assurance℠
- Access℠
- Short term

The statute does not apply to third parties that process claims on behalf of BCBSNC, including, but not limited to, claims for mental health services processed by Magellan Behavioral Health, claims for pharmacy services processed by Merck-Medco Managed Care LLC., and claims for dental services processed by Dental Benefit Providers, Inc., or ACS Benefit Services, Inc.

Methods of Disclosure

BCBSNC uses the following primary means of communicating our claim submission policies:

1. The BCBSNC *Blue Book*℠ Provider eManual: This Provider eManual provides comprehensive information to assist BCBSNC network participating health care providers with effectively administering our BCBSNC products. The manual is given to providers when they join a BCBSNC network and 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. In addition to the providers section of the Web, the Provider eManual is also available to providers having free ***Blue e℠*** connectivity. Providers are reminded that this manual 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 eManual in the providers section of the BCBSNC Web site at ***http://www.bcbsnc.com/providers/***, or by using ***Blue e℠***. In the event that a provider experiences difficulty accessing or opening the *The Blue Book*℠ from our Web site, or if the provider is a ***Blue e℠*** user and needs assistance with *The Blue Book*℠ viewing, providers are requested to please contact their local network management field office *(field office contact information is available in chapter two of this manual)*. Additionally, providers without access to the BCBSNC Web site or ***Blue e℠*** are requested to contact their local network management field office to receive a copy of the manual in another format.
2. Blue Link℠: The BCBSNC provider newsletter provides updated information when we change our policies and procedures. Our provider newsletters are available on the providers section of our Web site, ***bcbsnc.com***.
3. ***bcbsnc.com***: The providers section of our Web site offers access to our medical policies and our electronic claim submission policies, and important news. The important news section of our Web site offers providers information regarding changes in our policies, BCBSNC initiatives, and general updates and news about BCBSNC topics that may affect their business interactions with us. Through the ***Blue e℠*** portal we offer access to Clear Claim Connection "C-3," a tool that helps providers and their office staff understand better, how claims are reviewed for adjudication on the PowerMHS system.
4. Provider notice: As outlined in our provider agreements, we may also send to providers, written notice of changes in our claim submission policies.

Disclosure Type	BCBSNC Policy	Policy Availability
General claim submission	*The Blue Book*℠ Provider eManual: • Chapter six, Inter-Plan Programs, BlueCard® and Other National Programs • Chapter ten, Claims – Billing and Reimbursement	*The Blue Book*℠ Provider eManual available on the BCBSNC Web site at ***http://www.bcbsnc.com/providers/***. If you need assistance obtaining from the Web site, please contact your local network management field office. For a list of our network management offices, please see chapter two of this manual.
Electronic claims	HIPAA companion guide	The providers section of the BCBSNC Web site, ***bcbsnc.com***, under electronic solutions and HIPAA at ***https://www.bcbsnc.com/providers/edi/hipaainfo.cfm***
	Blue e℠ instructions	The providers section of the BCBSNC Web site, ***bcbsnc.com***, under electronic solutions and ***Blue e***℠ at ***https://www.bcbsnc.com/providers/edi/bluee.cfm***
	RealMed instructions	Instructions have been provided to all registered users of RealMed. Your local RealMed representative can provide you with information on how you may receive these instructions and ongoing updates.
Claims bundling and other claims editing processes	Administrative medical policy: • Bundling guidelines	The providers section of our Web site, ***bcbsnc.com*** under medical policy at ***https://www.bcbsnc.com/services/medical-policy/***. If you need assistance obtaining from the Web site, please contact your local network management field office. For a list of our network management offices, please see chapter two of this manual.
	The Blue Book℠ Provider eManual: • Chapter ten, Claims – Billing and Reimbursement	*The Blue Book*℠ Provider eManual available on the BCBSNC Web site at ***http://www.bcbsnc.com/providers/***. If you need assistance obtaining from the Web site, please contact your local network management field office. For a list of our network management offices, please see chapter two of this manual.

Disclosure Type	BCBSNC Policy	Policy Availability
Claims bundling and other claims editing processes	Clear Claim Connection* "C-3" *(for CMS-1500 professional claims)*	Through the ***Blue e***℠ portal, available free to BCBSNC contracting providers at ***https://providers.bcbsnc.com/providers/login.faces***. Providers not already signed up for ***Blue e***℠ are encouraged to contact their local eSolutions field representative or sign up through the Web at ***https://www.bcbsnc.com/providers/edi/bluee.cfm#signup***. Chapter two of this manual contains contact information for your eSolutions local field representative. If you need assistance obtaining from the Web site, please contact your local network management field office. For a list of network management offices, please see chapter two of this manual.
Recognition or non-recognition of CPT modifiers	Administrative policy: • Modifier guidelines	The providers section of our Web site, ***bcbsnc.com*** under medical policies at ***https://www.bcbsnc.com/services/medical-policy/***. If you need assistance obtaining from the Web site, please contact your local network management field office. For a list of our network management offices, please see chapter two of this manual.
Payment based on relationship of procedure code to diagnosis code	*The Blue Book*℠ Provider eManual: • Chapter ten, Claims – Billing and Reimbursement	*The Blue Book*℠ Provider eManual available on the BCBSNC Web site at ***http://www.bcbsnc.com/providers/***. If you need assistance obtaining from the Web site, please contact your local network management field office. For a list of our network management offices, please see chapter two of this manual.
Other reimbursement policies	BCBSNC medical policies *(including but not limited to the following)*: • Clinical trial services for life threatening conditions • Investigational *(experimental)* services • Medical necessity	The providers section of our Web site, ***bcbsnc.com*** under medical policy at ***https://www.bcbsnc.com/services/medical-policy/***. If you need assistance obtaining from the Web site, please contact your local network management field office. For a list of our network management offices, please see chapter two of this manual.

* Clear Claim Connection "C-3" is a Web-based code auditing reference tool designed to mirror how ClaimCheck code auditing process, used by BCBSNC, evaluates code combinations during the auditing of claims. Clear claim connection is a tool that indicates only:

  1) how combinations of codes *(including modifiers)* will be bundled and/or unbundled; and

  2) whether the codes are in conflict with the age and gender information that is entered. Edits that occur in the PowerMHS system, outside of ClaimCheck and are not disclosed by clear claim connection. For more information on the additional edits, see BCBSNC's reimbursement policy entitled code bundling rules not addressed in ClaimCheck at ***https://www.bcbsnc.com/services/medical-policy/***.

  Additionally, clear claim connection does not take into account many of the circumstances and factors that may affect adjudication and payment of a particular claim, including, but not limited to, a member's benefits and eligibility, the medical necessity of the services performed, the administration of BCBSNC's health coaching and intervention program, the provisions of the provider's contract with BCBSNC, and the interaction in the claims adjudication process between the services billed on any particular claim with services previously billed and adjudicated.

10.4 Health Coaching and Intervention Requirements

Please refer to chapter eight, Health Coaching and Intervention for instructions on certifications and prior review for BCBSNC membership.

Please note the following two exceptions:

- BlueCard®: For certification requirements for BlueCard® members, please contact the member's Blue Cross and/or Blue Shield health care plan as described in chapter six, Inter-Plan Programs of this manual.
- State Health Plan CMM *(indemnity)*: For certification requirements please refer to chapter five, State of North Carolina Teachers' and State Employees' "SHP" Comprehensive Major Medical Plan "CMM" and NC Health Choice of this manual.

10.5 Mental Health and Substance Abuse Services Claims

Note to the reader: Providers are encouraged to review information about our mental health and substance abuse management programs located in chapter eight of this manual in advance of providing services.

Claims for HMO and POS members, BCBSNC delegate's claims processing for mental health and substance abuse services to Magellan Behavioral Health. For information on where to submit claims to Magellan Behavioral Health, see chapter two, Quick Contact Information.

Claims for PPO and CMM members, BCBSNC processes mental health and substance abuse claims. All claims should be submitted to BCBSNC according to the guidelines provided in chapter two, Quick Contact Information.

Please note that mental health and substance abuse service claims for members enrolled in the State of North Carolina Teachers' and State Employee Comprehensive Major Medical "CMM" *(indemnity)* plan are sent to:

Claims Processing Contractor
P.O. Box 30025
Durham, NC 27702

Additional information about mental health and substance abuse administration for State Health CMM *(indemnity)* members is located in chapter five of this manual.

Mental health and substance abuse service claims for member's enrolled the NC Smart*Choice*SM plan for State PPO members are sent to:

BCBSNC
P.O. Box 30087
Durham, NC 27702

Providers servicing member's in the Federal Employee Program can find additional information about mental health and substance abuse administration in chapter four of this manual.

10.6 General Filing Requirements

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 BCBSNC electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/*** 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 payer 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 via the HIPAA 270 inquiry, ***Blue e***SM, RealMed or the Provider Blue Line℠. Providers with electronic capabilities can verify a member's eligibility and benefits immediately, and from the convenience of their desktop computer. Providers without electronic resources should call the Provider Blue Line℠ at **1-800-214-4844**. To find out more about your electronic options, visit BCBSNC electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/***, or refer to chapter 12 of this manual.
- Always file claims with the correct member ID number including the alpha prefix and member suffix, whenever applicable. This information can be found on the member's ID card as it appears in chapter three, Health Benefit Plans and ID Cards.
- 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 BCBSNC assigned provider number *(and group number if applicable)*.
  - Remember that a distinct number is 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.
- You are required to follow BCBSNC's claim filing guidelines stated in this Provider eManual. In the absence of specific BCBSNC requirements regarding coding, you are required to follow the general coding guidelines that are published by the issuer of the coding methodology utilized. For example, for CPT code filings, you must file the most accurate CPT codes specific to the services rendered.

Requirements for Professional CMS-1500 (08-05) Claim Forms

- All professional claims must be filed on a CMS-1500 (08-05) claim form or the equivalent.
  - If filling on paper, you get the fastest turnaround time of reimbursement to you by using the red and white CMS-1500 (08-05) claim form.
- Once you have registered your NPI with BCBSNC, you must 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 must 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 must correspond to the NPI or provider number filed in field 33.
- 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 must be reported using the NPI only and the provider's use of the BCBSNC assigned provider number must be discontinued.
- When submitting an accident diagnosis, include the date that the accident occurred in field 14.
- 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 block of field 24.
- If you are billing services for consecutive dates *(from and to dates)*, it is critical that the units must be accurately reported in field 24G.
- 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 definition *(UN = unit; GR = gram; ML = milliliter; F2 = international unit)*.
- Please note that fields 21 and 24e of the CMS-1500 *(version 08-05)* claim form are designated for diagnosis codes and pointers/reference numbers. Only four diagnosis codes may be entered into block 24e. Any paper CMS-1500 paper claim form submitted with more than four diagnosis codes or pointers/reference numbers will be mailed back to the submitting provider.

Requirements for Institutional UB-04 Claim Forms

- All claims must be filed electronically using the HIPAA 837 transaction.
  - If filling on paper, the red and white printed version must be used.
- For therapies and treatments covered under a single episode of care, services must be billed at the end of treatment or on a monthly basis whichever occurs first *(serial billing)*.

- Do not file new charges until the new rates have been accepted by BCBSNC.
  - Rate negotiations for hospital agreements may continue beyond the hospital's new fiscal year. Our claims processing system is not updated with new rates until an agreement is reached between the hospital and BCBSNC. We will notify you when the claims processing system is updated and ready to receive claims at the new reimbursement rates.
  - Verify the status of rate negotiations with your finance department before filing claims at the beginning of each new fiscal year, including admissions that continue into the new fiscal year.
  - Do not submit claims with proposed or new charges until advised by BCBSNC.
- ICU charges must be itemized on a separate line *(i.e. nursing increments, equipment, room rate).*
- Plan codes are not required on claims. However if incorrect plan codes are submitted, the claims will error out.
- Revenue codes for room and board must match the agreed upon room rate.
- Bill full charges not BCBSNC rates.
- 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 is performed.
  - Field locator 74 must not be populated when reporting outpatient services.
- Do not submit a second/duplicate claim without checking claim status first on ***Blue e***[SM].
  - Providers must allow 30 days before inquiring on claim status via ***Blue e***[SM].
  - Please wait 45 days before checking claim status through the Provider Blue Line[SM].
- Emergency room services can be billed on a UB-04 outpatient claim with a bill type of 13J whenever the inpatient services are denied for non-authorized services or certification was not obtained.
  - This applies to HMO, PPO, POS and CMM claims processed on the PowerMHS system *(State Health Plan CMM [indemnity], Federal Employee Program and Inter-Plan [*BlueCard®*] claims are excluded).*
  - You will be notified via the Explanation of Payment, "EOP," that ER services should be submitted using a bill type 13J.

10.7 Electronic Claims Filing

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 capabilities, please refer to chapter 12 of this manual, Electronic Solutions, or visit BCBSNC eSolutions on the Web at ***http://www.bcbsnc.com/providers/edi/***.

10.8 Claims Filing Addresses

Please see chapter two of this manual *(Quick Contact Information)* for mailing instructions for medical health care claims, mental health/substance abuse service claims, and chiropractic care claims.

Please note that claims mailing information for State Health Plan CMM *(indemnity)* member's claims is located in chapter five of this manual.

10.9 Claim Filing Time Limitations

Participating providers agree to complete and submit a claim to BCBSNC for services and/or supplies provided to 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.

The claim should be submitted only after all charges and credits have been recorded *(no interim billing)*.

Professional claims must be submitted within 180 days of providing the service, with the exception of claims for FEP members and State Health Plan CMM *(indemnity)* members.

Institutional/facility claims must be submitted within 180 days of the discharge date, with the exception of claims for FEP members and State Health Plan CMM *(indemnity)* members.

Claims for services provided to FEP members must be filed by December 31 of the year following the year the service was rendered.

State Health Plan CMM *(indemnity)* claims must be submitted within 18 months.

10.10 Verifying Claim Status

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

1. Check claim status from your desk top computer using the HIPAA 276 inquiry, RealMed or ***Blue e***[SM]. ***Blue e***[SM] enables users to verify the status of all claims, including BlueCard® and FEP claims. Providers without ***Blue e***[SM] access can call the Provider Blue Line[SM] at **1-800-214-4844**. To find out more about ***Blue e***[SM], RealMed and other electronic options visit BCBSNC electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/***, or refer to chapter 12 of this manual.
2. Complete a provider claim inquiry form, *(see chapter 23, Forms)*, and mail it to:

Blue Cross and Blue Shield of North Carolina
Customer Service Department
P.O. Box 2291
Durham, NC 27702-2291

10.11 Incomplete Claims

If information necessary to process a claim is missing from the claim form, we will mail the Notification of Payment "NOP" to you requesting submission of additional information or you will receive a provider claim mailback form *(see chapter 23, Forms)* along with the claim. You should respond as quickly as possible to a request for additional information in order to expedite the processing of the claim.

Professional claims that are electronically submitted, which contain errors, are documented on the provider error report or online via the ***Blue e***℠ interactive network. You should work your error report daily and resubmit those claims electronically.

Institutional/facility claims that are electronically submitted, which contain errors, are documented on the UB-04 provider error report or online via the ***Blue e***℠ interactive network. You should work your error report daily and re-submit those claims electronically.

If an institutional/facility claim is for services related to a clinical trial, you should submit the signed informed consent and the clinical protocols.

10.12 Corrected Claims and Mailbacks

10.12.1 Definitions

Corrected Claim:

- In general, a corrected claim is any claim for which you have received a notification of payment "NOP"/explanation of payment "EOP," and for which you need to make corrections on the original submission. Corrections can be additions *(e.g., late charges)*, a replacement of the original claim, or a cancellation of the previously submitted claim.

If you received an EOP with any of the following codes, **please do not submit a corrected claim**. Submit a **new claim** to allow the claim to be correctly processed.

The following codes apply to claims processed on the Power MHS system:

EM0	Incorrect place of service for service.
EM1	Claim denied for invalid procedure code. Please resubmit correct procedure code.
EM2	Claim denied. Please resubmit procedure code for which anesthesia was provided.
EM3	Claim has been mailed back for additional information.
EM4	Claim submitted with incorrect or inactive provider or group number. Please resubmit claim with a correct provider or group number.
EM5	Resubmit split billing for authorized days.
EM6	Services for newborn need to be split into two claims. For normal delivery, split for 48 hours and for c-section, split for 96 hours. Resubmit as two claims.
EM8	Our records indicate for the date of service filed, the individual provider was not part of the group's practice. Please resubmit claim with an active provider or group number.
EM9	Claim denied for incorrect bill type for service(s) rendered. Please resubmit with correct bill type.

Th following codes apply to claims processed on the Legacy system:

M1	Give description of procedure code – should use procedure code DINVL
M2	Give procedure code for anesthesia
M3	Misc. mailback, add to CL1083 why claim mailed back, and print a copy of claim image using DCN Query. Complete appropriate mailback form, attach to claim and return to responsible party.
M4	Need valid provider number
M5	Split days for approved/non-approved authorizations
M6	Split 48/96 hours newborns
M8	Provider not linked with vendor
M9	Incorrect bill type for service(s). Resubmit with correct bill type.

Mailback:

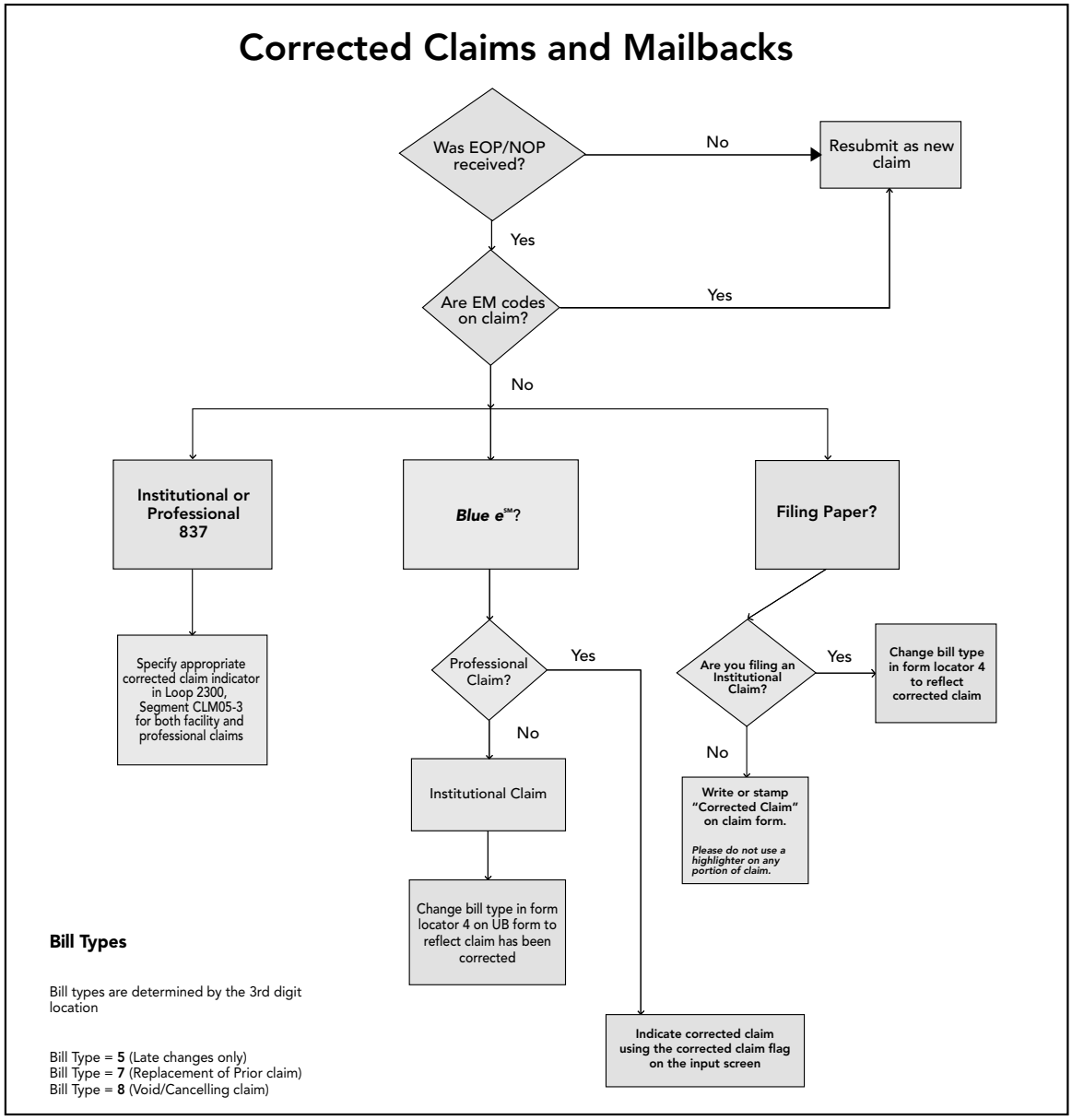
- In general, claims mailed back to you have not been logged into our claims processing systems. We were unable to successfully enter the claim because of missing, incomplete or invalid information. The claim is being returned to you to complete the missing, incomplete or invalid information. In these situations, you must submit a new claim.

  For 837 mailbacks, you will only receive a mailback form, not a copy of the claim.

Corrected Claim	Mailback
Electronic submission **HIPAA compliant 837 claims** • 837 institutional claim Specify appropriate corrected claim indicator** in loop 2300, segment CLM05-3. • 837 professional claim Specify appropriate corrected claim indicator** in loop 2300, segment CLM05-3. **837 corrected claim indicators: - 5 – Late charges only - 7 – Replacement of a prior claim - 8 – Void or cancel claim	If your claim is returned with a mail back form, check to see if you received a NOP about the claim. If not, make the necessary changes and re-file the claim as an original claim. If you file electronically, make the corrections and resubmit the claim electronically. You do not have to file the claim on paper. An electronic resubmission is still considered to be a new claim. Update your system so the error will not be repeated on future submissions. We cannot add any missing information to your claim.

Corrected Claim	Mailback
Electronic *Blue e*SM – Institutional Only • Change bill type in form locator four (4) on the UB claims entry screen to reflect that it is a corrected claim.	If your claim is returned with a mail back form, check to see if you received a NOP about the claim. If not, make the necessary changes and re-file the claim as an original claim. If you file electronically, make the corrections and resubmit the claim electronically. You do not have to file the claim on paper. An electronic resubmission is still considered to be a new claim. Update your system so the error will not be repeated on future submissions. We cannot add any missing information to your claim.
Paper • Facility paper claim Change bill type in form locator four (4) to reflect claim has been corrected. • Facility and professional paper claim Write or stamp corrected claim on the top of the claim form.*** *** Please do not use a highlighter on any portion of the corrected claim.	

10.12.2 Figure 1 – Corrected Claims and Mailback Process Flow



Bill Type Indicators:

- When the 3rd digit of the bill type is five *(5 [late charges-only claim])*, please only submit the late charges.
- When the 3rd digit of the bill type is seven *(7 [replacement of prior claim])*, you should submit the original charges plus the new charges.
- When the 3rd digit of the bill type is eight *(8 [void or canceling claim])*, you should void or cancel claim.

Do not attach a provider inquiry form to a corrected claim as this delays processing.

Please make sure that facility claims have been filed with a bill type that indicates corrected or adjusted billing. We may deny or return these claims back to your facility if it is determined that the claim should have been filed as a corrected claim. You can file a corrected claim either electronically or by mail.

10.12.3 Tips for Corrected Claims

- You can correct a claim in one of the following ways:
  1. File a corrected facility claim electronically, or key the corrected UB-04 claim via ***Blue e***[SM], being sure to change the bill type in form locator four.
  2. Providers who file claims using the HIPAA compliant 837 corrector claim format *(professional and institutional)* can submit corrected claims electronically.
  3. File a paper UB-04 claim, changing the bill type in form locator four. Do not use a highlighter on any portion of the re-filed claim.
  4. For CMS-1500 forms, stamp corrected claim across the top of the claim form. Corrected claims should be mailed to:

     Blue Cross and Blue Shield of North Carolina
     Claims Department
     P.O. Box 35
     Durham, NC 27702

- Remember that the corrected claim replaces the original claim. Please do not attach the original claim with the corrected claim(s).
- When filing a corrected claim, submit all charges that were on the original claim rather than just the charge that has changed. If only one charge is resubmitted, it will appear that you intend to remove all previously processed charges and a refund will be requested for previously paid amounts.
- Please submit all charges that are to be considered for payment. If you are removing charges, there is no need to submit a zero charge line to indicate you have removed the charge. Indicate the change by not placing the charge on the corrected claim.
- When submitting late charges only *(bill type five [5])*, please only submit the late charges.

10.12.4 Mailbacks

In general, claims mailed back to you have not been logged into our claims processing systems. We were unable to successfully enter the claim because of missing, incomplete or invalid information. The claim is being returned to you to complete the missing, incomplete or invalid information. In these situations, you must submit a new claim. Please do not mark these claims as corrected.

- For 837 mailbacks, you will only receive a mailback form, not a copy of the claim.

10.12.5 How to Avoid Claim Mailbacks

Claim mailbacks cause additional work for your organization, as well as delay processing of the claims. When filing claims, make sure the information on your claim is complete and accurate.

We may deny or mailback claims if it is determined that the claim should be filed as a new claim.

The top reasons claims are mailed back are listed below:

- Invalid, incomplete or missing member ID number *(remember FEP numbers start with R)*
- Invalid or missing BCBSNC individual or group provider number
- Invalid accommodation rate
- Missing primary payer's Explanation of Benefits "EOB"
- Missing admission and discharge dates for inpatient claims
- Missing onset date of symptoms
- Missing or incomplete specific diagnosis
- Invalid place of service
- Missing or incorrect number of units
- Missing patient's date of birth

If you receive a claim mailback form with your returned claim, do not provide the missing information on the mailback form. Please make corrections to the claim and resubmit as a new claim without marking it corrected. If you file electronically, make the corrections and resubmit the claim electronically. Electronic filing reduces processing time.

10.12.6 Mailback Claims Tips

In general, claims mailed back to you cannot be successfully logged into our claims processing system(s) due to incomplete or invalid information. The claim cannot be processed until all information is submitted.

If a claim is mailed back to you for any reason:

- Make the necessary corrections in your billing system
- Resubmit it as a new claim *(electronically, if possible)*
- Do not mark the resubmission as a corrected claim

Since a new claim is needed, please do not return the mailback form with your corrections. The mailback form does not contain sufficient information to process a claim.

10.13 Billing BCBSNC Members

Participating providers agree not to bill BCBSNC members for services until you receive the BCBSNC explanation/notification of payment, except for copayments or amounts actually owed by the member as reflected on the EOP/NOP. However, you may bill BCBSNC members prior to the receipt of the EOP/NOP for services BCBSNC verifies are non-covered in advance of the service. Any amounts that both you and the member agree were collected erroneously for any reason must be refunded to the member within 45 days of the receipt of the EOP/NOP or your discovery of the error.

10.13.1 Amounts Billable to Members

- Applicable copayments may be collected at the time service is rendered.
- Applicable coinsurance and deductible amounts may be collected from BCBSNC members only after the provider has received the Notification of Payment "NOP" or Explanation of Payment "EOP."
- Non-covered services may be collected, only if they meet the criteria outlined in this chapter's *(chapter ten)* instruction for the hold harmless provision.
- Any amounts collected erroneously by you from a member for any reason shall be refunded to the member within forty-five (45) days of the receipt of the notification/explanation of payment from BCBSNC or your discovery of the error.

10.13.2 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 deductible amounts.

Providers may not balance bill BCBSNC 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 health coaching and intervention programs and policies or medical necessity criteria or are otherwise non-covered, except as outlined within this chapter's *(chapter ten)* instructions for billing members as a non-network provider.

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.

10.13.3 Administrative Services Fees

Providers having a policy to charge fees for administrative services may not bill members for services relating to, obtaining authorization, requesting prior approval, or providing medical records when required by BCBSNC. All medical services, administrative services related to prescription refills, and administrative fees associated with providing these administrative services should be billed when applicable as a properly coded claim to BCBSNC.

A provider may charge a fee for administrative services related to but not limited to filling out forms and preparation for FMLA, disability or services not related to BCBSNC benefit plans.

10.13.4 Billing Members as a Non-Network Provider

If a provider is participating only in BCBSNC's Comprehensive Major Medical "CMM" *(indemnity)* insurance plans and provides covered services to an HMO, POS or PPO member, the provider must wait to receive a Notification of Payment "NOP" or Explanation of Payment "EOP" prior to billing the member any coinsurance or deductible amounts. In addition, the member may only be billed for the difference between the amount paid by BCBSNC and the agreed upon allowable charge under the providers CMM participation agreement with BCBSNC. Providers may not bill members up to their charge.

10.13.5 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 Blue Line℠ at **1-800-214-4844** *(see chapter two, Quick Contact Information)*.

Confirmation of benefit eligibility does not guarantee payment as other factors may affect payment *(e.g. BCBSNC health coaching and intervention programs, medical necessity)*.

Providers may bill PPO and CMM members for non-covered services up to the provider's BCBSNC CMM allowance.

10.14 Hold Harmless Provision

Provider agrees not to bill or otherwise hold members, BCBSNC or any third party responsible for payment for health care services and/or supplies provided to members, which are determined by us not to be medically necessary and/or not in compliance with applicable BCBSNC health coaching and intervention programs and policies and/or not eligible under the member's benefit plan, except when the following conditions shall have been met:

- The provider obtained prior authorization or prior certification by BCBSNC in advance of providing the specific services and/or supplies to the member.

and/or

- The provider gave specific written notification to the member in advance of providing the non-medically necessary services or other non-covered services, explaining that such service might not be covered by BCBSNC under the member's benefit plan; and the member signed a written authorization stating that:

  (i) The member received from the provider notification that the specific services and/or supplies may not be covered by his or her benefit plan.

  (ii) The member received the notification prior to receiving the specific services and/or supplies.

(iii) The notification informed the member that the particular services and/or supplies, if not covered by BCBSNC under the member's benefit plan, are provided at the member's own expense, if the member elects to receive the specific services and/or supplies.

(iv) The provider obtained the member's written authorization prior to rendering the specific services and/or supplies.

(v) The member's authorization includes that such services and/or supplies may not be covered by his or her benefit plan and the member agrees to pay for such services and/or supplies apart from his or her benefit plan.

(vi) The member's authorization specifies that the member elects to receive such services and/or supplies at the member's own expense and the provider has obtained the member's written authorization.

The notification by the provider and the authorization by the member, as set forth in the agreement, shall be given regarding a particular service at issue in the specific treatment of a member and not as a matter of general or standard procedure in all cases.

Providers agree to provide BCBSNC with a copy of any and all such written authorizations upon request.

Refer to your health care businesses' contractual agreement with BCBSNC to review your businesses' hold harmless provision and how the provision applies. If you have questions regarding your health care businesses' hold harmless provision, please contact your local BCBSNC network management field office *(see chapter two, Quick Contact Information)* for more information.

10.15 Payment Guidelines

You are notified of payment guidelines via special messages on the Notification of Payment "NOP" or Explanation of Payment "EOP." For example, a special message will be created for situations in which services that are considered incidental to the primary service are not eligible for separate reimbursement.

Payment for Covered Services Only

As set forth in providers reimbursement section of their agreement, as a participating provider, provider shall be paid by BCBSNC only for medically necessary covered services to members which are in compliance with BCBSNC's health coaching and intervention programs.

Manner of Payment – General

As a participating provider, provider agrees to accept as full and final payment by BCBSNC for medically necessary covered services to members which are in compliance with BCBSNC's health coaching and intervention programs either:

i) the allowed amount, minus deductible, coinsurance, and/or copayment amounts, or

ii) provider's accepted charge minus deductible, coinsurance, or copayment amounts;

whichever is less. The allowed amount shall be determined in accordance with the following subsections of the provider's reimbursement section of the agreement regarding provider participation and payment.

BCBSNC is establishing reimbursement rates for a limited group of service/procedure codes *(primarily supply and drug codes)*. These codes were previously unpriced by BCBSNC because pricing from external sources *(such as Medicare or St. Anthony's)* was unavailable at the outset of provider contracting.

Since external source pricing is now available for many of these codes, BCBSNC has notified providers of the application of a pricing procedure that will price these codes consistent with the reimbursement level in your fee schedule for codes in the same range.

Effective April 1, 2005, BCBSNC makes revisions to the reimbursement for the above-referenced service/procedure codes according to the methodology listed in the following section of this manual *(pricing policy for procedure/service codes applicable to all PPO, POS and HMO products)*. Additional pricing procedures are also included which apply to the products indicated.

If you have any questions, or if you would like a list of affected codes for your specialty made available, please contact your local BCBSNC network management office.

10.16 Pricing Policy for Procedure/Service Codes (applicable to all PPO, POS and HMO products) Effective April 1, 2005 Revised January 1, 2007

The following policy applies to BCBSNC's payment to contracted providers for procedure/service codes billed on a CMS 1500 or successor claim form.

Previously Priced Codes

If a price was formally established in your fee schedule based on then-available external source pricing, that pricing will remain in place unless otherwise changed in accordance with your contract or this policy.

General Pricing Policy

When new CPT/HCPC codes are published, and an external pricing source exists for such codes, BCBSNC will price these codes in the following manner:

- If available, the most current NC Medicare pricing will be applied to that code. The percentage of such NC Medicare pricing that is applied to the new code will be matched to the percentage that was initially applied to establish your fee schedule for codes in the same range of codes.
- If NC Medicare pricing is unavailable, BCBSNC will apply the most current CIGNA Medicare allowable pricing, using the same methodology described above, to establish your fee schedule.
- The most current NC Medicare pricing or CIGNA Medicare allowable pricing means that pricing in place on the date the code was first eligible for use. If NC Medicare or CIGNA Medicare revises the pricing or allowable pricing for any new code retroactive to the date the code was first eligible for use, BCBSNC will revise your fee schedule for that code *(or codes)* within 30 days of the NC Medicare or CIGNA Medicare publishing of the revised pricing or allowable pricing. BCBSNC will not readjudicate or adjust affected claims based upon NC Medicare's or CIGNA Medicare's retroactive revised pricing or allowable pricing. The revised fee applicable to your fee schedule will become effective only for dates of service rendered on or after BCBSNC's loading of your revised fee.

- If NC Medicare pricing or CIGNA Medicare allowable pricing are unavailable, BCBSNC will apply the most current Ingenix RVU pricing, using the same methodology described above, to establish your fee schedule.
- For durable medical equipment, the Palmetto DME fee schedule will be used in place of the above-referenced external sources.
- Drug CPT and HCPCS codes will be priced as outlined below.
- Upon initial pricing of a code as described above, that pricing will remain in place unless otherwise changed in accordance with the terms of your contract or this policy.
- Thereafter, on an ongoing basis and within 120 days of the publishing of each new external source pricing, BCBSNC will repeat the above procedure for previously unpriced codes.
- BCBSNC reimburses the lesser of your charge or the applicable pricing in accordance with your contract and this policy.
- 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 policy to external source pricing refer to the following:

- NC Medicare pricing *(available at **www.cms.gov**)*
- CIGNA Medicare allowable pricing *(available at **www.cignamedicare.com**)*
- Ingenix *The Essential RBRVS (available at **www.ingenixonline.com**)*
- Palmetto durable medical equipment fee schedule *(available at **www.palmettogba.com**)*

In the event that the names of such external source pricing change *(e.g. a new Medicare intermediary is selected)*, references in this policy 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 policy.

Payment of Remaining Unpriced Codes

Procedure/service codes that remain unpriced after each application of the above procedure will be paid in the interim at the lesser of your charge or the statewide average charge *(if available)* for a given code. The statewide average charge will be determined and updated annually, using the most recent 12-month period for which complete data has been received and entered into BCBSNC's claim system. If a statewide average charge cannot be determined due to limited claims data, BCBSNC will assign a fee to the service that will be the lesser of your charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable providers for similar services under a similar health benefit plan. BCBSNC's methodology is based on several factors including BCBSNC's Payment Guidelines and Reimbursement Policy as described in *The Blue Book*℠, and Pricing and Adjudication Principles for Professional Providers as described on our medical policy Web site. Under these guidelines, some procedures charged separately by you may be combined into one procedure for reimbursement purposes.

Drug CPT And HCPC Codes

These codes are priced based on a percentage of average wholesale prices "AWPs." A national drug-pricing vendor determines AWPs, and the AWP methodology is as follows:

> For a single-source drug or biological, the AWP equals the AWP of the single-source product. For a multi-source drug or biological, the AWP is equal to the lesser of the median AWP of all the generic forms of the drug or biological or the lowest brand name product of the AWP. A "brand name" product is defined as a product that is marketed under a labeled or proprietary name that may be different than the generic chemical name for the drug or biological. AWPs will be subject to quarterly changes *(January 1st, April 1st, July 1st, October 1st)* based on national vendor data.

In the event that new external source pricing generally acceptable in the industry and acceptable to BCBSNC becomes available *(e.g. average sales price to determine reimbursement for drug CPT and HCPC codes)*, such external source pricing may be incorporated by BCBSNC into this procedure.

Our specialty pharmacy drugs are priced according to our standard fee schedule. The current list of specialty pharmacy drugs is available on ***bcbsnc.com*** *(please see the "Injectable Drug Network; Availability" link in the, "I'm a provider" section)*. The list also includes the next quarterly update *(January 1st, April 1st, July 1st, October 1st)*. Please contact your local network management office to obtain fee schedule amounts for specialty pharmacy drugs.

Policy On Payment Based On Charges *(applies to all products)*

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: (1) all charges billed to BCBSNC are reasonable; (2) all charges are consistent with your fiduciary duty to your patient and BCBSNC; (3) all charges are not excessive in any respect; and (4) all charges are no greater than the amount regularly charged to the general public, including those persons without health insurance.

Policy On Pricing Of General Or Unlisted Codes *(applies to all products)*

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 your 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's methodology is based on several factors including BCBSNC's Payment Guidelines and Reimbursement Policy as described in *The Blue Book*℠, and Pricing and Adjudication Principles for Professional Providers as described on our medical policy Web site. Under these guidelines, some procedures charged separately by you 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.

Some codes that are listed as specific codes in the CPT/HCPC manuals relate to services that can have wide variation in the type and/or level of service provided. These codes will be treated by BCBSNC in the same manner as general codes, as described in the above paragraph.

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 10% above 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.

10.17 Payment Based on Usual, Customary and Reasonable (Applies to The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical "CMM" [Indemnity] Plan, North Carolina Health Choice and BlueCard® Traditional Plans)

Reimbursement to CostWise participating providers is dictated by our Usual, Customary and Reasonable "UCR" methodology, which is also outlined in the terms of your provider contract. Our health plans subject to the UCR methodology are: State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan *(State Health Plan non-PPO)*, North Carolina Health Choice, and some BlueCard® traditional plans.

Under usual, customary and reasonable methodology allowable benefits are based on the lesser of:

- The doctor's usual charge,
- The doctor's usual charge on record, or
- The maximum customary allowance

A percentage of the maximum allowed amount in accordance with the subscriber's contract is paid to the doctor participating in CostWise. A usual charge is the fee generally charged by an individual doctor or group practice for a particular service *(i.e., the charge submitted on the CMS-1500 claim form)*. The usual charge on record is a computer-calculated charge, based on usual charges for an individual doctor or group practice for a particular service. Claims are reviewed every six months; approximately half of the services in April and the remainder in October. The April review is based on claims data from the previous April through December; the October review is based on claims data from the previous October through June. The usual charge on record is initially established at the accumulated 90th percentile of charges for a particular service is higher than the established usual charge on record, then the usual charge on record is based on the rise, if any, in the all-items Consumer Price Index "CPI," as published by the Bureau of Labor Statistics, U.S. Department of Labor, for the most recent 12-month period.

The maximum customary allowance is a computer-calculated charge for a particular service, based on all claims data submitted by individual doctors and group practices who are participating in CostWise. This data is reviewed every six months, in April and October. The April review is based on claims data from the previous April through December; the October review is based on claims data from the previous October through June. The maximum customary allowance is initially established at the accumulated 90th percentile of charges for all doctors, or for doctors of a particular specialty when over 50% of the charges reported come from a particular specialty. Once established, the maximum customary allowance can be increased every six months based on the rise, if any, in the all-items CPI. This increase depends on whether the charge found at the accumulated 90th percentile of usual charges on record for participating doctors is higher than the established maximum customary allowance.

A reasonable charge is an amount that meets the criteria of usual and customary charges or, after appropriate peer review, is justified because of the special circumstances of a case.

A profile is the current listing of usual charges on record of an individual doctor or group practice.

Charges are put on the profile in two ways:

- By automatic review twice a year of paid claims information.
- If sufficient data is not available, by doctors notifying BCBSNC of their charges.

If benefits under UCR coverage are paid at less than the expected percentage of charges for a given service, benefits may have been based on less than the amount charged. BCBSNC is willing to review any determination it makes. Peer review consultants and/or committees representing major specialties review new, unusual, or precedent setting cases and recommend benefit allowances at the request of the subscriber, BCBSNC, or the participating doctor. The participating doctor has the opportunity to provide all pertinent information. The participating doctor is then notified of the result.

The State of North Carolina has contracted with Blue Cross and Blue Shield of North Carolina to administer its traditional health plan for state employees, retirees, and teachers through the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan *(State Health Plan)* and NC Health Choice. The SHP determines the discounts off UCR and providers are informed in writing of any such changes to UCR.

10.18 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 Provider Blue Line℠ at **1-800-214-4844** to verify benefit coverage.

- Not *medically necessary*
- *Investigational* in nature or obsolete, including any service, drugs, procedure or treatment directly related to an *investigational* treatment
- Any *experimental* drug or any drug not approved by the Federal Food and Drug Administration "FDA" for the applicable diagnosis or treatment. However, this exclusion does not apply to prescription drugs used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:
  1. The American Medical Association drug evaluations
  2. The American Hospital Formulary Service drug information
  3. The United States Pharmacopeia drug information
- Not prescribed or performed by or upon the direction of a *doctor* or *other provider*
- For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state industrial commission or other applicable regulatory agency approving a settlement agreement.

- For *inpatient* admissions primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy.
- For care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*
- For *custodial care*, domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments or any similar facility or institution
- Received prior to the *member's effective date* or during an *inpatient* admission that began prior to the *member's effective date*, even if *inpatient* care continues beyond the *effective date* except as otherwise required by law
- Received on or after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
- For complications or side-effects arising from services, procedures or treatments excluded from coverage under this health benefit plan
- For care that the *provider* cannot legally provide or legally charge
- Provided and billed by a licensed health care professional who is in training
- Available to a *member* without charge
- For care given to a *member* by a *provider* who is in a *member's* immediate family
- For any condition suffered as a result of any act of war or while on active or reserve military duty
- In excess of the *allowed amount* for services usually provided by one *doctor*, when those services are provided by multiple *doctors*
- For cosmetic purposes except when such care is necessary for the correction of impairment caused by an injury or illness
- For routine foot care - arch supports, support stockings, corrective shoes and care for the treatment of corns, bunions *(except capsular or bone surgery)*, calluses, toe nails *(except radical surgery for ingrown nails)*, flat feet, fallen arches, weak feet, chronic foot strain or other symptomatic conditions of the feet
- For dental care, denture, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by your health benefit plan
- Dental services provided in a *hospital*, except when a hazardous condition exists at the same time, or covered oral *surgery* services are required at the same time as a result of bodily injury

- For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of obesity, except for surgical treatment of morbid obesity
- Wigs, hair pieces and hair implants are typically not covered
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or *group*
- For *sexual dysfunction* unrelated to organic disease
- Treatment or studies leading to or in connection with sex changes or modifications and related care
- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- Hypnosis, acupuncture, acupressure and continuous epidural anesthesia except when used for control of chronic pain associated with terminal cancer
- *Surgery* for psychological or emotional reasons
- Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by a health benefit plan
- Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control or to enhance the environmental setting
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, jacuzzis, heated spas, pool or memberships to health clubs
- Vitamins, except for *prescriptions* for prenatal vitamins or specific vitamin deficiencies
- Eye glasses, contact lenses, or fitting for eyeware, radial keratotomy and other refractive eye *surgery*, and related services to correct vision except as specifically covered by your health benefit plan
- Hearing aids or examinations for the *prescription* or fitting of hearing aids except as specifically covered by your health benefit plan
- Treatment of developmental dysfunction and/or learning differences
- *Medical care* provided by more than one *doctor* for treatment of the same condition
- Take-home drugs furnished by a *hospital* or *non-hospital facility*
- Biofeedback except for the treatment of urinary incontinence and the following specific pain syndromes:
  - muscle contraction headaches
  - muscle re-education or muscle tension
  - Reynaud's phenomena
  - migraine headaches

- torticollis, including facial tics
- paralumbar or back pain

- For maintenance therapy. Maintenance therapy includes therapy services that are provided over a long period of time in order to keep your condition stable
- For massage therapy services
- For holistic medicine services
- For services primarily for educational purposes, including but not limited to books, tapes, pamphlets, seminars, classroom instruction and counseling, except as specifically covered by your health benefit plan

10.19 Release of Medical Records

At times, it is necessary for BCBSNC to request medical records from you in order to determine appropriate claims payment, ensure contractual compliance or perform quality improvement activities.

Under HIPAA guidelines, no additional authorization is needed when medical records are requested for purposes of claims processing. Providers participating with Blue Cross and Blue Shield of North Carolina should be aware that medical records requested for the purpose of claims processing fall within BCBSNC's payment and health care operations as those terms are defined in the HIPAA privacy rule.

Contracting providers have agreed to provide BCBSNC with medical records as requested without further payment or authorization from the member or BCBSNC.

Do not send medical records unless requested by BCBSNC. Complete the BCBSNC record request form provided by BCBSNC when sending records. For more information on releasing medical records, as stated in the enrollment application, see chapter 23, Forms.

10.20 Notification of Payment or Explanation of Payment

We report payment and denial of claims to providers on a notification of payment or explanation of payment report. The table below explains key information on the explanation of payment.

Item	Explanation
Patient number	Number assigned by providers to identify patient accounts
POS or place	Place of service
Type of service	Brief description of the service rendered
PC/Days	If facility claims, number of days admitted as an inpatient
Billed charges	Provider's charges as billed
Contracted charges	The charge after contractual reductions
Non-covered/Disallowed	Non-covered amounts/disallowed amount
Deduct amount	The member's deductible amount owed by the member
Remaining member expense	Amount the member can be billed by the provider

Item	Explanation
DEN code	The denial or adjustment code that further explains the payments/denial
Remarks	Written explanation for DEN codes
Amount paid	Total amount paid to provider
Contract types of services and special codes	This field indicates special coverage, type of transmission, or other key information: PCN - Provider communication network *(electronically filed)* COB - Coordination of benefits CONADJ - Contractual adjustment SPCADJ - Special adjustment Blue Care® Classic Blue® PS-C - Preferred Care *Select* CMM - CostWise/Comprehensive Major Medical

10.21 Electronic Remittance Advice "ERA"

BCBSNC offers an electronic remittance using the standard HIPAA 835 transaction to participating providers. See chapter 12, Electronic Solutions for information regarding the HIPAA 835.

10.22 Overpayments

Participating providers agree that in the event of any overpayment, duplicate payment, or other payment in excess of the member's benefits payable according to the member's benefit plan, payment will be promptly remitted to BCBSNC. BCBSNC may recover overpayments by offset against current or future amounts payable to you after 45 days of a request for a refund. If within 45 days of this request, if the requested refund has not been made and you have not disputed the payment error, BCBSNC may recover this amount by offset of future amounts payable to you. Prior to recovery by offset we will make best efforts to first recover this overpayment through a written request for the refund.

10.22.1 When You Notice an Overpayment

Complete form G252 - Refund of Overpayment form *(see chapter 23, Forms)*

OR

Write a letter including the following information:

- The amount of the overpayment
- The member's ID number associated with the overpayment
- Date of service
- Provider number under which service was paid
- Copy of the EOP/NOP
- The reason you believe the payment is in error

Mail a check, along with a copy of your letter or G252 form to:

Financial Processing Services
Blue Cross and Blue Shield of North Carolina
P.O. Box 30048
Durham, NC 27702-3048

For questions related to overpayments, call the Provider Blue Line℠ at **1-800-214-4844** or Inter-Plan Programs at **1-800-487-5522** and speak with a representative.

10.22.2 When We Notice an Overpayment

If we discover an overpayment, an invoice will be sent requesting payment within 45 days. Please return the invoice with your payment. If payment is not received after 45 days of our notification to you, we will deduct the amount owed from a future payment to you, and indicate the member's identification number, date of service and a message indicating the reason on the explanation of payment.

10.23 Enterprise Business Continuity

I. **Executive Summary**

A. BCBSNC has established an enterprise business continuity program, its mission to enhance the overall protection of:

1. Employees
2. Customers and service activities
3. Property and other assets
4. Brand, image and reputation

II. An EBC governance committee has been formed to ensure BCBSNC's enterprise business continuity methodology is derived from and executed according to industry best practices and provides for the specific needs of BCBSNC and its customers. Moreover, the EBC governance committee is responsible for the confluence and oversight of all related business continuity efforts and programs.

III. **Pay Providers Recovery Plan**

A. In the event of catastrophic systems loss preventing the electronic submission and processing of claims, BCBSNC will implement a plan to pay most participating providers on an interim basis for up to 90 days. Providers meeting a pre-designated level of claims over the most recent three month period will receive a weekly receipts over that period. These interim payments should be tracked by the providers, as they will be subtracted from payments made for adjudicated claims once BCBSNC systems are back in operation.

10.24 Using the Corrected 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 is located in chapter 22 of the manual *(Health Insurance and Portability Act [HIPAA])*, and on the Centers for Medicare and Medicaid Services "CMS" Web site at ***http://www.cms.hhs.gov/NationalProvidentStand/***.

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 and Medicaid Services" enumeration system, National Plan and Provider Enumeration System, "NPPES."

- 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.

10.24.1 NPI – Facility Type Code "FTC" Billing

If your health care business files both UB-04 facility claims and CMS-1500 professional claims and use only one NPI for both bill types, claims must be reported with the appropriate facility type code/place of service or the services may be processed under the incorrect BCBSNC associated provider number.

BCBSNC accepts NPI on transactions, maps the NPI submission to the appropriate BCBSNC PPN, the PPN continues the transaction through the claims processing system and is mapped back to the NPI, prior to being transmitted back to the provider.

Providers have the option to receive multiple NPIs but if only one NPI is requested, BCBSNC will use a facility type code *(filter)* to differentiate between two PPNs. *(The facility type code is the [bill type] on the UB-04 and the place of service on the CMS-1500.)* If a provider has chosen to receive only one NPI but has two BCBSNC PPNs, the FTC is available to identify the appropriate PPN. The provider must agree to use a specific FTC for a specific PPN. If any other FTC is filed the claim will map to the other PPN and the provider must accept the payment as received. We will not be adjusting these claims if the provider files with the incorrect FTC.

10.24.2 PA and Nurse Practitioner NPI

If your office staff includes physician assistants or advanced practic nurse practitioners, you may have applied and received National Provider Identifiers "NPI" for them. However, please do not use physician assistant or advanced practice nurse practitioners "NPI" when reporting services in claim submissions to BCBSNC unless the physician assistant or advanced nurse practitioner has been approved by BCBSNC for inclusion on the practitioner roster. Otherwise, report services provided by physician assistants and advanced practice nurse practitioners employed in your office, under the NPI and/or BCBSNC assigned provider number of the supervising physician providing the oversight.

Please note that generally, BCBSNC does not directly reimburse physician assistants or advanced practice nurse practitioners for services provided in a physician's office and that filing claims using non-rostered physician assistants or registered nurses NPI can delay claims processing which can also delay payment to your practice.

10.25 Using the Correct Claim Form for Reporting Your Health Care Services

BCBSNC recognizes and accepts the CMS-1500 claim form *(version 08-05)* for professional providers and the UB-04 *(CMS-1450)* claim form for institutional/facility providers. The National Uniform Claim Committee "NUCC" and 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 / Services	Claim Form
Providers office	Form CMS-1500 (8-05)
Home Durable Medical Equipment "HDME"	Form CMS-1500 (8-05)
Reference lab	Form CMS-1500 (8-05)
Licensed registered dietitian	Form CMS-1500 (8-05)
Specialty pharmacy	Form CMS-1500 (8-05)
Ambulance provider	Form CMS-1500 (8-05)
Hospital facility	Form UB-04 CMS-1450
Ambulatory surgical center	Form UB-04 CMS-1450
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 Form CMS-1500 (08-05)

Please note that providers with electronic capability who submit paper claims will be asked to submit claims electronically. In addition, providers who do not file electronic claims will be contacted to discuss electronic filing options.

For more information on the CMS-1500 *(version 08/05)* claim form, visit the National Uniform Claim Committee "NUCC" Web site at ***www.nucc.org***. For more information on the UB-04 claim form, visit the National Uniform Billing Committee "NUBC" Web site at ***www.nubc.org***.

CMS-1500 (08/05) Claim Filing Instructions

Field #	Description
1	Leave blank
1a	Insured's ID - Enter the member identification number exactly as it appears on the patient's ID card. The member's ID number is 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, & 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.
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.

Field #	Description
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 *(Blue Shield 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 NP 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.
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

Field #	Description
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 *(Blue Shield 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
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.

Field #	Description
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

10.25.1 Sample CMS-1500 Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | 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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

10.26 UB-04 Claim Filing Instructions

Form Locator Number	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)*
9a	Patient's address – street
9b	Patient's address – city
9c	Patient's address – state

Form Locator Number	Description of Content
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 — 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
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 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

<table>
<tr><th>Form Locator Number</th><th>Description of Content</th></tr>
<tr><td>15
(continued)</td><td>For Newborns
1. Normal delivery
2. Premature birth
3. Sick baby
4. Extramural birth</td></tr>
<tr><td>16</td><td>Discharge hour:
<table><tr><th>Code</th><th>Time AM</th><th>Code</th><th>Time PM</th></tr><tr><td>00</td><td>12:00-12:59 midnight</td><td>12</td><td>12:00-12:59 noon</td></tr><tr><td>01</td><td>01:00-01:59</td><td>13</td><td>01:00-01:59</td></tr><tr><td>02</td><td>02:00-02:59</td><td>14</td><td>02:00-02:59</td></tr><tr><td>03</td><td>03:00-03:59</td><td>15</td><td>03:00-03:59</td></tr><tr><td>04</td><td>04:00-04:59</td><td>16</td><td>04:00-04:59</td></tr><tr><td>05</td><td>05:00-05:59</td><td>17</td><td>05:00-05:59</td></tr><tr><td>06</td><td>06:00-06:59</td><td>18</td><td>06:00-06:59</td></tr><tr><td>07</td><td>07:00-07:59</td><td>19</td><td>07:00-07:59</td></tr><tr><td>08</td><td>08:00-08:59</td><td>20</td><td>08:00-08:59</td></tr><tr><td>09</td><td>09:00-09:59</td><td>21</td><td>09:00-09:59</td></tr><tr><td>10</td><td>10:00-10:59</td><td>22</td><td>10:00-10:59</td></tr><tr><td>11</td><td>11:00-11:59</td><td>23</td><td>11:00-11:59</td></tr></table></td></tr>
<tr><td>17</td><td>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
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”</td></tr>
</table>

Form Locator Number	Description of Content
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 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

Form Locator Number	Description of Content
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
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

Form Locator Number	Description of Content
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 **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

Form Locator Number	Description of Content
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 processing • **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" – not required for BCBSNC processing • **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)* • 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

Form Locator Number	Description of Content
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)*

10.26.1 Sample UB-04 Claim Form

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 CODE	OCCURRENCE DATE	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a														a
b														b

38	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A						57	A
B						OTHER	B
C						PRV ID	C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX	67	A	B	C	D	E	F	G	H	68
		I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

10.27 Split Claim Guidelines

BCBSNC reserves the right to request a split claim where necessary to support correct adjudication of the claim.

In certain situations it may be necessary to divide a claim into sections by either date range or service, in order to process a claim and apply member benefits correctly. The below chart has been designed to assist you to identify the types of claim situations that can result in a split claim being required.

	Claim Situation	BCBSNC HMO, POS, PPO and CMM *(Includes fully insured, State PPO and ASO)*	Medicare Supplement *(CMM legacy)*	State Health Plan CMM *(Indemnity)*	Federal Employee Program PPO
1	For calendar year split	No	No	No, State Health Plan is on a fiscal year. Only non-DRG inpatient claims are required to be split.	No
2	For hospital contract changes	No	Yes	No	Inpatient = No; Outpatient = Yes
3	For hospital contract change with room rate changes	No	No	Yes	No
4	If the member's policy terms while inpatient	Yes	Yes	No	No
5	When the patient is admitted from the ER without an inpatient authorization	Yes	No	No	No
6	When authorized and non-authorized days are in the same admission and reimbursement is percent of charge	Yes	No	No	No
7	When authorized and non-authorized days are in the same admission and reimbursement is DRG *(case pay)*	No	No	Yes, for DRG	No

	Claim Situation	BCBSNC HMO, POS, PPO and CMM *(Includes fully insured, State PPO and ASO)*	Medicare Supplement *(CMM legacy)*	State Health Plan CMM *(Indemnity)*	Federal Employee Program PPO
8	When authorized and non-authorized days are in the same admission and reimbursement is DRG *(percent of charge)*	Yes	No	No	No
9	Newborns: If baby has not been added to the policy, split the claim to bill for the first 48 or 96 hours depending on method of delivery. Same for a sick baby who is on the policy but not authorized past the first 48 or 96 hours.	Yes	Yes	Yes	Yes; split the claim from the date when the sick baby is admitted in its own right

Inter-plan program (BlueCard®) request for split claims are dependent on the home Plan's processing requirements and/or member benefits. This means that the same type of claim may need to be split for one plan but not for another.

Definitions

- **Case pay:** A prospective payment methodology for facility inpatient service in which the allowance for covered services is negotiated for the entire inpatient stay. *(A fixed dollar amount is agreed to for the entire inpatient stay.)*
- **Per diem rate:** A prospective payment methodology for facility inpatient service in which the allowance for covered services is a negotiated daily rate. *(An agreed allowance amount is reimbursed for each BCBSNC-approved inpatient day.)*
- **Percent of approved charges:** A payment methodology in which the allowance for covered services is calculated on BCBSNC approved charges.

Please note that BCBSNC reserves the right to request a split claim where necessary to support correct adjudication of the claim.

10.28 Notification of Payment or Explanation of Payment

We report payment and denial of claims to providers on a notification of payment or explanation of payment report. The table below explains key information on the explanation of payment.

Item	Explanation
Patient number	Number assigned by providers to identify patient accounts
POS or place	Place of service
Type of service	Brief description of the service rendered
PC/Days	If facility claims, number of days admitted as an inpatient
Billed charges	Provider's charges as billed
Contracted charges	The charge after contractual reductions
Non-covered/Disallowed	Non-covered amounts/disallowed amount
Deduct amount	The member's deductible amount owed by the member
Remaining member expense	Amount the member can be billed by the provider
DEN code	The denial or adjustment code that further explains the payments/denial
Remarks	Written explanation for DEN codes
Amount paid	Total amount paid to provider
Contract types of services and special codes	This field indicates special coverage, type of transmission, or other key information: PCN - Provider communication network *(electronically filed)* COB - Coordination of benefits CONADJ - Contractual adjustment SPCADJ - Special adjustment Blue Care® Blue Options℠ Classic Blue® PCP - Personal Care Plan MPT - Med*Point* PS-C - Preferred Care *Select* CMM - CostWise/Comprehensive Major Medical

10.28.1 Sample EOP

BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF PAYMENT

Provider Name: **FEEL GOOD FAMILY CARE**
Provider Number: **00123**

02/22/2001 Page: 001 of 003

Patient's Name / Type of Service	ID Number PC/Days	Prov ID	Dates of Service Billed Charges	Contracted Charges	Patient Number Noncovered/ Disallowed	Deductible Amount	Medical Rec Number Copay Amount	Remaining Mbr Expense	Place Den Code	Amount Paid
JONES SUBSCRIBER H	001102220 1		12/20/2000	12/20/2000					EMERGENCY ROOM	
EMERGENCY ROOM CONSULATATION	99821	12345	200.00	120.00	80.00	0.00	20.00	20.00	A03/A04	100.00
			12/15/2000	12/15/2000						

INTEREST ACCURAL BEING PAID ON THIS INSURED'S CLAIM BASED ON TIME PROCESSING GUIDELINES AS SPECIFIED BY NORTH CAROLINA STATE LAW 58-3-100(C), CLAIM RECEIPT DATE: **12/29/2000**
BLUE OPTIONS **CLAIM #: 011229005022** **EFT BATCH #: 0000000904** **INTEREST: 15.00**
CLAIM TOTAL: 115.00

10.29 Maternity Claims

A global charge should be billed for maternity claims. Prenatal care is considered an integral part of the global reimbursement and will not be paid separately. However, prenatal care may be filed alone if that is the only care provided by that particular physician. In the event you provide prenatal care for only part of the nine months and you do not perform the delivery *(such as when a patient moves during her pregnancy)*, you may file using the antepartum care only codes applicable to the number of times the patient was seen prior to the delivery.

Applicable codes:

- 59425 Antepartum care only *(4-6 visits)*
- 59426 Antepartum care only *(7 or more visits)*

For more information, please refer to the BCBSNC maternity reimbursement medical policy, on our Web site at ***https://www.bcbsnc.com/services/medical-policy/pdf/guidelines_for_global_maternity_reimbursement.pdf***. If these codes should change after the publication of this manual, please use the most current code.

10.30 Filing Immunizations

Vaccines for immunizations can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered. BCBSNC 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 BCBSNC member. Providers with questions are encouraged to contact their local network management representative.

Participating providers are encouraged to participate in the State of North Carolina immunization program, which reimburses serum cost for specific immunizations.

The purpose of the immunization filing procedure is to permit BCBSNC's quality improvement staff to monitor the immunization status of our members for HEDIS reporting. BCBSNC submits immunization data concerning its members to the National Committee for Quality Assurance "NCQA" and the North Carolina Department of Insurance "NCDOI."

You should file immunizations as follows:

- Each immunization given must be filed on a single line of the CMS-1500 using one CPT-4 code:
- 90657 Flu shot for 6 months of age to 35 months
- 90658 Flu shot for 3 years
- 90660 Flu mist

If these codes should change after the publication of this manual, please use the most current code.

- The -25 modifier must be used with all evaluation and management services except preventive services CPT 99381-99397, when reporting a significant, separately identifiable service in addition to the immunization services.
- It is inappropriate to use the unlisted vaccine code CPT 90749 to report immunization administration services.
- The invoice from the laboratory or pharmacy the vaccine has been purchased from may be requested for claim review.
- **BCBSNC HMO, POS, PPO and CMM products:**
  - Submit state-supplied vaccines with the immunization code and a *(zero)* charge amount. Claims for vaccines that are not supplied by the state should indicate the cost of the vaccine.
  - CPT codes CPT 90471 or CPT 90472 are the preferred method of requesting payment for administering all immunizations. A practice may use the specific CPT code with the *(52)* modifier to request payment for the administration of state-supplied vaccines.
- **BlueCard® Host, FEP and State CMM *(indemnity)* products:**

  Submit state-supplied vaccines with the immunization code affixed with the -52 modifier *(do not use 90471 or 90472)*.

The Blue Cross and Blue Shield of North Carolina "BCBSNC" preventive care guidelines are updated regularly and available to providers on the ***bcbsnc.com*** Web site for providers at: ***http://www.bcbsnc.com/members/guidelines.cfm***.

Providers should note that although guidelines exist, benefit allowances are subject to the terms and limitations of the member's eligibility and preventive care benefits at the time service is provided. Providers are encouraged to verify a member's benefits and eligibility in advance of providing service.

10.30.1 State Supplied Immunization Reimbursement Notice

As of September 1, 2007, claims reported for HMO, POS, PPO and CMM members for the administration of a state supplied vaccine, filed with the appropriate immunization CPT code and a 52-modifier, are considered for reimbursement according to the providers contracted fee schedule. Please note that this reimbursement notice does not apply to the State Health Plan CMM *(indemnity)* or Federal Employee Program products.

10.30.2 Vaccines and Medicare Part D

When a vaccine is considered a prescription drug benefit under Part D vs a medical benefit, eligible members are to obtain the vaccine from their health care provider. A member should never be sent to a pharmacy to obtain the vaccine as it is always to be received by the administering provider. Therefore, we are currently asking that members with Medicare Part D *(not BCBSNC commercial members)* pay at the provider's office for the vaccine and then file a member's claim form directly to BCBSNC for their charge. Please note that at the time of this publication BCBSNC is working with Medco, our pharmacy benefits manager, to develop an easier way for office-administered vaccines to be adjudicated under Medicare Part D. Please check our Web site and review the online version of *The Blue Book*℠ for an update to this process.

10.31 Venipuncture and Handling Fee

BCBSNC has established allowances for laboratory services inclusive of venipuncture and usual supplies.

BCBSNC's medical policy does not allow separate reimbursement for venipuncture. Handling and/or conveyance of a specimen is eligible for payment when the laboratory service is not performed in the provider's office and the independent laboratory bills BCBSNC directly for the test.

Handling fees are paid to HMO/POS providers by BCBSNC only when the laboratory specimen is sent to an outside reference lab for processing and that lab bills BCBSNC directly for the laboratory services. Use CPT code 99000 to bill BCBSNC for the handling fee.

10.32 Participating Labs and Billing

Any contracting laboratory, physician office or hospital laboratory may provide and bill laboratory services for all BCBSNC lines of business. The physician office should not bill for the same lab service they have asked a contracted lab to bill.

10.33 Anesthesia Services

Anesthesia services include the following:

- General anesthesia
- Spinal block anesthesia
- Regional block anesthesia *(nerve trunk block and IV anesthesia proximal to elbow and knee)*
- Monitored anesthesia care *(when used in lieu of general anesthesia)*

Regional block and monitored anesthesia care are regarded as equivalent to general anesthesia. Anesthesia services must be administered by a medical doctor or a qualified anesthetist under the direction of a medical doctor.

The anesthesia service is considered to include all services incidental to the anesthesia including pre- and post-operative visits, administration of anesthetic, fluids and/or blood administered by the Medical Doctor of Anesthesiology "MDA" or qualified anesthetist, and necessary drugs and materials provided by the MDA, interpretation of invasive and/or non-invasive monitoring procedures including: EKG, EEG, EMG, blood gases, capnography, oxygen saturation, evoked potentials and recovery room supervision. Additional reimbursement is not available for the above-referenced procedures when they are billed separately from the anesthetic administration. Reimbursement is not provided for administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant. All anesthesia services are subject to BCBSNC's bundling requirements.

The following anesthesia services may be considered medically necessary:

- General anesthesia
- Spinal block anesthesia

- Regional block anesthesia *(nerve trunk block and IV anesthesia proximal to elbow and knee)*
- Monitored anesthesia care *(when used in lieu of general anesthesia)*

Regional block and monitored anesthesia care are regarded as equivalent to general anesthesia. Anesthesia services must be administered by an anesthesiologist or a qualified anesthetist under the direction of an anesthesiologist.

The following components are considered an integral part of the anesthesia service and additional benefits are not provided:

- Pre-anesthesia evaluation
- Postoperative visits
- Administration of anesthetic, fluids and/or blood administered by the Medical Doctor of Anesthesiology "MDA" or qualified anesthetist and necessary drugs and materials provided by the MDA
- Interpretation of invasive and/or non-invasive monitoring procedures including: EKG, EEG, EMG, blood gases, capnography, oxygen saturation, evoked potentials
- Services administered in recovery room

When anesthesia services are not covered:

- The administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant is considered incidental to the surgical procedure. This includes sedation given for endoscopic procedures including colonoscopy. Separate reimbursement is not provided for incidental services. *(Refer to separate policy number ADM9020, Bundling Guidelines.)*
- Monitoring of IV sedation by an anesthesiologist for gastrointestional endoscopy, arteriograms, CT scans, MRIs, cardiac catherizations, and PTCA is generally considered not medically necessary. Please review the medical policy for anesthesia services at ***bcbsnc.com***.

Please note: If service begins on one day and ends on another day, provider must bill based upon the beginning service date.

10.33.1 CRNAs

Filing:

BCBSNC does not assign CRNAs individual provider numbers. Claims must be filed under the directing MDA's individual provider number and group number along with the appropriate modifier, which will then be recognized for reimbursement.

BCBSNC Secondary to Medicare:

BCBSNC provides benefits for Certified Registered Nurse Anesthetists "CRNA" *(or other qualified anesthetists, henceforth referred to as anesthetist)* services on behalf of its members who are Medicare beneficiaries. These claims should be submitted through the Medicare Crossover program, which forwards the claims to the Medicare carrier for determination of Medicare benefits. The Medicare carrier will forward the necessary data to BCBSNC for processing of secondary benefits.

10.33.2 Anesthesia Time

Anesthesia time must be reported in one-minute increments. Anesthesia time should begin when the MDA begins personal and continuous preparation of the patient for induction of anesthesia in the operating room or an equivalent area *(i.e., holding area)*. It is recognized that services rendered in the holding area will result in variance of operating room time when compared to actual time of anesthesia administration. Anesthesia time ends when the patient's condition can safely be managed by post-operative supervision other than the personal attention of the MDA.

Anesthesia time units are calculated at one unit for each minute of anesthesia time. Anesthesia base units and the anesthesia provider's Conversion Factor "CF" are adjusted by BCBSNC *(internally)* relative to this one minute time unit, i.e., the base unit value is multiplied by fifteen and the CF is divided by fifteen.

BCBSNC considers the following list of codes to be non-timed procedures, which differs from the ASA relative value guide:

Code	Description
01960	Anesthesia for vaginal delivery
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery

Please note: CFs are based on 15-minute increments. *For example*, in a procedure with an anesthesia base unit value of 4 requiring 2 hours and 12 minutes of anesthesia time *(properly reported as "132" in the claim's units field)*: the time units *(132)* are added to the base unit value of 60, *(or 4 x 15)*, producing a total unit value of 192 units for this anesthesia service.

This total unit value is then multiplied by the provider's CF *(CF divided by 15 and rounded to the nearest cent)*. See Example 1 below:

Example 1: Method for Calculating Reimbursement for Timed Anesthesia Procedures

Scenario: CF = $30.00 Base Unit = 4 Time Units = 2 hrs, 12 mins *(or 132 min)*

Calculation:		
Allowance	=	($CF/15) x ((base unit x 15) + minutes)
	=	($30.00/15) x ((4 x 15) + 132)
	=	$2.00 x (60 + 132)
	=	$2.00 x 192
	=	**$384.00**

Physicians Office

10.33.3 Anesthesia Modifiers

All anesthesia services are reported by use of the anesthesia five-digit procedure code plus the addition of a modifier(s). Modifiers are added to modify or give additional definition to the service performed, and in certain circumstances add additional units to the base unit values. The anesthesia modifier must be submitted first after the procedure, before other non-anesthesia modifiers. Please include all modifiers for a procedure code on one line.

1. **Modifiers for timed anesthesia:** The following modifiers must be used with the appropriate anesthesia codes. Every timed service must have a modifier. Choose the appropriate modifier from the following:

   "AA" Physician personally performed
   "AD" Medically supervised by a physician for more than four concurrent procedures
   "AD" Direction of residents in furnishing not more than two concurrent anesthesia procedures
   "QK" Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
   "QS" Monitored anesthesiology care services
   "QX" CRNA with medical direction by a physician
   "QY" Medical direction of one CRNA by an anesthesiologist
   "QZ" CRNA without medical direction by a physician

2. **Physical status modifiers:** When filed with a five-digit procedure code, the following modifiers will add additional unit(s) to the base unit value. In order to receive additional base units, these modifiers must be filed in the first position on the claim form or electronic transaction.

   P1 – A normal healthy patient 0
   P2 – A patient with mild systemic disease 0
   P3 – A patient with severe systemic disease.....1
   P4 – A patient with severe systemic disease that is a constant threat to life.....2
   P5 – A moribund patient who is not expected to survive without the operation.....3
   P6 – A declared brain-dead patient whose organs are being removed for donor purposes 0

The above six levels are consistent with the ASA's ranking of patient physical status. Physical status is included in CPT-4 to distinguish between various levels of complexity of the anesthesia service provided.

Please note: These lists are subject to change as nationally recognized code sets change.

10.34 Assistant Surgeon

Benefits are allowed when medical necessity and appropriateness of services are met. Generally, Medicare guidelines are used to determine this, although cases may be reviewed on an individual consideration basis. Benefits for a covered procedure is 20% of the maximum allowed for the procedure. Applicable modifier is – 80.

Benefits are allowed when medical necessity and appropriateness of assistant surgeon services are met. An assistant surgeon must be appropriately board certified or otherwise highly qualified as a skilled surgeon and licensed as a physician in the state where the services are being provided.

Physician assistants not employed by a hospital may act as an assistant surgeon when the above criteria are met. RN-LPN-first assistants and physician assistants employed by a hospital are not eligible for reimbursement as surgical assistants. BCBSNC corporate medical policy regarding assistant surgeons may be viewed online at ***bcbsnc.com***.

10.35 Physician Assistant

Benefits are allowed when medical necessity and appropriateness of assistant surgeon services are met, and when the physician assistant is under direct supervision of the performing surgeon. The PA must be appropriately certified or licensed in the state where the services are rendered, and be credentialed in the facility where the procedure is performed. The physician assistant benefits for a covered procedure is 85% of the maximum allowed for an assistant surgeon. Applicable modifier for surgical assistant is – AS.

RN-first assistant and nurse practitioners are not eligible for reimbursement as surgical assistants.

Please refer to our online medical policy on co-surgeon, assistant surgeon and physician assistant guidelines for complete details.

10.36 Telephone Consultations

Telephone consultations are non-covered services and are not reimbursed by BCBSNC. You may bill members directly for these services only if this is your standard practice procedure, and the member has previously received a written statement of this procedure, or your standard procedure for telephone consultations is posted in your office in a prominent location.

10.37 Billing for Missed Appointments

BCBSNC does not cover charges for missed appointments. You may bill members directly for missed appointments only if this is a standard procedure for your practice, and the member has previously received a written statement of this procedure, or your standard procedure for missed appointments is posted in your office in a prominent location.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE CMS-1500 (08/05) CLAIM FORM Physician's Office

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): YPPW12345678

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

3. PATIENT'S BIRTH DATE MM DD YY: 02 08 1919 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 550 Nobel Avenue

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 550 Nobel Avenue

CITY: Charlotte STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: Charlotte STATE: NC

ZIP CODE: 28220 TELEPHONE (Include Area Code): (704) 555-9099

ZIP CODE: 28220 TELEPHONE (Include Area Code): (704) 555-9099

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: QT0321

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 02 08 1919 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: First Bank

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield - NC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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: Signature on File DATE: 4/28/1999

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: Signature on File

14. DATE OF CURRENT: MM DD YY: 04 28 1999 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 04 28 1999

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: Lackey, James M.D.

17a. 1B C4612

17b. NPI 1234567891

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. 250.0 Diabetes
2.
3.
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	04 27 99		04 27 99			11		99214			50 00	1		1B	040X0
														NPI	0123456789
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 56-9876543 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 987654321

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 50 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 50 00

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: Signature of Claim Preparer DATE:

32. SERVICE FACILITY LOCATION INFORMATION: Regis Medical Center 999 Event Drive Charlotte, NC 28220

a. 1123456789 b.

33. BILLING PROVIDER INFO & PH #: (704) 555-1111 Regis Medical Center 999 Event Drive Charlotte, NC 28220

a. 0123456789 b. 1B040X0

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

10.38 Participating Reference Labs and Billing

Definition

Laboratory services - 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 using CPT/HCPCS coding
- Specify services provided and include all of the statistical and descriptive medical, diagnostic and patient data
- 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

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE REFERENCE LABORATORY CLAIM FORM

Ancillary Providers

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA ☐☐☐ 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) XXXW12345678
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) John Doe	3. PATIENT'S BIRTH DATE MM DD YY 04 15 1970 SEX M [X] F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) John Doe
5. PATIENT'S ADDRESS (No., Street) Any Street	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) Any Street
CITY: Any City STATE: NC	8. PATIENT STATUS Single ☐ Married [X] Other ☐ Employed [X] Full-Time Student ☐ Part-Time Student ☐	CITY: Any City STATE: NC
ZIP CODE: 12345 TELEPHONE (Include Area Code): (000) 000-0000		ZIP CODE: 12345 TELEPHONE (Include Area Code): (000) 000-0000
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 615
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY 10 01 2003 SEX M [X] 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 Working Group
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield - NC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 10012003		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 10 01 2003 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 10 01 2003	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM _____ TO _____
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. _____ 17b. NPI _____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM _____ TO _____
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. 250.0 Diabetes 2. _____ 3. _____ 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	10	22	03	10	22	03			82131						NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER 00-0000000 SSN ☐ EIN [X]	26. PATIENT'S ACCOUNT NO. 000000000-0	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] 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 Any Lab Name 1234 Street Any Town, NC USA a. 1123456789 b.	33. BILLING PROVIDER INFO & PH # ( ) Any Lab Name 1234 Street Any Town, NC USA a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

10.39 Licensed Dietitian Nutritionist Services

Definitions

- Routine supplies and services: The following services are considered routine supplies and services for which payment is included in the reimbursement for licensed dietitian nutritionist services. These items are not separately billable:
  - Educational materials

General Billing Guidelines

Provider agrees to:

- Bill only those codes for services indicated as billable licensed dietitian nutritionist services.
- Submit claims either electronically or on a typed red and white CMS-1500 *(version 08/05)*.
- Bill us your retail charges.
- File claims within 180 days of providing service.

Billable Licensed Dietitian Nutritionist Services		
Billing Code	**Service Description**	**Unit**
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	1 Unit *(1 unit equals 15 minutes)*
97803	Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	1 Unit *(1 unit equals 15 minutes)*
97804	Group *(2 or more individual[s])*, each 30 minutes	1 Unit *(1 unit equals 30 minutes)*
S9465	Diabetic management program, dietitian visit	Per Visit
S9470	Nutritional counseling, dietitian visit	Per Visit

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE LDN CLAIM
CMS-1500 (08-05)
Ancillary Providers

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): XXXW12345678

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

3. PATIENT'S BIRTH DATE MM DD YY: 04 15 1970 SEX M [X] F ☐

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse ☐ Child ☐ Other ☐

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

CITY: Any City STATE: NC

8. PATIENT STATUS: Single ☐ Married [X] Other ☐ Employed [X] Full-Time Student ☐ Part-Time Student ☐

CITY: Any City STATE: NC

ZIP CODE: 12345 TELEPHONE (Include Area Code): (000) 000-0000

ZIP CODE: 12345 TELEPHONE (Include Area Code): (000) 000-0000

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: 615

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 10 01 2003 SEX M [X] 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: Working Group

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield - NC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 10012003

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 10 01 2003 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 10 01 2003

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. 250.0 Diabetes
2.
3.
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	03	06	07	03	06	07	11		97802			20 00			1B 566XY
														NPI	0123456789
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 00-0000000 SSN ☐ EIN [X]

26. PATIENT'S ACCOUNT NO.: 000000000-0

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES ☐ NO

28. TOTAL CHARGE $ 20 00

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
Dietitian Care
123 Blue Street
Blue Town, NC 12345
a. 0123456789 b.

33. BILLING PROVIDER INFO & PH # ( )
Dietitian Care
123 Blue Street
Blue Town, NC 12345
a. 0123456789 b. 1B 566XY

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

10.40 Home Health Billing and Reimbursement

Please note that home health services are included in BCBSNC's prior review requirements. Please refer to chapter eight, Health Coaching and Intervention in this manual to learn more about prior review for BCBSNC members and see our most current prior review listing, available on the BCBSNC Web site at ***https://www.bcbsnc.com/providers/ppa/***.

10.40.1 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 worker
Home Health Aide "HHA"	Home health aide

- Patient must be homebound
- Postpartum early discharge

  If a covered service, when mother and newborn are discharged from an inpatient facility before the expiration of 48 hours for a normal vaginal delivery or 96 hours for a cesarean section, provider may bill a skilled nursing visit if rendered no later than 72 hours following discharge. Prior review must be obtained for this service.

10.40.2 Billing Codes and Unit Definitions

Revenue Codes	Services	Units
0551	Skilled nursing *(RN/LPN)*	Visit
0421	Physical therapy	Visit
0429	PT by physical therapy assistant	Visit
0441	Speech therapy	Visit
0431	Occupational therapy	Visit
0561	Medical social services	Visit
0571	Home health aide	Visit*
0272, 0279	See section 10.40.3, Billable Non-Routine Home Health Supplies	Unit of supply

*Note: State Health Plan CMM *(indemnity)* reimburses home health aide services by the hour *(limit of four hours per day per member)*.

Home Health Billing

Provider agrees:

- To bill on UB-04 claim form.
- To bill us your retail charges.
- To file claims after complete services have been provided.
- In addition to the home health visit, to 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)*.
- For non-routine supplies, to include a valid HCPCS code with the revenue code on the UB-04.

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.

The following services may not be billed under home health and are not part of your home health contract with BCBSNC:

- Services rendered to a hospice patient being cared for by a BCBSNC contracting hospice agency *(billed by hospice)*
- Home durable medical equipment *(billed by HDME provider)*
- Respiratory therapist services *(billed by HDME provider)*
- Skilled nursing visits on home infusion patients *(falls under home infusion services and is considered an integral part of infusion per diem rates)*
- Oral prescription drugs *(billed by pharmacy)*
- Any services when patient is not homebound
- EKGs
- Holter monitoring

10.40.3 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)*.

Listed on the following page is a list of billable non-routine home health supplies. These non-routine supplies are the only supplies home health providers may separately bill to BCBSNC.

Ancillary Providers

Billable Non-Routine Home Health Supplies	
Description	**Revenue Code**
Insertion tray without drainage bag and without catheter	0272
Insertion tray without drainage bag with indwelling catheter, Foley type two way latex with coating	0272
Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone	0272
Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	0272
Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone	0272
Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	0272
Indwelling catheter, Foley type, two-way, latex with coating	0272
Indwelling catheter, specialty *(e.g., Coude, mushroom, wing, etc.)*	0272
Indwelling catheter, Foley type, three-way, for continuous irrigation	0272
Indwelling catheter, Foley type, two-way, all silicone	0272
Insertion tray with drainage bag but without catheter	0272
Hydrogel dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	0272
Hydrogel dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	0272
Hydrocolloid dressing, wound cover, pad size more than 16 sq. in., without adhesive border, each dressing	0272
Hydrocolloid dressing, wound cover, pad size more then 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	0272
Specialty absorptive dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	0272
Specialty absorptive dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	0272
Foam dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	0272

Ancillary Providers

Billable Non-Routine Home Health Supplies	
Description	**Revenue Code**
Foam dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	0272
Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per roll *(at least 10 yards, stretched)*	0272
Heel or elbow protector, each	0272
Tracheotomy or laryngectomy tube	0279
Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	0279
Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	0279
Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	0279
Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	0279
Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	0279
Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	0279
Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	0279
Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	0279
Tracheotomy or laryngectomy tube	0279

10.41 Home Health Reimbursement

10.41.1 Eligible Services

- Patients must be homebound to be eligible for coverage. A patient is considered homebound by BCBSNC if the patient:
  1. Has a condition or injury restricting his or her ability to leave home
  2. Has a condition or injury for which leaving the home is medically contraindicated; and/or
  3. Would require the physical assistance and significant supervision of another person in order to leave the home
  4. Transportation issues do not determine if a member is homebound
- You may bill for each home health visit and only the non-routine supplies as identified in your contract and reimbursement schedule.
- *Post-partum early discharge services* - If a covered service, when mother and newborn are discharged from an inpatient facility before the expiration of 48 hours for a normal vaginal delivery or 96 hours for a cesarean section, you may bill a skilled nursing visit if rendered no later than 72 hours after discharge. Prior Review must be obtained for this service. A skilled nursing visit will not be covered if an office visit occurred on the same day. Additional services are subject to medical necessity review. Note: This coverage is not available for State Health Plan CMM *(indemnity)* and NC Health Choice members and FEP members at this time.

10.41.2 Ineligible Services

- The following services may not be billed under home health and are not part of your home health contract with BCBSNC. This is not an exhaustive list.
  - Any services when patient is not homebound *(refer to medical policy on skilled nursing visits)*
  - Services rendered to a hospice patient under care of a BCBSNC contracting hospice agency *(billed by hospice)*
  - Home durable medical equipment *(billed by HDME provider)*
  - Respiratory therapy *(billed by HDME provider)*
  - Oral prescription drugs *(billed by pharmacy)*
  - Aerosolized drugs *(billed by pharmacy)*
  - Blood draw nursing visits for home infusion patients *(billed as bundled service by home infusion provider)*
  - EKGs
  - Holter monitoring
  - Psychiatric services
- Visit our Web site at ***bcbsnc.com*** to view our corporate medical policy on home nursing services.

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
PRN Nurses 25 Harvest Street Wilson, NC 28214 (919) 000-0000		0000000 b. MED. REC. #	331
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
		00-0000000	100103 100103

8 PATIENT NAME	9 PATIENT ADDRESS
a John Doe	a Any Street, USA Any Town, USA
b	b c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
03221946	M	100103					01													

31 CODE	31 DATE	32 CODE	32 DATE	33 CODE	33 DATE	34 CODE	34 DATE	35 CODE	35 SPAN FROM	35 SPAN THROUGH	36 CODE	36 SPAN FROM	36 SPAN THROUGH	37
a														a
b														b

38	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
Any Person Any Street Any Town, USA	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0551	Skilled Nursing		10/01/03	1	75 00		1
2	0551	Skilled Nursing		10/01/03	1	75 00		2
3								3
4	0001	Total Charges				150 00		4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE ____ OF ____	CREATION DATE		TOTALS			23

Sample Home Health Claim

UB-04

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	BCBSNC	03X0X	Y	Y	0 00		57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	John Doe	01	000-00-0000	DTP, Inc.	4316
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	T40328		DTR, Inc.
B			
C			

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
174.9						
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL
LAST		FIRST
77 OPERATING	NPI	QUAL
LAST		FIRST
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 CMS-1450 OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

10.42 Private Duty Nursing "PDN"/Skilled Nursing Services Billing and Claims Submission

Please note that all PDN services require prior review from BCBSNC in advance of services being provided. Please refer to chapter eight, Health Coaching and Intervention in this manual to learn more about prior review for BCBSNC members and see our most current prior review listing, available on the BCBSNC Web site at ***https://www.bcbsnc.com/providers/ppa/***.

10.42.1 Definition

Private Duty Nursing "PDN" is defined as follows:

- Patient requires four or more hours of continuous skilled nursing care per day in the home.
- Patient must be homebound.
- Services must be rendered by Registered Nurse "RN" or Licensed Practical Nurse "LPN."

10.42.2 Billing Codes and Unit Definitions

Revenue Codes	Services	Units
0552	RN per hour *(PDN)*	Hour
0559	LPN per hour *(PDN)*	Hour

10.42.3 Private Duty Nursing "PDN" Billing

Provider agrees to:

- Bill on UB-04 claim form.
- File claims after complete services have been provided.
- Bill us your retail charges.

Provider agrees that:

- All medical supplies provided in conjunction with PDN services are considered an integral part of the PDN reimbursement and cannot be billed separately *(under home durable medical equipment [HDME] provider number or any other provider number)*
- Skilled nursing visits may not be billed on the same days as private duty nursing visits.
- Use your appropriate provider number.
- File claims after complete services have been provided.
- Bill us your retail charges.

Provider agrees that:

- All medical supplies provided in conjunction with PDN services are considered an integral part of the PDN reimbursement and cannot be billed separately *(under home durable medical equipment [HDME] provider number or any other provider number)*
- Skilled nursing visits may not be billed on the same days as private duty nursing visits.

10.43 Skilled Nursing Billing and Claims Submission

Definition

Skilled nursing care is inpatient care, 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. The member must require continuous *(daily)* skilled nursing services for the level of care to be considered covered. The per diem rate includes all services rendered to the member.

Billing

Provider agrees to:

- Bill on UB-04 claim form.
- Bill only when the patient must require continuous *(daily)* skilled nursing services.

The following services are not part of your skilled nursing facility contract with BCBSNC and must be billed by a provider contracted with BCBSNC to provide:

- Medical care rendered by a physician.
- Services rendered in a place of setting other than the skilled nursing facility while the member is an inpatient.

Skilled nursing services include but are not limited to the following components:

- Assessing the total needs of the patient.
- Planning and managing of a patient treatment plan involving services where specialized health care knowledge must be applied in order to attain the desired result.
- Observing and monitoring the patient's response to care and treatment.
- Teaching, restoring, and retraining the patient.
- Providing direct services to the patient where the ability to provide the services requires specialized education and skills.

Providers should not file claims unless a covered level of care has been provided.

Providers with traditional contracts should bill the rates listed in the contract using the following grid to determine the appropriate revenue code, services and units.

REIMBURSEMENT SCHEDULE		
UB-04 Description	**Revenue Code**	**Unit**
Room and board - semi-private Routine service charges incurred for accommodations with two beds.	120	Per Diem
Physical therapy	420	15 minutes
Occupational therapy	430	15 minutes

REIMBURSEMENT SCHEDULE		
UB-04 Description	**Revenue Code**	**Unit**
Speech-language pathology	1440	15 minutes
All other ancillary services	Various	15 minutes

Services for HMO, POS and PPO members are negotiated through health coaching and interventions on a case by case basis.

10.44 Private Duty Nursing/Skilled Nursing Services Reimbursement

10.44.1 Eligible Services

- Patients must be homebound to be eligible for coverage. A patient is homebound if the patient:
    1. Has a condition or injury restricting his or her ability to leave home
    2. Has a condition or injury for which leaving the home is medically contraindicated
    3. Would require the physical assistance and significant supervision of another person in order to leave the home
    4. Transportation issues do not determine if a member is homebound
- PDN patients must require 4 or more hours of continuous skilled nursing care per day.
- All PDN services require certification for all BCBSNC plans.

10.44.2 Eligible Healthcare Providers

- PDN services must be performed by individuals licensed in North Carolina as a Registered Nurse "RN" or Licensed Practical Nurse "LPN." You must include the names, license numbers, and shifts on each claim.
- PDN services provided by home health aides are ineligible for reimbursement for all BCBSNC lines of business.

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
Nursing Station 2053 Olive Boulevard Nashville, NC 27210		b. MED. REC. #	331
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
		00-0000000	100103	100103	

8 PATIENT NAME	9 PATIENT ADDRESS
a John Doe	a Any Street, USA Any Town, USA
b	b c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
09011925	M	100103					01			

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
Any Person Any Street Any Town, USA	a b c d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0552	RN Nursing Services		10/01/03	5	150 00		1
2	0552	RN Nursing Services		10/01/03	4	120 00		2
3								3
4	001	Total Charges				270 00		4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE ____ OF ____	CREATION DATE		TOTALS			23

Sample Private Duty Nursing/ Skilled Nursing Services Claim

UB-04

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	BCBSNC	002XV	Y	Y	0 00		57	A
B	AETNA	12346	Y	Y	00 00		OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	John Doe	02	XXXW12345678	Ford Equipment	325
B	John Doe	02	XXXW12345678		x431
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	76431		Ford Equipment
B			
C			

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
707.0			
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING	NPI	QUAL
LAST		FIRST
77 OPERATING	NPI	QUAL
LAST		FIRST
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

80 REMARKS	81CC	
A5	a	
	b	
	c	
	d	

UB-04 CMS-1450 OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

10.45 Ambulance and Medical Transport Services Billing and Claims Reimbursement

Definitions:

- Ambulance and medical transport services involve the use of specially designed and equipped vehicles to transport ill or injured patients. Ambulance and medical transports may involve:
  1. The emergency ambulance transport of a patient to the nearest hospital with appropriate facilities for the treatment of the patient's illness or injury; or
  2. The non-emergency medical transport of a registered hospital inpatient to another location to obtain medically necessary specialized diagnostic or treatment services.
- Ambulance services typically involve ground transportation, but may, in exceptional circumstances involve air or sea transportation.

Billing

Provider agrees to:

- Bill only for contracted services as defined in their most current BCBSNC ambulance services provider agreement.
- Submit claims to BCBSNC within 180 days of the date of service.
- Bill electronically or on a typed CMS-1500 *(version 08/05)* claim form using the appropriate HCPCS code and billing unit.

Eligible services

- Ground emergency ambulance services are eligible for the transport of a patient when all of the following criteria are met:
  - The ambulance must be equipped with appropriate emergency and medical supplies and equipment; the patient's condition must be such that any other form of transportation would be medically contraindicated; the patient must be transported to the nearest hospital with the appropriate facilities for the treatment of the patient's illness or injury.
- Non-emergency medical transport services for the transport of a hospital inpatient to another facility for specialized services are eligible for the transport of a patient when all of the following criteria are met:
  - The patient is a registered inpatient in an acute care hospital; the specialized services are not available in the hospital in which the patient is registered; the provider of the specialized services is the nearest one with the required capabilities.
- Air or sea ambulance services are eligible in exceptional circumstances when all of the criteria pertaining to ground transportation are met, as well as one of the following additional conditions:
  - The patient's medical condition must require immediate and rapid ambulance transport to the nearest appropriate medical facility that could not have been provided by land ambulance; the point of pick-up is inaccessible by land vehicle; great distances, limited

time frames, or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities for treatment; the patient's condition is such that the time needed to transport a patient by land to the nearest appropriate medical facility poses a threat to the patient's health.

Ambulance or medical transport services are considered eligible for coverage if the patient is legally pronounced dead after the ambulance was called, but before pickup, or enroute to the hospital.

Ineligible services

Ambulance and medical transport services are not covered for:

- A patient legally pronounced dead before the ambulance is called.
- Transportation from the member's home to a facility other than a hospital, skilled nursing facility, or nursing home is not covered.
- Transportation from a facility other than a hospital, skilled nursing facility, or nursing home to the member's home is not covered.
- Air or ground transportation provided for patient convenience.

Bundled services

- Reusable devices are considered an integral part of the general ambulance and medical transport services and are not eligible for coverage as separate services.

1500

SAMPLE CMS-1500 (08/05) CLAIM FORM
Ambulance and Medical Transport

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): YPPW12345678

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

3. PATIENT'S BIRTH DATE MM DD YY: 02 08 1919 SEX M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 550 Nobel Avenue

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

7. INSURED'S ADDRESS (No., Street): 550 Nobel Avenue

CITY: Charlotte STATE: NC

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

CITY: Charlotte STATE: NC

ZIP CODE: 28220 TELEPHONE (Include Area Code): (704) 555-9099

ZIP CODE: 28220 TELEPHONE (Include Area Code): (704) 555-9099

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: QT0321

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH MM DD YY: 02 08 1919 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: First Bank

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield - NC

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: Signature on File DATE: 4/28/1999

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: Signature on File

14. DATE OF CURRENT: MM DD YY: 04 28 1999 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 04 28 1999

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Lackey, James M.D.

17a. 1B C4612

17b. NPI 1234567891

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

19. RESERVED FOR LOCAL USE: PT Xport to Dialysis, Stretcher D/T PT HX: ESRD, Bilateral AKA, CHF

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. 585 End Stage Renal Disease "ESRD"
2. 897.6 Amputation, Bilateral "LEGS"
3. 428.1 Congestive Heart Failure "V"
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	BLS NonEmerg Transport - BER															
	03	26	07	03	26	05	41	9	A0428	RJ	1.2.3	175 00	1		NPI	
2	BLS Mileage - BERT															
	03	26	07	03	26	05	41	9	A0425	RJ	1.2.3	153 00	17		NPI	
3	BLS Disp Supplies - BERT															
	03	26	07	03	26	05	41	9	A0382	RJ	1.2.3	42 00	1		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 $ 370 00

29. AMOUNT PAID $ 305 53

30. BALANCE DUE $ 64 47

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 Signature of Claim Preparer DATE

32. SERVICE FACILITY LOCATION INFORMATION
From: 111 Blue Road
Blue Town, NC 12345
To: 4 Blue Street
Blue City, NC 12356

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

10.46 Specialty Pharmacy Billing and Reimbursement

Definitions:

The dispensing of physician prescribed, member specific, pharmaceuticals intended to improve clinical outcomes. Including utilization of information systems to perform safety checks, drug interaction screening and generic substitution *(when appropriate)*.

Billing Requirements:

- Bill on typed CMS-1500 *(version 08/05)* claim form using the appropriate HCPCS or CPT billing code and billing unit.
- Provide the NDC number when there is not a specific code available for a drug, as these drugs will suspend to medical review for individual consideration. Medical review uses the AWP for the specific NDC number, subject to provider contract discounts.
- File claims after complete services have been provided.
- Bill retail charges.

10.47 Home Infusion Therapy Billing and Reimbursement

Home Infusion Therapy Services for HMO/POS/PPO

Home infusion therapy is infusion services the member receives in the home. Home infusion is on the prior review list. Therefore, these services require prior review prior to services being rendered. When requesting authorization, the request needs to be specific and cover the following elements:

Definitions

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

Billing

Provider agrees to:

Bill home infusion therapy requiring regular nursing services in three components:

1. Per diem component *(covering all home infusion services, equipment and supplies except the prescription drug and licensed nursing services)* for each day the drug is infused. The per diem must relate to services being rendered. For second and subsequent per diems, documentation as to the protocol and items used must be sent with the request for coverage. Continuous infusions that are greater than 24 hours but less than 48 hours = one per diem. If the continuous infusion is equal to or greater than 48 hours, per diem = 2. Per diems are recognized by the number of hours the member receives the infusion and not by the day span.

2. Nursing services provided by a Registered Nurse "RN" or Licensed Practical Nurse "LPN." The home infusion provider is responsible for requesting and providing any needed nursing services related to the infusion and any care needed during the visit.
3. Drug component *(only bill for the quantity of drug actually administered, not unused mixed, compounded or opened quantities)*. To be requested and billed with the specific code and only the amount of units the member actually received.
   - Bill on the CMS-1500 *(version 08-05)* claim form.
   - Use your appropriate provider number.
   - File claims after services have been provided.
   - Bill your retail charges for infusion services.
   - Bill your retail charges for drug codes.

Note: Medicare Supplemental products *(Medicare Crossover)*. Use only billing codes as instructed by Medicare. Do not use BCBSNC home infusion codes for Medicare supplemental members.

- Providers additionally agree that:
  - Home infusion therapy per diems and nursing visits are defined by the standard codes.
  - Drug and drug units are defined by the standard codes.

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.

The following services may not be billed under home infusion and are not part of your home infusion contract with BCBSNC:

- Oral prescription drugs *(billed by pharmacy)*
- Aerosolized drugs *(billed by pharmacy)*
- Services to hospice patients being cared for by a contracting hospice provider *(billed by hospice)*
- Durable medical equipment not directly related to the home infusion *(billed by HDME provider)*

Please refer to your contract with BCBSNC for specific details and instructions.

10.47.1 Bundled Services

- The following are included in the home infusion therapy per diem rates established in your contract and reimbursement schedule and may not be billed separately:
  - 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.
- Home Infusion services should not be billed from a setting other than home.
- Enteral feeds are not covered under the home infusion therapy benefit. This service is considered a part of the DME benefit.

10.48 Home Durable Medical Equipment Billing and Reimbursement

Definitions

- Home durable medical equipment is any equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses that can withstand repeated use and is primarily and customarily used to serve a medical purpose and is appropriate for use in the home.
- A rented item is considered the property of the provider and should be returned to the provider after it is no longer medically necessary for the member; however, a member will retain possession of the rented item until it is no longer considered medically necessary. The conversion of a rental to a purchase may be done at any time prior the reaching the listed purchase price of the item. If an item is converted from rental to purchase prior to the rental reaching the purchase price, it is considered the property of the member and is not returned to the provider.

Please note that the HDME supplier must meet eligibility and/or credentialing requirements as defined by BCBSNC, in order to be eligible for reimbursement. HDME when eligible for coverage is considered as part of the member's HDME benefits provision.

Home Durable Medical Equipment Billing Requirements – General

- Bill on a typed CMS-1500 *(version 08/05)* claim form.
- Bill maintenance and repair modifier codes first after the procedure code.
- Submit all claims for repairs with a complete description of services provided.
- Use E1399 or other miscellaneous HCPCS codes only if no suitable HCPCS billing code exists. Each claim with such codes must include special documentation:
  - Always submit a complete description of the item.
  - With the initial claim, submit a factory invoice for the item *(catalogs and retail price listings are not acceptable)* and, if appropriate, a certificate of medical necessity form with physician's signature *(use appropriate form in chapter 23, Forms)*.
  - Do not staple this documentation to the claim form.
  - Submit all initial claims on paper to ensure the appropriate documentation is received in the same envelope. Electronically submitted claims do not transmit the additional documentation.

Ancillary Providers

Billing Requirements – Rentals

- Always include modifier code on rental claim forms.
  - Always include the modifier "RR" in the first modifier location of field 24D on claims for rented items.
  - Bill for services already provided to a member.
  - Bill each 30 days of rental as one unit.
  - Indicate beginning and ending dates of a rental period.
  - If an item is still being rented at the time of the claim, indicate the last day of the billing cycle as the ending date of service.
  - Items filed without the rental modifier and rental dates are assumed to be purchases and are paid accordingly.

Billing Requirements – Repairs and Maintenance

- Use only standard codes and identifiers *(HCPCS)* when submitting maintenance and repair claims.
- Bill the labor component of the repair under the appropriate repair code.
- Bill all replacement parts separately under the appropriate repair code.
- Bill repairs only on purchased items; they may not be billed on rented equipment.
- 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.
- For claims with a repair code, submit a complete description of the services provided.
- Failure to provide appropriate documentation when using repair codes can result in processing delays and/or denials.

Reimbursement – General

- Medical review documentation: All services that are not authorized in advance *(i.e. certification number obtained)* will be subject to medical review. The medical review process will be expedited if your files include:
  - Physician's plan of treatment, including anticipated time frame that the equipment will be needed
  - Predicted outcomes *(therapeutic benefit)*
  - Physician's involvement in supervising the use of the prescribed item
  - Detailed description of the member's clinical and functional status so that a determination of medical necessity can be made.
- Additional detail can be found in the BCBSNC corporate medical policy for durable medical equipment *(policy number: DME0040)* located on our Web site for providers at ***http://www.bcbsnc.com/services/medical-policy/pdf/durable_medical_equipment_(dme).pdf***.

- Reimbursement for new or revised HCPCS codes will be reviewed and adjusted as pursuant to BCBSNC pricing policy. For example, if a new HCPCS code is reviewed and approved, it will automatically be added to the fee schedule *(for specific details and instructions, please refer to your contract with BCBSNC and see in chapter ten of this manual the pricing policy for procedure/service codes).*

Reimbursement – Rentals

- BCBSNC will reimburse rentals up to the purchase price.
- Rental rates are all inclusive. They include all equipment, accessories, supplies, delivery, shipping and handling, labor, set-up, visits, education, maintenance, repairs and replacement parts of HDME.
- Rental rates are monthly. Rental claims that are ongoing will only be processed at the end of each month of service.
- Indicate the last day of the billing cycle as the ending date of service if an item is still being rented at the time you file the claim to BCBSNC.

Reimbursement – Repairs and Maintenance

Certain items are eligible for maintenance fees after the items have been purchased or if rented to the extent that the combined rental fees have reached or exceeded the price had the item been purchased. Non-routine repairs that require the skill of a technician may be eligible for reimbursement.

Ownership of Rental Items

- A rented item is considered the property of the provider and should be returned to the provider after it is no longer medically necessary for the member.
- However, a member will retain possession of a rented item until it is no longer considered medically necessary. Providers may not retrieve a rented item until this time.
- The conversion of a rental to a purchase may be done at any time prior to reaching the listed purchase price of the item. If an item is converted from rental to purchase prior to the rental reaching its purchase price, it is considered the property of the member and is not returned to the provider.
- Covered supplies relating to an item that has reached the purchase price will be reimbursed according to the providers contract.

10.49 Claim Form Detail for Home Infusion and Durable Medical Equipment

The following patient and subscriber information is required on the CMS-1500 *(version 08/05)* claim form:

Field #	Description
1	Put [X] in group health plan or other box
1a	Subscriber's BCBSNC I.D. number
2	Patient's name *(last name, first name, middle initial)*
3	Patient's date of birth *(MM/DD/YYYY)* and sex
4	Subscriber's name *(last name, first name, middle initial)*
5	Patient's address and telephone number
6	Patient's relationship to the subscriber
7	Subscriber's address and telephone number
8	Patient's marital and employment status
9	Additional subscriber's name *(last name, first name, middle initial)*
9a	Additional subscriber's policy or group number
9b	Additional subscriber's date of birth *(MM/DD/YYYY)* and sex
9c	Additional subscriber's employer's name or school name
9d	Additional subscriber's insurance plan name
10	Is patient's condition related to employment or accident?
11	Subscriber's policy or group number
11a	Subscriber's date of birth *(MM/DD/YYYY)* and sex
11b	Subscriber's employer's name or school name
11c	Subscriber's insurance plan name
11d	Does patient have an additional health insurance policy?
12	Patient's or authorized person's signature
13	Subscriber's or authorized person's signature

- For field 12, it is acceptable to 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.
- For field 13, it is acceptable to indicate signature on file in lieu of an actual signature if you have the original signature of the subscriber or other authorized person on file authorizing assignment of payment to you.

Ancillary Providers

The following provider information is required on the CMS-1500 claim form:

Field #	Description
14	Date of current service *(MM/DD/YYYY)*
15	First date of similar service *(MM/DD/YYYY)*
16	Leave blank
17	Referring physician's name
17a	Referring physician's I.D. number
18	Leave blank
19	• Enter national drug code (NDC#) for each drug billed for Home Infusion • Leave blank for DME
20	Leave blank
21	Diagnosis code and description
22	Leave blank
23	**HMO and POS *(POS membership ended 6/1/05)* certification number** • Prior Plan Approval is required for all home infusion therapy services for HMO and POS *(POS membership ended 6/1/05)* members • Specific HDME services require Prior Plan Approval (see Certification List in Section 8.5.1.5)
24A	Date(s) of Service *(MM/DD/YYYY) (Start DOS, End DOS)*
24B	Place of Service 12 Home
24C	Type of Service 9 Other medical service A Used DME L Rental supplies in the home
24D	BCBSNC billing code(s) Home Infusion • Enter billing code for drug, per diem or other service as indicated in provider contract and reimbursement schedule • The drug billing code must be entered on the line prior to associated per diem for those therapies which have both a drug and associated per diem billing code DME • HCPCS or BCBSNC billing code(s) for supplies / equipment • Use "RR" modifier in the first modifier field to indicate that an item is a rental • If no "RR" modifier is used, the item will be considered a purchase

Ancillary Providers

Field #	Description
24E	Diagnosis code from Block 21 as it relates to each item in 24D
24F	• For drug billing codes, bill retail charges, do not submit charges with the $ symbol • For all other services providers may bill either typical charges or contracted rates for items in 24D • See provider contract and reimbursement schedule for contract rates
24G	Enter days/units. Units of items listed in 24D If you are billing services for consecutive dates *(from and to dates)* it is *critical* that you provide the units accurately in block 24G <u>DME</u> • Rental items should be listed as 1 unit / month • See HDME Fee Schedule for unit information on specific items
24H-K	Leave blank
25	Enter provider's federal tax identification number ☒ Indicate whether this number is social security number (SSN) or employer identification number (EIN)
26	*For Provider's Record Keeping Purposes*
27	Accept assignment ☒ **Yes** must be indicated in order to receive direct reimbursement • Contracting providers have agreed to "accept assignment"
28	Total billed amount for items on this claim
29	Enter any payments received for these services
30	Enter total amount due • Total contracted rates minus any payments received
31	Provider's signature and date
32	Name and physical address of provider
33	Provider's name, billing address, telephone number BCBSNC home infusion therapy or durable medical equipment provider number (PIN#)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE CMS-1500 (08/05) CLAIM FORM
Home Infusion Therapy

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): XXXW12345678

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

3. PATIENT'S BIRTH DATE MM DD YY: 06 15 1976 SEX M [X] F [ ]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] Other [ ]

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

CITY: Any City STATE: NC

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Any City STATE: NC

ZIP CODE: 00000 TELEPHONE (Include Area Code): (000) 000-0000

Employed [ ] Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: 00000 TELEPHONE (Include Area Code): (000) 000-0000

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: 615

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 03 29 1956 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: Jerome Group

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [X] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield - NC

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: Signature on File DATE: 10012003

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: Signature on File

14. DATE OF CURRENT: MM DD YY: 10 01 2003 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 10 01 2003

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: D.M. Smith, MD

17a.

17b. NPI: E47638

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

19. RESERVED FOR LOCAL USE: NDC# 00074653301

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. 486 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 127643

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	10 01 03	10 01 03	12	9	J3370		1	AWP*	5		NPI	
2	10 01 03	10 01 03	12	9	S9497		1	43 00	5		NPI	
3	10 01 03	10 01 03	12	9	99601		1	61 00	1		NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 56-7774321 [X]

26. PATIENT'S ACCOUNT NO.: 654320198-1

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $

29. AMOUNT PAID $ 0 00

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: Signature of Claim Preparer DATE

32. SERVICE FACILITY LOCATION INFORMATION: PRN Services, 4444 Olive Road, Any Town, USA

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ): PRN Services, 4444 Olive Road, Any Town, USA

a. 04X01 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

SAMPLE CMS-1500 (08/05) CLAIM FORM HDME Rental

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 [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): YPAW12345678

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

3. PATIENT'S BIRTH DATE MM DD YY: 10 28 1963 SEX M [X] F [ ]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

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

CITY: Any City STATE: NC

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY: Any City STATE: NC

ZIP CODE: 00000 TELEPHONE (Include Area Code): (000) 000-0000

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 00000 TELEPHONE (Include Area Code): (000) 000-0000

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: R56273

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 28 1963 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: HAAS Industries

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield - NC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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: Signature on File DATE: 10012003

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: Signature on File

14. DATE OF CURRENT: MM DD YY: 10 01 2003 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 10 01 2003

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: D.M. Smith, MD

17a.

17b. NPI: C12345

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

19. RESERVED FOR LOCAL USE: NDC# 1098576822

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. 486.2 COPD
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 127643

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	10 01 03	10 01 03	12	L	E0601	RR		1	105 00	1			NPI	
2													NPI	
3	*Certificate of Medical Necessity Attached												NPI	
4													NPI	
5													NPI	
6													NPI	

25. FEDERAL TAX I.D. NUMBER: 56-1234567 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 105 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 105 00

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.)

Signature of Claim Preparer

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: Home Medical Supplier, Inc. 2945 Fern Drive Any Town, USA

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ): Home Medical Supplier, Inc. 2945 Fern Drive Any Town, USA

a. 04XXX b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE CMS-1500 (08/05) CLAIM FORM HDME Purchase

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): XXXW12345678

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

3. PATIENT'S BIRTH DATE MM DD YY: 05 20 1953 SEX M [X] F [ ]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

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

CITY: Any City STATE: NC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: Any City STATE: NC

ZIP CODE: 00000 TELEPHONE (Include Area Code): (000) 000-0000

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 00000 TELEPHONE (Include Area Code): (000) 000-0000

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: T0321

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 000-00-0000

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 05 20 1953 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 04 28 1951 SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: First Bank

c. EMPLOYER'S NAME OR SCHOOL NAME: Medline, Inc.

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield - NC

d. INSURANCE PLAN NAME OR PROGRAM NAME: Unity Health Plan

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] 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: Signature on File DATE: 10012003

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: Signature on File

14. DATE OF CURRENT: MM DD YY: 10 01 2003 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 10 01 2003

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: D.M. Smith, MD

17a.

17b. NPI: C46124-OX

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. 250.0 Diabetes
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 127643

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 10 01 03		12		E0607			51 00	1		NPI	
2				Blood Glucose Monitor						NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 56-9876543 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 987654321

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 51 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 51 00

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.)

Signature of Claim Preparer SIGNED DATE 082903

32. SERVICE FACILITY LOCATION INFORMATION

Equipment Depot
62 North Main Street
Any Town, USA

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Equipment Depot
62 North Main Street
Any Town, USA

a. 040X0 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Ancillary Providers

10.50 Hospice Billing and Claims Submission

Definition

- Hospice care services – services for the care of the terminally ill member with a life expectancy of six months or less. Hospice is a continuum of palliative and supportive care, directed by the patient's physician and coordinated by the hospice care team. The services must be provided according to a doctor-prescribed treatment plan. Hospice care services shall be available 24 hours a day, seven days a week. All covered services must be performed by appropriately qualified/licensed personnel. Continuity of care must be assured for the patient and family *(considered a unit of care)* regardless of setting *(home, inpatient or residential)*.
- Levels of care – there are four levels of care provided by a licensed hospice program, and each level of care includes all services rendered to the member:
  1. Routine home care is home care provided by the hospice program when fewer than 8 hours of care during a 24-hour period is necessary. This may not be billed on days when the patient is an inpatient.
  2. Continuous home care is care provided in the home during a period of crisis necessary to maintain the patient in the home setting. The patient requires mainly nursing care to achieve relief of acute medical symptoms. A minimum of 8 hours of care during a 24-hour period must be necessary to qualify for this level of care. Continuous home care begins with the 9th hour of care rendered within a 24-hour period, and is in addition to the routine home care *(per diem)* that was rendered during the initial 8 hours.
  3. Inpatient respite care is when the patient is admitted to a hospice unit for no greater than 5 days to provide relief to the regular family caregivers.
  4. General inpatient care is when the patient is admitted to a hospice for round-the-clock care. Situations which may require general inpatient care are medication adjustment which cannot be provided in another setting and stabilization of treatment. This level of care is short-term and is not intended to be a permanent solution when the patient doesn't have a caregiver in the home.

Per diem rate – the per diem rate *(routine home care, inpatient respite care or general inpatient care)* will be paid each day during which the member is under a comprehensive program of care. The routine home care per diem is billable regardless of whether direct services are provided on a given day. The per diem rate includes all services rendered to the member.

Billing

Provider agrees to:

- File claims electronically using the HIPAA 837 format or:
  - Bill on UB-04 claim form.
  - Bill us the CMM allowed amount.
  - Bill only one per diem per day.
  - File claims after complete services have been provided.

- Bill the retail charge for hospice services, not contracted rates.
- The routine home care per diem is billable regardless of whether direct services are provided on a given day.

10.51 Hospice Reimbursement

10.51.1 Eligible Services

- Providers may bill for each day the member is under hospice care as identified in your contract and reimbursement schedule.
- Services for the care of a terminally ill member with a life expectancy of six months or less. Hospice is a continuation of palliative and supportive care, directed by the patient's physician and coordinated by the hospice care team.
- The services must be provided according to a doctor-prescribed treatment plan.
- The covered services must be performed by appropriately qualified/licensed personnel.

10.51.2 Ineligible Services

- Medical care rendered by a physician
- The maximum number of hours of continuous home care per day is 16 hours.

Please refer to your contract with BCBSNC for specific details and instructions.

Visit our Web site at ***bcbsnc.com*** to view our corporate medical policy on hospice care.

10.51.3 Billing Codes and Unit Definitions

- **Levels of care -** There are four levels of care provided by a licensed hospice program, and each level of care includes all services rendered to the member:

Revenue Codes	Services	Units
0651	Routine home care	Per diem
0652	Continuous home care	Per hour *(beginning with the ninth hour)*
0655	Inpatient respite care	Per diem
0656	General inpatient care	Per diem

- Routine home care is home care provided by the hospice program when fewer than eight hours of care during a 24-hour period is necessary. Routine home care may not be billed on the same day as general inpatient respite care.
- Continuous home care is care provided in the home during a period of crisis necessary to maintain the patient in the home setting. The patient requires mainly nursing care to achieve relief of acute medical symptoms. A minimum of eight hours of care during a 24-hour period must be necessary to qualify for this level of care. Continuous home care begins with the ninth

hour of care rendered within a 24-hour period and is in addition to the routine home care *(per diem)* which was rendered during the initial eight hours.

- Inpatient respite care is when the patient is admitted to a hospice unit for no greater than five days to provide relief to the regular family caregivers.
- General inpatient care is when the patient is admitted to a hospice unit for round-the-clock care. Situations which may require general inpatient care are medication adjustment which cannot be provided in another setting and stabilization of treatment. This level of care is short-term and is not intended to be a permanent solution when the patient does not have a caregiver in the home.

10.51.4 Bundled Services

- Per diem rates for hospice are all inclusive rates. The per diem includes, but is not limited to:
  - Nursing care
  - Home infusion services
  - Durable medical equipment
  - All drugs, medical supplies and equipment related to the terminal illness
  - Home health aide services
  - Social work services
  - Pastoral services
  - Volunteer support
  - Bereavement services
  - Counseling services
  - Nutrition services
  - Speech therapy
  - Occupational therapy
  - Physical therapy
  - In-home lab fees
  - Educational services
  - Respite services

Sample Hospice Claim UB-04

Field	Value
1	Hospice Station 222 Medical Drive Riverview, NC 99211
2	
3a PAT. CNTL #	0000000
b. MED. REC. #	
4 TYPE OF BILL	331
5 FED. TAX NO.	00-0000000
6 STATEMENT COVERS PERIOD FROM	100103
6 STATEMENT COVERS PERIOD THROUGH	100103
7	
8 PATIENT NAME	a John Doe
9 PATIENT ADDRESS	a Any Street, USA Any Town, USA
10 BIRTHDATE	09251965
11 SEX	M
12 ADMISSION DATE	100103
13 HR	
14 TYPE	
15 SRC	
16 DHR	
17 STAT	50
18–28 CONDITION CODES	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39–41 VALUE CODES CODE / AMOUNT	a b c d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0651	Routine Home Care		10/01/03	1	50 00		
2							
3 0651	Routine Home Care		10/01/03	1	50 00		
4							
5 0652	Continuous Home Care		10/01/03	16	160 00		
6							
7 0651	Routine Home Care		10/01/03	1	50 00		
8							
9 0001	Total Charges				310 00		
10–22							
23	PAGE ____ OF ____	CREATION DATE		TOTALS			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A BCBSNC	XX223	Y	Y			57
B						OTHER
C						PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A John Doe	01	000-00-0000-00	First Bank	QT7777
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 99999999		First Bank
B		
C		

66 DX 67 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE
586					
c. OTHER PROCEDURE CODE	**DATE**	**d. OTHER PROCEDURE CODE**	**DATE**	**e. OTHER PROCEDURE CODE**	**DATE**
V56.0	080300				

75

	NPI	QUAL
76 ATTENDING		
LAST D.M. Smith, MD	FIRST	
77 OPERATING		
LAST	FIRST	
78 OTHER		
LAST	FIRST	
79 OTHER		
LAST	FIRST	

80 REMARKS

81CC a b c d

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

10.52 Lithotripsy Billing and Claims Submission

Please refer to the following listing for lithotripsy services *(included versus excluded)*:

Specific Services Included	
Institutional lithotripsy services	Hospital outpatient services, including: • Treatment room services *(mobile lithotripter)* • Ancillary services delivered in mobile lithotripter unit *(including KUB, anesthesia supplies and drugs, and medical surgical supplies)* • Use of lithotripter
Billing for institutional lithotripsy services	Services would be billed via the UB-04 claim form using: • ICD-9 diagnosis codes 592.0 or 592.1 • Revenue code 790 • A single global bill will be submitted for all services listed above
Professional employed "CRNA" services	All services of an employed CRNA are included in the institutional lithotripsy services rate
Professional urology services	All services of the urologist, notwithstanding location, including: • Routine operative and other services delivered on the date of the ESWL procedure • Routine post-operative services delivered after the date of the ESWL procedure. *(The currently accepted post-operative period for CPT number 50590 is 90 days.)*
Billing for professional urology services	Services will be billed via the CMS-1500 claim form using: • ICD-9 diagnosis codes 592.0 or 592.1 • CPT-4 procedure code number 50590 • A single global bill will be submitted for all services listed above.
Institutional facility services	Hospital inpatient services • When lithotripsy procedure(s) are delivered to members admitted as inpatients, all lithotripsy and related services will be billed by the hospital facility Hospital outpatient services, including: • Routine and non-routine pre-ESWL services delivered before the day of the ESWL procedure, including diagnostic studies and laboratory tests • Routine and non-routine, post-ESWL services delivered after day of the ESWL procedure, including diagnostic studies and laboratory terms • All other hospital facility services not delivered in the mobile lithotripter unit • Observation room

Specific Services Excluded *(continued)*	
Professional urology services	All services of the urologist delivered on the day of ESWL or after the date of the ESWL procedure that are a result of complications from ESWL, the patient's condition of urolithiasis, or any other medical condition.
Institutional professional services *(hospital based physician services)*	• All services of the anesthesiologist, pathologist, and radiologist on the day of the lithotripsy • All services of the anesthesiologist, pathologist, and radiologist not delivered on the day of the lithotripsy
Retreatments	Follow up treatment on the same stone or stone fragments, or subsequent treatment on other stones will be reimbursed in the same manner and at the same level as stand-alone initial services, whether or not the re-treatment of subsequent treatment occurred within 90 days of the initial treatment or beyond 90 days of the original treatment.
Bilateral treatments	Treatment to stones on both kidneys on the same date of service will be reimbursed in the same manner and at the same level as stand-alone services.

Revenue Codes	Services	Units
790	Institutional lithotripsy services *(as defined above)*	1
50590 *(CPT-4 Code)*	Professional urology services *(current suite of products)*	1
50590 *(CPT-4 Code)*	Professional urology services *(Blue Edge suite of products)*	1

10.53 Dialysis Billing and Reimbursement

BCBSNC conducts audits of claims to ensure appropriate billing of these services. Please note claims submission reflecting variances in billing patterns not outlined in your current provider agreement, can subject providers to recovery of excess payments/overpayments.

Please refer to the most current version of your contract to review contractual obligations and responsibilities and detailed instructions for billing and claims submission.

Ancillary Providers

Sample Dialysis Claim UB-04 for PPO Members

Field	Value
1	Feel Better Health Care Department at 00000 Atlanta, GA 00000-0000 (000) 000-0000
2	
3a PAT. CNTL #	0000000
b. MED. REC. #	
4 TYPE OF BILL	331
5 FED. TAX NO.	00-0000000
6 STATEMENT COVERS PERIOD FROM	100103
6 STATEMENT COVERS PERIOD THROUGH	100103
7	
8 PATIENT NAME	a John Doe
9 PATIENT ADDRESS	a Any Street, USA Any Town, USA
10 BIRTHDATE	07111943
11 SEX	M
12 ADMISSION DATE	100103
13 HR	
14 TYPE	3
15 SRC	
16 DHR	
17 STAT	01
18–28 CONDITION CODES	71 (24)
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	Any Person Any Street Any Town, NC
39 VALUE CODES (CODE / AMOUNT)	a 49 / 32 10
40 VALUE CODES (CODE / AMOUNT)	a 68 / 65100 00
41 VALUE CODES (CODE / AMOUNT)	

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	821	Hemo/Composite		90935	7	2898 00			1
2	636	Drugs Requiring Specific		90658	1	8 95			2
3	636	Drugs Requiring Specific		90747	1	275 92			3
4	636	Drugs Requiring Specific		J1955	14	504 00			4
5	636	Drugs Requiring Specific		J3370	4	43 88			5
6	635	Epoetin, More Than 9,999		Q9932	20	240 00			6
7	634	Epoetin, Less Than 10,000		Q9932	45	541 20			7
8									8
9	001	Total Charge				4511 95			9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A	BCBSNC	0059T		Y			57
B							OTHER
C							PRV ID

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	John Doe	01	XXXW12345678		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	992361010		First Bank
B			
C			

66 DX	67	A	B	C	D	E	F	G	H	68
	585	V04.8	V05.3	263.1	425.4	996.62	285.9			

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL — LAST D.M. Smith, MD FIRST

77 OPERATING NPI QUAL — LAST FIRST

78 OTHER NPI QUAL — LAST FIRST

79 OTHER NPI QUAL — LAST FIRST

80 REMARKS
Dialysis Dates 01 03 05 08 10 26 29
Services Rendered in State of NC

81CC a b c d

UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

10.54 Mandated Benefits for Services Related to Ovarian/Cervical Cancer

- Use the following revenue codes:
  - 0306 - Laboratory/bacteriology and microbiology
  - 0402 - Ultrasound
  - 0311 - Cytology
- Always file a V72.3 diagnosis code when an exam is performed for a member to obtain a pap smear.
- File the specific revenue codes when seeking reimbursement for screening mammograms or pap smear services:
  - 0403 - screening mammograms
  - 0923 - for pap smears

10.55 New Services to Hospital's Charge Master

BCBSNC must be notified for the following types of modifications to a hospital's charge master:

- New hospital services.
- Changes to the existing charge schedule not reflecting a price increase to BCBSNC members *(i.e., price decreases, service description changes, service code changes)*.
- Pharmacy or medical/surgical supply additions to the charge master.
- Pharmacy and medical/surgical supplies are to be priced through the approved pricing formula on file with BCBSNC.

As required by the contracting hospital agreement and hospital participation agreement, modifications to the charge master must be submitted in writing 30 days prior to the proposed effective date. Approval of the modifications is contingent on the extent they meet the Plan's coverage policies as outlined in the coverage and billing policies and procedures and specific group and non-group certificates.

Payment for specific charges will be dependent upon the terms of the member's certificate, less any applicable discount. Correspondence regarding changes should be sent to:

Health Care Analyst, Network Management
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, NC 27702-2291

If BCBSNC does not approve the proposed changes, the facility will be notified within thirty days of our receipt of your letter requesting the new service.

10.56 UB-04 Claims Filing and Billing Coverage Policies and Procedures for BCBSNC

For a complete listing of our policies and procedures, refer to our Web site at ***bcbsnc.com***.

10.56.1 Anesthesia Supplies

- May be charged individually as used or included in a charge, based on time, in one minute increments.
- A charge that is based on time must be computed from the induction of anesthesia (time of first drug given in O.R. by anesthesiologist to induce sedation) 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 0370.

The following anesthesia services may be considered medically necessary:

- General anesthesia
- Spinal block anesthesia
- Regional block anesthesia *(nerve trunk block and IV anesthesia proximal to elbow and knee)*
- Monitored anesthesia care *(when used in lieu of general anesthesia)*

Regional block and monitored anesthesia care are regarded as equivalent to general anesthesia. Anesthesia services must be administered by an anesthesiologist or a qualified anesthetist under the direction of an anesthesiologist.

The following components are considered an integral part of the anesthesia service and additional benefits are not provided:

- Pre-anesthesia evaluation
- Postoperative visits
- Administration of anesthetic, fluids and/or blood administered by the Medical Doctor of Anesthesiology "MDA" or qualified anesthetist and necessary drugs and materials provided by the MDA
- Interpretation of invasive and/or non-invasive monitoring procedures including: EKG, EEG, EMG, blood gases, capnography, oxygen saturation, evoked potentials
- Services administered in recovery room

When anesthesia services are not covered:

- The administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant is considered incidental to the surgical procedure. This includes sedation given for endoscopic procedures including colonoscopy. Separate reimbursement is not provided for incidental services. *(Refer to separate policy number ADM9020, Bundling Guidelines.)*

- Monitoring of IV sedation by an anesthesiologist for gastrointestional endoscopy, arteriograms, CT scans, MRIs, cardiac catherizations, and PTCA is generally considered not medically necessary. Please review the medical policy for anesthesia services at ***bcbsnc.com***.

10.56.2 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.

10.56.3 Autopsy and Morgue Fee

- Autopsy and morgue fees are not covered under BCBSNC certificates.

10.56.4 Certified Registered Nurse Anesthetist "CRNA"

- Hospital employed CRNA services are reimbursed as a hospital technical fee.
- Use revenue code 0370 to bill for CRNA services *(do not file a separate UB-04 claim form for CRNA services)*.

10.56.5 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 nurse to two 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 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.

10.56.6 Diabetes Education *(Inpatient)*

- Admissions solely for the purpose of diabetic education are not covered under BCBSNC certificates.

10.56.7 Dietary Nutrition Services

- Dietary evaluation and other nutritional assessment services *(e.g., Optifast)* are not covered under BCBSNC certificates.
- If included on the UB-04 claim form use UB-04 revenue code 0940**.**

10.56.8 Durable Medical Equipment "DME"

- Our current certificates provide benefits for the rental of DME up to but not exceeding the total purchase price of the equipment.
- Charges for these items will be reimbursed as a flat fee and should not be priced through the medical and surgical supply pricing formula.
- Charges for DME should be billed using revenue code 0291**.**

10.56.9 EKG

- The charge for EKG services includes the use of a room, qualified technicians and supplies *(e.g., electrodes, gel).*

10.56.10 Handling/Collection Fee

- Generally, BCBSNC does not cover handling/collection fees as separate line ancillaries, unless the specimens are sent to an outside lab for testing. If the hospital does the testing, the handling fees are considered part of the procedure charge. Any markup applied to outside lab send outs must cover all services associated with the send outs *(e.g., handling, collection, preparation).*

10.56.11 Hearing Aid Evaluation

- Hearing aid evaluation, hearing aid fitting and hearing screening are not covered under BCBSNC certificates.
- If included on the UB-04 claim form use revenue code 0940**.**

10.56.12 Intensive Outpatient Programs

- BCBSNC does provide coverage for intensive outpatient programs. Since intensive outpatient programs are treatment programs, BCBSNC cannot accept individual unbundled charges for the programs. Patients must attend a minimum of a half day to be considered as intensive outpatient treatment. A half day is defined as 3-6 hours. Hospitals are required to negotiate a half and full day program charge with BCBSNC prior to providing this service. The therapies included in the program charge are listed for daily psychiatric services.

- The description for intensive outpatient programs includes:
  - Adult - full day
  - Adult - half day
  - Adolescent - full day
  - Adolescent - half day
  - Child - full day
  - Child - half day
- Use revenue code 0944 to bill for drug rehabilitation and 0945 for alcohol rehabilitation.

10.56.13 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.

10.56.14 Reference Labs

Some institutional providers may have a separate agreement for reference lab services. Providers are required to bill a global charge for both the technical and professional components.

10.56.15 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.

10.56.16 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 0180 with zero charge in form locator 47.

10.56.17 Clinic Billing

BCBSNC will no longer recognize revenue codes 0510 - clinic billing, 0519 - other clinic billing, or 0520 - free standing clinic billing for payment when submitted on a UB-04 by a contracted provider. Charges to BCBSNC for these services will be billable only on the professional CMS-1500 claim form from the physician. BCBSNC members should not be billed for denials related to this policy.

10.56.18 Mobile Services

- Mobile lithotripsy services are reimbursed through all-inclusive fees. Claims should be submitted with a 0790 revenue code with the surgery code in the primary surgical field of the UB-04 *(locator 80)*. A single global bill will be submitted for all services. For additional information please refer to section 10.52, Lithotripsy Billing and Claims Submission.

10.56.19 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 0762.
- 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.

10.56.20 Occupational Therapy

- Occupational therapy is a covered ancillary service in a general medical and surgical short-term hospital and rehabilitation hospital, when ordered by a physician to restore function following stroke, trauma, surgery or congenital conditions.
- Occupational therapy is not a covered ancillary service when used in the treatment of mental and nervous illnesses, whether provided in a general short-term hospital or specialty hospital. In these cases, it is considered part of daily general services and reimbursed by the daily accommodation and general services allowance.
- The itemization must be submitted on the claim.

10.56.21 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. BCBSNC will allow reimbursement of up to 15 minutes after the documented end of procedure to permit time for any needed prep of the member for the transportation to the recovery area when the care delivered to the patient during this time is documented in the appropriate medical record to substantiate the need for the additional time.

- Operating room services should be billed using revenue code 0360.
- The operating room charge includes, but is not limited to, the cost of:
  a. Use of the operating room
  b. Qualified technical and nursing personnel
  c. Surgical clamps, connectors, connecting tubing
  d. Surgical gloves, Anti Fog Devise
  e. Surgical marking pens
  f. Surgical packs
  g. Surgical sheets
  h. Surgical sponges
  i. Surgical towels
  j. Surgical retractors
  k. Surgical blades *(exception cuda and gator blades)*
  l. Surgical needles *(e.g., spinal needles)*, Needle Book Holder, Needle Counter
  m. Drapes
  n. Table covers
  o. Sterile sleeves and leggings
  p. Syringes
  q. Test tube cultures
  r. Vaginal bibs
  s. Surgeon's gowns
  t. Surgery prep kits, skin prep.
  u. Surgery pads
  v. Surgery kits, trays and packs.
  w. Warming Systems (e.g. Baer Hugger patient warming system, hypo/hyperthermic unit, radiant warmer, etc.)
  x. Bovie/Cautery
- Sutures and staples may be billed as operating room supplies or included in the operating room time charge.

10.56.22 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.

10.56.23 Behavioral Health Treatment – Partial Hospitalization

BCBSNC provides coverage for psychiatric partial hospitalization therapy. Since partial hospitalization is a treatment program, BCBSNC cannot accept individual unbundled charges for this program. Patients must attend a minimum of a half day to be considered for partial hospitalization benefits. A half day is defined as 3-6 hours. Hospitals are required to negotiate a half and full day program charge with BCBSNC prior to providing this service.

Therapies included in the program charge are:

- Activity therapy
- Psychiatric and psychological services
- Individual therapy
- Group therapy
- Family therapy
- Psychiatric social worker
- Adjunctive therapy
- Art therapy
- History and physical
- Music therapy
- Occupational therapy
- Psychotherapy

Use revenue code 0912 to bill for partial hospitalization.

10.56.24 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 0999.
- Example of personal supplies include:
  - Hair brush
  - Mouthwash
  - Nail clippers
  - Powder
  - Razor
  - Shampoo and conditioner
  - Shaving cream
  - Shoe horn

- Toothpaste
- Toothbrush

10.56.25 Pharmacy

- Take-home drugs should not be filled.
- All pharmacy charges should be billed to BCBSNC using revenue code 0250.
- BCBSNC covers all drugs fully approved by the Food and Drug Administration for general public use.
- Pricing expensive drugs such as Tissue Plasminogen Activator "TPA" using the pharmacy formula would not be reasonable.
- A separate markup may be negotiated for expensive drugs.
- The pharmacy pricing formula must cover the cost of covered drugs prescribed by the attending physician, the cost of materials necessary for their preparation and administration (IV pumps, secondary IV tubing, saline flushes, etc.) and the services of registered pharmacists and other pharmacy personnel.
- Medications furnished to patients must be billed at the negotiated with no additional charge either for administration of drugs (e.g., IV admixture fee, administration or infusion fees, dispensing fee, etc.) or to cover pharmacy overhead (e.g. pharmacy profile fee, drug assessment fee, dosage consultation, etc.).

10.56.26 Physical Therapy

- Physical therapy services should be billed using UB-04 revenue code 0420.
- The itemization must be submitted with the claim.
- The charge for physical therapy must include services of qualified technicians, use of the room and all supplies related to the procedure.
- These charges may be established on a per day treatment basis.
- Physical therapy services are limited to one hour of treatment and/or evaluation or three treatment modalities on a given day.
- To be considered eligible for coverage, the physical therapy services must be delivered by a qualified provider of physical therapy services. A qualified provider is one who is licensed where required and is performing within the scope of the license.

10.56.27 Professional Fees

- Professional fees using revenue codes 096X, 097X and 098X should not be billed on the UB-04 claim form.
- Professional charges should be filed on the CMS-1500 *(version 08-05)* claim form.

10.56.28 Psychiatric Room and Board

- The psychiatric daily room charge includes the cost of all items listed in acute care as well as the following therapy services:
  - Adjunctive therapy
  - Art therapy
  - Group therapy
  - History and physical head
  - Occupational therapy
  - Psychiatric social worker
  - Psychotherapy
  - Music therapy

10.56.29 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.
- Any time after the initial recovery phase should be as observation if billed at all.
- In instances whereby a facility elects to leave BCBSNC members in a recovery room setting versus transferring the patient to observation status following an outpatient/day surgery, the total of the hourly charges associated with the extended recovery room stays (regardless of tier level) cannot exceed the charges we would expect to receive for observation stays following an outpatient surgery.

  Reminder: Charges related to an observation stay may not exceed the most prevelent semi-private room rate.

10.56.30 Rehabilitation Room

- The rehabilitation room charge includes the cost of all items listed in acute care plus the psychiatric room therapy services.

10.56.31 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.
- Emergency room services can be billed on a UB-04 outpatient claim with a bill type of 13J whenever the inpatient services are denied for non-authorized services or certification is not obtained. This applies to HMO, PPO, POS and CMM claims processed on the PowerMHS claims processing system.

- The following should be included in the E.R. charge and should not be billed as separate items to BCBSNC or its members:
  - Administration of medications including IVs. IV Therapy fees, drug administration fees, injection or infusion fees.
- You will be notified via explanation of payment to submit the ER services with a bill type of 13J.

10.56.32 Room Accommodation

- Bill the appropriate rate and corresponding UB-04 revenue code as shown on the BCBSNC hospital participation agreement Statement of Accommodation "SOA." See example of SOA in chapter 23, Forms *(form number S133)*.

10.56.33 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
  - 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)*

10.56.34 Special Beds

- Bill t+-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

- Clensicair incontinence management system and Keane specialty beds are not covered as separate line ancillaries. These beds are covered only as part of the approved daily hospital services charge.
- Nelson patient handling bed is a part of routine orthopedic care and is covered only in the daily accommodation allowance. Do not bill as a separate charge to BCBSNC or our members.
- Burke beds and Big-boy beds are not covered. The charges for these beds should be billed to the patient as they are the patient's liability.
- When the bed is covered, the charge must include the bed itself, the delivery fee, set up and scales.
- Charges for special beds will be reimbursed as a flat fee and should not be priced through the medical and surgical supply pricing formula.

10.56.35 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.

10.56.36 Speech Therapy

- Covered speech therapy services should be billed using UB-04 revenue code 0440.
- 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.

10.56.37 Take-Home Drugs

- Covered take-home drugs should be billed using UB-04 revenue code 0253.
- BCBSNC health benefit plans do not provide inpatient hospital benefits for take-home items.

10.56.38 Take-Home Supplies

- Covered take-home supplies should be billed using UB-04 revenue code 0273.
- BCBSNC health plan benefits do not cover take-home supplies.
- Benefits are provided for take-home items when the member's health care coverage type includes extended benefits when these items are properly identified on the claim.

10.56.39 Transport Services

- Transport services *(e.g., nurse transport, attendant's fee and nursing support)* are not covered under BCBSNC certificates.
- Services necessary for transporting the patient are provided by the ambulance service.
- These charges should be billed directly to the patient as they are the patient's liability. The patient may then submit a claim for individual consideration using the subscriber submitted claim form.

10.56.40 Transfer Services

- Transfers within a participating facility are considered a continuous episode of care and will be included in a single complete claim and reimbursed as one payment. Facilities who have separate provider numbers for inpatient care such as rehabilitation or psychiatric care may bill each episode of care with the appropriate provider number.

10.57 Fraud and Abuse

Fraud and abuse may include, but is not limited to, the following:

- Performing an unnecessary or inappropriate service;
- Billing a service that was not received or misrepresenting a service;
- Billing duplicate claims;
- Unbundling claims;

- Charging in excess of contracted or reasonable fees;
- Accepting referral fees *(i.e. kickbacks)*;
- Collecting monies except for deductible amounts, coinsurance amounts, copayment amounts, and non-covered items as permitted pursuant to BCBSNC's final notification of payment.

Your submission of a claim for payment constitutes a representation by you that the services or supplies reflected on the claim submission, including all quantities set forth on that claim, indeed (1) were medically necessary in your reasonable judgment *(except with respect to cosmetic services)*, (2) were actually performed by you to the member, (3) were filed accurately and using appropriate coding, and (4) have been properly documented in the medical records of the member. Your submission of a claim for payment also constitutes your representation that the claim is not submitted as a form of, or as a part of a practice of, fraud and abuse as described above. Additionally, you agree not to repeatedly and intentionally waive members' deductibles, coinsurance, and copayments. You are responsible for, and these provisions likewise apply to, the actions of your staff members and agents.

Any amount billed by you in violation of this section, if paid by us, constitutes an overpayment by us that is subject to the overpayment recovery process pursuant to your contract. Additionally, any amounts billed to members in violation of this section, if paid by such members, must be immediately refunded to members. Members should not be billed for amounts due resulting from a violation of this section.

Please call the BCBSNC Special Investigation Unit at **1-800-324-4963**, if you suspect fraud and abuse.

10.58 Departmental Revenue Analysis General Instructions

The coverage and billing policies and procedures have been updated to include Blue Cross and Blue Shield of North Carolina "BCBSNC" coverage policies. These coverage policies apply to all participants covered under your current hospital agreement; they do not apply to other third party payors or self-paying patients. Our coverage policies are based on the BCBSNC's insurance certificates, which have been filed with and approved by the North Carolina Insurance Department. BCBSNC benefits are payable only for covered services as defined in your current hospital agreement and as further explained in this section.

The coverage presented in this document is not all-inclusive of BCBSNC's policies and procedures. It is here to serve as a guide in developing charges for BCBSNC members. This document is not a substitute for your complete charge master. For more information regarding our policies and procedures, visit our Web site at ***bcbsnc.com***.

The hospital must bill for covered hospital services rendered to BCBSNC participants in accordance with the approved charge schedule. It is our understanding that pharmacy and medical/surgical supplies are priced using the approved pricing formula. Any charge code with a corresponding dollar amount of $0.00 will be considered a hospital service requiring no additional charge to BCBSNC or the patient unless the hospital specifically requests and receives approval from BCBSNC to use miscellaneous codes. When miscellaneous codes are used, actual cost information must be well documented in patient files to support the amount billed. BCBSNC and its participant-patients cannot accept liability for miscellaneous items where the cost is not adequately documented.

Changes to the approved charge schedule must be submitted to BCBSNC, in writing, at least 30 days in advance of the effective date of the proposed change. BCBSNC and its participant-patients will not accept liability for charges, which have not been agreed to by the hospital and BCBSNC in accordance with your hospital agreement.

Professional fees using revenue codes 96X, 97X, and 98X are not recognized on the UB-04 claim form. Professional charges should be filed on the CMS-1500 claim form.

Job related injuries are covered by Workers' Compensation. Workers' Compensation cases must not be billed to BCBSNC.

Benefits are excluded for procedures determined by BCBSNC to be experimental or investigative in nature. When a medical or surgical procedure is determined to be experimental or investigative, benefits are excluded for all hospital services associated with the procedure. Complications arising from any experimental or investigative procedures are also not covered. Experimental or investigative procedures are patient liabilities.

Uniform Billing Codes

Copies of the Uniform Billing "UB-04" may be ordered from:

The North Carolina Hospital Association
Post Office Box 4449
Cary, North Carolina 27519-4449

If you have questions, please call the North Carolina Hospital Association at **(919) 677-4224**. All hospital services must be billed on the UB-04 claim form.

10.58.1 General Coverage Determinations

Clinic Billing Revenue Code Updates

The following revenue codes are not reimbursable when submitted on a UB-04 form:

510 – clinic billing

519 – other clinic billing

520 – free-standing clinic billing

Positron Emission Tomography "PET":

For our complete medical policy, refer to our Web site at ***bcbsnc.com***. When billing for covered services, please use UB-04 revenue code 0404.

Stand-by services and call-back services are covered only when actually received by the patient. Stand-by services that are not used are considered overhead costs. A hospital's overhead costs must be incorporated into its charges for services that are actually rendered to and received by the patient. BCBSNC and its members cannot accept liability for services not received.

Stat and after-hours services are covered only when they are ordered by the physician to be done immediately. Charges for after-hours services are not to be billed to BCBSNC just because they are incurred outside normal working hours.

Hospitals and Facilities

Observation beds are covered outpatient services when it is determined that the patient should be held for observation but it has not been determined that the patient should be admitted as an inpatient. For our complete medical policy, refer to our Web site at ***bcbsnc.com***.

- Bill observation services under revenue code 762.
- The charges related to an observation bed may not exceed the most prevalent semi-private daily room rate.
- BCBSNC would not expect to 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.

Collection (e.g., venipuncture) and handling fees are not covered unless an outside lab performs the test. If the hospital does the testing, the fee is considered part of the procedure charge.

Items specially built for handicapped patients (e.g., hair and toothbrushes, knives, forks, spoons) are non-covered under our present certificate. Non-covered services are the patient's liability and should be billed directly to the patient.

The goal of **total parenteral nutrition**, **hyperalimentation**, is to replace and maintain all essential nutrients by intravenous infusion in patients for whom oral or tube feedings are contraindicated or inadequate. Hyperalimentation solutions used with a long-term parenteral nutrition system are covered as drugs by BCBSNC certificates.

Special monitoring equipment (e.g., dinemapp, swan ganz, cardiac, pressure monitor, and telemetry) charges must include the use of the 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 must not be billed. Monitoring equipment used during transport is considered a continuation of services.

Set up fees that represent personnel time only are considered part of the procedure/treatment fee. A separate fee must not be billed to BCBSNC or the participant-patient.

10.58.2 Charge-To-Charge Comparison

Daily Hospital Service-Acute Care - Daily hospital service is recommended as a replacement for the phrase "Room and Board." Services and supplies included in the daily hospital service charge are:

a. Room and complete linen service. Examples include: bath cloth, pillow case, soap, blanket, sheets, towels

b. Dietary service: meals, therapeutic diets, required nourishment, dietary consultation, and diet exchange list.

   Dietary supplements are especially formulated products designed to increase the amount of various food elements required to maintain or to correct a deficiency, which may exist.

   BCBSNC certificates generally do not provide benefits for dietary supplements. These supplements are considered to be a part of daily hospital service and are not to be billed for separately either to BCBSNC or to its participant-patients. Examples of dietary supplements and/or tube feeding supplements are: Ensure, Isocal, Sustagen, Forta, Osmolite, Vivonex

c. General nursing services including patient education (e.g., instructions and materials). This does not include private duty nursing.

d. All equipment needed to weigh the patient (e.g., scales). A separate fee must not be billed to BCBSNC or the participant-patient.

e. Thermometers, blood pressure apparatus, gloves, tongue blades, cotton balls, and similar items used in the examination of patients.

f. Use of examining and/or treatment rooms for routine examinations.

g. Routine supplies provided as a part of routine care. Examples are: all tape, wipes, swabs, scrubs, bib, scales, body lotion, bedpans, bedside commode, urinals, toilet tissue, elevated toilet seat, air freshener, deodorizing machine, water pitcher, patient gown, facial tissues, emesis basin, breast pump and supplies, nursing pads, petroleum jelly, hydrogen peroxide, alcohol, epsom salts, adult diapers, specimen traps, hot water bottles, ice bags, heating pads, humidifiers, vaporizers, limb restraints, chux, and underpads.

h. Administration of enemas and medications including IV/administration/infusion or IV ad mixture. Please note that the costs of the medication and administration sets are covered ancillary items.

i. Postpartum services.

j. Recreation therapy.

k. Enterostomal therapy. Please note that the costs of the enterostomal supplies are covered ancillary items.

Special monitoring equipment (e.g., dinemapp, swan ganz, cardiac, pressure monitor, and telemetry) charges must include the use of the supplies (e.g., electrodes, guidewires, and telemetry pouches). Special monitoring equipment charges may be billed separately when used by a patient in routine or general accommodations.

Special Beds

The following beds are covered as a separate charge when medically necessary:

a. Bio-Dyne bed

b. Clinitron bed

c. Flexicare bed

d. Fluidair bed

e. Just Step mattress

f. Ken-Air bed

g. Kinetic Therapy bed

h. Pegasus Airwave System

i. Restcue bed (Hill-Rom EFICA CC™)

j. Roto-Rest bed

k. Therapulse bed

Clensicair Incontinence Management System and Keane Specialty Beds are not covered as separate line ancillaries. These beds are covered only as part of the approved daily hospital service charge.

Nelson Patient Handling Bed is a part of routine orthopedic care and is covered only in the daily accommodation allowance. Do not bill as a separate charge to the BCBSNC or our members.

Burke beds and Big-boy beds are not covered. The charges for these beds should be billed to the patient as they are the patient's liability.

When the bed is covered the charge must include the bed itself, the delivery fee, set up, and scales.

Charges for special beds will be reimbursed as a flat fee and are **not** to be priced through the medical and surgical supply pricing formula. These beds must be billed using UB-04 revenue code 0946 or 0947.

Nursery - The services and supplies indicated in the daily hospital service charge for acute care are also included in the daily hospital service charge for nursery plus other similar items necessary in the routine care of infants such as bottles, diapers, baby powder, sterile safety pins, isolettes, and radiant warmers.

Labor and Delivery Room - The labor room charge and delivery room charge each must include the cost of:

a. The use of the room.

b. The services of qualified technical personnel.

c. Linens, instruments, equipment, and routine supplies.

The hospital must not bill the Plan for an OB room in addition to the labor room fee when the patient is still in the labor room at time of census.

Hospitals and Facilities

Psychiatric Room - The psychiatric room charge includes the cost of all items listed in acute care as well as the following therapy services:

a. Adjunctive therapy

b. Art therapy

c. Group therapy

d. History and physical

e. Music therapy

f. Occupational therapy

g. Psychiatric social worker

h. Psychotherapy

i. Recreation therapy

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, please use revenue code 0180.

Partial Hospitalization/Intensive Outpatient Programs - The program charges include the therapy services listed for daily psychiatric services. Partial hospitalization must be billed using UB-04 revenue code 0912. Intensive outpatient must be billed using UB-04 revenue codes 0944 for drug rehab and 0945 for alcohol rehab. Patients must attend a minimum of a half-day to be considered as partial hospitalization/intensive outpatient.

Rehabilitation Room - The rehabilitation room charge includes the cost of all items listed in acute care plus the psychiatric room therapy services listed above.

Critical Care Units - Critical care units represent special treatment areas of a hospital for critically ill patients. Care includes continuous observation by specially trained nurses and the availability of special equipment and lifesaving techniques. To be considered a critical care unit, the unit must meet the following conditions:

a. The unit must be in the hospital.

b. The unit must be physically separate from general routine patient care areas and ancillary service areas.

c. There must be specific written policies that include criteria for admission to, and discharge from, the unit.

d. Registered nursing care must be furnished on a continuous 24-hour basis.

e. A minimum nurse-patient ratio of one nurse to two patients per patient day must be maintained.

f. The unit must be equipped, or have available for immediate use, lifesaving equipment necessary to treat the critically ill patients for whom it was designed. This equipment includes, but is not limited to, respiratory and cardiac monitoring equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.), cardiac defibrillators, and wall or canister oxygen.

A critical care unit is not a post-operative recovery room or a post-anesthesia room.

The charge for a critical care unit, though generally stated as a single dollar amount, has two components:

a. The room charge includes the cost of all items listed under acute care.

b. The nursing/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.

Ventilators are billable separate line ancillaries. The ventilator charge must include the use of the equipment and **all** supplies.

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.

When a patient is using monitoring equipment in the recovery room and is transported to another ancillary department or a room, a separate monitoring equipment charge should not be billed for use of this equipment during transport. Monitoring equipment used during transport is considered a continuation of recovery room services.

Warming systems (e.g., Bair Hugger Patient Warming System, hypo/hyperthermic unit, radiant warmer, etc.) are considered part of the departmental overhead cost where it is used (e.g., recovery room). A separate fee must not be billed to BCBSNC or the participant-patient.

Operating Room - The operating room charge may be based on time or on a procedural basis. When time is the basis for arriving at the charge, it must be calculated from the induction of anesthesia to the completion of the procedure. The operating room charge includes the cost of:

a. Use of the operating room

b. Qualified technical and nursing personnel

c. Surgical clamps or connectors

d. Surgical gloves

e. Surgical marking pens

f. Surgical packs

g. Surgical sheets

h. Surgical sponges

i. Surgical towels, utility towels

j. Surgical retractors

k. Surgical blades

l. Surgical needles (e.g., spinal needles)

m. Drapes

n. Table covers

o. Sterile sleeves and leggings

p. Syringes

q. Test tube cultures

r. Vaginal bibs

s. Surgeon's gowns

t. Surgery prep kits, pads, trays

Sutures and staples may be billed as operating room supplies or included in the operating room time charge.

Stand-by services are not covered unless they are actually used.

Stereotactic Radiosurgery: For our complete medical policy, refer to our Web site at ***bcbsnc.com***.

Operating Room Services

Sutures and staples may be billed as operating room supplies or included in the operating room time charge.

Certified Registered Nurse Anesthetist "CRNA" - Hospital employed CRNA services are considered to be hospital services under your current hospital agreement and will be reimbursed as a hospital technical fee. The hospital should bill for CRNA services on the hospital UB-04 form using UB-04 revenue code 0370.

Anesthesia Services - Anesthesia supplies 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.

Anesthesia supplies may be either charged individually as used or included in a charge based on time, but not both.

Diagnostic Services - The charges for radiology, CT scans, ultrasound, MRI, nuclear medicine, and other diagnostic tests must include the use of a room, qualified technicians, films, dyes (e.g., ionic contrast agents, other enhancing agents), and supplies. Separate charges will be negotiated for injection fees and expensive dyes (e.g., non-ionic contrast agents).

- **Call-back and Stat Charges**

  Call-back and stat charges are not to be billed just because they are incurred outside normal working hours. These charges are covered only when the procedure is ordered by the physician to be done immediately.

Hospitals and Facilities

EKG - The charge for EKG services includes the use of a room, qualified technicians, and supplies (e.g., electrodes, gel).

- **Cerebral Death EEG**

  Cerebral death EEG is not covered under our present BCBSNC certificates. This charge must not be billed as a separate line ancillary to BCBSNC.

- **Stat Charges**

  Stat charges must not be billed just because they are incurred outside normal working hours. These charges are to be billed to BCBSNC only when the procedure is ordered by the physician to be done immediately.

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. The charge for tissue (pathology) should include the cost of all supplies (e.g., arterial blood gas kits) related to the tests performed. Arterial puncture charge should be included in charge for test.

- **Stat Charges**

  Stat charges should not be billed just because they are incurred outside normal working hours. These charges should be billed to BCBSNC only when the procedure is ordered by the physician to be done immediately.

Handling/Collection Fee

Generally, BCBSNC does not cover handling/collection fees as separate line ancillaries, unless the specimens are sent to an outside lab for testing. If the hospital does the testing, the handling fees are considered part of the procedure charge. Any markup applied to outside lab send outs must cover all services associated with the send outs (e.g., handling, collection, preparation).

American Red Cross "ARC"

Charges for blood units received from the ARC should include pass through costs from the ARC, minor supplies, administrative costs, and additional lab tests performed on blood by the hospital.

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 of 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.

Directed Blood Donations

Directed blood donations (e.g., from relatives) are covered only to the extent that regular homologous blood donations are covered. No additional charges for directing the blood is covered. This would be the patient's liability.

Central Supply - The medical and surgical supply pricing formula must cover the cost of the supplies and the cost of preparing, handling, and storing the supplies.

Special supplies are those given directly to patients for whom a charge is made, e.g., sterile trays and the use of equipment.

Hospitals and Facilities

General supplies are those used by other departments, the cost of which is included in the charge for the department where it is used, such as operating room supplies and daily hospital service supplies.

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 0999. The liability for payment of these charges is that of the patient and not BCBSNC. Examples of personal supplies include:

- Baby car seat
- Baby oil
- Batteries
- Bedroom shoes
- Books
- Clothes bag
- Combs
- Cot or bed rental
- Denture cup
- Deodorant
- Father's supplies
- Guest meals
- Hair brush
- Hair spray
- Home humidifier
- Key holder
- Linen saver
- Mirror stand
- Mouthwash
- Nail clippers
- Patient's gown
- Patient education books
- Pillow paws (disposable shoes)
- Powder
- Razor
- Shampoo and conditioner

- Shaving cream
- Shoe horn
- Shoe laces
- Sunglasses
- Telephone calls
- Television
- Toothpaste
- Toothbrush

Take-Home Supplies

BCBSNC certificates do not provide inpatient or patient hospital benefits for take-home items. Benefits are provided for take-home items by comprehensive and supplemental major medical and extended benefits when these items are properly identified on the claim. Please use UB-04 revenue code 0273 when billing supplies for take-home use.

Isolation Supplies

Isolation supplies related to patient care are covered when the patient must be isolated due to a contagious disease or infection. Isolation supplies used for the convenience or protection of visitors are not covered and should be billed directly to the patient.

Tampons, sanitary pads, and sanitary belts are covered for OB/GYN patients only.

Durable Medical Equipment "DME"

BCBSNC certificates provide benefits for the rental of Durable Medical Equipment "DME" up to but not exceeding the total purchase price of the equipment. Charges for these items will be reimbursed as a flat fee and should not be priced through the medical and surgical supply pricing formula. Charges for durable medical equipment should be billed using UB-04 revenue code 0291 so that claims may be processed promptly and accurately.

Pharmacy - Generally, BCBSNC covers all drugs fully approved by the FDA for general public use.

Pricing expensive drugs such as Tissue Plasminogen Activator "TPA" using the pharmacy formula would not be reasonable. A separate markup may be negotiated for expensive drugs.

The pharmacy pricing formula must cover the cost of covered drugs prescribed by the attending physician, the cost of materials necessary for their preparation and administration, and the services of registered pharmacists and other pharmacy personnel. Medications furnished to patients must be billed at the negotiated rate with no additional charge either for the administration of drugs (e.g., I.V. admixture fee, dispensing fee, etc.) or to cover pharmacy overhead (e.g., pharmacy profile fee, drug assessment fee, dosage consultation, etc.).

Take-Home Drugs

BCBSNC certificates do not provide inpatient or patient hospital benefits for take-home items. Benefits are provided for take-home items by comprehensive and supplemental major medical and extended benefits when these items are properly identified on the claim. Please use UB-04 revenue code 0253 when billing for prescriptions filled by the pharmacy for take-home use.

Inhalation Therapy - The charge established for this service must include the use of any special room, qualified technicians, and supplies.

Physical Therapy - The charge must include the use of a room, qualified technicians, and all supplies related to the procedure. These charges may be established on a per treatment basis, a modality basis, or a time basis. Physical therapy services are limited to one hour of treatment and/or evaluation or three treatment modalities on a given day. To be considered eligible for coverage, the physical therapy services must be delivered by a qualified provider. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered physical therapy services should be billed using UB-04 revenue code 0420.

Activities in Daily Living and Home Programs

Activities in daily living/and or home programs instruction are not covered under the present BCBSNC certificates. These services should be billed to the patient as they are the patient's liability.

Occupational Therapy - Occupational therapy is physical medicine primarily directed to restoration of functional activities and coordination, and prevention of deformities through exercise, muscle strengthening, retraining, and/or re-education.

Occupational therapy is a covered ancillary when ordered by a doctor and delivered by a qualified provider of occupational therapy services to restore function following stroke, trauma, surgery, or congenital conditions. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered occupational therapy services should be billed using UB-04 revenue code 0430.

Occupational therapy is not a covered ancillary when used in the treatment of mental and nervous illnesses. In these cases, it is considered a part of daily general services and reimbursed by the daily accommodation and general services allowance.

Speech Therapy - Speech therapy is treatment for the correction of speech impairment resulting from disease, surgery, injury, or congenital anomaly. Speech therapy is covered only when used to restore a function following surgery, trauma, or stroke. There is no benefit coverage for the following diagnoses:

a. Attention disorder

b. Behavior problems

c. Conceptual handicap

d. Mental retardation

e. Psychosocial speech delay

To be considered eligible for coverage, these services must be delivered by a qualified provider. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered speech therapy services should be billed using UB-04 revenue code 0440.

Hearing Aid

Hearing aid evaluation and hearing aid fitting are not covered under our present BCBSNC certificates. If included on the UB-04 claim form, please use revenue code 0940. Otherwise these charges should be billed to the patient.

Consultations/Evaluations

Consultations/evaluations for physical therapy, inhalation therapy, occupational therapy, and speech therapy are covered only if they are actually for tests and measurements with appropriate reports. However, if the evaluation is just a consultation, it is not covered.

Outpatient Services -

Outpatient Cardiac Rehabilitation Programs

BCBSNC reimburses hospitals for outpatient cardiac rehabilitation programs **only** when the programs are certified by the North Carolina Cardiac Rehabilitation Plan. Covered outpatient services should be billed using UB-04 revenue code 0943.

Inpatient cardiac rehabilitation is considered part of routine care for a cardiac patient and is reimbursed through the daily hospital service charge.

Outpatient Services

1. The outpatient cardiac rehabilitation program must be certified by the North Carolina Cardiac Rehabilitation Plan.

Outpatient Diabetes Program

BCBSNC provides reimbursement for outpatient diabetes self-care services. Reimbursement will be made for the three types of services listed below. One total charge should be made for each program, not a per visit charge:

a. Outpatient diabetic self-care program: 3-6 hours of individual counseling for survival skills to include medication administration, diet basics, potential emergencies (e.g., diabetic, ketosis, hypoglycemia, acute illness), and glucose testing.

b. Comprehensive outpatient diabetic self-care program: 12-16 hours (with a minimum of 4 hours of individual counseling) to include pre and post assessment, review of survival skills, medication adjustment, exercise, pathophysiological teaching, and preventive aspects.

c. Follow-up review of diabetic self-care program: minimum of 2 hours, to be performed at 6 months, 12 months, and annually thereafter.

Covered services should be billed using UB-04 revenue code 0949.

Inpatient Diabetes Education

Admissions solely for the purpose of diabetic teaching are not covered under our present certificates.

Dietary/Nutrition Services

Dietary evaluation and other nutritional assessment services (e.g., Optifast) are non-covered under our present BCBSNC certificates. If included on the UB-04 claim form, please use UB-04 revenue code 0940.

Autopsy and Morgue Fee

Autopsy and morgue fees are not covered under our present BCBSNC certificates.

Transport Services

Transport services (e.g., nurse transport, attendant's fee, and nursing support) are not covered under our present BCBSNC certificates. We would expect services necessary to transport the patient to be provided by the ambulance service. These charges should be billed directly to the patient as they are the patient's liability. The patient may then submit a claim for individual consideration using the Subscriber Submitted Claim Form. The patient can obtained this form from their nearest BCBSNC service office.

Mobile Services

Mobile cardiac catheterization and mobile lithotripsy services will be reimbursed through all-inclusive fees.

Lithotripsy

Extracorporeal shock wave lithotripsy "ESWL" is generally accepted medical practice for removal of stones in the renal calyx, pelvis, and upper half of the ureter when the following indications are present:

a. Patient would undergo a surgical procedure to remove the stone if ESWL were not performed;

b. Stones are at least 3 millimeters in diameter;

c. The stone-containing kidney is functional;

d. Contraindications are not present.

Treatment of stones that are asymptomatic or likely to pass spontaneously is not medically necessary.

The Plan expects stones of the size 1½ cm or less to be successfully removed by a single ESWL treatment. Therefore, there will be no additional reimbursement for professional or hospital charges for subsequent treatments of stones that were originally 1½ cm or less in size unless documentation of extenuating circumstances is provided.

Extracorporeal shock wave lithotripsy devices for gallstones have not received FDA approval; therefore, ESWL for gallstones is considered investigational and is not covered by BCBSNC. Charges for this service should be billed to the patient.

10.59 Hospital Agreements

- The Contracting Hospital Agreement "CHA" typically provides the basis for BCBSNC's other hospital agreements except for those with a Hospital Participation Agreement "HPA."
- Changes to a hospital's approved charge master schedule or the addition of new services must be submitted to BCBSNC in writing at least 30 days before the effective date of the proposed change, as stated in section VII B of the CHA and attachment 3 of the HPA.
- Acceptance of a hospital's price increase is conditional upon the return of the signed Statement of Accommodation "SOA" charges form, Exhibit I *(for an example of the SOA, please see chapter 23, Forms)*.

Hospitals and Facilities

10.60 Standard Reimbursement Methodologies

Inpatient Services	Outpatient Services
• Per case rate by type of case with additional per diem payments for outlier cases • Per diem rate by type of case • Payment based on Diagnosis Related Groups "DRG" • Percentage of CHA or HPA approved charges	• Case rate for select procedures • Percentage of CHA or HPA approved charges • Percentage of CHA or HPA approved charges with a maximum cap

Ambulatory Surgical Centers

10.61 Claims Submission

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 to BCBSNC on the same UB-04 form using revenue code 0490. The following requirements also apply to ASC claims:

- The principle procedure must be listed in form locator 80.
- The principle procedure must also be placed in the first position of form locator 44.
- Secondary procedures should be listed in form locator 44, following the placement of the primary procedure. (Up to seven secondary procedures may be considered in addition to the primary procedure.)
- ASC providers should file with the revenue code 490 with the bill type 831.
- Except for non-grouped procedures, ASC reimbursements are all-inclusive and are not reimbursed separately for ancillary charges in addition to the surgical procedure.
- ASC providers should file corrected claims with bill type 837 to indicate the replacement of a prior claim.

Ambulatory Surgical Centers

Health Benefit Plans	Reimbursement Methodology
Comprehensive Major Medical *(includes the State of NC Teachers' and State Employees' Comprehensive Major Medical Plan)*	• The case-type categories are based upon CPT-4 codes that are paid on a fixed amount per procedure • For surgical CPT-4 codes falling outside these defined ASC groupings, reimbursement is based on a negotiated percentage of the ASC provider's accepted charge • For multiple surgical procedures, the provider is reimbursed 100% of the BCBSNC allowance for the procedure listed on the first line of the claim, and 50% of the BCBSNC allowance for the remaining eligible procedures. • Procedures performed in conjunction with the primary surgical procedure considered by BCBSNC to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures generally include secondary procedures performed by the same physician through the same incision or by the same operative approach.
PPO products	• Prospective reimbursement based upon a negotiated discount from the lesser of a) the traditional/comprehensive major medical indemnity level or b) retail charges • For multiple surgical procedures, the provider is reimbursed 100% of the BCBSNC allowance for the procedure listed on the first line of the claim, and 50% of the BCBSNC allowance for the remaining eligible procedures.

Health Benefit Plans	Reimbursement Methodology
PPO products *(continued)*	• Procedures performed in conjunction with the primary surgical procedure considered by BCBSNC to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures generally include secondary procedures performed by the same physician through the same incision or by the same operative approach.
HMO and POS products	• Prospective reimbursement based upon a negotiated discount from the lesser of a) the comprehensive Major Medical indemnity level or b) retail charges • For multiple surgical procedures, the provider is reimbursed 100% of the BCBSNC allowance for the procedure listed on the first line of the claim, and 50% of the BCBSNC allowance for the remaining eligible procedures. • Procedures performed in conjunction with the primary surgical procedure considered by BCBSNC to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures generally include secondary procedures performed by the same physician through the same incision or by the same operative approach.

10.62 Billing

Payment of an all inclusive fixed charge per procedure group includes, but is not limited to, the use of the facility including the following:

- Pre-operative complete blood count and urinalysis
- Pre-operative preparation
- Use of facility including pre-operative area, operating rooms and recovery rooms - primary and secondary
- All surgical equipment, anesthesia, surgical supplies, drugs and nourishment

- Donor services, EKG, implants, pumps, labs, radiology, etc.
- Extended stay/recovery
- Services of staff

In order to receive the expected contractual reimbursement, ASC claims should be filed with an amount equal to the indemnity rate and CPT code as indicated in the contract.

10.63 Primary Procedures

The first procedure listed on the first line of claim in form locator #44 will be designated as the primary procedure and will be processed at 100% of the allowable charge. The primary procedure code must also be listed in the principle procedure field in form locator field #80. The eligible secondary procedures will continue to be processed at 50% of the allowable charge. If the primary procedure is bilateral, the total charge is divided by the number of units to get the per unit charge. The first unit will be processed at 100% of the allowable per unit charge and the second unit will be processed at 50% of the allowable per unit charge.

10.64 Incidental Procedures

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.

10.65 Integral Procedures

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.

10.66 Non-Grouped Procedures

If the first procedure on the first line of form locator #44 is a non-grouped CPT code and falls outside of the defined ASC groupings, this will be considered the primary procedure.

Non-grouped primary surgical procedures will be allowed at a percent of the provider's accepted charge for indemnity members "CMM."

Non-grouped primary surgical procedures will be allowed at the applicable managed care allowance for managed care members.

If the non-grouped procedure(s) is on the second or subsequent lines of form locator #44, it is considered a secondary procedure(s) and if eligible for payment, will be allowed at 50% of the provider's accepted allowance for that member's line of business, *[i.e., PPO, HMO, POS, CMM]*.

10.67 Modifiers

For bilateral procedures, BCBSNC will accept modifier -50 in conjunction with CPT codes on the UB-04 claim form in form locator #44. Form locator #44 may have a separate line for each CPT code with 1 unit in form locator #46 or a single line CPT code in form locator #44 with 2 units reflected in form locator #46. RT and LT modifiers may be used when applicable.

BCBSNC allows additional reimbursement for secondary procedures according to Clear Claim Connection "C-3" logic. C-3 is accessible through current ***Blue e***℠ applications. The billing of modifier 59 on a secondary procedure will not allow additional reimbursement if C-3 logic disallows the code or bundles the code into the primary procedure code. To learn more about signing up for ***Blue e***℠ and obtaining C-3 access, visit BCBSNC electronic solutions on the Web at ***http://www.bcbsnc.com/providers/edi/***, or refer to chapter 12 of this manual.

10.68 Ambulatory Surgical Center "ASC" Reimbursement

Any amounts collected erroneously by you from a member for any reason will be refunded to the member within forty-five (45) days of your receipt of notification or your discovery of such error.

Participating providers agree to accept as full and final payment by BCBSNC for medically necessary covered services which are in compliance with BCBSNC health coaching and intervention programs for either of the following:

- The allowed amount, minus deductible, coinsurance, and/or copayment amounts;
- The provider's accepted charge minus deductible, coinsurance, or copayment amounts;
- A percent of the provider's accepted charge minus deductible, coinsurance, or copayment amounts, whichever amount is less.

Ambulatory Surgical Center "ASC" claims are reimbursed according to an internally developed ASC grouping system. The ASC groupings were created by identifying surgical CPT-4 codes that can generally be performed in an outpatient setting and then grouped according to the amount of resources required to perform the procedure. These groupings are updated for changes, additions and deletions in CPT-4 codes.

BCBSNC ASC groupings are similar in concept to Medicare's current ASC groupings, but are more comprehensive, and utilize more payment groups. The BCBSNC ASC groupings are unique to BCBSNC.

If the ASC files a code which conflicts with coding submitted by the attending physician one of the following actions will be taken by BCBSNC:

- Mail the claim back.
- Request operative notes.

Coordination of Benefits "COB"

11. Coordination of Benefits "COB"

11.1 Coordination of Benefits "COB"

Generally, coordination of benefits "COB" is the method of combining payments when more than one health insurance carrier covers the same person *(the patient)* such that total benefits paid are limited to 100% of eligible charges. When there is an indication of additional health insurance coverage, and when COB is legally and contractually permissible, it is the policy of BCBSNC to seek to identify the other coverage and to establish the order of benefits prior to adjudicating the claim. This process is known as pursue and pay.

BCBSNC's policies on COB are generally intended to make sure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources.

BCBSNC may determine that we do not have primary liability for a covered service based on the coordination of benefits provisions in the member's benefit plan or that we have partial liability under other provisions of the member's benefit plan. When this occurs our payment to you will not exceed the amount necessary to bring your total payment including but not limited to all amounts paid by us under other benefit plans or by third party benefit plans or by the member to the amount that you are entitled to receive as payment in full under your current provider agreement.

This section will provide general guidelines for determining order of benefits. The COB processes described in this document reflect BCBSNC's current policies and are intended to comply with current law as applicable. These descriptions are general, and may not take into account all that apply.

Under BCBSNC policy, when a provider submits a claim for a spouse or a dependent child of a BCBSNC subscriber that reports other coverage but BCBSNC has not received or does not have in its records definitive information to correctly determine liability, BCBSNC will deny the claim and request additional information pertaining to the other coverage. BCBSNC will re-open the claim when the requested information is received within 18 months of the date of service (per the member's benefit booklet) or one year from the date of denial, whichever is later.

11.2 BCBSNC as Secondary Carrier

For BCBSNC to determine our liability as the secondary carrier, all claims must be filed with the primary insurance carrier first, then filed electronically with primary payment information or sent via paper to BCBSNC with an explanation of benefits "EOB" from the primary insurance carrier. Whether the primary insurance carrier paid or denied the claim, BCBSNC must receive an official indication of this determination to determine liability. Even though some members with dual coverage may wish to use a particular plan because it may have better benefits than the other plan, claims still must be filed with primary insurance carrier first. In order for BCBSNC to pay secondary liability with respect to any service or benefit, the member must follow our applicable rules and guidelines. That means member must follow same authorization/approval procedures as if we were the only carrier. In all cases, the amount owed by BCBSNC as secondary liability will be no more than BCBSNC's allowed amount.

If BCBSNC is secondary, the following rules apply:

Procedural Rules:

- All prior review and certification policies and procedures must be followed according to the member's BCBSNC plan. A member is considered a member whether they are a primary, secondary or tertiary subscriber of a Blue Cross and/or Blue Shield insurance policy. Your contract applies whether the member is primary, secondary or tertiary. File with the primary plan first.
- After the primary plan pays its benefits, you must electronically file the secondary claim along with the primary payment information. Please refer to the electronic filing section for additional instructions if needed.
- If you do not submit claims electronically, forward the primary plan's Explanation of Payment/Notification of Payment "EOP/NOP" along with a paper claim form to BCBSNC. Please do not staple EOB to claim form.

Determining BCBSNC's and Member's Payment Amount:

- BCBSNC may determine that we do not have primary liability for a covered service based on the coordination of benefits provisions in the applicable member's benefit plan. When this occurs, participating providers agree that the BCBSNC payment to you will not exceed the amount necessary to bring the total payment including but not limited to all amounts paid by BCBSNC under other benefit plans, or by third party benefit plans, or by the member, as to the amount you are entitled to receive as payment in full under the agreement you have with BCBSNC.
- If BCBSNC receives a claim for which BCBSNC is secondary, the claim will be suspended pending BCBSNC's receipt of an official record of the primary plan's payment or denial. When the claim is suspended for this reason, a message will appear on the EOP/NOP. BCBSNC will coordinate benefits up to the contractual allowance as defined by the contract. In accordance with your contract, payments received by the provider from the primary carrier or by any other third party are considered payment towards the contractual allowance under your BCBSNC contract. The member's liability is always limited to the member's deductible, coinsurance and/or co-payment under the BCBSNC policy. Additionally, BCBSNC and our member's combined liability is always further limited to the amount that remains unpaid toward the contractual allowance under your BCBSNC contract. The amounts payable by BCBSNC and by the member are as specified in the NOP. Disallowed amounts/services cannot be billed to the member.
- If the primary carrier has paid as much or more than BCBSNC's contractual allowance, the member should not have any liability.

11.3 Maintenance of Benefits

Because ASO groups are not subject to North Carolina law on coordination of benefits, some ASO groups choose to apply Maintenance of Benefits "MOB" rather than standard COB. MOB is a different type of COB option offered on ASO groups where the member remains responsible for all co-pays, deductibles, and coinsurance. This applies both to coordination with other group coverage as well as Medicare. This type of coordination puts greater financial liability on the member. Under MOB, the member's liability is generally calculated as other coverage allowed minus BCBSNC allowed amount minus BCBSNC deductible, coinsurance and co-pay. If anything remains, it will be paid towards coordination. You, as a provider, should come out whole; greater financial liability is on the member.

11.4 BCBSNC as Dual Coverage

If a member has dual BCBSNC coverage *(i.e., BCBSNC is both primary and secondary)*, the secondary BCBSNC coverage is typically responsible for covering any member co-payments, coinsurance and deductibles, but not responsible for any disallowed amounts as a consequence of our contractual agreement.

When BCBSNC is both primary and secondary, you must submit two (2) separate claims. Submit the first claim to the primary BCBSNC plan using the member's complete identification number *(alpha prefix and subscriber number including suffix, if applicable)*. Upon receipt of the primary EOP/NOP, submit another claim to the secondary BCBSNC plan using the member's complete second identification number *(alpha prefix and subscriber number including suffix, if applicable)* indicating the primary EOP/NOP payment amount for electronic claims.

For paper claims, submit a copy of the primary payer's EOP/NOP with the secondary claim. If our records indicate the BCBSNC is secondary and the primary plan's *(including BCBSNC)* EOP/NOP information is not received, we will deny the claim and request that the primary plan's EOP/NOP information *(for electronic claims)* or EOP/NOP copy *(for paper claims)* be submitted with the secondary claim filing to BCBSNC.

11.5 BlueCard®

Effective 4/21/02, all secondary claims can be filed through BlueCard®. Refer to section six, Inter-Plan Programs for more COB information.

11.6 Worker's Compensation

BCBSNC will not pay for services provided for any illness or injury sustained by a member if benefits *(in whole or in part)* are either payable or required to be provided under any worker's compensation or occupational disease laws. If a claim is received for specific illnesses or injuries, a letter will be sent to the member to obtain additional information. When benefits for an occupational condition, disease, or injury are no longer available under the worker's compensation law, the exclusion no longer applies. However, maximum benefits are allowed only if all applicable referral and certification requirements are met. Once you receive your EOP/NOP from BCBSNC, you may file with the secondary carrier.

11.7 Non-COB List

In most cases, BCBSNC will not coordinate with the following types of policies. The following is a partial list of the non group plans we do not coordinate with:

- AFLAC
- AARP
- CHAMPUS
- EDS Federal
- Carolina Alternatives
- Carolina Access

- NC Access
- Medicaid
- School insurance policies
- TRICARE
- Workman's compensation policies

11.8 Order of Benefit Determination – Commercial

COB for Subscriber or Spouse:

1. If one of the two insurance carriers does not have a COB clause in its policy that plan is primary. Blue Advantage® does not have a COB clause, meaning that Blue Advantage® will coordinate only with Medicare as the primary policy.
2. If both carriers have a COB clause in their policies, the carrier covering the patient as its subscriber or policyholder is primary, and the carrier covering the patient as a spouse of the policyholder is secondary.

COB for Dependent Children:

When the parents are not separated or divorced, determining primary/secondary carrier when a dependent child is the patient is done by applying the parent's birthday rule. The parent whose birthday comes first during the year is primary; the parent's birth month that comes first is primary. If both parents have the same birth month then the primary carrier is based on the birth whichever parent's birthday comes first during that month. If both parents have the same birthday, the parent's carrier whose coverage has been in effect longer is primary. If the other plan has a rule based upon the gender of the parent instead of the birthday rule, the rule in the other plan determines the order of primary or secondary carrier.

When the parents are separated or divorced, the following order of benefit determination applies, unless a court decree indicates otherwise:

When one parent has custody:

1. The parent with custody is primary. The certificate of the parent with court ordered financial responsibility for medical, dental, or health care expenses is determined primary
2. The step-parent with custody is secondary
3. The parent without custody is third carrier to pay
4. The step-parent without custody is the fourth carrier to pay

When parents have joint custody:

1. Primary – parent with the earliest birthday *(not year)*
2. Secondary – parent with the latest birthday *(not year)*
3. Third – step-parent married to the parent with the earliest birthday *(not year)*
4. Fourth – step-parent married to the parent with the latest birthday *(not year)*

When custody is not indicated:

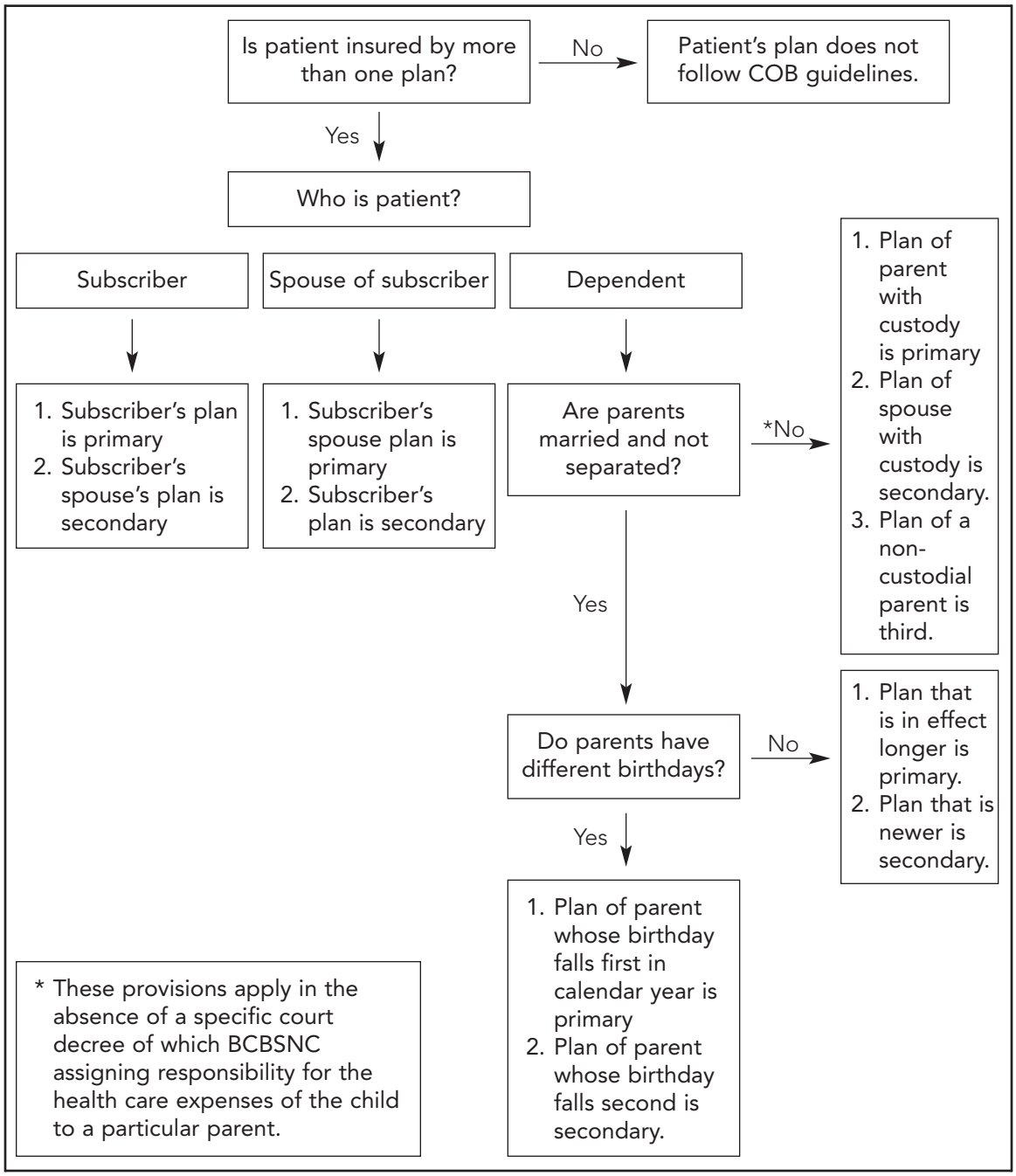
When custody has not been indicated, BCBSNC assumes custody is held by the parent with whom the child resides, and determines the order of benefits as follows:

1. Primary – parent where the child resides
2. Secondary – step-parent married to the parent where the child resides
3. Third – parent where the child does not reside
4. Fourth – step-parent married to the parent where the child does not reside

COB for Newborns:

Please wait until after the birth of the child to file a claim in order to determine which policy applies using the birthday rule.

Order of Benefits Determination Chart



11.9 Coordination of Group Policies with Medicare

In certain instances, as defined by the Social Security Act, health plans are responsible for making primary payment in connection with medical services provided to specified Medicare beneficiaries with dual health care coverage. The rules are complicated and vary depending on numerous factors. Contact Medicare directly for specific questions.

We can provide the following general information for you. In the event of any conflict with Medicare's rules, Medicare's rules will apply:

Medicare pays secondary to BCBSNC for the following circumstances.

- BCBSNC is primary for individuals with End-Stage Renal Disease "ESRD" during the first 30 months of Medicare eligibility.
- For individuals 65 and over, that are covered by employers that employ 20 or more employees, BCBSNC is primary if the individual or the individual's spouse *(of any age)* has current employment status.
- For disabled individuals under 65 that are covered by employers that employ 100 or more employees, BCBSNC is primary if the individual or a member of the individual's family has current employment status.
- For individual policies, once Medicare is effective, Medicare becomes primary.

11.10 Order of Benefits Determination – Medicare

There are separate procedures for determining the order of benefits when Medicare is involved.

Please refer to the following chart to help determine when Medicare is primary or secondary to a group health plan.

Medicare Beneficiary is... Over 65	Medicare Primary	Group Primary
Actively working and the employer has less than 20 employees	X	
Actively working and the employer has 20 or more employees		X
Retired and has group coverage through a spouse who is actively working for an employer with less than 20 employees	X	
Retired and has group coverage through a spouse who is actively working for an employer with 20 or more employees		X
Retired and has group coverage through a spouse who is retired	X	

Medicare Beneficiary is... Over 65 *(continued)*	Medicare Primary	Group Primary
Retired employee	X	
Has COBRA coverage	X	

Medicare Beneficiary is... Under 65 and Disabled	Medicare Primary	Group Primary
Actively working and the employer has less than 100 employees	X	
Actively working and the employer has 100 or more employees		X
Not actively employed	X	
Not actively employed and has group coverage through a spouse who is actively working for an employer with less than 100 employees	X	
Not actively employed and has group coverage through a spouse who is actively working for an employer with 100 or more employees		X
Has COBRA coverage	X	

ESRD Entitlement Beneficiary is receiving dialysis treatment at a Treatment Center	Medicare Primary	Group Primary
Beneficiary has group coverage, including a retirement plan or COBRA coverage. First 30 months of Medicare entitlement. Entitlement starts 3 months after the first date of dialysis unless beneficiary has received self-dialysis training. Example: A person starts a regular course of dialysis on July 15th they would be entitled to Medicare on October 1st.		X
Beyond 30 months of Medicare entitlement.	X	
Medicare eligibility due to age or disability occurred prior to ESRD eligibility and Medicare was appropriately the primary payer following the age and disability rules above	X	

ESRD Entitlement Beneficiary is receiving self-dialysis	Medicare Primary	Group Primary
Beneficiary has group coverage, including a retirement plan or COBRA coverage. First 30 months of Medicare entitlement. Entitlement starts with first date of month in which dialysis begins.		X
Beyond the first 30 months of Medicare entitlement.	X	
Medicare eligibility due to age or disability occurred prior to ESRD eligibility and Medicare was appropriately the primary payer following the age and disability rules above	X	

Note: For multiple employer arrangements *(including labor union plans)* if any employer within the group has 100 or more employees the plan is considered a large group health plan for purposes of applying the disability rules set out above, and Medicare due to disability is secondary to the group coverage for employees of all employers within that group.

Caution: Fluctuations in the group size may occur for small group and major accounts. Be aware that these fluctuations can affect the Medicare primary status.

11.11 Hold Harmless Provision

The provider contracts contain language regarding when the member is to be held harmless from any additional payment other than amounts stated in the member's benefit booklet and the EOP/NOP. A member is considered a member whether they are a primary, secondary or tertiary subscriber of a Blue Cross and/or Blue Shield insurance policy. Your contract applies whether the member is primary, secondary or tertiary. Participating providers are expected to file all member claims regardless of order of benefits.

Refer to your contract to determine the hold harmless provisions that apply to your practice. If you have questions regarding your hold harmless provision, please contact your local BCBSNC network management field office *(see section 2.12, BCBSNC Network Management Local Offices)* for more information.

11.12 Group COB Examples

The following examples are intended to assist you in understanding basic COB processes. They are not intended to explain our processes, and in the event of any conflict between these examples and our processes or applicable law, our processes or applicable law will control. All of these examples assume that the service is covered and that all processes have been followed.

Commercial Carrier Primary:

CMS-1500

Charge amount $1000.00

Commercial carrier paid	$ 800.00
Group allowance	$ 900.00
Group liability	$ 100.00

(we pay secondary up to our liability/allowance. If the other carrier has paid more than the group's allowance, we will not make a secondary payment. Claims are still subject to the SHP deductible and coinsurance, if applicable. We will apply deductible and coinsurance to any payments)

UB-04:

Charge amount	$1000.00
Commercial carrier paid	$ 800.00
Group allowance	$1000.00
Group liability	$ 200.00 *(Benefits will be applied)*

Medicare Primary:

CMS-1500:

If provider accepts Medicare's assignment

Charge amount	$1000.00
Medicare allowed	$ 800.00
Medicare paid	$ 640.00
Group liability	$ 160.00 *(Medicare allowed, less Medicare payment)*

If provider does not accept Medicare's assignment

Charge amount	$1000.00
Group allowed	$ 800.00
Medicare paid	$ 640.00
Group liability	$ 360.00 *(Charge, less Medicare payment)*

UB-04:

If provider accepts *(or does not accept)* Medicare's assignment

The group plans liability is Medicare's coinsurance and/or deductible. Our payment may not equal 100% of Medicare's coinsurance and deductible. *(The provider's participation with Medicare does not affect our secondary liability.)*

11.13 Individual Business COB Examples

Medicare is always primary once member becomes effective with Medicare.

CMS-1500:

If provider accepts Medicare assignment:

I.	Charge amount	$545.00
	Medicare allowed	$247.51
	Medicare paid	$198.01
	BCBSNC liability	$ 49.50

(Medicare allowed, less Medicare payment. Our payment may not equal 100% of Medicare's coinsurance and deductible)

II.	Charge amount	$2456.00
	Medicare allowed	$ 0.00
	Medicare paid	$ 0.00
	BCBSNC liability	$? *(See scenario's a and b below)*

a. EOB shows charges as denied, verify Medicare action code. If Medicare will reconsider the charge we will deny the claim awaiting the Medicare EOB.

b. If Medicare will not reconsider the charge will pay BCBSNC liability.

If provider does not accept Medicare assignment:

Charge amount	$1000.00
Medicare allowed	$ 800.00
Medicare paid	$ 640.00
BCBSNC liability	$ 360.00

Provider charge minus the Medicare payment.

UB-04:

Accept assignment or not, Plan's liability is coinsurance and/or deductible amounts. Our payment may not equal 100% of Medicare's coinsurance and deductible.

A1 = Inpatient deductible
A2 = Inpatient coinsurance
B1 = Outpatient deductible
B2 = Outpatient coinsurance

The following deductibles apply under 2006 Medicare;

- Inpatient deductible = $952.00 *(Medicare Part A)*
- Outpatient deductible = $124.00 *(Medicare Part B)*

11.14 State Health Plan "SHP" COB Examples

Administrative Services Only "ASO" / Commercial Carrier Primary:

CMS-1500:

Charge amount	$1000.00
Commercial carrier paid	$ 800.00
SHP liability	$ 200.00

(the SHP's liability is still subject to deductibles and co-payments)

Medicare Primary:

CMS-1500:

If provider accepts Medicare's assignment

Charge amount	$1000.00
Medicare allowed	$ 800.00
Medicare paid	$ 640.00
State's liability "SHP"	$ 360.00 *(Charge, less Medicare payment)*

UB-04:

If provider accepts *(or does not accept)* Medicare's assignment

The State Health Plan's liability is Medicare's coinsurance and/or deductible. *(The provider's participation with Medicare does not affect our secondary liability.)*

BCBSNC Primary Carrier:

Total billed amount	$1500.00
BCBSNC allowed amount	$1000.00
BCBSNC paid amount	$ 800.00
SHP's liability	$ 200.00

11.15 Federal Employee Program "FEP" COB Examples

Administrative Services Only "ASO" / Commercial Carrier Primary:

CMS-1500:

Charge amount	$1000.00
Commercial carrier paid	$ 800.00
FEP allowance	$ 900.00
FEB liability	$ 200.00

(the FEP's liability is still subject to deductibles and coinsurance)

UB-04:

Charge amount	$1000.00
Commercial carrier paid	$ 800.00
FEP liability	$ 200.00

(the FEP's liability is still subject to deductibles and coinsurance)

Medicare Primary:

CMS-1500:

If provider accepts Medicare's assignment

Charge amount	$1000.00
Medicare allowed	$ 800.00
Medicare paid	$ 640.00
FEP's liability	$ 160.00

(Medicare allowed, less Medicare payment)

If provider does not accept Medicare's assignment

Charge amount	$1000.00
Medicare allowed	$ 800.00
Medicare paid	$ 640.00
FEP's liability	$ 160.00

(Please note for FEP the physicians who do not accept Medicare assignment can only bill up 115% of the Medicare approved amount called the limiting charge.)

UB-04:

BCBSNC Primary Carrier:

Total billed amount	$1500.00
BCBSNC allowed amount	$1000.00
BCBSNC paid amount	$ 800.00
FEP's liability	$ 200.00

11.16 Coordination of Benefits "COB" Rules

When a member is covered by more than one insurance carrier, one plan must be designated as primary and the other as secondary. Coordination of benefits rules are used to determine which plan pays first on the claim. BCBSNC prior review and certification requirements apply whether we are primary or secondary. Please refer to the order of benefits determination section for further information.

11.17 Which Health Benefit Plan is Primary?

Final determination of primary status is made in accordance with the terms of the applicable member contracts and North Carolina law *(if applicable)*. If one of the carriers does not have a Coordination of Benefits "COB" provision, that plan is considered primary and always pays first. Otherwise, please refer to the order of benefits determination section to determine which carrier is primary.

11.17.1 BCBSNC as Primary

If BCBSNC is primary, and another insurance plan is secondary, use the following guidelines:

- All prior review and certification policies and procedures must be followed according to the member's BCBSNC plan.
- You should first file with BCBSNC.

11.18 HIPAA – 837 Professional Batch Claims

When filing an 837 professional claim to BCBSNC as the secondary or tertiary payer, please note the following for proper claim handling:

- At the claim level, file only the actual amount paid by the other carrier in the 2300 AMT segment for payer amount paid. Do not include deductible, coinsurance, co-payments, or other adjustments in the payer paid amount field. *(See table below.)*
- File all other adjustments in the CAS segment with the appropriate reason code.
- Include the allowed amount in the appropriate AMT segment.
- At the line level, provide the actual amount paid by the other carrier in the 2430 SVD segment for line adjudication information if possible. All other adjustments should be filed in the 2430 CAS segment with the appropriate reason code.

837 Professional Claim					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
2320	SBR	Other subscriber information			
			SBR01	Claim filing indicator code	P =
	CAS	Line adjustment			
			CAS01	Claim adjustment group code	CO = CR = Correction and reversals OA = Other adjustments PI = Payer initiated reductions PR = Patient responsibility

837 Professional Claim					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
	AMT	COB payer paid amount			
			AMT01	Monetary amount	D =
			AMT02	Monetary amount	Fill the actual amount paid by the other carrier. Do not include deductible, coinsurance, co-payments, or other adjustments in the payer paid amount field.
	AMT	Coordination of Benefits "COB" allowed amount	AMT01	Amount qualifier code	B6 = Allowed - actual
2330B	NM1	Other payer name			
			NM101	Entity type qualifier	PR = Payer
			NM103	Payer name	Use last name or organization name
	DTP	Claim adjudication date			
			DTP01	Date/time qualifier	573 = Date claim paid
2430		Service line level			
2430	SVD	Line adjudication information			
			SVD02	Monetary amount	Important note: please provide the actual amount paid by the other carrier in the SVD segment for line adjudication information. All other adjustments should be filed in the CAS segment with the appropriate reason code.
2430	CAS	Line adjustment			

837 Professional Claim					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
			CAS01	Claim adjustment group code	CO = CR = Correction and reversals OA = Other adjustments PI = Payer initiated reductions PR = Patient responsibility
2430	DTP	Line adjudication information			
			DTP01	Date/time qualifier	573 = Date claim paid

11.19 HIPAA – 837 Institutional

When filing an 837 institutional claim to BCBSNC as the secondary or tertiary payer, please note the following for proper claim handling:

- At the claim level, file only the actual amount paid by the other carrier in the 2300 AMT segment for payer amount paid. Do not include deductible, coinsurance, co-payments, or other adjustments in the payer paid amount field. *(See table below.)*
- File all other adjustments in the CAS segment with the appropriate reason code.
- Include the allowed amount in the appropriate AMT segment.

837 Institutional Claim					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
2320	SBR	Other subscriber information			
			SBR01	Claim filing indicator code	P =
	CAS	Line adjustment			
			CAS01	Claim adjustment group code	CO = CR = Correction and reversals OA = Other adjustments PI = Payer initiated reductions PR = Patient responsibility
	AMT	Payer prior payment			

837 Institutional Claim					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Rules**
	AMT	Coordination of Benefits "COB" total allowed amount			
			AMT01	Amount qualifier code	B6 = Allowed - actual
2330B	NM1	Other payer name			
			NM101	Entity type qualifier	PR = Payer
			NM103	Payer name	Use last name or organization name
	DTP	Claim adjudication date			
			DTP01	Date/time qualifier	573 = Date claim paid

***Blue e*SM – CMS-1500 Health Care Claims Filing**

At this time we are unable to process secondary HCFA claims via ***Blue e*SM**. Please submit these claims on your 837 professional batch file.

***Blue e*SM – UB-04 Health Care Claims Filing**

To file a BCBSNC secondary claim via ***Blue e*SM**, please follow the same guidelines as you would when filing a paper claim. BCBSNC payer information should show on line A for payer name "FL50," insured's name "FL58," and certificate number "FL60." The primary payer information should show on line B for the same information. Please remember to complete the prior payments field "FL54" for line B.

11.20 CMS-1500 Claim Form Detail

In order to process your COB claim efficiently and accurately, please pay particular attention to these items and fill them out correctly.

Please note: This detail only depicts the COB-related items of the professional claim form. Please refer to the full claim form detail for a complete listing of the filing details.

Block	Field Name	Description	Comments
1a	Insured's ID number	Insured's ID - Enter the member identification number exactly as it appears on the patient's ID card. The member's ID number is 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. *(Suffixes apply to New Blue products only.)*	File the most current member ID number. Please be sure to update your system to reflect the most recent ID information.
9	Other insured's name *(last name, first name, middle initial)*	Show the last name, first name, and middle initial of the person having other coverage that applies to this patient.	*Complete this block only when the patient has other insurance coverage.*
9a	Other insured's policy or group number	Enter the policy and/or group number of the other insured's policy.	
9b	Other insured date of birth	Enter the other insured's date of birth *(MM/DD/YYYY)* and sex.	
9c	Employee's name or school name	Enter the other insured's employer's name or school name.	
9d	Insurance plan name or program name	Enter the other insured's insurance company name.	
10a-10c	Is patient's condition related to: a) Employment? *(current or previous)* b) Auto accident? c) Other accident?	Use one character (X) to mark yes or no to indicate whether employment, auto liability, or other accident involvement applies to services in Item 24 *(diagnosis)*.	
24f		Enter the total charges for each line item. Enter up to 7 numeric positions. Dollar signs are not required.	Professional claims must be filed line by line to assist correct coordination.
27		Accept assignment ☐ YES must be indicated in order to receive direct reimbursement. Contracting providers have agreed to accept assignment.	
29		Enter the amount paid by the primary insurance carrier. *(Reminder: Only co-payments may be collected at time of service.)*	For State Health Plan use only.

* You will still need to fill out the entire claim. This section only emphasizes COB.

11.21 UB-04 Claim Form Detail

In order to process your COB claim efficiently and accurately, please pay particular attention to these items and fill them out correctly.

Please note: This detail only depicts the COB-related items of the professional claim form. Please refer to the full claim form detail for a complete listing of the filing details.

Form Locator Number	Description of Contents	Comments
39-41	**Value codes:** 01 - Most common semi-private rooms 02 - Provider has no semi-private rooms 06 - Blood deductible 09 - Medicare coinsurance amount A1 - Deductible payer A A2 - Coinsurance payer A B1 - Deductible payer B B2 - Coinsurance payer B C1 - Deductible payer C C2 - Coinsurance payer C	
50a,b,c	Insurance carrier name Line A - Primary payer Line B - Secondary payer Line C - Tertiary payer	
51a,b,c	Provider number Enter BCBSNC provider number on appropriate line	
52a,b,c	Permission to release medical/billing information to process this claim ☐ Y or ☐ N	
53a,b,c	Accept Assignment Yes must be indicated in order to receive direct reimbursement • Contracting providers have agreed to accept assignment	
54a,b,c	Prior payments/source P - Patient A - Primary payer B - Secondary payer C - Tertiary payer	
55a,b,c	Estimated amount due from each payer	Information in this section is only used by State Health Plan.
60a,b,c	Subscriber's identification number	

* You will still need to fill out the entire claim. This section only emphasizes COB.

11.22 Filing Medicare Crossover Claims

Medicare Crossover Claims

The Medicare crossover program is a program that automatically files electronic claims for secondary payment, saving your facility the time and expense of filing a paper claim to BCBSNC. Under the Medicare Crossover program, you need to submit only one claim to the Medicare Part B carriers. The Medicare Part B carriers will process as the secondary payer.

The Medicare remittance advice will indicate whether a paper claim needs to be filed with BCBSNC.

If the claim was crossed over by Medicare, the Medicare payment advice/EOMB should have remark code MA 18 printed on it, which states: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

The remark code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

Claim Not Crossed Over

If the Medicare payment advice/EOMB does not indicate the claim was crossed over and you accepted Medicare assignment, file the claim to BCBSNC if the claim has a prefix.

If no prefix, file the claim to the address on the back of the card. BCBSNC or the member's BCBS Plan will pay you the Medicare supplemental benefits. If you did not accept

Blue Card® Medicare Services

The Medicare Crossover program is not designed to cover out-of-state Medicare patients. The Medicare Crossover program does not automatically file electronic claims for secondary payments for out-of-state patients. Notify BCBSNC network management field office if there are any changes in your Medicare provider number or participation status.

More information regarding Medicare and BlueCard® COB can be found in section six, Inter-Plan Programs and section seven, Medicare/Medicare Supplement.

Please note: There is a 15-day processing time for Medicare intermediaries before claims are crossed over to BCBSNC.

11.23 Explanation of Payment or Notification of Payment "EOP/NOP"

We report payment and denial of claims to providers on an EOP/NOP report. This information may be available electronically through the 835 Remittance transaction *(see chapter 12, Electronic Solutions, for additional information)*.

Please note: Your contract overrides information on the EOP/NOP especially where BCBSNC is the secondary payer.

11.24 Overpayments

11.24.1 When You Notice an Overpayment

Call the Provider Blue Line℠ at **1-800-214-4844** or Inter-Plan Programs at **1-800-487-5522** and speak with a representative

OR

- Complete form G252 - Refund of Overpayment form *(see chapter 23, Forms)*

OR

Write a letter including the following information:

- The amount of the overpayment
- The member's ID number associated with the overpayment
- Date of service
- Provider number under which service was paid
- Copy of the EOP/NOP
- The reason you believe the payment is in error

Note: If you receive a refund request, please make sure that you return the invoice with your check.

11.24.2 Disbursement of Overpayments

The following products licensed by Blue Cross Blue Shield of North Carolina only coordinate benefits when Medicare is the primary carrier. Any overpayments related to coordination of benefits, excluding Medicare, received by providers on the following products should be forwarded to our member.

- Blue Advantage®/associated group number IADV01 & IADV15
- Blue Access℠/associated group number IACC01-IACC12
- Blue Assurance℠/associated group number IBAS01
- Conversion/associated group number ICMM01-ICMM12
- Short-term/associated group number IBST01 & IBST02

11.25 Prompt Payment and COB

Prompt payment penalties apply beginning 30 days after the receipt of all information required to process the claim. In the case of coordination of benefits, primary payer information or an EOB is a required piece of information for claim processing. Prompt payment penalties may apply 30 days after the receipt of all required information including primary payer information or the EOB.

The prompt payment mandate does not apply to the following programs:

- ASO business *(self-funded groups)*. However, the mandate does apply to Multiple Employer Welfare Arrangement "MEWA" groups.
- Medicare Supplement
- BlueCard® claims

- Federal Employee Program

If you are interested in learning more about the prompt payment mandate and how it affects you, please contact your local Blue Cross and Blue Shield of North Carolina network management field office *(see section 2.12, BCBSNC Network Management Local Offices)*.

11.25.1 Tips for Reducing Payment Delay and Improving Accounts Receivable

1) Ask all Patients about Secondary Insurance Coverage

Have an office procedure to document and/or confirm the most current primary/secondary insurance information at each visit. Ask patients to provide the following information about themselves and their spouses and dependents: social security number, birth date, group or policy number for other medical coverage *(if applicable)*, and Medicare or Medicaid ID card *(if applicable)*. Document this information at the time the appointment is booked to allow time for your staff to confirm eligibility prior to the visit.

2) Know What Plans and Payers Need to Pay Claims

Although each plan and payer may have slightly different requirements, there are some requirements that are nearly universal. For example, nearly all plans require a copy of the EOB from the primary payer prior to paying a claim as the secondary payer – or appropriate primary carrier payment information *(filed through the 837)* if the claim is not already submitted to the secondary carrier through Medicare crossover. Most plans and payers publish their requirements and the information should be available in Provider eManuals, online, and by contacting provider representatives.

3) Determine Primary and Secondary Payers

It is important for providers to determine primary and secondary payers so that claims can be sent to the primary payer first. Some plans will be able to tell providers whether they are primary or secondary at the time the provider contacts the plan to verify eligibility. Typically, the following rules are used by plans and payers to determine the primary and secondary payer:

a) The payer covering the patient as a subscriber will be the primary payer.

b) If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the birthday rule.

4) Include Primary Payment amounts from Primary Payers When Submitting Claims to Secondary

After the primary plan pays its benefits, electronically file the secondary claim along with the primary payment information. Please refer to the electronic filing section for additional instructions if needed.

A Special Consideration for Medicare Claims

Many health plans receive Medicare claims automatically when they are the secondary payer. In this case, the Explanation of Medicare Benefits "EOMB" will indicate that the claim has been automatically crossed over for secondary consideration. Providers should look for this indication on their EOMBs and should not submit a paper claim to the secondary payer. A paper claim submitted in this circumstance would be coded as a duplicate and rejected by the secondary payer.

Please note: There is a 15-day processing time for Medicare intermediaries before claims are crossed over to BCBSNC.

Electronic Solutions
(Using EDI Services)

12. Electronic Solutions *(Using EDI Services)*

In 2006, the EDI services team adopted a name change to electronic solutions. This change reflects the increasing scope of transactions that are now offered by BCBSNC. For purposes of this manual, EDI Services will be used as the term to describe these services.

EDI services enables the transmission of electronic files for the business processing of health care information. BCBSNC provides electronic solutions in both batch and real-time modes to our contracted health care providers. These health care transactions, include claims, remittances, admission notifications, eligibility and claim status inquiries. EDI services provides customer support for all of our trading partners that submit electronic transaction files.

EDI services also offers two Web-based products, ***Blue e***℠ and RealMed, for making interactive inquiries about eligibility and claim status, admission notifications and claims entry. BCBSNC has developed electronic solutions that allow contracted health care providers to access detailed claim management information from BCBSNC, and customize that information to the workflows in their organizations.

Health care providers, clearinghouses, billing services and practice management system vendors who wish to send electronic transactions to BCBSNC can obtain resources and required forms on the electronic solutions Web site at ***bcbsnc.com/providers/edi/***. All direct senders of batch files will need to sign and submit a Blue Cross and Blue Shield of North Carolina trading partner agreement and an electronic connectivity request Form. ***Blue e***℠ interactive network agreements are also available at this Web site. Information regarding RealMed can be found at ***www.realmed.com***.

This chapter outlines the range of electronic solutions offered by BCBSNC.

12.1 HIPAA

The Health Insurance Portability and Accountability Act "HIPAA" mandates the standardization of data exchange formats for health care data transmission, including claims, authorizations, remittances, eligibility and claim status inquiries. The HIPAA 837 format replaces proprietary electronic formats with ASC X12N transactions.

EDI Services has produced a companion guide to assist trading partners in understanding Blue Cross and Blue Shield of North Carolina code and situation handling used in processing the ANSI ASC X12N transactions. This companion guide is available at ***bcbsnc.com/providers/edi/***.

12.1.1 BCBSNC HIPAA Companion Guide

Blue Cross and Blue Shield of North Carolina accepts the following HIPAA-compliant transactions:

BCBSNC Companion Guide Chapters and/or HIPAA Transaction
Introduction to the companion guide to EDI transactions *(for all trading partners)*

BCBSNC Companion Guide Chapters and/or HIPAA Transaction
837 institutional health care claim
837 professional health care claim
837 dental health care claim
835 health care claim payment/advice
270 and 271 health care eligibility inquiry and response
276 and 277 claim status request and response
278 health care services review and response
BCBSNC HIPAA glossary
Appendix A: adjustment reason codes
Appendix B: BCBSNC business edits for 837 professional
Appendix C: BCBSNC business edits for 837 institutional

You can download BCBSNC companion guide chapters that are essential to understanding issues applicable to all transmissions with BCBSNC.

12.1.2 Tools and Forms

The following agreements, contracts, instructions and sample documents are also available online as pdf files for download:

- **Trading Partner Agreement**

  This contract establishes the formal relationship between a direct sender of electronic files and Blue Cross and Blue Shield of North Carolina. This agreement, along with the electronic connectivity request form, needs to be completed by all trading partners and submitted to EDI services before electronic transmissions are exchanged.

- **Trading Partner Agreement Instructions**

  These instructions include information about who needs to complete the trading partner agreement, to whom it is sent and what other forms need to be included for setup to occur. Send the original copy to BCBSNC EDI services before electronic transmissions can be tested and exchanged.

- **Electronic Connectivity Request "ECR" Form**

  Any health care provider wishing to transmit files electronically to BCBSNC, either directly or via a business associate, needs to complete the form pertinent to the transmission that is to be sent.

- **ECR: Information and Instructions**

  These instructions include information about who needs to complete the form, to whom it is sent and what other forms need to be included for setup to occur.

HIPAA Sample Documents

- **Claims Audit Report Sample**

  Trading partners can download their claims audit reports from their BCBSNC electronic mailboxes. The claims audit report is returned for 837 transactions only.

- **997 Transaction Sample**

  The 997 transaction serves as both a positive acknowledgement and a report of HIPAA implementation guide errors within a functional group "GS/GE" or a transaction set "ST/SE."

- **TA1 Acknowledgement Sample**

  The TA1 transaction serves as both a positive acknowledgement and a report of HIPAA implementation guide errors within an interchange control "ISA/IEA."

12.1.3 EDI Electronic Connectivity Request "ECR" Form

Electronic Connectivity Request "ECR" forms must be completed for any organization or provider that wants to submit or receive electronic transactions with BCBSNC. The following ECR forms are available:

- Master ECR for 837 claim, 27X inquiry and 235 remit
- The 835 payment/remittance advice for Medicare Crossover

Commonly Asked Questions About ECR Forms

1. **Who completes an EDI Electronic Connectivity Request "ECR" form?**

   Every health care provider wishing to exchange electronic information with BCBSNC, whether submitting information directly or via another party, must complete an ECR form. However, an ECR form must be accompanied by a BCBSNC trading partner agreement. Only direct senders of electronic transmissions need to file a trading partner agreement. Verify with your vendor/clearinghouse that a trading partner agreement has been established with BCBSNC on your behalf.

   Providers who do not transmit transactions directly to BCBSNC may have their vendor/clearinghouse or billing service complete the detail information on the ECR form; however, each provider must sign the form. Clearinghouses or billing services cannot sign the ECR form on behalf of the provider they are servicing.

   Each form contains sections that are clearly marked as provider, vendor/clearinghouse or billing service information.

2. **Which forms should be submitted?**

   - Each ECR form is transaction-specific. Providers should complete those forms that are applicable to their business needs and the specific transaction sets that they wish to send to BCBSNC.

3. **What information is required for HIPAA transactions that was not previously needed?**

   - The ECR form requires sender or receiver ID Qualifiers, depending upon the transaction being sent, and the actual sender or receiver ID. BCBSNC requires direct senders of transactions to use their federal tax ID for their sender or receiver ID. The qualifier code for the federal tax ID is "30." Direct senders who may not have a federal tax ID may use the "ZZ" sender ID qualifier and their social security number for the sender ID.
   - The type of transaction box includes an effective date – the date by which the sender will be ready to transmit. This section also includes an X12 version indicator. At this time, only the ASC 4010A1 version is available.

4. **What do I do with the completed ECR form(s)?**

   Completed forms may be faxed to BCBSNC EDI Services at **1-919-765-7101**. BCBSNC EDI services returns a notification letter to the contact person listed in the form, verifying receipt of the ECR form(s), the information submitted, and the date submitters can expect to transmit.

12.2 Electronic Claims Filing

BCBSNC encourages you to file claims electronically whenever possible. Electronic claims submission improves the turnaround time for reimbursement to you and reduces expensive administrative tasks for your staff.

Claims can be submitted electronically for all BCBSNC policies, Federal employee plans, State Health Plan and BlueCard® policies.

- If you are interested in submitting the HIPAA compliant 837 claim transaction as a direct submitter, please reference the HIPAA information page on our Web site at ***bcbsnc.com/providers/edi*** for resources and the necessary forms. You must complete a Trading Partner Agreement "TPA" as well as an Electronic Connectivity Request "ECR" form for the transaction. *(Please note that the electronic connectivity request forms are transaction specific. If you want to submit transactions other than claims, more than one ECR form may be required. Instructions/information for submitting ECR forms are contained in chapter 12).*
- All BCBSNC trading partners are required to test their file submission formats with BCBSNC before submitting production files. The BCBSNC companion guide to EDI transactions is available at the BCBSNC Web site, and can assist with test preparation and execution.
- If you are currently utilizing the services of a vendor/clearinghouse that submits claims electronically on your behalf, you do not need to complete a TPA. However, you or your vendor/clearinghouse do need to complete the ECR form for electronic connectivity, and you as the provider must sign this form to authorize your set up.
- If you are currently utilizing the services of a vendor/clearinghouse, but not yet filing electronic claims, contact your vendor to begin filing claims electronically.
- You should contact your vendor or clearinghouse to determine their ability to transmit all of the HIPAA transactions on your behalf, as well as their ability to retrieve and route acknowledgements to you.

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

12.3 Tips for Electronic Claims Filing

- Submit correct and complete member ID numbers, including any alpha prefixes and numeric suffixes, *(see chapter 3, Health Benefit Plans and ID Cards)* or the BCBSNC companion guide chapters on 837 transactions *(see identification codes and numbers)* for more information.
- The provider should retrieve claims audit reports electronically. If you cannot retrieve this report, contact EDI Services Customer Support at **1-888-333-8594** or contact your EDI services field consultant for more information.
- Correct all electronic claim errors on your internal system and resubmit those claims electronically via the 837 transaction.
- The claims error listing is contained in the claims audit report. You may electronically access your claims audit report for the 837 health care claim transaction. Paper copies of the 837 claims error listing are not available.
- Professional corrected claims can be submitted electronically using the 837 professional claim transaction or by direct data entry through the ***Blue e***℠ CMS-1500 transaction. Specify the corrected claim indicator in loop 2300, segment CLM05-3 on the 837 professional claim transaction. Or indicated corrected claim by setting the Corrected Claim flag to "Yes" on the ***Blue e***℠ CMS-1500 transaction.
- Institutional corrected claims can be submitted electronically using the 837 institutional claim transaction or by direct data entry through the ***Blue e***℠ UB-04 transaction. Specify the corrected claim indicator in loop 2300, segment CLM05-3 on the 837 institutional claim transaction. Or indicate corrected claim by setting the Frequency Code which is the last digit of the bill type on the ***Blue e***℠ UB-04 transaction. On the UB-04, the bill frequency code is in form locator 4.
- BCBSNC professional secondary claims can now be submitted electronically using the 837 professional claim transaction. Include the COB payer paid amount in loop 2320; AMT segment, AMT01 qualifier = D; AMT02 = $ amount, COB payer allowed amount qualifier B6; AMT02 = $ amount allowed may also be included.
- Prior to electronically submitting claims for a newly assigned group or individual provider number, contact the EDI Services Customer Support Department at **1-888-333-8594** to verify that the connectivity request form has been completed.

12.4 Electronic Funds Transfer "EFT"

BCBSNC financial services offers a setup to contracted health care providers that allows direct transfer of funds for claim payments to the provider's bank account. Generally, EFT funds are accessible by providers sooner than remittances received through a traditional process of paper checks deposited by the provider. The following outlines the process steps for setup of an EFT stream to the provider.

- Health care provider submits request for EFT set up to BCBSNC financial services on their letterhead at the following address:

BCBSNC Financial Services
P.O. Box 2291 - HQ2
Durham, NC 27702-2291
Attention: Electronic Funds Transfer

[Phone Number 1-919-765-7678]

- Financial services, upon receipt of request from provider, will send provider an authorization form to be completed and returned to BCBSNC.
- Information from the request form is verified by financial services including:
  - Bank name
  - Transit number
  - Account number
- After verification, EFT status is loaded to the BCBSNC claims system. The average time to set up a provider is 5 days from receipt of all documentation by BCBSNC.
- All EFT payments are made to the vendor *(group provider number)* level.
- Under special circumstances, an EFT provider can be issued a special check *(paper check)* while designated an EFT provider.
- A paper copy of the check and the EOP is issued to the provider through normal distribution channels.

12.5 *Blue e*SM

Blue eSM is a Web-based tool available on the internet, free of charge, for physicians, hospitals and other health care providers. It allows health care providers to access a secure electronic network and perform a variety of interactive transactions from their own desktops.

With ***Blue e***SM, you can do the following from your desktop:

- Search for a member's ID number by name, including FEP members
- Obtain detailed member eligibility including FEP and BlueCard® members
- Submit and list claims
- View status of submitted claims, including BlueCard® claims
- View check/payment amounts for the past seven days

BCBSNC encourages your participation in this interactive network for exchanging information and simplifying administrative tasks. Complete information on ***Blue e***SM, a user agreement and technical template are available online at ***bcbsnc.com/providers/edi/bluee.cfm***. You may also contact your local EDI field consultant for more information regarding the ***Blue e***SM interactive network.

12.6 RealMed

RealMed is a North Carolina based IT company that contracts with physician practices to use a software application that integrates to BCBSNC systems. This product allows claim submission, claim status and member eligibility inquiries to be sent to BCBSNC and many other health care payers for a response in real time. It is a cost-effective and easy to use Internet based application. RealMed is compatible with most practice management systems without deep integration, and provides the additional resource of back-end reporting capability that quickly captures the status of all claims that are processed through the RealMed system. The result is a significant reduction in administrative expenses related to claims creation, submission and followup for your organization. Using RealMed, your staff can also:

- Verify BCBSNC member eligibility
- Complete a professional claim

- Submit a claim to BCBSNC
- Receive notification of the acceptance and adjudication of the claim from BCBSNC

RealMed has developed capabilities for taking paper claims print files and turning them into electronic claims. RealMed can take non-compliant NSF and CMS-1500 professional claim formats and turn them into realtime claims or compliant HIPAA 837 professional transactions. RealMed allows providers to check eligibility and submit claims electronically to many national health care payers. For this multi-payer access, providers pay RealMed a monthly fee based on the size of their organization. To learn more about RealMed Corporation, their product, or to schedule a demonstration for your organization, visit the RealMed Web site at ***www.RealMed.com***. A local RealMed representative can work with EDI Services field staff to help you decide if RealMed is right for you.

12.7 EDI Services Contact List

The address at our Durham headquarters is:

Blue Cross and Blue Shield of North Carolina
EDI Services - CSC1N
PO Box 2291
Durham, NC 27702-2291

Phone 1-919-765-3514 *(main)*
Fax 1-919-765-7101

Customer Support 1-888-333-8594

EDI customer support is available Monday through Friday, 8:00 am to 5:00 pm.

EDI field consultants are located in each BCBSNC regional field office and may be reached directly at the following address and telephone numbers. Note – because field consultants travel extensively within their territory, you may be placed into voice-mail. EDI field consultants are dedicated to returning phone messages within one business day.

Field Contact Information

Region	Address	Phone/Fax	Counties
Charlotte region	P.O. Box 35209 Charlotte, NC 28235	**704-561-2751** 704-676-0501 (Fax)	Anson, Cabarrus, Cherokee, Clay, Gaston, Henderson, Jackson, Lincoln, Macon, Mecklenburg, Polk, Rowan, Rutherford, Stanly, Transylvania, Union
Greensboro region	The Kinston Building 2303 West Meadowview Road Suite 200 Greensboro, NC 27407	**336-316-5346** 336-316-0259 (Fax)	Alamance, Alleghany, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Randolph, Richmond, Rockingham, Stokes, Surry, Yadkin

Field Contact Information *(continued)*

Region	Address	Phone/Fax	Counties
Greenville region	P.O. Box 1447 Greenville, NC 27835-1447	**252-931-7223** 252-752-6705 (Fax)	Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington,Wayne, Wilson
Hickory region	P.O. Box 1588 Hickory, NC 28601-1588	**828-431-3142** 828-431-3155 (Fax)	Alexander, Ashe, Avery, Buncombe, Burke, Caldwell, Catawba, Cleveland, Graham, Haywood, Iredell, Madison, McDowell, Mitchell, Swain, Watauga, Wilkes, Yancey
Raleigh region	2501 Aerial Center Drive Suite 225 Morrisville, NC 27560	**919-765-4658** 919-469-6909 (Fax)	Chatham, Durham, Franklin, Granville, Harnett, Johnston, Lee, Moore, Orange, Person, Vance, Wake, Warren
Wilmington region	2005 Eastwood Road Suite 201 Wilmington, NC 28403	**910-509-0605** 910-509-3822 (Fax)	Bladen, Brunswick, Carteret, Columbus, Cumberland, Duplin, Hoke, New Hanover, Onslow, Pender, Robeson, Sampson, Scotland

Provider Review – Hospitals and Ambulatory Surgical Centers and Skilled Nursing Facilities

13. Provider Review – Hospitals and Ambulatory Surgical Centers, Birthing Centers and Skilled Nursing Facilities

13.1 Provider Review Overview

Upon request and at reasonable times, your contract grants BCBSNC and our authorized representatives the right to inspect and conduct periodic reviews of your medical and administrative records relating to services and/or supplies provided to our members. Hospital fees for these reviews/audits are not billable to BCBSNC or our members.

BCBSNC currently contracts with outside vendors to conduct post-payment hospital bill reviews for both inpatient and outpatient claims. The purpose of these reviews is to ensure appropriateness of billings, identify inappropriate billing practices and recognize areas where education is needed.

The audit staff consists of nurses, CPT coding specialists and physicians who have a thorough knowledge of medical practices, medical terminology and CPT coding.

13.2 Provider Review Guidelines and Procedures

- The auditor determines the number of medical records to be reviewed based on various edits. There is no restriction on the number of records that can be reviewed by an auditor.
- The auditor sends a written request for review to the business office manager or designated hospital representative along with a list of claims to be reviewed on site or by desk *(external)* review.
- The hospital agrees to obtain the member's authorization to release medical records. BCBSNC warrants that our members have given us the contractual right to obtain information about the services and/or supplies provided them through their enrollment application, therefore no further authorization will be required from either BCBSNC or their representatives for release of records or audit of those records.
- The hospital agrees to make all medical and financial records (including UB-04s and itemized bills prior to audit) available to the auditor without audit fees, and upon request make copies of these records at no additional charge to BCBSNC or their representatives.
- All medical and financial information will be kept in the strictest confidence.
- The auditor will schedule the review at a convenient time for all parties: the auditor, the medical records department and the patient account representatives. BCBSNC reserves the right to conduct non-scheduled audits.
- The hospital agrees to provide the auditor with a comfortable work area, including access to a telephone and power outlet during the scheduled review time.

- The auditor will give a complete, impartial and factual account of member services, institutional charges and reimbursement. The auditor will validate documented unbilled services discovered during the audit. These services become eligible for payment if they are submitted to the auditor before the audit period has expired.
- The auditor will review and evaluate all supporting documentation submitted by you.
- The auditor will inform you of all detected billing discrepancies within 30 days of completing the review.
- You may ask for a higher level of review within 15 days from the notice of discrepancies by requesting an appeal from the outside vendor conducting the review.
- Upon finalization and receipt of the audit results in our office, BCBSNC will proceed with our normal adjustment process to recover the audit findings.
- BCBSNC members are not responsible for billing discrepancies and should not be subsequently billed.
- Please call the BCBSNC Special Investigation Unit at **1-800-324-4963**, if you suspect a provider of fraudulent, abusive or otherwise improper billing practices.

13.3 Provider Notification

When new audit vendor contracts are secured, a letter of introduction will be furnished to you to be inserted into this manual. Letters of introduction for CGI Group, Inc. *(formally known as Dhyrstone Systems, Inc.)* and HealthDataInsights, Inc. *(formerly known as Integrated Healthcare Solutions)* are included on the following pages.

BlueCross BlueShield of North Carolina

Sample Letter of Introduction

Dear Sir or Madam:

The Network Management Division of Blue Cross and Blue Shield of North Carolina "BCBSNC" has an ongoing educational program which is supported by a periodic review of claims for health care services. These initiatives were adopted to improve the quality of our services and to fulfill our responsibilities to our customers by working with our providers. The periodic reviews will test the proper payment of claims.

HealthDataInsights, Inc., *(formally known as Integrated Healthcare Solutions)* is an authorized representative to conduct these reviews. The process will require assistance on the part of your staff in supplying copies of medical records for the BCBSNC members, either through on site visits or written requests. Please assist HealthDataInsights, Inc. in this process on behalf of BCBSNC members in keeping with the obligations set forth in your contract with BCBSNC.

The initial review period covered the years 1997 and 1998. Thereafter, the review periods will continue forward. Your contact with HealthDataInsights, Inc. is Jane Minnick whose phone number is **1-407-206-8018**. Your contact with BCBSNC is Nancy Walker whose phone number is **1-919-765-7428**.

Your cooperation is greatly appreciated.

Sincerely,

cc: HealthDataInsights, Inc.

BlueCross BlueShield of North Carolina

Sample Letter of Introduction

Dear Sir or Madam:

The Network Management Division of Blue Cross and Blue Shield of North Carolina "BCBSNC" has an ongoing educational program which is supported by a periodic review of DRG claims for health care services. These initiatives were adopted to improve the quality of our services and to fulfill our responsibilities to our customers by working with our providers. The periodic reviews will test the proper payment of DRG claims.

CGI Group, Inc. *(formally known as Dhrystone Systems, Inc.)* is an authorized representative to conduct these reviews. The process will require assistance on the part of your staff in supplying copies of medical records for the BCBSNC members, either through on site visits or written requests. Please assist CGI Group, Inc. in this process on behalf of BCBSNC members in keeping with the obligations set forth in your contract with BCBSNC.

The initial review period covered the years 1997 and 1998. Thereafter, the review periods will continue forward. Your contact with CGI Group, Inc. is Mary Hoffman whose phone number is **1-216-687-6707**. Your contact with BCBSNC is Nancy Walker whose phone number is **1-919-765-7428**.

Your cooperation is greatly appreciated.

Sincerely,

cc: CGI Group, Inc.

13.4 Eligibility Requirements for Managed Care Products

- To be eligible for participation in BCBSNC managed care networks, facility providers must meet the eligibility criteria listed below.
- All credentials must be maintained in good standing to remain a contracting provider.

The National Committee for Quality Assurance "NCQA" will require initial credentialing of any provider who seeks reinstatement in any of our networks after being out-of-network for more than 30 days. Please note that this is a change from the previous timeframe of 90 days.

Eligibility Requirements for Managed Care Networks	Accredited Hospitals and Ambulatory Surgical Centers	Non-Accredited Hospitals and Ambulatory Surgical Centers	Birthing Centers	Skilled Nursing Facility
1. Current North Carolina license	Required	Required	Required	Required
2. Current JCAHO, AAAHC or CARF certificate or letter of recommendation. *(For birthing centers, JCAHO or NACC certification)*	Required	--	Required	Required
3. Medicare/Medicaid certificate	Required	Required	Required	Required
4. Copy of anesthesia or sedation policy	--	Required	--	--
5. Report of medical review of NC denials by type for the most recent 12 months	--	Required	--	--
6. Quality management program	--	Required	--	--
7. Health coaching and intervention program	--	Required	--	--
8. Organizational structure, including the level and reporting relationship of full time quality and utilization management staff	--	Required	--	--
9. Report of disciplinary actions if any taken within the last 5 years by any licensing or accrediting body against the facility *(provide action plans and outcome)*	--	Required	--	--
10. Letters of recommendation from the medical staff president, a member of the facility's board of trustees, and a community leader not directly employed by or associated with the facility. Letters should attest to the quality, accessibility, and cost effectiveness of medical care rendered by the facility.	--	Required	--	--
11. An on-site quality assessment of the facility conducted by utilizing BCBSNC criteria	--	Required	--	--

Eligibility Requirements for Managed Care Networks	Accredited Hospitals and Ambulatory Surgical Centers	Non-Accredited Hospitals and Ambulatory Surgical Centers	Birthing Centers	Skilled Nursing Facility
12. Documented policy and procedure for coverage arrangements *(participating provider and hospital)*, in the event of an emergency situation	--	--	Required	--
13. Copy of current liability insurance certificate, verification of effective and expiration dates, and coverage in the amounts of $1 million per occurrence and $1 million aggregate.	Required	Required Non-JCAHO exemption form required	Required	Required

Quality Improvement Program for Physician Office

14. Quality Improvement for Physician Offices

14.1 Quality Improvement Overview

BCBSNC's quality improvement program is an important component of our HMO, POS and PPO products. The quality improvement program supports BCBSNC's ongoing commitment to quality health care.

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]

In determining the scope and content of our 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' unique needs and expectations must be satisfied and exceeded
- Physician and provider relationships with patients and BCBSNC must be continually improved
- Legislative and regulatory requirements must be met, while aiding governmental efforts in health care reform

Our quality improvement program is ongoing and designed to be proactive. Its purpose is to objectively and systematically monitor the quality and appropriateness of the care and service provided to members. Our quality improvement program then identifies, implements and monitors appropriate interventions to improve the quality of care and service. In other words, the quality improvement program is designed to link the concern for quality and demonstrated improvement. The program goals are:

- To continuously improve the care and service delivered to our members
- To increase the accountability for results of care and service
- To protect patient confidentiality and member rights as health care processes are evaluated and clinical outcomes are assessed
- To meet or exceed customer expectations for quality and service, utilizing evaluative feedback from members and providers to assess and continually enhance care
- To improve clinical effectiveness
- To incorporate quality improvement program 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/member
- To enhance the overall marketability and positioning of BCBSNC by showing it to be the best HMO, POS and PPO programs in North Carolina

- To promote healthy lifestyles and reduce unhealthy behaviors in our members and throughout the communities we serve
- To minimize the administrative cost and burden incurred throughout the spectrum of health care service delivery
- To maintain and enhance quality improvement processes and outcomes that merit the highest accreditation status from the National Committee for Quality Assurance "NCQA" accreditation

[1] Adapted from the Institute of Medicine's statement about quality of medical care.

14.2 Medical Policy

Our corporate medical policy consists of medical guidelines and payment guidelines. Medical guidelines detail when certain medical services are medically necessary, and whether or not they are investigational. *(For more information concerning medical necessity and investigational criteria, please see these specific policies.)* Our medical guidelines are written to cover a given condition for the majority of people. Each individual's unique, clinical circumstances may be considered in light of current scientific literature. Medical guidelines are based on constantly changing medical science, and we reserve the right to review and update our policies periodically. Payment guidelines provide editing logic for CPT and HCPCS coding. Payment guidelines are developed by clinical staff, and include yearly coding updates, periodic reviews of specialty areas based on input from specialty societies and physician committees, and updated logic based on current coding conventions. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Therefore, medical policy is not an authorization, certification, explanation of benefits, or a contract. Benefits are determined by the group contract and the subscriber certificate that is in effect at the time services are rendered.

When the company reviews medical policy, supportive information sources can include a comprehensive literature search, consultant physician review, recommendations from a physician advisory group, or legislative enactments. Benefits for medical services are reviewed in terms of our definition of medical necessity and investigational as well as the benefit provisions of the member's policy.

Note that corporate medical policy is separate and distinct from utilization review criteria or practice guidelines, although they may at times appear very similar. Corporate medical policy is available to assist you in understanding how we administer benefit coverage.

The dynamic and changing field of medicine requires us to continually update our corporate medical policies. Due to the evolving nature of our corporate medical policy, the most up-to-date policies are available online at ***bcbsnc.com***. Corporate medical policy is also available by calling the Provider Blue Line℠ at **1-800-214-4844**. A representative will send you the most up-to-date corporate medical policy.

14.3 Members' Rights and Responsibilities

We have assembled a list of member's rights and responsibilities that apply directly to our BCBSNC members. This list is distributed to members annually in the member magazine, Active Blue and is available online at ***bcbsnc.com***. These rights and responsibilities are important guides to help all members use and receive health care services in a convenient and appropriate manner.

Member rights and responsibilities, as distributed to members, appear below:

As a Blue Cross and Blue Shield of North Carolina member, you have the right to:

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

As a BCBSNC member, you should:

- Present your BCBSNC ID card each time you receive a service.
- Read your BCBSNC benefit booklet and all other BCBSNC member materials.
- Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear.
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide BCBSNC and your doctors complete information about any illness, accident or health care issues which may be needed in order to provide care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor's office at least 24 hours' notice.

- Play an active part in your health care.
- Be polite to network doctors, their staff and BCBSNC staff.
- Tell your place of work and BCBSNC if you have any other group coverage.
- Tell your place of work about new children under your care or other family changes as soon as you can.
- Protect your ID card from improper use.
- Comply with the rules outlined in your member benefits guide.

[SM] Service mark of Blue Cross and Blue Shield of North Carolina
[®] Registered mark of the Blue Cross and Blue Shield Association

14.4 Network Quality

At least every three years, in conjunction with the re-credentialing process, our quality management consultants visit primary care and OB/GYN physician practices to assess compliance to established access to care, facility and medical record standards. Quality management consultants also play an educational role for physicians, assisting them in keeping up-to-date with our latest documentation and facility requirements and keeping communication lines open between BCBSNC and the network physicians.

The initiative described above has been recommended by community physicians who are members of our Provider Advisory Group "PAG" and the Triad Quality Improvement Team "TQIT."

The following components of our network quality program are discussed below:

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

14.4.1 Access to Care Standards *(Primary Care Physicians)*

BCBSNC and 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, but reasonable efforts should be made to accommodate patients. Life threatening emergencies must be managed immediately.
(C) Work-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 that the physician receives enough information to make a determination.

4. Office Hours - indicates the posted hours during which appropriate personnel *(i.e., MD, DO, FNP, PA)* is available, to care for members within the above standards for waiting times.

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.

14.4.2 Access to Care Standards *(Specialists Including Non-MD Specialists)*

The following access to care standards for specialists have been established by the BCBSNC physician advisory group. Non-MD specialists are chiropractors "DC," podiatry "DPM," physical therapy "PT," speech therapy "ST," and occupational therapy "OT."

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
Adults	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) Work-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

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/week minimum covering at least 4 days

5. Availability Hours

Daytime hours/week	40 hours/week
Night hours/week	24 hour/day coverage of some sort

14.4.3 Facility Standards

The following standards for the facilities of practices participating in our managed care programs 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 our members. Please note new standards *(effective September 1, 2003)* printed in italics.

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 space and provide privacy 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.

4a. A fire extinguisher is clearly visible and is readily available.

4b. *Fire extinguishers are checked and tagged yearly.*

4c. *Smoke detectors are recommended.*

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 the handicapped *(i.e., grab bars)*.

8a. There is an evacuation plan posted in a prominent place or exits are clearly marked, visible and unobstructed.

8b. *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., specialists, 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.

11a. 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.

11b. *Controlled substances are maintained in a locked container/cabinet. A record is maintained of use.*

11c. *There is a procedure for monitoring expiration dates of all medications in the office.*

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

12b. *Emergency procedures are in place and are periodically reviewed with staff members.*

12c. *Emergency supplies include, but are not limited to, emergency medications, oxygen, mask, airway and ambu bag.*

12d. *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.*

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

15b. *There is periodic review and staff in service on infection control.*

15c. *Sterilization procedures and equipment are available.*

14.4.4 Medical Records Standards for Primary Care Providers and OB/GYN Providers*

The National Committee for Quality Assurance "NCQA" has identified the bold italicized elements as critical components of a medical record.

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 biographical/ 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.
3. The provider is identified on each entry.	3. Each entry in the medical record must contain author identification *(signature or initials)*.
4. All entries are dated.	4. Each entry in the medical record must include the date *(month, day, and year)*.
5. The record is legible.	5. The medical record must be legible to someone other than the writer.
6. There is a completed problem list.	6. The flow sheet includes age appropriate preventive health services. A blank problem list or flow sheet does not meet this standard.
7. Allergies and adverse reactions to medications are prominently displayed.	7. Medication allergies and adverse reactions are prominently noted in a consistent place in each medical record. If significant, allergies to food and/or substances may also be included. Absence of allergies must also be noted. Use NKA *(no known allergy)* or NKDA *(no known drug allergy)* to signify this. It is best to date all allergy notations and update the information at least yearly.

Standard	Supporting Documentation
8. The record contains an appropriate past medical history.	8. Past medical history *(for patients seen three or more times)* is easily identified and includes serious accidents, operations, illnesses. For children and adolescents *(age 18 and younger)* past medical history relates to prenatal care, birth, operations and childhood illness. The medical history should be updated periodically.
9. Documentation of smoking habits and alcohol use or substance abuse is noted in the record.	9. The medical record should reflect the use of or abstention from smoking *(cigarettes, cigars, pipes, and smokeless tobacco)*, alcohol *(beer, wine, liquor)*, and substance abuse *(prescription, over the counter, and street drugs)* for all patients age 14 and above who have been seen three or more times. It is best to include the amount, frequency, and type in use notations.
10. The record includes a history and physical exam for presenting complaints.	10. The history and physical documents appropriate subjective and objective information for presenting complaints.
11. Lab and other diagnostic studies are ordered as appropriate.	11. Lab and other diagnostic studies are ordered as appropriate to presenting complaints, current diagnosis, preventive care, and follow-up care for chronic conditions. It is best to note if the patient refuses to have recommended lab or other studies performed.
12. The working diagnoses are consistent with the diagnostic findings.	12. The working diagnosis is consistent with the findings from the physical examination and the diagnostic studies.
13. Plans of action/treatments are consistent with the diagnosis(es).	13. Treatment plans are consistent with the diagnosis.
14. Each encounter includes a date for a return visit or other follow-up plan.	14. Each encounter has a notation in the medical record concerning follow-up care, calls, or return visits. The specific time should be noted in days, weeks, months, or PRN *(as needed)*.
15. Problems from previous visits are addressed.	15. Unresolved problems from previous office visits are addressed in subsequent visits.

Standard	Supporting Documentation
16. Appropriate use of consultant services is documented.	16. Documentation in the record supports the appropriateness and necessity of consultant services for the presenting symptoms and/or diagnosis.
17. Continuity and coordination of care between primary and specialty physicians or agency documented.	17. If a consult has been requested and approved, there should be a consultation note in the medical record from the provider *(including consulting specialist, SNF, home infusion therapy provider, etc).*
18. Consultant summaries, lab and imaging study results reflect review by the primary care physician.	18. Consultation, lab, and x-ray reports filed in the medical record are initialed by the primary care physician or some other electronic method is used to signify review. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.
19. Care is demonstrated to be medically appropriate.	19. Medical record documentation verifies that the patient was not placed at inappropriate risk as a result of a diagnostic or therapeutic process.
20. A complete immunization record is included in the chart.	20. Pediatric medical records contain a completed immunization record or a notation that immunizations are up-to-date.
21. Appropriate use of preventive services is documented.	21. There is evidence in the medical record that age appropriate preventive screening and services are offered in accordance with the organization's practice guidelines. *(Refer to the medical policy section of your Provider eManual.)* It is best to note if patient refuses recommended screenings and/or services.
22. Charts are maintained in an organized format.	22. There is a record keeping system in place that ensures all charts are maintained in an organized and uniform manner. All information related to the patient is filled in the appropriate place in the chart.
23. There is an adequate tracking method in place to insure retrievability of every medical record.	23. Each medical record required for patient visit or requested for review should be readily available.

Standard	Supporting Documentation
24. Review of chronic medications if appropriate for the presenting symptoms.	24. There is documentation in the record, either through the use of a medication sheet or in the progress notes.

* OB/GYN medical records reviews taking on new depth.

We have historically performed only a medical record assessment on OB/GYN practices. Since so many of our female members are choosing OB/GYN practices to serve as their primary care providers, we feel it is important to conduct more thorough reviews of the medical records. OB/GYN practices will be monitored against the preceding medical records standards. The compliance goal established for 2004 is 85%. In addition to the medical record standards, OB/GYN practices will be monitored for use of and compliance to the preventive health guidelines.

14.5 Clinical Practice and Preventive Care Guidelines Overview

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.

14.5.1 Nationally Accepted Guidelines

BCBSNC endorses the following nationally recognized clinical practice and preventive care guidelines:

- Asthma
- Cholesterol management
- Diabetes
- Heart failure
- Hypertension
- Overweight and obesity
- Tobacco counseling
- Additional guidelines for:
  - Prenatal care
  - Depression
  - Attention Deficit Disorder, "ADD"
  - Attention Deficit Hyperactivity Disorder, "ADHD"
- Coronary Artery Disease, "CAD"

Please note that guidelines are subject to change and that the most current guidelines are published and made available to providers at the BCBSNC Web site: ***http://www.bcbsnc.com/members/guidelines.cfm***. Providers are encouraged to visit the ***bcbsnc.com*** Web site regularly to receive the most current and up to date information available.

14.5.2 Preventive Care Guidelines

The Blue Cross and Blue Shield of North Carolina "BCBSNC" preventive care guidelines are updated regularly and available to providers on the ***bcbsnc.com*** Web site for providers at: ***http://www.bcbsnc.com/members/guidelines.cfm***.

Providers should note that although guidelines exist, benefit allowances are subject to the terms and limitations of the member's eligibility and preventive care benefits at the time services is provided. Providers are encouraged to verify a member's benefits and eligibility in advance of providing service.

14.6 Quality of Care Concern Process

Definitions and Application

BCBSNC maintains an active and comprehensive quality concerns program that includes review of individual cases in which concern is expressed regarding the quality, service and/or access to care. These concerns may be identified internally by the Plan or externally by our members or providers.

14.6.1 Disposition Levels

Cases are reviewed by the quality review analyst or medical director for quality improvement. All cases are assigned a disposition level as follows:

- Not a quality of care/service/access issue
- Standard of care met:
  - No identified injury
  - Minor injury
  - Major injury/death
- Standard of care indeterminate:
  - No identified injury
  - Minor injury
  - Major injury/death
- Standard of care controversial:
  - No identified injury
  - Minor injury
  - Major injury/death

- Standard of care not met:
  - No identified injury
  - Minor injury
  - Major injury/death

14.6.2 Pattern of Care Reviews

When any provider complaint is received, a review of the quality database will be done to determine how many complaints have been filed relating to the involved provider. Provider complaints falling into the following patterns, regardless of disposition, will be forwarded to the BCBSNC medical director for a pattern of care review:

- 3 complaints within 6 months
- 5 complaints within 1 year
- 8 complaints within 2 years

Any complaint reviewed that results in a disposition of Standard of Care "SOC" was met or controversial standard of care met with minor or major injury will be forwarded to the medical director for a pattern of care review if any of the following patterns are identified:

- 2 in 6 months and additional complaints, regardless of disposition within 6 months
- 3 in 1 year and 2 additional complaints, regardless of disposition within 1 year
- 5 in 7 years and 4 additional complaints, regardless of disposition within 2 years

Any complaint reviewed that results in a disposition standard of care not met will be forwarded to the medical director for SOC review and then to the QI coordinator to prepare for the credentialing committee review.

Follow-up by the BCBSNC medical director may include, but not be limited to:

- A letter to the provider
- Request for a plan of action from the provider by the medical director
- Reporting the involved provider information to the credentialing committee or law and regulatory affairs department

See chapter 15, Credentialing for Professional Providers, to review the process followed once an issue is referred to the credentialing committee.

Visit BCBSNC's Web site at ***bcbsnc.com*** for the latest information and updates regarding preventive care guidelines including vaccine schedules.

14.7 Quality Improvement Initiatives Prevention and Health Education

14.7.1 Behavioral Health Initiatives

- **Follow-Up After Hospitalization for Mental Illness:** This HEDIS measure looks at appropriate follow-up care after discharge from a hospital with a mental health diagnosis. Magellan Behavioral Health, BCBSNC's mental health vendor, implements initiatives associated with this measure, with oversight provided by BCBSNC.

- **Postpartum Depression Screening:** Magellan sends new mothers the Edinburgh postnatal depression scale, which can be returned to Magellan for scoring. Members scoring above a threshold are contacted by a master's-level representative and assisted in seeking treatment.
- **Offspring Depression Screening:** Magellan sends parents with depression a screening tool to assess whether their child(ren) also might be suffering from the disorder. Parents can return the tool to Magellan for scoring; those who score above a threshold are assisted in getting the child(ren) into treatment.

14.7.2 Colorectal Cancer Screening Initiative

- Practice Guidelines sent to primary care providers along with patient education tear sheets to help discuss screening options.
- Reminder letters or automated phone calls sent to members age 50 and older that may be in need of a colorectal cancer screening. The reminder emphasizes the importance of routine screening as well as information regarding screening options.

14.7.3 Men's Health Initiatives

- Men's health chart stickers distributed to primary care physicians to remind them to perform preventive care screenings on their male patients, as appropriate.
- Reminder letters are sent to male members who are in need of preventive care screenings. The mailing includes a letter outlining the recommended preventive health screenings as appropriate by age, as well as a men's health pamphlet that presents health and lifestyle information.
- Loved one-targeted postcard sent to the homes of male members in need of preventive care screenings, outlining the preventive care needs of men at appropriate ages.

14.7.4 Women's Health Initiatives

- Birthday reminder postcards or telephone reminder calls are sent to women to remind them to have their annual Pap test and/or mammogram.
- Mammography counseling tools for providers who performed lower than their peers for breast cancer screening; includes breast health education tool kit containing beads representing the different lump sizes found through various screening methods, posters for patient waiting areas, and member education brochures. Physician training on mammography counseling skills is also available to practices with low screening rates.
- Prospective report to all primary care and OB/GYN providers listing women who are due for their Pap tests and mammograms in the coming year.
- Preventive health reminder stickers placed in medical charts of women who are due for a Pap test or mammogram, or who may need menopause counseling.
- Chlamydia screening outreach intervention sent to both members and providers. Young women due for a chlamydia screening are mailed an educational brochure. Providers also receive an educational packet including chlamydia screening and treatment guidelines, member education brochures, and a guide to sexual history taking.
- Breast health at worksites intervention sent to large employer groups encouraging routine breast cancer screening. The packet includes a listing of local radiology facilities as well as breast health posters.

14.7.5

Provider toolkits are available free to providers upon request. Please use the following order form to make a request.

BCBSNC Provider Toolkits

Please select the free toolkits that you would like to order for your practice. Please have a clinician fax this form to Member Health Partnerships at 1-919-765-1927

Preventive Care and Healthy Lifestyles

- ☐ Adult obesity prevention and treatment toolkit
  Includes 3 adult BMI wheels and tape measures; a pad of 50 patient education tear sheets on weight and pre-diabetes; guidelines for the assessment and treatment of obesity.
- ☐ Childhood obesity prevention and treatment toolkit
  Includes 3 child BMI wheels, patient education tear sheets on weight; guidelines for the assessment and treatment of obesity; growth chart pads; posters; and physical activity and nutrition quizzes.
- ☐ Adult tobacco cessation toolkit *(English)*
  Includes clinical practice guidelines for the assessment and treatment of tobacco dependence; Starting the Conversation materials and You Can Quit Smoking consumer booklet to aid in talking with patients about quitting; and promotional materials for the North Carolina's free tobacco quit line.
- ☐ Adult tobacco cessation toolkit *(Spanish)*
  Includes Starting the Conversation materials and Set Yourself Free consumer booklet to aid in talking with patients about quitting, You Can Quit Smoking tearsheets; and promotional materials for the North Carolina's free tobacco quit line.
- ☐ Stress management
  Includes 2 pads of 50 patient education tear sheets on techniques for managing stress – one on relaxation techniques and one on cognitive restructuring.

Preventive Screening Topics

- ☐ Chlamydia
  Includes a guide to taking a sexual history and patient sexual history questionnaire; CDC guidelines for Chlamydia screening; and 50 patient education brochures.
- ☐ Colorectal cancer
  Includes colorectal cancer screening information for providers; a pad of 50 patient education tear sheets on colorectal cancer screening options.
- ☐ Depression
  Includes Zung Self-Rating Depression Scale, 1 pad of 50 Overcoming Depression patient tear sheets, 3 Depression in Primary Care physician algorithms.
- ☐ Mammography
  Includes 3 color posters that illustrate the benefits of mammograms, 3 mammography counseling tip cards and a breast health bead necklace for patient education.

Your Name: _____ Phone Number: _____

Practice Name: _____ Practice Address: _____

Alternative delivery address *(if different from the one listed above)*: Note: We will need your street address for UPS shipping.

_____

_____

Fax this form to **1-919-765-1927**

If you have questions please contact Member Health Partnerships℠ at **1-800-218-5295** or ***quality@bcbsnc.com***.

Credentialing for Professional Providers

15. Credentialing for Professional Providers

15.1 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 60 days for completion from the date a completed application is received by BCBSNC. BCBSNC 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
- Malpractice insurance
- 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 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 our Web site at ***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 at least every three years. We agree to make best efforts to process all recredentialing information within 30 days of receipt of all required information.

Additional information required by network management includes the following:

- Individual provider number application* and/or group provider number application*
- Substitute W-9 form*

Any practitioner who seeks reinstatement in any of our networks after being out-of-network for more than 30 days is required to undergo initial credentialing.

* Samples of these forms may be found in chapter 23, Forms.
** For physicians that are not board certified, letters of reference will be required in support of the application.

15.2 Policy for Practitioners Pending Credentialing

Blue Cross and Blue Shield of North Carolina's "BCBSNC" current credentialing policy states that in order to receive the contracted reimbursement for covered services provided to a BCBSNC HMO, POS or PPO member, a practitioner must be credentialed by BCBSNC.

Claims for covered services provided to BCBSNC HMO, POS or PPO members by a non-participating practitioner in a participating provider group will be denied. The BCBSNC member will be held harmless, including any copayments, coinsurance or deductibles.

15.2.1 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 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 two, Quick Contact Information)*.

15.3 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 HMO/POS/PPO networks 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 HMO/POS/PPO networks. In addition to the circumstances outlined above, other information may be received regarding a network provider which may impact the participation status of that provider. 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.

15.3.1 Provider Notice of Termination for Recredentialing *(Level I Appeal)*

If the credentialing committee's recommendation is to terminate a provider from the HMO/POS/PPO networks 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.

15.3.2 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 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:** 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 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 30 days of the receipt of the initial notification or 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 all managed care networks *(HMO/POS/PPO)*. 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.

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.

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.

Quality and Credentialing Programs for Ancillary Providers

16. Quality and Credentialing Programs

16.1 Service Standards for All Networks

Home care providers must meet the following service standards:

- Initial response times for:
  - home infusion of less than or equal to four hours as required
  - home health and private duty nursing of less than or equal to 24 hours
- 24-hour per day telephone access for emergencies
- Specialized nursing care available for pediatrics, maternity, ventilator and other patients as necessary

HDME providers must meet the following service standards:

- Delivery response time for oxygen and related supplies of four hours or less
- Delivery response time for non-custom equipment of 24 hours or less

Hospice providers must meet the following service standards:

- Care must be available 24 hours per day seven days per week
- Continuity of hospice care must be assured for the patient and family *(considered a unit of care regardless of setting - home, inpatient or residential)*

16.2 Dialysis Facility Provider Standards

Dialysis facility providers must meet the following service standards:

- Patient must receives full amount of treatment as ordered by his/her physician.
- Patient should have 24 hour emergency telephone access to at least one member of the dialysis team *(i.e., nephrologist, nurse, dietitian or social worker)*.
- Patient's dietitian must chart patient's progress at least once a month *(more often if patient is not considered stable.)*
- Patient's social worker must chart patient's progress a minimum of once every six (6) months *(more often if patient is not considered stable)*.
- One member of the dialysis team *(preferable the social worker)* must be available as BCBSNC's primary contact regarding patient's care management.

16.3 Eligibility Requirements for Traditional/ Comprehensive Major Medical Products

- To be eligible for participation in BCBSNC traditional network, providers must meet the eligibility criteria listed below.

- All credentials must be maintained in good standing to remain a contracting provider.

Home Care Agency Eligibility for Traditional/Comprehensive Major Medical	Home Health Services	Home Infusion Therapy	Private Duty Nursing Services
1. Current home care license issued by NC Department of Health and Human Services, division of facility services for:			
Nursing services	required		optional
Physical therapy	required		
Speech therapy	required		
Occupational therapy	required		
Medical social services	required		
Home health aide	required		
Infusion nursing		required	
Private duty nursing			required
2. Current pharmacy permit from NC Board of Pharmacy or contact with NC licensed pharmacy		required	
3. Current commercial liability insurance with the following minimum coverage:			
$1 million per occurrence	required	required	required
$1 million in aggregate	required	required	required
4. Completion of ancillary provider application for participation	required	required	required

Hospice Credentials for Traditional/Comprehensive Major Medical	Hospice Services
1. Current home care or hospice license issued by NC Department of Health and Human Services, division of facility services for:	
Hospice home services	required
Inpatient hospice	required
2. Copy of Medicare certification	required
3. Current commercial liability insurance with the following minimum coverage:	
$1 million per occurrence	required
$1 million in aggregate	required
4. Completion of ancillary provider application for participation.	required

Dialysis Eligibility for Traditional/Comprehensive Major Medical	Dialysis Services
1. Copy of current Medicare/Medicaid certification	required
2. Current commercial liability insurance with the following minimum coverage:	
$1 million per occurrence	required
$1 million in aggregate	required
3. Completion of ancillary provider application for participation.	required
4. Completion of W-9 form	required

- Each provider will be re-evaluated at a minimum of every 3 years to ensure criteria continues to be met.

HDME Credentials for Traditional/Comprehensive Major Medical	Medical Equipment and Devices	Orthotics and Prosthetics
1. At least one of the following current North Carolina permits or licenses: • NC Board of Pharmacy - Device dispensing permit - Device and/or medical equipment dispensing permit - Pharmacy permit • NC Department of Health and Human Services, division of facility services home care license for directly related supplies and appliances	required	
2. Copy of letter from NC Board of Pharmacy verifying exemption from licensing		required
3. Current commercial liability insurance with the following minimum coverage:		
$1 million per occurrence	required	required
$1 million per aggregate	required	required
4. Completion of ancillary provider application for participation	required	required

16.4 Eligibility Requirements for Managed Care Products *(Credentialing)*

- To be eligible for participation in BCBSNC PPO, POS and HMO networks, providers must meet the credentialing criteria listed below.
- All credentials must be maintained in good standing to remain a contracting provider.
- Contracting providers will be recredentialed every three years.
- When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

Home Care Agency Credentials for Managed Care Products	Home Health Services	Home Infusion Therapy	Private Duty Nursing Services
1. Current home care license issued by NC Department of Health and Human Services, division of facility services for:			
Nursing services	required		optional
Physical therapy	required		
Speech therapy	required		
Occupational therapy	required		
Medical social services	required		
Home health aide	required		
Infusion nursing		required	
Private duty nursing			required
2. Current pharmacy permit from NC Board of Pharmacy		required	
3. Current accreditation from at least of the following agencies: • JCAHO • Community Health Accreditation Program "CHAP" • NC Accreditation Commission for Home Care "ACHC"	required	required	required
4. Current commercial liability insurance with the following minimum coverage:			
$1 million per occurrence	required	required	required
$1 million in aggregate	required	required	required
5. Completion of ancillary provider application for participation	required	required	required
6. Medicare/Medicaid certification	required*	required*	required*

* Certification not required if provider can provide documentation from Medicare/Medicaid that application for certification was made but not granted because Medicare/Medicaid ceased offering certifications for their area because Medicare/Medicaid's access of care standards have already been met.

HDME Credentials for Managed Care Products	Medical Equipment and Devices	Orthotics and Prosthetics
1. At least one of the following current North Carolina permits or licenses: • NC Board of Pharmacy - Device dispensing permit - Device and/or medical equipment dispensing permit - Pharmacy permit • NC Department of Health and Human Services, division of facility services home care license for directly related supplies and appliances	required	
2. Copy of letter from NC Board of Pharmacy verifying exemption from licensing	if applicable	required
3. Current accreditation from at least one of the following agencies: • Also, The Compliance Team Inc.'s Exemplary Provider Award Program "ISO" • JCAHO • Community Health Accreditation Program "CHAP" • NC Accreditation Commission for Home Care "ACHC" • American Board of Certification "ABC" in Orthotics and Prosthetics or the Board of Orthotics and Prosthetics "BOC" • Women's Prosthetics Accreditation, Inc. "ACHC" - breast prosthesis only *(orthotics and prosthetics)*	required	required
4. Current commercial liability insurance with the following minimum coverage:		
$1 million per occurrence	required	required
$1 million per aggregate	required	required
5. Completion of ancillary provider application for participation	required	required
6. Medicare/Medicaid certification or exemption form	required	required

Hospice Credentials for Managed Care Products	Hospice Services
1. Current home care or hospice license issued by NC Department of Health and Human Services, division of facility services for:	
Hospice home services	required
Inpatient hospice	required
2. Current accreditation/certification from at least one of the following agencies: • JCAHO or ACHC • Medicare/Medicaid or Medicare/Medicaid exemption form	required
3. Current commercial liability insurance with the following minimum coverage:	
$1 million per occurrence	required
$1 million in aggregate	required
4. Completion of ancillary provider application for participation	required

Dialysis Credentials for Managed Care Products	Dialysis Services
1. Copy of current Medicare/Medicaid certification	required
2. Current commercial liability insurance with the following minimum coverage:	
$1 million per occurrence	required
$1 million in aggregate	required
3. Completion of ancillary provider application for participation	required
4. List of all current services provided	required
5. Copy of current quality and outcomes data to include the following Dialysis Outcomes Quality Initiative "DOQI" indicators: URR (≥ 65%), K+/V (≥ 1.2), Hematocrit (33%-36%), albumin (3.5-5.2) and/or an equivalent indicator. Infection rates and transfers from the dialysis center(s) to acute care facilities is required when available as stated in the facility's QI or UM program. Copy of the UM, QM and infection control policy copy of CLIA Current copy of ESRD report Copy of ACCRED *(if applicable)*	required

Appeal and Grievance Procedures

17. Appeal and Grievance Procedures

17.1 Disclaimer

The information contained in this chapter is current as of the date of publication of this manual. For the most current information regarding the appeals process, call the Provider Blue Line℠ at **1-800-214-4844** or visit our Web site at ***bcbsnc.com***.

17.2 Member Appeal and Grievance Process

In accordance with state law and in response to heightened concerns about member privacy and the confidentiality of medical information, BCBSNC requires the member's written authorization in order for a third party, including the member's provider, to pursue an appeal or grievance on the member's behalf. The appeal and grievance processes are available to address member concerns about:

- Adverse medical necessity decisions *(non-certifications)*
- BCBSNC decisions related to the availability, delivery or quality of health care
- Claims payment, handling, or reimbursement
- The relationship between BCBSNC and the member

In order for you, the provider, to represent the member in a Level I Member Appeal, a written authorization must be obtained from the member. The member may obtain the Member Appeal Representation Authorization form by calling the customer service phone number located on the back of their ID card. A copy of this form is also included in chapter 23, Member Appeal Representation Authorization Form. Requests for review should also include pertinent additional medical records information not previously supplied to BCBSNC.

Member authorization must be received by BCBSNC for a specific issue. A blanket authorization statement for appeal cannot be used. A signed authorization will remain valid until the particular issue is resolved or until authorization is rescinded by the member. Providers should submit documents for a Level I Appeal along with the appeal representation form to the following address:

Blue Cross and Blue Shield of North Carolina
Level I Member Appeals
P.O. Box 30055
Durham, NC 27702-3055

or you can fax your inquiries to:

Member Appeals: 919-765-4409.

17.3 Appeals and Grievances for Mental Health and Substance Abuse Services

Because BCBSNC delegates claims processing for mental health and substance abuse claims for Blue Care® to Magellan Behavioral Health, courtesy review and first level appeals must be filed with Magellan Behavioral Health. After completing the formal appeal process with Magellan, if a member still believes a claim has not been processed correctly, a request may be made to BCBSNC for an additional review of the appeal. For information on how to file a mental health or substance abuse appeal on behalf of a member, call Magellan Behavioral Health at **1-800-359-2422**.

For Blue Options℠ and Classic Blue®, BCBSNC processes mental health and substance abuse claims. However, Magellan Behavioral Health will handle and communicate all first level appeals related to health coaching and intervention programs for Blue Options℠ and Classic Blue®.

Note: Please be aware that self-funded employer groups have the option of delegating the administration of mental health and substance abuse services to a provider of their choosing. Therefore, please check the member's identification card for the name of the provider.

17.4 Expedited Appeals

Providers have the right to request an expedited review on behalf of the member if a delay would reasonably appear to seriously jeopardize a patient's life or jeopardize the patient's ability to regain maximum function. Such expedited reviews may be requested by calling the provider Blue Line℠ at **1-800-672-7897**, **x57078**. A decision will be made within 72 hours of receiving all information, and a written decision from the Plan will be forwarded to you and the member within (2) business days, but no later than 3 days from the date all information necessary to review the appeal was received.

17.5 Member Grievance Policy

Occasionally, BCBSNC receives complaints from members about a provider or their staff regarding quality of care issues. In order to appropriately respond to our members, BCBSNC may ask you to review and provide a written response to such cases. You are required to cooperate with BCBSNC member grievance policies and must respond to BCBSNC direct inquiries within the time frame specified in each request. This will ensure the best service to our mutual customer, our member/your patient.

17.6 Post-Service Provider Courtesy Review "PCR" Process (also known as "Level I Provider Appeals")

Note: Pre-service Provider Appeals also referred to as Provider Courtesy Reviews are performed for pre-service denials of medical necessity. The process for pre-service reviews can be found in chapter 8, Health Coaching and Intervention.

Post-service Provider Courtesy Reviews "PCR" (also known as "Level I Provider Appeals") consist of retrospective reviews and do not require a member signed authorization. Post-service PCR of claims is performed based on your belief that a claim has been denied or adjudicated incorrectly. The PCR process is separate from BCBSNC's Member Rights and Appeals Process. Refer to

section 17.2 for the Member Appeal and Grievance Process. If at any time the member files an appeal during a provider appeal, the member's appeal supersedes the provider appeal. Providers may not appeal items related to member benefit or contractual issues.

If you believe a claim has been denied or adjudicated incorrectly, you may initiate a request for review through BCBSNC customer service department. To request a claim review regarding a processed claim related to:

- Medical necessity
- Coding, bundling, or fees
- Cosmetic services
- Investigational/Experimental services
- Certification not obtained for inpatient hospital admissions

Providers will have 180 calendar days from the claim adjudication date to submit a Level I Billing/Coding Dispute for any claim related to a Post-Service Billing/Coding Dispute that was adjudicated prior to August 21, 2008. If the adjudication date of the claim is August 21, 2008, or after, the provider will have 90 calendar days to submit the Level I Billing/Coding Dispute.

Providers will have 180 calendar days from the claim adjudication date to submit a Level I Provider Medical Necessity Appeal for any claim related to a Post-Service Medical Necessity determination that was adjudicated prior to September 15, 2008. If the claim adjudication date is September 15, 2008 or after, the provider will have 90 calendar days from the adjudication date to submit the Level I Medical Necessity Provider Appeal.

To request a review, contact BCBSNC using one of the following methods:

- Call the Provider Blue Line℠ at **1-800-214-4844**
- Complete the Level I Provider Appeal form including 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
  P.O. Box 2291
  Durham, NC 27702-2291

All inquiries regarding the status of the appeal should be routed through customer service. Customer service will forward appropriate issues to the appeals department for a provider resolution review. A provider appeal review is an informal review of a payment or denial of a claim. Provider appeal reviews are handled within 30 days from the date of receipt of all information. Supporting objective medical documentation should be submitted for provider appeal reviews. Providers may reduce administrative cost associated with records submissions by first verifying that the records document information consistent with BCBSNC medical policy, payment policy and claim check clinical edit rationale.

Types of post-service provider appeals available to providers are disputes of post-adjudicated claims related to coding, bundling, fees, cosmetic, investigational, experimental, no pre-authorization for hospital admission.

- Level I Provider Appeal Process for Coding, Bundling and Fees applies to ***processed*** claims related to:
  - Integral part of primary service
  - Mutually exclusive
  - Services not eligible for separate reimbursement
  - Incidental denials
  - Surgical global denials
- Level I Provider Appeal Process for Medical Necessity applies to ***processed*** claims related to:
  - Medical necessity
  - Cosmetic services
  - Investigational/Experimental services
  - No pre-authorization for hospital admission

All inquiries for processed claims that pertain to one of the above reasons should be directed to:

Blue Cross and Blue Shield of North Carolina
Provider Appeals Unit
P.O. Box 2291
Durham, NC 27702-2291

or you can fax your inquiries to:

Provider Billing/Coding (bundling and fees):	**919-287-8708**
Provider Medical Necessity:	**919-287-8709**
State PPO:	**919-765-2322**
Member Appeals:	**919-765-4409**

17.7 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.

Please refer to chapter 25, sections 25.3 and 25.4 for instructions on filing a Level II Post-Service Provider Appeal and a filing fee matrix.

17.8 Provider Resources

The provider Web site contains a form for requesting provider appeal reviews regarding coding, bundling, fees, cosmetic, investigational, experimental, no pre-authorization for hospital admission. This form is located at ***bcbsnc.com/provider***. BCBSNC provides resources that are readily available which may provide immediate resolution to questions for how a particular claim was considered.

Your BCBSNC Notification of Payment "NOP" and Explanation of Payment "EOP" provide a detailed summary of how a claim was adjudicated. ***Blue e***℠, accessed via the Internet allows you to search from your desktop: status of submitted claims, including payment amounts, member co-payment, co-insurance, deductible amounts, and status code explanations. Please refer to chapter 12, Electronic Solutions for additional information and services provided via ***Blue e***℠.

Clear Claim Connection (C3) provides to your desktop a Web-based connection to ClaimCheck claims payment policies, related rules, clinical edit clarifications, and source information in an easily accessible application. To view how ClaimCheck auditing evaluates code combinations, participating providers may access clear claim connection through the C 3 pass through page via the ***Blue e***℠ connection. Please refer to chapter 10, Claims – Billing and Reimbursement for additional information on payment guidelines and clear claims connection.

Medical policy consists of medical guidelines and payment guidelines. Medical guidelines detail when certain medical services are medically necessary, and whether or not they are investigational. Payment guidelines provide *(claims payment)* editing logic for CPT, HCPCS, and ICD-9-CM coding. Payment guidelines are developed by clinical staff, and include yearly coding updates, periodic reviews of specialty areas based on input from specialty societies and physician committees, and current coding conventions. Medical policy is available on the BCBSNC Web site located on the providers section, and may be searched by policy name, number, CPT code, or keyword. To view a specific medical policy or find out more, visit the BCBSNC Web site at ***http://www.bcbsnc.com/services/medical-policy/***.

For instructions related to Level II Provider Appeals, refer to chapter 25, Class Action Settlement Agreement (Settlement).

Specialty Networks

18. Specialty Networks

18.1 Pharmacy

This chapter does not apply to FEP, BlueCard® or State Health Plan.

18.1.1 Formularies

BCBSNC currently maintains three open formularies:

- 4 tier formulary
- 3 tier formulary
- 2 tier formulary

The formularies are developed through the efforts of the BCBSNC pharmacy and therapeutics committee, comprised of North Carolina practicing physicians and pharmacists.

The 4 tier formulary is intended to reflect current clinical practice in North Carolina and has three levels of member copayments:

Tier 1: All generic drugs. These have the lowest copayment.

Tier 2: Brand-name drugs that are clinically effective, cost-effective and meet the needs of most patients.

Tier 3: Brand-name drugs that have been reviewed by the BCBSNC pharmacy and therapeutics committee and determined not to have a significant therapeutic advantage over existing tier 2 drugs; new drugs that have not been reviewed by the pharmacy and therapeutics committee; drugs that are not usually recommended as first-line therapy and for which there are existing therapeutic alternatives; brand-name drugs that have a generic equivalent. These drugs have the highest copayment.

Tier 4: Specialty drugs: Includes covered biotechnical, gene therapies or other costly medications that are classified by the BCBSNC P&T committee as specialty medications, and generally have other therapeutic options available that are well-accepted and cost-effective. Those medications classified by BCBSNC as specialty drugs generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies. Tier 4 drugs have the highest co-payment or coinsurance amount.

Members who have the 4 tier formulary benefit will have three pharmacy copayments listed on their identification cards *(see chapter three, Health Benefit Plans and ID Cards)*. You may receive calls from members or pharmacists as members seek ways to lower their copayments by having tier 1 and tier 2 drugs prescribed. The 4 tier formulary is an open formulary and we encourage you to make treatment selections based on your clinical judgment, your knowledge of the patient's condition, medical history, and individual patient needs. The 3 and 2 tier formulary *(using different copayments or coinsurance for generic and brand drugs)* may be maintained for some groups.

We discourage the use of drugs designated as Not-Endorsed "NE" in the formulary. This formulary will continue to promote the use of the most clinically- and cost-effective pharmaceutical products.

For your convenience, the most current list of drugs in the fourth tier will be posted online at ***bcbsnc.com***. You may also find the searchable formulary helpful as well. Our formulary is updated on a quarterly basis, after careful review by the pharmacy and therapeutics committee, which is a group of practicing physicians and pharmacists in North Carolina.

18.1.2 Choosing Between Generic and Brand Name Drugs

Members who choose a brand name prescription drug when a generic alternative is available may be responsible for a higher cost and limited benefits.

In these cases, members will be required to pay the brand *(Tier 3 or 4)* copayment or coinsurance, and also be responsible for paying the difference in cost between the brand name and generic alternative drug. However, if you indicate that a brand name drug must be used, the member will only be responsible for the applicable brand copayment or coinsurance up to the coinsurance maximum.

We encourage you to prescribe lower cost, equally effective generic drugs, where appropriate, and to promote their use by your patients.

18.1.3 Requesting a Formulary

We are pleased to offer several ways to access the BCBSNC formulary.

BCBSNC Printed Formulary: To request a printed formulary, please call your regional network management representative.

BCBSNC Online Formulary: Searchable online formulary is available on our Web site at ***bcbsnc.com***.

BCBSNC Formulary for PDA: BCBSNC hosts its formulary with eProcrates, a clinical drug reference software for use on handheld computing devices. For more details on this free application, go to our online formulary at ***bcbsnc.com*** and follow the link to download formulary to PDA.

18.1.4 Notification of Changes to the Formularies

The pharmacy and therapeutics committee regularly updates the formulary as new drugs and new clinical information become available. All updates and changes to the 3 tier formulary are included in the Blue Link℠, our quarterly provider newsletter, and online at ***bcbsnc.com***.

18.1.5 Certification

BCBSNC may require certification for certain pharmaceuticals. Pharmaceuticals that require certification or have quantity limitations that require certification for greater quantities may be updated at any time without prior notification. For an up-to-date listing of the medications that may require certification or have quantity limitations please refer to our Web site, ***bcbsnc.com***.

18.1.6 Quantity Limitations

These programs apply to Blue Advantage®, Blue Care®, and Blue Options℠ members.

Quantity limits may apply to coverage of certain drugs with the goal of optimizing patient outcomes. This program, which applies coverage limits to drugs that have the potential for abuse or misuse, provides an immediate feedback mechanism to alert the physician to prescription purchasing patterns of members. If those patterns are different from what you intended, you will have the opportunity to intervene before the prescription is dispensed to the member.

BCBSNC will pay for quantities of limited drugs up to the allowed amount in a defined time period. If based on your clinical judgement, your knowledge of the patient's condition, medical history and individual needs, you think the patient should receive a quantity greater than that covered by BCBSNC, you may request certification for a greater quantity. Members may choose to pay cash for quantities that exceed BCBSNC's approved quantities.

The list of pharmaceuticals that have quantity limitations that require certification for greater quantities may be updated at any time without prior notification. For an up-to-date listing of the medications that may require certification or have quantity limitations, please refer to our Web site, ***bcbsnc.com***.

Requests for prior approval for any of the above prescription drugs or requests for quantity limit considerations that exceed the dosage limits should be directed to our Member Health Partnership Operations Department at **1-800-672-7897**.

18.1.7 Days Supply of Prescriptions

For members enrolled in Blue Care®, Blue Options℠, Classic Blue® and Blue Advantage®, each prescription drug copay will cover up to a 30-day supply. Physicians are asked to write new prescriptions for a 30-day supply or less to help minimize patient out-of-pocket expenses.

18.1.8 Extended Supply Prescriptions

Blue Care®, Blue Options℠, Classic Blue® and Blue Advantage®:

After first filling an initial 30-day supply of the same prescribed medication, members may obtain up to a 90-day supply of their medication from any participating pharmacy. A prescription for the initial 30-day supply must first be written before a prescription for a 90-day supply.

Medicare Supplement:

Members may obtain up to a 90-day supply of their medication from pharmacies participating in the extended supply network. Extended supply prescriptions must be written for a 90-day supply rather than a 30-day supply, regardless of the number of refills.

18.1.9 Drug Utilization Review

BCBSNC conducts quarterly retrospective drug utilization reviews. You will periodically receive correspondence from us or our vendor detailing member utilization of targeted drugs. Member-specific data is obtained from claims submitted by pharmacies. These letters are designed to notify you of prescribing patterns that are inconsistent with national treatment guidelines or peer prescribing trends. Please review the letters and make changes to member drug therapy as appropriate based on your clinical judgment, your knowledge of the patient's condition, medical history, and individual patient needs.

18.1.10 Over-the-Counter "OTC" Medication Online Resource

An OTC medication online resource is now available on the Blue Cross and Blue Shield of North Carolina pharmacy services Web page to help members navigate the world of OTC medications. This free resource can be accessed by clicking on Find a Drug on the ***bcbsnc.com*** home page.

This online resource provides members with:

- Education information on the uses and benefits of OTC medications
- Information on common conditions that may be managed/treated by OTC medications
- Examples of OTC medications that may effectively treat the symptoms of these conditions

This resource is a value-added service and is not part of the member's health insurance contract.

18.2 Mental Health and Substance Abuse Services

For HMO and POS members with mental health and substance abuse benefits, BCBSNC provides coverage for services through Magellan Behavioral Health.

For members in PPO and CMM products, access to services for mental health and substance abuse is through the BCBSNC provider network.

18.2.1 Referrals/Prior Review/Health Coaching and Intervention

Mental health and substance abuse services do not require a referral from the primary care physician, but prior review and certification for service must be issued by Magellan Behavioral Health for the following products:

- Blue Care®
- Blue Options℠
- Classic Blue®

Prior approval and inpatient admission certification for mental health and substance abuse services is not required for the following products:

- Blue Advantage®
- Blue Assurance℠
- Access℠
- CMM conversion

To arrange for mental health and substance abuse services:

- The member or physician must call Magellan Behavioral Health at **1-800-359-2422** prior to arranging for services by the mental health provider.
- Some HMO and POS contracts do not access mental health and substance abuse services through Magellan Behavioral Health. Members with access through Magellan Behavioral Health have this information on their member ID card. Eligibility and benefits for mental health and substance abuse services may also be verified via Provider Blue Line℠ at **1-800-214-4844**.

Magellan Behavioral Health is responsible for health coaching and intervention functions for the following products:

- Blue Care®
- Blue HMO℠
- Blue Options℠
- Classic Blue®

18.2.2 Provider Relations

Participating Magellan Behavioral Health providers are asked to refer to the Magellan Behavioral Health provider handbook for questions relating to prior review and certification, inpatient services, claims processing, benefit and eligibility verification and the member grievances and appeals process. Please call Magellan Behavioral Health at **1-800-359-2422**.

18.2.3 Mailing Address for Magellan Appeals/Grievances

Attention: Appeals Coordinator
Magellan Behavioral Health
P.O. Box 1619
Alpharetta, Georgia 30009

18.2.4 Member Relations

Please call Magellan Behavioral Health at **1-800-359-2422**.

18.2.5 Participating Providers

Providers may call the Provider Blue Line℠ for assistance locating participating PPO and CMM mental health and substance abuse providers. For PPO and CMM providers, call **1-800-214-4844**, or access our provider directories online Web site at ***bcbsnc.com***.

- For HMO and POS members call **1-800-359-2422**

Blue Extras for BCBSNC Members

19. Blue Extras for BCBSNC Members

The following special programs are made available to BCBSNC members as value-added services. These services are not covered benefits or otherwise a part of the member's health insurance contract and therefore are payable solely by the member. Additional information about each program is available.

19.1 Alt Med Blue℠

Alt Med Blue℠ is a program offered through American Whole Health that provides discounts up to 25%, on popular alternative medicine services. Services available include:

- massage therapy
- fitness centers
- somatic education
- chiropractic services
- stress management
- guided imagery
- biofeedback
- acupuncture
- nutritional counseling
- health spas
- personal trainers
- yoga
- health and fitness magazines

The discount varies by service type and is deducted from the charge to the member at the time of service.

- Services are available to BCBSNC members simply by showing their BCBSNC ID card to participating providers.
- Services must be received through a participating Alt Med Blue℠ network practitioner. Participating practitioners are available throughout the country.
- BCBSNC does not accept claims or reimburse providers for these services. Members are fully responsible for paying all bills.
- For more information on available services or to locate a participating practitioner, visit ***bcbsnc.com*** or call **1-888-336-2583**.
- To become a participating Alt Med Blue℠ provider, contact the vendor directly at **1-888-336-2583**.

19.2 Vita Blue℠

Vita Blue℠ is a mail order service offering vitamins, minerals and herbal supplements at discounts of up to 40% off of market prices.

- Members can order products online
- For more information visit ***bcbsnc.com*** or call **1-888-234-2413**

19.3 Blue Points℠

Blue Points℠, our online physical activity incentive program, rewards members for staying active through exercise. Members exercise for just 30 minutes a day and earn points toward great prizes.

- Members log on to ***bcbsnc.com*** to register. Once a registered Blue Points℠ member, Blue Points℠ users log in their 30 minutes of activity in their online log.
- There are four levels in all: B, L, U and E. For each 250 point level, members are then prompted to choose a prize.

For more information visit ***bcbsnc.com*** or call **1-888-705-7050**.

19.4 Optic Blue℠

Optic Blue℠ is a corrective laser eye surgery discount program.

- Members receive discounts of about 20% off the market price for laser eye surgery through a network of participating ophthalmologists.
- The price paid by the member is a global charge of $1,249 per eye that includes the initial consultation, the laser procedure, all follow up visits and any procedures for over/under correction.
- For more information or to locate a network provider, visit ***bcbsnc.com*** or call **1-800-755-0507**.

19.5 Cosmetic Surgery Blue℠

Cosmetic Surgery Blue℠ is a program offering a cosmetic surgery discount, information and provider referrals available to eligible Blue Cross and Blue Shield of North Carolina members. It is the first discount program of its kind in North Carolina and one of the first in the country.

Cosmetic Surgery Blue℠ provides members easy access to a network of credentialed plastic surgeons that have agreed to offer members a 15% discount on their services. Cosmetic Surgery Blue℠ also provides members easy access to information and resources to make educated, safe choices about cosmetic surgery procedures. The information includes procedure descriptions and expectations, potential risks, and questions to ask their plastic surgeon.

For more information on Cosmetic Surgery Blue℠, visit ***bcbsnc.com*** or call **1-877-755-1111**.

19.6 Audio Blue℠

Thanks to Audio Blue℠, members can save $250 or 25% on a single hearing aid. Members can choose from a variety of hearing aid models and prices. With a discount of 25% off hearing aid MSRP or $250 off usual and customary fees, whichever provides greater savings, members will also save on:

- Hearing aid fittings
- Follow-up visits up to one year

- One-year warranties for service, loss or damage
- Free hearing aid cleanings and checks up to one year
- One-year supply on batteries

To receive the discount, members simply show their BCBSNC ID card to a participating provider at one of many locations throughout North Carolina. Members can find the closest participating audiologist by visiting our Web site at ***bcbsnc.com*** or by calling **1-877-979-8000**.

19.7 Get Fit Blue℠

Get Fit Blue℠ is a nutrition and fitness resource and discount program. Get Fit Blue℠ offers discounts on nutrition and fitness products, programs and services. Plus, BCBSNC members have fast, easy access to recipes, calorie counters, nutrition and exercise advice and more.

Get Fit Blue℠ can help BCBSNC members save money with discounts on the following and more:

- Select weight management programs
- Scales, heart rate monitors, body fat analyzers, blood pressure monitors and electronic pulse massagers

19.8 Cosmetic Dentistry Blue℠

Cosmetic Dentistry Blue℠ is an innovative program offering discounts on cosmetic dental procedures. Cosmetic Dentistry Blue℠ provides members easy access to a statewide network of credentialed dentists who have agreed to offer members up to 30% discounts on the following services:

- Teeth whitening
- Tooth colored fillings
- Veneers
- Tooth contouring and reshaping
- Bonding
- Implants

19.9 Program Availability by Product

The following chart summarizes which programs are available by product:

	Alt Med Blue℠	Vita Blue℠	Blue Points℠	Optic Blue℠	CSB	Audio Blue℠	Get Fit Blue℠	Healthline Blue℠	Cosmetic Dentistry Blue℠
Blue Care®	X	X	X	X	X	X	X	X	X
Blue Options℠	X	X	X	X	X	X	X	X	X
Classic Blue®	X	X	X	X	X	X	X	X	X
Blue Advantage®	X	X	X	X	X	X	X	X	X
Medicare Supplement	X								X
Short-Term									X
Access℠	X	X		X	X	X	X		X
Conversion	X	X	X	X	X	X	X		X
Blue Assurance℠	X	X		X	X	X	X		X
BlueCard®	X	X		X	X	X	X		
State Health Plan CMM *(indemnity)*/NC Health Choice	X	X		X	X	X	X		
Federal Employee Plan	X	X		X	X	X	X		X

Brand Regulations
How to Use Our Name and Logos

20. Brand Regulations - How to Use Our Name and Logos

Brand regulations are the legal rules that must be followed when using the Blue Cross and Blue Shield "BCBS" brands and must be consistent with the terms of the BCBS license agreement *(executed by all licensees)*. To download BCBSNC corporate logos, visit ***bcbsnc.com/news/onlinepr/comp-logos1.cfm***. Or, visit our corporate style guide at ***bcbsnc.com/inside/style-guide/***. These are the only sources for downloading the BCBSNC corporate logos.

20.1 How to Use the Blue Cross and Blue Shield of North Carolina "BCBSNC" Name Correctly

The following guidelines should be used when using the BCBSNC name:

20.1.1 Using the BCBSNC Name in Text

As an independent licensee, we are legally obligated to disclose our brand and location. If you are using our company name in text, it must be written as follows:

Blue Cross and Blue Shield of North Carolina

Variations such as BlueCross BlueShield, Blue Cross/Blue Shield of NC or Blue Cross & Blue Shield/NC are not acceptable.

If you are producing a long text document *(e.g., a newspaper article)*, you may use the acronym "BCBSNC" for secondary mentions. Make sure you use the full name the first time it is mentioned in any communication.

20.1.2 Logos

The BCBSNC logo is available in two formats, flush-left and centered. Both are available in one-color *(black, white)* and two-color *(cyan logos with either black or white type)* versions. Do not alter any elements within the logos.

BlueCross BlueShield of North Carolina

BlueCross BlueShield of North Carolina

BlueCross BlueShield of North Carolina

BlueCross BlueShield of North Carolina

20.1.3 Licensee Disclosure

Licensee disclosure is also a Blue Cross and Blue Shield Association "BCBSA" requirement. One of the following two statements must be included whenever the company name is mentioned.

> Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.
>
> OR
>
> An independent licensee of the Blue Cross and Blue Shield Association.

The statement can be placed anywhere on the piece. The type can be small *(e.g., six point)*, as long as it remains legible and relatively independent of other copy or graphics.

20.1.4 Camera Ready Art

BCBSNC's logos are available in both hard-copy *(Photostat)* and electronic *(Mac or PC)* formats. They can be delivered by overnight mail, standard mail, or e-mail. Contact creative services at **1-919-765-3858** with questions or for assistance.

20.1.5 Approvals

All pieces that are being developed for dissemination to the public must be approved by BCBSNC's creative services department and the law and regulatory affairs department. Contact Creative Services at **1-919-765-3858** for coordination of approvals from creative services and law and regulatory affairs.

20.2 How to Use Registered Marks (®) and Service Marks (SM) Correctly

If any other registered mark is shown on a piece, they must be differentiated from our registered marks. To do this add a numeral to the other registered marks: ®1, ®2 etc.

Disclose multiple registered marks as follows:

® Registered marks of the Blue Cross and Blue Shield Association

®1 Registered mark of *(mark owner's name)*

If any other service mark is shown on a piece, they must be differentiated from our service marks. To do this add a numeral to the other service marks: SM1, SM2 etc.

Disclose multiple registered marks as follows:

SM Service mark of the Blue Cross and Blue Shield Association

SM1 Service mark of *(mark owner's name)*

Health Insurance Portability and Accountability Act "HIPAA"

21. Health Insurance Portability and Accountability Act "HIPAA"

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.

HIPAA impacts:

- Electronic transactions
- Code sets and identifiers
- Security of protected health information
- Privacy of protected health information

21.1 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

Specific information about standard transactions to BCBSNC is discussed in chapter 12, Electronic Solutions and at the eSolutions Web site, ***bcbsnc.com/providers/edi***.

21.2 Code Sets and Identifiers

Providers should use the following standardized codes to submit claims to health plans:

- ICD-9 – CM
- CPT
- HCPCS
- CDT *(formerly HCPCS dental codes, but now ADA codes, 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 regarding this process.

21.3 Security

The HIPAA security rule, sets forth the standards for the security of electronic protected health information (ePHI). Health plans, health care providers and health care clearinghouses are required to develop and implement appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of ePHI. In addition to implementing and complying with the security rule, BCBSNC is also subject to the requirements of the North Carolina customer information safeguards act, which provides protection for customer information, whether maintained in paper or electronic form. BCBSNC has implemented appropriate safeguards as required by the security rule and applicable North Carolina laws.

National Provider Identifier "NPI"

NPI is the 10-digit unique health identifier for health care providers as required by the Health Insurance Portability and Accountability Act of 1996 "HIPAA." A health care provider is defined as any provider of medical or health services and any other person or organization who furnishes, bills, or is paid for health care. NPI is required for the processing of all electronic transactions effective May 23, 2008. The NPI replaces all legacy provider identifiers such as UPIN, Medicaid number, Medicare number, BCBSNC number, and other carrier numbers on all HIPAA-defined electronic transactions. The national versions of both professional CMS-1500 and institutional UB-04 claim forms have also been revised to include the NPI as an element to identify health care providers. For more information about NPI please access the centers for Medicare and Medicaid services at ***www.cms.gov/hipaa*** or call **1-410-786-3000**.

21.4 Privacy

The HIPAA privacy rule addresses the way in which a health plan, provider that transmits PHI electronically and 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. The privacy rule permits the sharing of information for treatment, payment and health care operations, including such BCBSNC required functions as quality assurance, utilization review or credentialing, without patient consent or authorization.

Please refer to our notice of privacy practices enclosed in this Provider eManual for a complete understanding of the ways in which BCBSNC may use and disclose its members' protected health information.

21.5 Additional HIPAA Information

- Additional HIPAA information is available through the following organizations:
  - Department of Health and Human Services at ***www.hhs.gov***
  - North Carolina Health Care 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**
  - BCBSNC will provide additional information in future Blue Link℠ provider newsletters, or other targeted communications.
- Check with individual payers, clearinghouses, etc. for their individual plans, state of readiness, and updates.

A list of clearinghouses that are capable of submitting transactions to BCBSNC is located at the EDI services Web page at ***www.bcbsnc.com/providers/edi***.

Privacy and Confidentiality

22. Privacy and Confidentiality

At Blue Cross and Blue Shield of North Carolina, we take very seriously our duty to safeguard the privacy and security of our members Protected Health Information "PHI," as we know you do. BCBSNC has developed corporate privacy policies and procedures that address all applicable privacy laws and regulations. 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 privacy official and a privacy committee that are charged with approving and reviewing BCBSNC's privacy policies and procedures. They are responsible for the oversight, implementation and monitoring of the policies.

22.1 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 legally permitted or required.
- 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 the following 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.

BlueCross BlueShield of North Carolina

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Responsibilities...

Blue Cross and Blue Shield of North Carolina is committed to protecting the privacy of the medical information and other personal information we keep regarding our members. We call this information **Protected Health Information** or **"PHI"** throughout this notice. We are required by law to maintain the privacy of your Protected Health Information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. **This notice takes effect on April 14, 2003** and will remain in place until we replace it.

We reserve the right to change this notice and our privacy practices at any time. We also reserve the right to make the changes in our privacy practices and the new notice effective for all PHI that we already have about you as well as for PHI that we may receive in the future. Before we make a material change in our privacy practices, we will update this notice and send the new notice to our health plan subscribers within 60 days of the time we make the change.

You may request a copy of this notice at any time by calling the customer service number on the back of your identification card or writing to us at P.O. Box 2291, Durham, NC 27702-2291. You may also obtain a copy from our Web site, *www.bcbsnc.com*. For more information or questions about our privacy practices, please contact the Privacy Office at the address provided above.

How We Use and Disclose Your Protected Health Information...

We may use and disclose your protected health information as permitted by federal and state privacy laws and regulations. We have described below how we are most likely to use and disclose your protected health information under these laws and regulations. Generally, we will only use and disclose your PHI as authorized by you or as permitted or required by law. If you cease to be a member, we will no longer disclose your PHI, except as permitted or required by law.

The federal health care privacy regulations known as "HIPAA" generally do not take precedence over state or other applicable privacy laws that provide individuals greater privacy protections. As a result, when a state law requires us to impose stricter standards to protect your health information, we will follow the state law rather than the HIPAA Privacy Regulations. *For example*, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing or reproductive rights.

We may use and disclose your PHI for the following purposes:

PAYMENT... We may use and disclose your PHI for payment purposes or to otherwise fulfill our responsibilities for coverage and providing benefits as established under your policy. *For example*, we may use or disclose your PHI to pay claims from your health care providers for their services that are covered under your health plan, determine your eligibility for benefits, coordinate benefits, determine the medical necessity of the treatment that you received or plan to receive, obtain premiums, issue explanations of benefits to the person who subscribes to the health plan in which you participate, and other purposes related to payment.

HEALTH CARE OPERATIONS... We may use and disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing the competence or qualifications of your health care provider and evaluating the performance of your health care provider, conducting training programs, accreditation, certification, licensing or credentialing activities, rating our risk and determining our premiums for your health plan, medical review, legal services and auditing, business management and general administrative activities, including activities relating to privacy, customer service and resolution of grievances, business planning and business development. *For example*, we may use or disclose your PHI: *(i)* to inform you about one of our disease management programs; *(ii)* to respond to a customer service inquiry from you; *(iii)* in connection with fraud and abuse investigations and compliance programs; or *(iv)* to survey you concerning how effectively we are providing services. We may also disclose your PHI to the North Carolina Department of Insurance during a review of our health insurance operations. We may also disclose your PHI to non-affiliated third parties where allowed by law and as necessary to help us fulfill our obligations to you.

YOUR AUTHORIZATION... You may give us written authorization to use or disclose your PHI for any purpose. If you give us an authorization, you may revoke it at any time by giving us written notice. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Without your authorization, we may not use or disclose your PHI for any reason except as described in this notice.

YOUR FAMILY AND FRIENDS... We may disclose PHI to a family member, a friend or other persons whom you indicate are involved in your care or payment for your care. We may use or disclose your name, location and general condition or death to notify or help with notification of a family member, your personal representative, or other persons involved in your care about your situation. If you are incapacitated or in an emergency, we may disclose your PHI to these persons if we determine that the disclosure is in your best interest. If you are present, we will give you the opportunity to object before we disclose your PHI to these persons.

YOUR HEALTH CARE PROVIDER... We may use and disclose your PHI to assist health care providers in connection with their treatment or payment activities. *For example*, we may disclose your PHI when needed by a health care professional to render medical treatment to you.

UNDERWRITING... We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us. If the contract is placed with us, we will only use or disclose your PHI as described in this notice.

BUSINESS ASSOCIATES... We may contract with individuals and entities called business associates to perform various functions on our behalf or to provide services to you. To perform these functions or services, business associates may receive, create, maintain, use or disclose your PHI, but only after the business associate has agreed in writing to safeguard your PHI. *For example*, we may disclose your PHI to a business associate who will administer your health plan's prescription benefits, or perform pre-enrollment medical screenings.

REQUIRED BY LAW AND LAW ENFORCEMENT... We may use or disclose your PHI when we are required to do so by state or federal law. We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with federal privacy laws. We may disclose your PHI in connection with legal proceedings such as in response to an order from a court or administrative tribunal, or in response to a subpoena. We may also disclose your PHI for law enforcement purposes.

ABUSE OR NEGLECT... We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence.

WORKERS' COMPENSATION... We may disclose your PHI to comply with workers' compensation laws and other similar laws that provide benefits for work-related injuries or illnesses.

PUBLIC HEALTH AND SAFETY, HEALTH OVERSIGHT ACTIVITIES... We may use or disclose your PHI for public health activities for the purpose of preventing or controlling disease, injury or disability. We may also disclose your PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections, licensure or disciplinary actions.

RESEARCH... We may disclose your PHI to researchers when an institutional review board or privacy board has reviewed the research proposal and established protocols to protect the privacy of your PHI. We may also make limited disclosures of your PHI for actuarial studies.

MARKETING... We may use your PHI to contact you with information about our health-related products and services, product enhancements or upgrades, or about treatment alternatives that may be of interest to you.

EMPLOYER OR ORGANIZATION SPONSORING A GROUP HEALTH PLAN... We may disclose your PHI and the PHI of others enrolled in your group health plan to the employer or other organization that sponsors your group health plan. Please see your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration. We may also disclose summary information about the enrollees in your group health plan to the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

DEATH AND ORGAN DONATION... We may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization to assist them in performing their duties.

MILITARY ACTIVITY, NATIONAL SECURITY, PROTECTIVE SERVICES... If you are or were in the armed forces, we may disclose your PHI to military command authorities. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President of the United States, other federal officials or foreign heads of state.

CORRECTIONAL INSTITUTIONS... If you are an inmate, we may disclose your PHI to a correctional institution or law enforcement official for: *(i)* providing health care to you; *(ii)* your health and safety and the health and safety of others, *(iii)* the safety and security of the correctional institution.

INFORMATION WE COLLECT ABOUT YOU...

In the normal course of our operations, we may collect information from: *(i)* **You** (through information you give us on your applications for insurance or on other forms, through telephone or in-person interviews with you, and through information you provide to an insurance agent or your employer such as your address, telephone number, or your health status, or other types of insurance coverage you have; *(ii)* **Your Transactions** with us, such as your claims history; *(iii)* **Other Insurance Companies** that currently insure you or that have insured you in the past, such as your claims history; *(iv)* **Your Employer**, such as information your employer receives from you for purposes of eligibility for insurance coverage; or *(v)* **Your Health Care Providers** who currently treat you or have treated you in the past, such as information about your health status.

OUR POLICIES FOR PROTECTING YOUR PROTECTED HEALTH INFORMATION...

We protect the PHI that we maintain about you by using physical, electronic, and administrative safeguards that meet or exceed applicable law. When our business activities require us to provide PHI to third parties, they must agree to follow appropriate standards of security and confidentiality regarding the PHI provided. Access to your PHI is also restricted to appropriate business purposes.

We have developed privacy policies to protect your PHI. All employees receive training on these policies and they must sign a privacy acknowledgment form, binding them to abide by our policies and procedures.

In addition to these safeguards, we have developed a variety of other protections, including: *(i)* using only aggregate or non-identifiable information for research or quality measurement purposes whenever possible; *(ii)* using confidentiality provisions in our contracts with third parties to protect the confidentiality of your personal information and restrict use and disclosure of this information; *(iii)* restricting access to personal information through internal procedures and pass code access to computer systems; and *(iv)* restricting access to personal information by physical security measures in certain areas of our business operations, including employee badges, and restricted business areas.

Your Rights...

The following is a list of your rights with respect to your PHI:

Right to Access, Inspect and Copy Your PHI... You have the right to see or get a copy of the PHI that we maintain about you. Your request must be in writing. You may visit our office to look at the PHI, or you may ask us to mail it to you. We will charge a reasonable fee to cover the cost of copying the information. We will contact you to review the fee and obtain your agreement to pay the charges. If you wish to access your PHI, please call the number on the back of your identification card and request an access to PHI form.

Right to Correct, Amend or Delete Your PHI... You have the right to ask us to correct, amend or delete your PHI. Your request must be in writing. We are not required to agree to make the correction, amendment or deletion. *For example*, we will not generally make a correction, amendment or deletion if we did not create the PHI or if we believe that the PHI is correct. If we deny your request, we will provide you a written explanation. You have the right to file a statement explaining why you disagree with our decision and setting forth what you believe is the correct, relevant and fair information. We will file the statement with your PHI and we will provide it to anyone who receives any future disclosures of your PHI. If we accept your request to correct, amend or delete your PHI, we will make reasonable efforts to inform others, including people you name, of the amendment and include the changes in any future disclosures of your PHI. If you wish to correct or amend your PHI, please call the telephone number on the back of your identification card and request an amendment of PHI form.

Right to Request an Accounting of Disclosures... You have a right to receive a list of certain instances in which we or our business associates disclosed your PHI for purposes other than our treatment, payment or health care operations and certain other activities. You are entitled to this accounting of disclosures for the six years prior to the date you make the request, but not for disclosures made before April 14, 2003. We will provide you with the date on which we made a disclosure, the name of the person or entity that received your PHI, a description of the PHI that we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for preparing the list. Your request must be in writing and you may call the number on the back of your identification card and request an accounting of disclosures form.

Right to Request Restrictions... You have the right to ask us to place additional restrictions on our use or disclosure of your PHI for our treatment, payment and health care operations. *We are not required to agree to these restrictions.* In most instances, we will not agree to these restrictions unless you have requested Confidential Communications as described below.

Right to Confidential Communications... If you believe that a disclosure of your PHI could endanger you, you may ask us to communicate with you confidentially at a different location. *For example*, you may ask us to contact you at your work address or other place instead of your home address. You may call the number on the back of your identification card to request a confidential communications form. Once we have received your confidential communications request, we will only communicate with you as directed on the confidential communications form, and we will also terminate any prior authorizations that you have filed with us.

Right to File a Privacy Complaint... You may complain to us if you believe that we have violated your privacy rights. You may also file a complaint with us by contacting the Chief Privacy Official, P.O. Box 2291, Durham, NC 27702-2291. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, DC. We will not take any action against you or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Right to Obtain a Copy of this Privacy Notice... You have a right to request a copy of this notice at any time by calling the number on the back of your identification card or you may obtain a copy from our website. Even if you agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Forms

23. Forms

The following forms are referenced in the preceding chapters of this manual. We have included copies of the following forms for your convenience.

- V508 – Individual Provider Enrollment application
- V510 – Group Provider Enrollment application
- G102 – Provider Claim Inquiry
- Level One Provider Appeal Form
- BCBSNC Certification/Prior Review Request form
- BCBSNC Certificate of Medical Necessity form
- BCBSNC Provider and Institutional Mailback form
- BCBSNC Provider and Institutional Mailback form *(two pages)*
- G291 – Provider and Institutional Electronic Mailback form
- G292 – Provider and Institutional Paper Mailback form
- G252 – Refund of Overpayment form
- G293 – Inter-Plan Programs Par/Host Plan form
- S115 – Coordination of Benefits questionnaire (Inter-Plan Programs)
- ENROLL1 – Enrollment and Change application *(with health questions)*
- ENROLL2 – Enrollment and Change application *(without health questions)*
- EDI Services Batch Connectivity Request
  - ECR270 – 270/271 - Eligibility Inquiry, 276/277-Claim Status Inquiry
  - ECR835 – 835 - Payment/Remittance Advice
  - ECR837 – 837 - Claim/Encounter
- Member Appeal Representation Authorization form
- S133 – Statement of Accommodation Charges

V508 – Sample Individual Provider Enrollment Application

Blue Cross and Blue Shield of North Carolina
Individual Provider Enrollment Application
(Please print or type)

(Internal Use Only) BCBS#: _____
Analyst: _____ Eff Date: _____ Date rec: _____
Comp date: _____ Date board called: _____

Name: _____ Degree: _____ Specialty: _____
Last First Mid Init

National Provider Identifier (NPI): _____ Taxonomy Code/Description: _____

Soc. Sec. No.: _____ Phone number: _____

DEA Number: _____ License number:*** _____ Date originally issued: _____
Month/Day/Year

******Please attach a copy of your original license and your most recent license renewal slip***

UPIN number: _____ Medicare provider no.: _____

(internal use only)

Notes:

Actual office location: _____
Street/Suite no./Apt. no., etc.

_____
City State Zip County

Billing Address (if different from above):

_____
Street/Suite No./Apt. No., etc.

_____
City State Zip

If individual practice, specify date practice established: _____

Have you ever had a BCBSNC provider number before? Yes _____ No _____

If you checked "Yes", then list number(s): _____ _____ _____ _____

Are you a member of a group, clinic or partnership? Yes_____ No_____
If you checked "Yes", then specify the following:

_____ _____ _____
BCBSNC group provider number *(if applicable)* Group tax identification number *(IRS #)* Date you joined group, clinic, etc.

Indicate place(s) service(s) will be rendered:

1. _____ inpatient hospital
2. _____ outpatient hospital
3. _____ office
4. _____ home or skilled nursing facility
5. _____ all of the above
6. _____ other specify: _____

In order to insure compliance with Internal Revenue Service regulations, we must have your tax identification information to process your application. Please complete the enclosed W9 form and include it with your completed application. The W9 must indicate the name of the individual, group, corporate entity or partnership that is on record with the Internal Revenue Service.

Assignment of a Blue Cross and Blue Shield of North Carolina provider number does not indicate participation with any product. If you are interested in participation with a product you must contact your Professional Relations field office.

FIELD OFFICE USE ONLY Date Mailed: _____ Initials: _____

V508, 9/05

V510 – Group Provider Enrollment Application

Blue Cross and Blue Shield of North Carolina
Group Provider Enrollment Application
(Please print or type)

(Internal Use Only) BCBS#: _____
Analyst: _____ Eff Date: _____ Date rec: _____
Comp date: _____ Date board called: _____

Group Name: _____ Specialty: _____

Tax ID (IRS #): _____ Medicare number: _____ Phone number: _____

National Provider Identifier (NPI): _____ Taxonomy Code/Description: _____

Actual office location: _____ Date group established: _____
Street/Suite no./Apt. no., etc.

_____
City State Zip County

(internal use only)

Notes:

Billing Address (if different from above):

_____
Street/Suite No./Apt. No. or PO box

_____
City State Zip

Indicate place(s) service(s) will be rendered:

1. _____ inpatient hospital 2. _____ outpatient hospital
3. _____ office 4. _____ home or skilled nursing facility
5. _____ all of the above 6. _____ other specify: _____

Please complete for each individual provider in the group (attach additional pages as necessary):

Name	BCBSNC prov #	License number	Year licensed	Specialty	UPIN

In order to insure compliance with Internal Revenue Service regulations, we must have your tax identification information to process your application. Please complete the enclosed W9 form and include it with your completed application. The W9 must indicate the name of the individual, group, corporate entity or partnership that is on record with the Internal Revenue Service.

Assignment of a Blue Cross and Blue Shield of North Carolina provider number does not indicate participation with any product. If you are interested in participation with a product you must contact your Professional Relations field office.

FIELD OFFICE USE ONLY Date Mailed: _____ Initials: _____

V510, 9/05

Sample G102 - Provider Claim Inquiry

PROVIDER / DOCTOR CLAIM INQUIRY

PROVIDER INFORMATION

TELEPHONE NUMBER	FAX NUMBER
GROUP PROVIDER NUMBER	INDIVIDUAL PROVIDER NUMBER

TO: _____

_____

_____

FROM: _____

_____

_____

SAME PATIENT INFORMATION

PATIENT NAME

CERTIFICATE HOLDER

SUBSCRIBER ID WITH ALPHA PREFIX

DATE OF SERVICE

TOTAL CHARGE

PLACE OF SERVICE

- ☐ Office
- ☐ Inpatient facility
- ☐ Ambulatory surgical center
- ☐ Outpatient facility

PROGRAM

- ☐ HMO
- ☐ PPO
- ☐ State Health Plan
- ☐ SHP – PPO
- ☐ BlueCard®
- ☐ Blue Advantage®
- ☐ Federal Employees Program

The reason for this inquiry is:

1. ☐ New Claim
2. ☐ Corrected Claim
3. ☐ Claim(s) Status ☐ Blue ***e*** claim status has been reviewed
4. ☐ Overpayment / Underpayment
   - a. Patient's other coverage paid. . . . . $ _____
   - b. Payment was made by:
     - Name of company _____
     - Name of the group _____
     - Name of Insured _____
   - c. Possible underpayment of . . . . . $ _____
5. ☐ Medical Records - Reconsideration of a ***previously processed*** claim related to:
   - a. ☐ coding/bundling ☐ Clear Claim Connection supporting documentation included
   - b. ☐ medical necessity
   - c. ☐ potentially cosmetic, experimental or investigational services
   - d. ☐ pricing
   - e. ☐ pre-existing
6. ☐ Medical Records - Submission of solicited medical records for a pending claim related to:
   - a. ☐ medical necessity
   - b. ☐ pre-existing
   - c. ☐ pricing
   - d. ☐ potentially cosmetic, experimental or investigational services
7. ☐ Medical Records submitted for other reasons:

   Explanation: _____

   _____

   _____

G102, 4/06

Sample Level One Provider Appeal Form

LEVEL ONE PROVIDER APPEAL FORM

BlueCross BlueShield of North Carolina

Blue Cross and Blue Shield of North Carolina is 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 - - **Phone** - -

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

CODING, BUNDLING, or FEE DENIALS
Fax # 919-287-8708

- ☐ Integral Part of Primary Service
- ☐ Mutually Exclusive
- ☐ Services Not Eligible for Separate Reimbursement
- ☐ Incidental Denial
- ☐ Surgical Global Period Denial
- ☐ Re-bundling

MEDICAL NECESSITY DENIALS
Fax # 919-287-8709

- ☐ Inpatient vs. Observation
- ☐ Not Medically Necessary
- ☐ Investigational
- ☐ Cosmetic
- ☐ Experimental

ADMINISTRATIVE DENIALS
Fax # 919-287-8709

- ☐ No Authorization for Inpatient Hospital Admissions

---State PPO Authorization Only---
Fax # 919-765-2322

- ☐ Pharmacy – May Be Pre-Service

DENIAL REASON: Must be Post-Service.

Note: For Inter-Plan Program (IPP) requests, this form should be used for coding, bundling, or fee denials regarding non-NC members. All other IPP requests for Appeal review should be submitted using the Provider/Doctor Claim Inquiry Form in the Blue Book e-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 coding denials, services not considered medically necessary or administrative denials. Completed forms accompanied by any supporting documentation should be sent to: **Provider Appeal Department, Blue Cross and Blue Shield of North Carolina, P.O. Box 2291, Durham, NC 27702-2291** or **Fax: Billing/Coding (919) 287-8708** or **Medical Necessity/Administrative Denials Fax: (919) 287-8709**.

Inquiry requests for Federal Employees Program "FEP," State Comprehensive Major Medical "CMM" or for reasons other than review of a claim denial not specific to post service denials should not be requested by use of this form. Please refer to the Blue Book e-Provider Manual located on the BCBSNC Web site for providers at ***bcbsnc.com/providers/blue-book*** or contact your local Network Management field office for assistance with the claims inquiry process.

BCBSNC Certification/Prior Review Request Form

BCBSNC CERTIFICATION/PRIOR REVIEW REQUEST FORM

Please complete every field on this form to prevent delays in processing. You will receive a response from BCBSNC no later than 2 business days after the date all necessary information is received.

Please Print

Office Contact: _____ TODAY'S DATE: _____ /_____ /_____

Phone Number: ( ) _____ - _____ Fax Number: ( ) _____ - _____

PART I				
PATIENT NAME		**BCBSNC ID NUMBER**	**DATE OF BIRTH** _____ /_____ /_____	
SEX: ☐ FEMALE ☐ MALE		**Is this a Reconsideration?** ☐ YES ☐ NO		
MEDICAL RECORDS INCLUDED:	☐ Op Notes ☐ Photos	☐ H&P ☐ D/C Summary	☐ Complete Records ☐ Labs/X-rays/Diagnostics	☐ Consultation ☐ Progress Notes
TYPE OF PLAN:	☐ HMO	☐ PPO	☐ POS	☐ CMM

PART II	
PRIMARY CARE PHYSICIAN	PROVIDER #
ATTENDING PHYSICIAN	PROVIDER #
PRIMARY DIAGNOSIS	ICD-9 CODE
SECONDARY DIAGNOSIS	ICD-9 CODE

TREATMENT SETTING & DATE

☐ **INPATIENT**	☐ **OUTPATIENT/OBSERVATION/OFFICE**
ADMIT DATE _____ /_____ /_____	START DATE _____ /_____ /_____
FACILITY	FACILITY
OTHER	

PROCEDURES

CPT CODES

If you have questions about completing this form, please contact the BCBSNC Health Coaching and Intervention department at **1-800-672-7897.**

BCBSNC USE ONLY:	REVIEWER
	BCBSNC CERTIFICATION #

Sample BCBSNC Certificate of Medical Necessity

BCBSNC Certificate of Medical Necessity

Please furnish the information requested below and submit with initial paper claim form.

Patient's Name: _____ Subscriber ID: _____

Diagnosis: _____

Prognosis: _____

_____

1. Describe equipment, special features and attachments prescribed: _____

_____

_____

A. Date physician examined patient: _____
B. Effective date of need: _____
C. Length of time needed: _____
D. Frequency used: _____

2. Patient status - Please check items most appropriate for patient:

A. Bed Confined ☐
B. Room Confined ☐
C. Chair Confined ☐
D. Ambulation impaired _____
To what degree? _____
E. Extremity Strength _____
☐ Upper ☐ Lower

3. Can patient operate equipment independently? ☐ YES ☐ NO

4. Conditions or special circumstances that require individual consideration:
(Attach appropriate documentation)

_____

I, the undersigned, certify that the above prescribed equipment is medically indicated and in my opinion is reasonable and necessary with reference to accepted standards of medical practice and treatment of this patient's condition.

_____
Physician Signature Date

_____
Address

_____
City State Zip

( ) _____
Area Code Telephone Number

Sample BCBSNC Professional and Institutional Mailback

Professional and Institutional Mailback *(Electronic Claims)*

Please make the corrections in your database and refile the claim electronically.

Patient Name:_____ Date(s) of Service:_____

Provider Name:_____ Patient Account Number:_____

Provider Address:_____

City:_____ State:_____ Zip:_____

Total Charge:

M001		Invalid member ID number. Resubmit member ID number as it appears on the ID card. **Send copy of ID card.**
M003		Provide dates of admission and discharge.
M004		Provide onset date of symptoms according to the medical record.
M008		Itemize charges, dates and include valid procedure/revenue codes for services rendered.
M009		Provide complete and specific diagnosis for each service rendered.
M010		Provide correct number of units or minutes in the units fields.
M014		Billed charges are inconsistent with the number of days filed. Please recompute bill.
M015		CPT 99070/E1399 is a generic supply code. Please provide HCPCS code or description of service/supply.
M017		Modifer 26 is inconsistent with the place of service.
M018		File PA charges with the appropriate modifier for surgical assistance with the Surgeon's claim.
M019		Description of service is not consistent with the place of service.
M022		Provide the rendering physician's individual Blue Cross and Blue Shield of North Carolina provider number on each service line.
M024		Refile with Medicare. According to our records, Medicare is the primary insurance carrier.
M028		Accommodation rate is invalid for the date of service reported. Please correct and refile. Use Electronic Network Services, when possible.
M029		Verify if outpatient services were included in the inpatient charges for:_____
M030		Interim billing cannot be accepted. Please submit claim for member's complete admission.
M031		Provide the number of miles traveled for ambulance service.
M032		Provide most prevalent semi-private room rate for the patient.
M038		Please resubmit all lines from original claim on the corrected claim. If the correction is the omission of a service, please change the charge to $0.00. Please **do not** mark through the line to be omitted. Please **do not** highlight anything on the claim.
M039		If this provider will be rendering total OB care, please submit total OB care claim at the time of delivery. If the patient has transferred to another physician, please resubmit the claim with supporting documentation verifying each date of service.
M040		Please resubmit with correct Type of Bill. No record of original claim on file.

Professional and Institutional Mailback • PO Box 35 • Durham, North Carolina 27702-0035 • **1-919-489-7431**

Sample BCBSNC Professional and Institutional Mailback

Professional and Institutional Mailback *(Paper Claims)*

Please make the necessary corrections on the claim form. DO NOT make changes to the Mailback Form and send to BCBSNC. Print a new red and white claim form and resubmit. File electronically whenever possible.

Patient Name:_____ Date(s) of Service:_____

Provider Name:_____ Patient Account Number:_____

Provider Address:_____

City:_____ State:_____ Zip:_____

Total Charge:

M001		Invalid member ID number. Resubmit member ID number as it appears on the ID card. **Send copy of ID card.**
M002		Provide both the tax ID number and the Blue Cross and Blue Shield of North Carolina assigned provider number.
M003		Provide date of admission and discharge.
M004		Provide onset date of symptoms according to the medical record.
M005		If accident related, give onset date of injury.
M006		Provide specific dates for each service rendered.
M007		Verify patient information and give the missing data (patient name, sex, or month, day and year of birth).
M008		Itemize charges, dates and include valid procedure/revenue codes for services rendered.
M009		Provide complete and specific diagnosis for each service rendered.
M010		Provide correct number of units/minutes in the units field.
M011		Provide valid procedure/revenue code for each service.
M012		Error in total charge. Please recompute.
M013		Facility charges must be filed on a UB-04 claim form. Resubmit using the correct form. North Carolina providers should resubmit claims using Electronic Network Services, when possible.
M014		Billed charges are inconsistent with the number of days filed. Please recompute bill.
M015		CPT 99070/E1399 is a generic supply code. Please provide valid HCPCS code or description of service/supply.
M016		Provide drug name, quantity, and NDC number for code:_____
M017		Modifier 26 is inconsistent with the place of service.
M018		File PA charge with the appropriate modifier for surgical assistance with the Surgeon's claims.
M019		Description of service is not consistent with the place of service.
M020		The claim includes charges for services not yet rendered. Please refile this claim once services have been performed.
M021		Provide name of supervising M.D. or PhD.
M022		Provide the rendering physician's individual Blue Cross and Blue Shield of North Carolina provider number on each service line.
M023		Professional charges must be filed on CMS-1500 claim form or the equivalent. Resubmit using the correct form.
M024		Refile with Medicare. According to our records, Medicare is the primary insurance carrier.
M025		Submit copy of Medicare EOB or indicate on the claim form if Medicare non-covered or exhausted.
M026		The member ID number is not valid or is no longer in effect for this patient. Verify member ID number with patient, then refile claim with the appropriate member ID number or health insurance carrier.
M027		File all prescription drug claims to Advance PCS: PO Box 853901, Richardson, TX 75085-3901.
M028		Accommodation rate is invalid for the date of service reported. Please correct and refile. Use Electronic Network Services, when possible.

This form is continued on the reverse side.

M029		Verify if outpatient services were included in the inpatient charges for:_____
M030		Interim billing cannot be accepted. Please submit claim for member's complete admission.
M031		Provide the number of miles traveled for ambulance service.
M032		Provide most prevalent semi-private room rate for this patient.
M033		Other:_____
M034		Procedure code:_____ is inconsistent with the patient's diagnosis. Please correct and refile.
M035		Diagnosis/procedure code is inconsistent with the sex of the patient.
M036		_____ procedure code requires multiple dates of service.
M037		Provide Principle procedure code (institutional claims only).
M038		Please resubmit all lines from original claim on the corrected claim. If the correction is the omission of a service, please change the charge to $0.00. Please **do not** mark through the line to be omitted. Please **do not** highlight anything on the claim.
M039		If this provider will be rendering total OB care, please submit total OB claim at the time of delivery. If the patient has transferred to another physician, please resubmit the claim with supporting documentation.
M040		Please resubmit with correct Type of Bill. No record of original claim on file.

The following error(s) has (have) prevented your red and white claim from scanning into our system successfully.		
1		All dates must be eight digits in MMDDCCYY (month, day, century, and year) format. This includes birth date, dates of service and onset dates.
2		Your five-digit Blue Cross and Blue Shield of North Carolina assigned provider number must be in the lower right corner of field # 33b.
3		All scannable claims should be computer printed or typed. The ink should also be dark and easy to read.
4		Only six lines per CMS-1500 are acceptable. Do not list multiple lines in the same block.
5		Do not use a decimal point in the units field.
6		Other:_____

Professional and Institutional Mailback • PO Box 35 • Durham, North Carolina 27702-0035 • **1-919-489-7431**

Please send State Claims to:
P.O. Box 30025
Durham, North Carolina 27702-3025

Sample G291 - SHP Professional and Institutional Electronic Mailback

North Carolina State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan

PO Box 30025
Durham, North Carolina 27702-3025
1-800-422-4658

Patient Name:	Date(s) of Service:
Provider Name:	Patient Account Number:
Provider Address:	**Total Charges:**
City: State: Zip:	**Claim Number:**

Please make the necessary corrections to the claim and refile electronically.

M001		The member ID is not valid for this patient. ☐ Send copy of ID card. ☐ Verify member ID number and health insurance carrier. ☐ Alpha prefix missing or invalid. ☐ Re-file claim with the complete member ID number as shown on the card to the appropriate carrier.
M003		The provider number is missing/invalid for this date of service. ☐ Group ☐ Individual NPI discrepancy. Claim cannot be processed until resolved. Please contact your BCBSNC Network Management Field Office. ☐ Group ☐ Individual
M004		Provide dates of admission and discharge.
M009		Itemize charges, dates and include valid procedure/revenue codes for services rendered.
M010		Provide complete and specific diagnosis for each service rendered.
M016		CPT 99070/E1399 is a generic supply code. Provide valid HCPCS code or description of service/supply.
M018		Modifier 26 is inconsistent with the place of service.
M019		File PA charges with the appropriate modifier for surgical assistance with the surgeon's claims.
M020		Description of service is not consistent with the place of service.
M023		Our records indicate the provider rendering the services is not associated with the group. Contact Network Management to update your records.
M025		Refile with Medicare. According to our records, Medicare is the primary insurance carrier.
M028		Accommodation rate is invalid for the date of service reported. Correct and refile.
M029		Verify if outpatient services were included in the inpatient charges for: _____
M030		Interim billing cannot be accepted. Submit claim for member's complete admission.
M031		Provide the number of miles traveled for ambulance service.
M032		Provide most prevalent semi-private room rate for the facility.
M039		We have already considered a claim for: _____ If this is a corrected claim, resubmit all lines from original claim with correct type of bill.
M040		If this provider will be rendering total OB care, submit total OB care claim at the time of delivery. If the patient has transferred to another physician, resubmit a claim with supporting documentation verifying each date of service.
M043		Services span fiscal/calendar year. Separate the charges using _____ as the end date and _____ as the start date.
M044		Provide appropriate modifier for anesthesia services.
M046		File the claim with the patient's pharmacy benefits manager.
M047		You are reminded that all claims must be filed no later than December 31st of the calendar year following the one in which the covered care or service was performed. In order for these returned bills to be reconsidered for benefits, all required information must be included and they must be received no later than the December 31st deadline for filing claims or 90 days from the date of this letter, whichever is later.
M049		Other:

Name:	Department:	Date:

G291, 6/07

Sample G292 - SHP Professional and Institutional Paper Mailback

North Carolina State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan

PAPER Mailback
PO Box 30025 • Durham, North Carolina 27702-3025
1-800-422-4658

Patient Name:	Date(s) of Service:
Provider Name:	Patient Account Number:
Provider Address:	**Total Charges:**
City: State: Zip:	**Claim Number:**

Make the necessary changes and re-submit on a new red and white claim form.
Please update your systems if applicable to expedite future claims processing. Do not use red ink or highlight.
File electronically whenever possible.

M001		The member ID is not valid for this patient. ☐ Send Copy of ID card. ☐ Verify member ID number and health insurance carrier. ☐ Alpha prefix is missing or invalid. ☐ Re-file claim with the complete member ID number as shown on the card to the appropriate carrier.
M002		Provide the tax ID number.
M003		The provider number is missing/invalid for this date of service. ☐ Group ☐ Individual The NPI and associated provider number are an invalid match for this date of service. ☐ Group ☐ Individual The NPI has not been registered with BCBSNC. Please contact your BCBSNC Network Management Field Office. ☐ Group ☐ Individual NPI discrepancy, Claim cannot be processed until resolved. Please contact your BCBSNC Network Management Field Office. ☐ Group ☐ Individual
M004		Provide dates of admission and discharge.
M005		Provide onset date of symptoms.
M006		Accident diagnosis requires the date of injury.
M007		Provide specific dates for each service rendered.
M008		Verify patient information and give the missing data *(patient name, sex, or month, day and year of birth).*
M009		Itemize charges, dates and include valid procedure/revenue codes for services rendered.
M010		Provide complete and specific diagnosis for each service rendered.
M011		Provide valid number of ☐ units for _____ ☐ minutes for _____.
M012		Provide valid procedure/revenue code for each service.
M013		Error in total charge. Recompute bill.
M014		Facility charges must be filed on a UB claim form. Resubmit using the appropriate form. North Carolina providers should resubmit claims electronically when possible.
M015		Billed charges are inconsistent with the number of days filed. Recompute bill.
M016		CPT 99070/E1399 is a generic supply code. Provide valid HCPCS code or description of service/supply.
M017		Provide drug name, quantity, and NDC number for code _____.
M018		Modifier 26 is inconsistent with the place of service.
M019		File PA charges with the appropriate modifier for surgical assistance with the surgeon's claims.
M020		Description of service is not consistent with the place of service.
M021		The claim includes charges for services not yet rendered. Refile this claim after services have been performed.
M023		Our records indicate the provider rendering the services is not associated with the group. Contact Network Management to update your records.
M024		Professional charges must be filed on the CMS1500 claim form or the equivalent. Resubmit using the ☐ CMS1500 (12/90) or ☐ CMS1500 (08/05). North Carolina providers should resubmit claims electronically when possible.
M025		Refile with Medicare. According to our records, Medicare is the primary insurance carrier.
M026		Submit copy of Medicare EOB or indicate on the claim form if Medicare non-covered or exhausted.
M027		File all prescription drug claims to Medco Health Solutions, PO Box 2080, Lee's Summit, MO 64063.

G292, 6/07

M028		Accommodation rate is invalid for the date of service reported. Refile with the valid accomodation rate. North Carolina providers should resubmit claims electronically when possible.
M029		Verify if outpatient services were included in the inpatient charges for _____.
M030		Interim billing can not be accepted. Submit claim for member's complete admission.
M031		Provide the number of miles traveled for ambulance service.
M032		Provide most prevalent semi-private room rate for this facility.
M033		Provide 2 digit place of service code.
M034		☐ Procedure code: _____ or ☐ diagnosis code is inconsistent with patient's: ☐ Age ☐ Sex ☐ Diagnosis
M035		The attached EOMB does not indicate Medicare's payment determination. Re-submit claim with the appropriate EOMB.
M036		The attached EOMB does not match the claim. Re-submit the claim with the appropriate EOMB.
M037		_____ procedure code requires multiple dates of service.
M038		☐ Provide the ICD-9 procedure code and date for INPATIENT Facility Services. ☐ Provide the HCPCS procedure code and date for OUTPATIENT Facility Services.
M039		We have already considered a claim for _____. If this is a corrected claim, resubmit all lines from original claim with correct type of bill.
M040		If this provider will be rendering total OB care, submit total OB care claim at the time of delivery. If the patient has transferred to another physician, resubmit a claim with supporting documentation verifying each date of service.
M042		Update your records and submit your claim to the appropriate address: ☐ **Commercial & FEP Claims, PO Box 35, Durham, NC 27702** ☐ **State CMM Claims, PO Box 30025, Durham, NC 27702** ☐ **State PPO Claims, PO Box 30087, Durham, NC 27702**
M043		Services span fiscal/calendar year. Separate the charges using _____ as the end date and _____ as the start date.
M044		Provide appropriate modifier for anesthesia services.
M045		Complete attached form and submit to address provided.
M046		File the claim with the patient's pharmacy benefits manager.
M047		You are reminded that all claims must be filed no later than December 31st of the calendar year following the one in which the covered care or service was performed. In order for these returned bills to be reconsidered for benefits, all required information must be included and they must be received no later than the December 31st deadline for filing claims or 90 days from the date of this letter, whichever is later.
M048		Type of service is missing or invalid.
M049		Other:

Name:	Department:	Date:

Sample G252 - Refund of Overpayment Form

Provider Refund Return

Please complete this form when returning overpayments to Blue Cross and Blue Shield of North Carolina. This will help us properly identify and credit the correct certificate and will assist in reducing the return of funds to your office.

Thank you for your cooperation.

Subscriber Name: _____

Subscriber ID: (prefix) _____

Check One:

- ☐ Blue Cross and Blue Shield of NC plan
- ☐ Blue Cross and Blue Shield Service Benefit Plan (Federal Employee Program)
- ☐ North Carolina Teachers and State Employees' Health Plan
- ☐ Other Health Plan (Specify): _____

Patient Name: _____ Date(s) of Service: _____

Provider Name: _____ Provider Number: _____

If provider is outside of North Carolina, IRS Tax-ID Number: _____

Amount of Refund: _____

Please check reason(s) for Refund:

- ☐ Duplicate Payment (submit need both Blue Cross and Blue Shield of North Carolina vouchers)
- ☐ Worker's Compensation (give date of onset of injury/sickness): _____
- ☐ Medicare payment is primary (submit Medicare EOB)
- ☐ Other carrier paid primary (submit other carrier's EOB)
- ☐ Corrected claim/billed in error (submit copy of corrected claim)
- ☐ Filed under wrong patient (submit copy of corrected claim)
- ☐ Incorrect date of service (submit corrected claim)
- ☐ Medicare adjusted payment (submit EOB)
- ☐ Other carrier adjusted payment (submit EOB)
- ☐ Not our patient

Please include the applicable BCBSNC Explanation of Payment or Notification of Payment with this form.

Other Comments: _____

_____

_____

Return to:
Financial Processing Services
Blue Cross and Blue Shield of North Carolina
PO Box 30048
Durham, NC 2770-3048

Contact Person: _____

Phone Number: _____

Sample G293 - Inter-Plan Programs Par/Host Plan

INTER-PLAN PROGRAMS PAR / HOST PLAN

Please use this form as a checklist to insure that you are submitting the information necessary to support a returned claim payment *(refund)* for an out-of-area member's claim. Providing this information will allow BCBSNC to more effectively represent your interest when communicating with the patient's Home Plan.

1. Break down of the refund per claim

2. Provide the Explanation of Benefits (EOB) documentation for all insurance carriers associated with the claim. Insure that the EOB documentation details the following items:
   - ☐ a. Provider's name _____
   - ☐ b. Provider's BCBSNC ID number _____
   - ☐ c. Policy Holder's full name _____
   - ☐ d. Policy Holder's ID *(include prefix and number)* _____
   - ☐ e. Patient's full name _____
   - ☐ f. Patient's date of birth _____
   - ☐ g. Date of Service _____
   - ☐ h. Amount of charge for the original claim _____
   - ☐ i. Amount paid for the original claim _____
   - ☐ j. Date of payment for the original claim _____
   - ☐ k. Amount being returned against the original charge _____

3. Specific reason for the refund
   - ☐ a. Duplicate Payment *(requires both BCBSNC vouchers)*
   - ☐ b. Worker's Compensation *(provide the date of the onset)* _____
   - ☐ c. Medicare payment is primary *(requires EOB)*
   - ☐ d. Other carrier paid primary *(requires EOB)*
   - ☐ e. Corrected claim / billed in error *(need a copy of the claim)*
   - ☐ f. Filed under wrong patient *(requires a copy of the claim)*
   - ☐ g. Incorrect date of service *(requires a corrected claim)*
   - ☐ h. Medicare adjusted payment *(requires EOB)*
   - ☐ i. Other carrier adjusted payment *(requires EOB)*
   - ☐ j. Not our patient

Please return the check and all attached information to:

Blue Cross Blue Shield of North Carolina
ATTN: Cashiers Department
PO Box 30048
Durham, NC 27702-3048

4. Provide Corrected Claim Form *(if necessary)*

5. If this is a rebuttal to a payment issue previously raised to BCBSNC, please attach a copy of the information described above, as well as a copy of the BCBSNC check voucher to the check.

6. Provide the following support documentation *(if available)*
   - ☐ a. Original Claim Number or Copy of the Original Claim
   - ☐ b. Original Notification of Payment (NOP)

Again as the Host Plan, BCBSNC requests that you submit one check per claim. Organizing this information in this manner will allow BCBSNC to affectively represent you the provider as we engage the Home Plan or National Account to resolve payment contention issues for which they were originally held responsible for.

Thank you in advance for providing the necessary information and attaching it to the check to be sent to BCBSNC.

G293, 8/06

Sample S115 – Coordination of Benefits Questionnaire (Inter-Plan Program)

Coordination of Benefits Questionnaire

BlueCross BlueShield of North Carolina

Your Blue Cross Blue Shield contract may contain a Coordination of Benefits (COB) provision. We depend upon your help in order for us to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact the policyholder's Blue Cross Blue Shield plan immediately.

Please send this completed form to the BCBS Plan that you are a member of.
You can call the customer service phone number on your membership ID card to get the address.

BCBS Policyholder Name

BCBS Group Number | BCBS Member ID Number

Section **A** | **Other Insurance** *If this does not apply, skip to Section B.*

Are you or any other member of this Blue Cross Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross Blue Shield policy or Medicare?

☐ **No** If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

☐ **Yes** If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply: ☐ Other Health Insurance ☐ Other Dental Insurance

What type of policy is this? ☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name

Address

City | State | Zip | Phone Number

Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name | Policyholder's Date of Birth (/ /) | ID Number

Effective Date of Other Insurance (/ /) | If Cancelled, Cancellation Date (/ /)

Is the policyholder: ☐ Actively working for the group ☐ Inactive

☐ Retired, retirement date: (/ /) ☐ On COBRA, which began: (/ /)

Policyholder's Employer

Address

City | State | Zip | Phone Number

S115

Sample ENROLL1 – Enrollment and Change Application

ENROLLMENT AND CHANGE APPLICATION *with health questions*

☐ **CHANGE REQUEST:**
*For changes, complete sections **A**, **B**, and all other applicable sections*

Instructions: ALL new Employees Complete **B**, **C**, **D**, **E**, **F**, **H**
If your group has selected any Life Products also complete and provide your signature in **G**

COMPLETED BY GROUP ADMINISTRATOR ONLY	
Effective Date	MM DD YYYY
Group Number	
Package Number	
Dept/Division/Class	

Please type or print in black or blue, NOT RED ink

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

Check All That Apply:
- ☐ Name Change
- ☐ Open Enrollment
- ☐ Address Change
- ☐ Other Insurance Information
- ☐ Telephone Change
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ E-Mail Address
- ☐ Other _____

Add Dependent(s): (Date of Occurrence)
- ☐ Marriage MM DD YYYY
- ☐ Newborn MM DD YYYY
- ☐ Adoption MM DD YYYY
- ☐ Other _____ MM DD YYYY

Remove Dependent(s): (Date of Occurrence)
- ☐ Marriage MM DD YYYY
- ☐ Divorce MM DD YYYY
- ☐ Student Status MM DD YYYY
- ☐ Death MM DD YYYY
- ☐ Other _____ MM DD YYYY

Reinstate Coverage:
Reason: _____

Cancel Coverage: (Date)
- ☐ Not Eligible MM DD YYYY
- ☐ Left Employment MM DD YYYY
- ☐ Subscriber Request MM DD YYYY
- ☐ Other

Reason: _____

B. EMPLOYEE INFORMATION

☐ ACTIVE EMPLOYEE ☐ COBRA/STATE CONTINUATION:

COBRA/State Continuation Qualifying Event: ☐ Termination of Employment ☐ Reduction in Hours ☐ Death of Subscriber ☐ Divorce ☐ Over Age Dependent ☐ Medicare Eligible

What was the date of the Qualifying Event? MM DD YYYY
Date Continuation Started MM DD YYYY
Date Continuation Ends MM DD YYYY

First Name	Middle Initial	Last Name	Suffix

Employee Social Security Number | Employee Birthdate MM DD YYYY

Address	Apt. No.	City	State	Zip Code

☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | Height | Weight

Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.)
☐ African American/Black ☐ Asian/Asian American ☐ Choose not to report
☐ White/Caucasian ☐ Hispanic/Latino ☐ Native American/Alaskan Native ☐ Other (specify)_____

Company Name | Occupation

Work Location | Date of Full Time Employment MM DD YYYY | Language Preference ☐ Spanish ☐ English ☐ Other _____

Work Phone Number ( ) | Home Phone Number ( )

Your E-Mail Address (optional)

ENROLL1, 11/06

Application Continued on Next Page ⟶

Employee Name:

C. COVERAGE SELECTION – Complete for BCBSNC Health and Dental

Coverage (Check only one medical plan):	☐ Blue Care® (HMO) ☐ Blue Options℠ (PPO)	☐ Classic Blue® (CMM) ☐ Blue Options HSA℠	☐ Dental Blue
☐ **MEDICAL BENEFITS SELECTED:**	☐ Employee Only ☐ Employee and Child(ren)	☐ Employee and Spouse ☐ Employee and Family	☐ No Medical Benefits
☐ **DENTAL BENEFITS SELECTED:**	☐ Employee Only ☐ Employee and Child(ren)	☐ Employee and Spouse ☐ Employee and Family	☐ No Dental Benefits

D. FAMILY INFORMATION – Complete for Anyone Taking Medical and/or Dental Coverage

- List family members taking medical or dental.
- Student status and handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents.

NAME First, Middle Initial, Last, Suffix	Social Security Number	Marital Status	Birthdate	Sex	HEIGHT	WEIGHT	HEALTH	DENTAL	If Child Is Over Age 19, Please Indicate Status And School Name	Child Status (if applicable)
Spouse		☐ Single ☐ Married	mm/dd/yyyy	☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N		
Child 1		☐ Single ☐ Married	mm/dd/yyyy	☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N	☐ Handicapped ☐ Full-Time Student At:_____	☐ Foster ☐ Adopted
Child 2		☐ Single ☐ Married	mm/dd/yyyy	☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N	☐ Handicapped ☐ Full-Time Student At:_____	☐ Foster ☐ Adopted
Child 3		☐ Single ☐ Married	mm/dd/yyyy	☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N	☐ Handicapped ☐ Full-Time Student At:_____	☐ Foster ☐ Adopted

*If you have more than three children, complete **Section D** on another application.

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION

E1. PRIOR HEALTH INSURANCE

*This section **MUST** be completed to receive credit for prior coverage and **REDUCE** or **ELIMINATE** any applicable waiting period.*

Have you had any health insurance within the last sixty-three (63) days? ☐ Yes ☐ No **If YES, complete the following:**

Name of Health Insurance Company	Address	
Phone Number ( )	Policy Number	Policyholder Date of Birth MM DD YYYY
Policyholder First Name	Policyholder Last Name	
If other coverage will remain in effect, write N/A in term box and complete section below.	Effective Date MM DD YYYY	Termination Date or Expected Termination Date MM DD YYYY

Family Members Covered **List FIRST and LAST Names:**

Have you or any family dependents been a previous Blue Cross and Blue Shield of North Carolina member? ☐ Yes ☐ No

Names, Dates and ID Numbers

Notice About Your Pre-Existing Condition Limitations

This plan imposes a pre-existing condition exclusion for all employees and dependents whether they are timely or late enrollees. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days of birth, adoption, or placement for adoption or foster care. Eligible children (newborns, adoptive children, foster children, and those added as a result of a court order) are not subject to this exclusion period when enrolled more than 30 days after one of the events listed above if your coverage type or the premiums owed are not affected by adding the child. When applicable, this exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage".

Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not

Application Continued on Next Page →

Employee Name:

experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give BCBSNC a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, BCBSNC will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact BCBSNC if you need help demonstrating creditable coverage. Throughout this notice, all references to "you" are meant to refer to both the employee and their dependents.

Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "30 days" or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption or foster care.

For questions or to obtain more information, contact a BCBSNC Customer Service Representative at:

Blue Cross and Blue Shield of North Carolina Customer Service
1-877-258-3334

E2. OTHER HEALTH INSURANCE

*This section **MUST** be completed if you will have additional insurance in force during this new policy.*

Will you or your covered dependents have other insurance in addition to this policy? ☐ Yes ☐ No

Are any dependents covered under another plan due to divorce/separation? ☐ Yes ☐ No **If YES to either question, complete the following:**

Name of Health Insurance Company	Policyholder First Name	Middle Initial	Last Name

Policy Number	Policyholder Date of Birth	If Individual coverage CHECK HERE ☐
	MM DD YYYY	

Effective Dates of Coverage: **FROM:** MM DD YYYY **TO:** MM DD YYYY

Individuals Covered (List FIRST and LAST names):

Family Members Covered by Medicare (List FIRST and LAST names):

Medicare Claim Number	Is Medicare Eligibility Due to:	**Part A** Effective Date:	**Part B** Effective Date:
	☐ Renal Disease ☐ Disability ☐ Age	MM DD YYYY	MM DD YYYY

F. HEALTH QUESTIONS

All questions in this Section (Section F) MUST be answered in their entirety. Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information. Please use "Month/Day/Year" where required.

PLEASE NOTE: "Section F.2" information is required for all disorders with a "YES" answer.

Has any person applying for coverage sought medical attention and/or advice, been diagnosed with or been treated for any of the following diseases or disorders (this includes diseases or disorders past and present):

DISORDER	YES	NO
1. Heart attack, angina, angioplasty, stent placement, bypass surgery, coronary artery disease or congestive heart failure?	☐	☐
2. An irregular heart rhythm that requires treatment?	☐	☐
3. Hypertension or high blood pressure?	☐	☐
a. How many times a year do you contact or visit your doctor to get a prescription for your hypertension, either to renew your current prescription or get a different or additional prescription to treat your hypertension? _____		
4. Emphysema, chronic bronchitis or chronic obstructive pulmonary disorder (COPD)?	☐	☐
a. Any use of oxygen?	☐	☐
b. Any inpatient treatment at a hospital for any of the above conditions?	☐	☐
5. Elevated cholesterol treated with medication within the last 12 months?	☐	☐
6. Inpatient or outpatient treatment at a hospital for asthma within the past 24 months?	☐	☐
7. a. Hepatitis A?	☐	☐
b. Hepatitis B?	☐	☐
c. Hepatitis C?	☐	☐
d. Hepatitis D?	☐	☐
8. Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, Parkinson's disease, Alzheimer's disease?	☐	☐

DISORDER	YES	NO
9. Chronic fatigue, chronic fibromyalgia, Epstein Barr and/or chronic lyme disease?	☐	☐
10. a. Depression?	☐	☐
b. Anxiety/stress?	☐	☐
c. Chemical imbalance?	☐	☐
d. Obsessive compulsive disorder?	☐	☐
e. Bipolar disorder?	☐	☐
f. Suicidal thoughts?	☐	☐
11. Brain damage, paralysis, stroke, Transient Ischemic Attack (TIA) or Hydrocephalus?	☐	☐
12. Kidney stones or renal colic within the past 36 months?	☐	☐
13. Do you have gall bladder disease or gall stones and STILL have your gallbladder?	☐	☐
14. Cirrhosis of the liver?	☐	☐
15. a. Colitis?	☐	☐
b. Crohn's disease?	☐	☐
c. Irritable bowel syndrome?	☐	☐
d. Inflammatory bowel disease?	☐	☐
e. Familial polyposis?	☐	☐
16. Osteoarthritis in the hips or knees?	☐	☐

Application Continued on Next Page →

Employee Name:

DISORDER	YES	NO
17. Joint replacement, or recommended joint replacement?	☐	☐
a. Primary - Date of surgery: MM DD YYYY		
b. Spouse - Date of surgery: MM DD YYYY		
18. Arthritis, such as inflammatory arthritis, rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis?	☐	☐
19. Diabetes?	☐	☐
a. Primary - Date of diagnosis: MM DD YYYY		
b. Spouse - Date of diagnosis: MM DD YYYY		
c. What is your most recent hemoglobin A1C (HGBA1C) reading taken by your doctor?		
Primary: _____ Spouse: _____		
20. Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
21. Within the last 5 years has anyone been diagnosed with cancer or had cancer surgery, radiation therapy or chemotherapy for:		
a. Cancer/malignancy, including melanoma?	☐	☐
b. Other forms of skin cancer?	☐	☐
22. Prostate disorders, including enlarged prostate, benign prostatic hypertrophy or elevated readings?	☐	☐
23. Bleeding disorder, such as Hemophilia or Von Willebrand's?	☐	☐
24. Sickle cell anemia, aplastic anemia or thalassemia major?	☐	☐
25. Moderate or severe psoriasis?	☐	☐
26. Sleep apnea?	☐	☐
27. Epilepsy or seizure disorder?	☐	☐
a. If yes, was the most recent seizure within the last 3 months?	☐	☐
28. Has anyone who is less than 12 years of age had more than 3 ear infections in the last year?	☐	☐
29. Has anyone ever had the following procedures or treatments performed:		
a. Spinal fusion?	☐	☐
b. Gastric bypass or gastric restrictive procedures, such as lap band?	☐	☐
c. Heart valve replacement?	☐	☐
d. Currently in treatment/therapy for ligament or tendon repair of knee or shoulder?	☐	☐
e. Cerebral shunt placement?	☐	☐
f. Permanent colostomy/ileostomy?	☐	☐
g. Surgery related to gastro esophageal reflux disorder (GERD)?	☐	☐
h. Any internal organ transplant?	☐	☐
i. Kidney dialysis?	☐	☐
j. Any past surgical procedure resulting in complications that still require treatment?	☐	☐
30. Has anyone been advised or scheduled to have surgery within the next 6 months?	☐	☐
31. Within the last 12 months, has anyone seen an allergist or received an immuno-therapy injection?	☐	☐
32. Has anyone been treated within the last 2 years for an eating disorder?	☐	☐
33. Has anyone seen a chiropractor or physical therapist more than 5 times in the last 12 months?	☐	☐
a. Primary - Date of your last visit: MM DD YYYY		
b. Spouse - Date of your last visit: MM DD YYYY		
34. Has anyone had any treatment in the last year for disc disorder of back or neck including surgery or injection therapy other than chiropractic care or physical therapy?	☐	☐
35. More than 2 breast biopsies in the last 5 years?	☐	☐
36. Within the past 12 months, has anyone had any treatment for heavy, frequent, AND prolonged periods; uterine fibroids; or endometriosis; but have NOT had total abdominal hysterectomy (TAH)?	☐	☐
37. Have either of your last two pap smears been abnormal?	☐	☐

DISORDER	YES	NO
38. Does anyone exercise for at least 20 minutes per day 3 or more times per week?	☐	☐
39. Within the last 12 months, has anyone smoked cigarettes, marijuana, cigars, pipes or used chewing tobacco or snuff?	☐	☐
40. Has anyone applying for coverage on this application been prescribed or advised to use or taken any of the following categories of prescription medications within the last 12 months?		
a. Anti-depressant?	☐	☐
b. Anti-psychotic?	☐	☐
c. Anti-anxiety?	☐	☐
d. Attention deficit (ADD) or attention deficit hyperactivity (ADHD) medication?	☐	☐
e. Antabuse or other medications used in the treatment of alcoholism?	☐	☐
f. Migraine medication?	☐	☐
g. Tracleer?	☐	☐
h. Blood thinner/anti-coagulant medication?	☐	☐
i. Nitroglycerin, Digoxin or Lanoxin?	☐	☐
j. Immunosuppressive medication, such as, Methotrexate, Imuran, Cytoxan?	☐	☐
k. Oral steroids taken or prescribed for use every day all year, or oral steroids or steroid injections taken for an ongoing condition requiring usage at least 3 times a year?	☐	☐
l. Plaquenil/Hydroxycholoroquine?	☐	☐
m. Growth hormones such as: Humotrope, Genotropin, Nutropin, Norditropin?	☐	☐
n. Gastrointestinal medication, such as Nexium?	☐	☐
o. Injection medication for rheumatoid arthritis, psoriasis, inflammatory bowel disease, ulcerative colitis or Crohn's Disease such as Arava?	☐	☐
p. Remicade?	☐	☐
q. Enbrel?	☐	☐
r. Infertility medication?	☐	☐
s. Pancreatic enzymes used in the treatment of Cystic Fibrosis, such as, Creon, Pancrease, Ultrase, Lipram?	☐	☐
t. Synagis?	☐	☐
We need to know only about medications that are specified in Question 40. Please do not list any other medications.		
41. Does anyone have a physical or mental impairment that substantially limits one or more major life activities: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working?	☐	☐
Describe each such physical or mental impairment and identify the person with such physical or mental impairment: _____		
Please describe how the physical or mental impairment substantially limits one or more of the major life activities stated previously: _____		
If yes, is the physical or mental impairment temporary or correctable?	☐	☐
If yes, please explain how the physical or mental impairments are temporary or how the person plans to have it corrected: _____		
42. Is anyone aware of any symptoms or conditions that have not yet been diagnosed by a doctor?	☐	☐
If yes, list them: _____		
43. Does anyone have any other conditions or symptoms for which no question was provided?	☐	☐
If yes, list them: _____		

Application Continued on Next Page →

Employee Name:

F2. For each item checked "YES" in the previous Section, please provide condition or diagnosis for each person.

	Person #1 Name:	Person #2 Name:	Person #3 Name:
Condition or Diagnosis:			

If additional space is needed, please attach a separate sheet, with your signature and the date (mm/dd/yyyy).

G. COVERAGE SELECTION Underwritten by USAble Life (if offered by employer)

Coverage Selection:

Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

Life/AD&D ☐ Yes ☐ No

Dependent Life ☐ Yes ☐ No

Weekly Disability ☐ Yes ☐ No

Long Term Disability ☐ Yes ☐ No

Supplemental Life/AD&D ☐ Yes ☐ No **Amount:** _____

☐ **No Benefits Selected**

Employee's Annual Salary

Primary Beneficiary Name **(required)**		Primary Beneficiary Address **(required)**		
Relationship	Date of Birth MM DD YYYY	Social Security Number		Percent[1]
Contingent Beneficiary Name **(required)**		Contingent Beneficiary Address **(required)**		
Relationship	Date of Birth MM DD YYYY	Social Security Number		Percent[1]

[1] NOTE: the primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I selected any of the products listed in this section that I will be covered by USAble Life.
- I understand that if I am not actively at work as defined in the policy(ies) (for the products selected above) on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

X Signature: _____ Date MM DD YYYY

H. STATEMENT OF UNDERSTANDING

I understand that the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina and/or the life insurance carrier contract and any changes provided for therein.

I understand that BCBSNC and/or the life insurance carrier may, within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, BCBSNC may take legal action at any time.

BLUE OPTIONS HSA PLANS ONLY:

I understand that if I am applying for Blue Options HSA, the HSA is provided to me directly by a separate administrator, unaffiliated with Blue Cross and Blue Shield of North Carolina (BCBSNC). BCBSNC is not responsible or liable for administration of the HSA. Detailed information regarding my HSA will be provided by that administrator. I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.

I understand that if my employer chooses select administrators for my HSA, my employer or their designees will share certain personal information about me with such administrators to facilitate the administrator's establishment of the HSA account. By signing this application, I authorize my employer or their designees to share pertinent information with these select administrators as applicable, which may include my name, address, social security number and my employer's name.

I understand that if issued a debit card in connection with my HSA, I agree that although BCBSNC's name and marks may be included on the face of the debit card for convenience, BCBSNC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.

I understand that BCBSNC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my BCBSNC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.

I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.

X Signature: _____ Date MM DD YYYY

ENROLL1, 11/06

Application Continued on Next Page →

Employee Name:

I. STATEMENT OF AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that if I refuse to sign this authorization that BCBSNC may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

(i) my past, present, or future physical or mental health or condition;

(ii) the provision of health care to me; or

(iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to Blue Cross and Blue Shield of North Carolina ("BCBSNC").

I further authorize BCBSNC to review any applications for health care coverage that I may have submitted to BCBSNC in the past.

I authorize BCBSNC to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that BCBSNC will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that BCBSNC will make every effort to safeguard my protected health information. I further understand that BCBSNC will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require BCBSNC to disclose my protected health information. I understand that BCBSNC may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

Rating
Blue Cross and Blue Shield of North Carolina
P.O. Box 30013
Durham, NC 27702

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

(i) for information that BCBSNC already used or disclosed, relying on this authorization or

(ii) if the authorization was obtained as a condition of coverage in BCBSNC and, by law, BCBSNC has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below. After 120 days expire, BCBSNC may no longer use this information.

Signature of Primary Applicant or Legal Personal Representative: X _____ Date MM DD YYYY

Name of Legal Personal Representative (please print): _____

Description of Legal Personal Representative's Authority: _____

ENROLL1, 11/06

Sample ENROLL2 – Enrollment and Change Application

ENROLLMENT AND CHANGE APPLICATION

☐ **CHANGE REQUEST:**
*For changes, complete sections **A**, **B**, and all other applicable sections*

Instructions: ALL new Employees Complete **B**, **C**, **D**, **E**, **G**
If your group has selected any Life Products also complete and provide your signature in **F**

Please type or print in black or blue, NOT RED ink

COMPLETED BY GROUP ADMINISTRATOR ONLY	
Effective Date	MM DD YYYY
Group Number	
Package Number	
Dept/Division/Class	

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

Check All That Apply:

- ☐ Name Change
- ☐ Open Enrollment
- ☐ Address Change
- ☐ Other Insurance Information
- ☐ Telephone Change
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ E-Mail Address
- ☐ Other _____

Add Dependent(s):

	Date of Occurrence
☐ Marriage	MM DD YYYY
☐ Newborn	MM DD YYYY
☐ Adoption	MM DD YYYY
☐ Other	MM DD YYYY

Remove Dependent(s):

	Date of Occurrence
☐ Marriage	MM DD YYYY
☐ Divorce	MM DD YYYY
☐ Student Status	MM DD YYYY
☐ Death	MM DD YYYY
☐ Other _____	MM DD YYYY

Reinstate Coverage:

Reason: _____

Cancel Coverage:

	Date
☐ Not Eligible	MM DD YYYY
☐ Left Employment	MM DD YYYY
☐ Subscriber Request	MM DD YYYY
☐ Other	

Reason: _____

B. EMPLOYEE INFORMATION

☐ ACTIVE EMPLOYEE ☐ COBRA/STATE CONTINUATION:

COBRA/State Continuation Qualifying Event: ☐ Termination of Employment ☐ Reduction in Hours ☐ Death of Subscriber ☐ Divorce ☐ Over Age Dependent ☐ Medicare Eligible

What was the date of the Qualifying Event? MM DD YYYY | Date Continuation Started MM DD YYYY | Date Continuation Ends MM DD YYYY

First Name	Middle Initial	Last Name	Suffix

Employee Social Security Number	Employee Birthdate
	MM DD YYYY

Address	Apt. No.	City	State	Zip Code

☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | Height | Weight

ENROLL2, 11/06

Application Continued on Next Page ⟶

Employee Name:

Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.)

☐ African American/Black ☐ Choose not to report ☐ Other (specify) _____
☐ White/Caucasian ☐ Hispanic/Latino
☐ Asian/Asian American ☐ Native American/Alaskan Native

Company Name	Occupation

Work Location	Date of Full Time Employment	Language Preference
	MM DD YYYY	☐ Spanish ☐ Other ☐ English

Work Phone Number	Home Phone Number	Your E-Mail Address (optional)
( )	( )	

C. COVERAGE SELECTION – Complete for BCBSNC Health and Dental

Coverage (Check only one medical plan):

☐ Blue Care® (HMO)	☐ Blue Options HSA℠/HRA℠	☐ Blue Options (PPO)
☐ Classic Blue® (CMM)	☐ High Plan	☐ High Plan
☐ Dental Blue	☐ Low Plan	☐ Low Plan

☐ **MEDICAL BENEFITS SELECTED:** ☐ Employee Only ☐ Employee and Spouse ☐ No Medical Benefits ☐ Employee and Child(ren) ☐ Employee and Family

☐ **DENTAL BENEFITS SELECTED:** ☐ Employee Only ☐ Employee and Spouse ☐ No Dental Benefits ☐ Employee and Child(ren) ☐ Employee and Family

D. FAMILY INFORMATION – Complete for Anyone Taking Medical and/or Dental Coverage

- List family members taking medical or dental.
- Student status and handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents.

NAME First, Middle Initial, Last, Suffix	Social Security Number	Marital Status	Birthdate	Sex	HEALTH	DENTAL	If Child Is Over Age 19, Please Indicate Status And School Name	Child Status (if applicable)
Spouse		☐ Single ☐ Married	mm/dd/yyyy	☐ Male ☐ Female	☐ Y ☐ N	☐ Y ☐ N		
Domestic Partner (if available)			mm/dd/yyyy	☐ Male ☐ Female	☐ Y ☐ N	☐ Y ☐ N		
Child 1		☐ Single ☐ Married	mm/dd/yyyy	☐ Male ☐ Female	☐ Y ☐ N	☐ Y ☐ N	☐ Handicapped ☐ Full-Time Student At:_____	☐ Foster ☐ Adopted
Child 2		☐ Single ☐ Married	mm/dd/yyyy	☐ Male ☐ Female	☐ Y ☐ N	☐ Y ☐ N	☐ Handicapped ☐ Full-Time Student At:_____	☐ Foster ☐ Adopted
Child 3		☐ Single ☐ Married	mm/dd/yyyy	☐ Male ☐ Female	☐ Y ☐ N	☐ Y ☐ N	☐ Handicapped ☐ Full-Time Student At:_____	☐ Foster ☐ Adopted

*If you have more than three children, complete **Section D** on another application.

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION

E1. PRIOR HEALTH INSURANCE

*This section **MUST** be completed to receive credit for prior coverage and **REDUCE** or **ELIMINATE** any applicable waiting period.*

Have you had any health insurance within the last sixty-three (63) days? ☐ Yes ☐ No

If YES, complete the following:

Name of Health Insurance Company	Address

Employee Name:

Phone Number ( )	Policy Number	Policyholder Date of Birth MM DD YYYY
Policyholder First Name	Policyholder Last Name	
If other coverage will remain in effect, write N/A in term box and complete section below.	Effective Date MM DD YYYY	Termination Date or Expected Termination Date MM DD YYYY

Family Members Covered **List FIRST and LAST Names:**

Have you or any family dependents been a previous Blue Cross and Blue Shield of North Carolina member?..... ☐ Yes ☐ No

Names, Dates and ID Numbers

E2. OTHER HEALTH INSURANCE

*This section **MUST** be completed if you will have additional insurance in force during this new policy.*

Will you or your covered dependents have other insurance in addition to this policy? ☐ Yes ☐ No

Are any dependents covered under another plan due to divorce/separation? ☐ Yes ☐ No

If YES to either question, complete the following:

Name of Health Insurance Company	Policyholder First Name	Middle Initial	Last Name
Policy Number	Policyholder Date of Birth MM DD YYYY	If Individual coverage CHECK HERE ☐	

Effective Dates of Coverage: **FROM:** MM DD YYYY **TO:** MM DD YYYY

Individuals Covered (List FIRST and LAST names):

Family Members Covered by Medicare (List FIRST and LAST names):

Medicare Claim Number	Is Medicare Eligibility Due to: ☐ Renal Disease ☐ Disability ☐ Age	**Part A** Effective Date: MM DD YYYY	**Part B** Effective Date: MM DD YYYY

F. COVERAGE SELECTION Underwritten by ■ Fort Dearborn Life Insurance Company ■ USAble Life (if offered by employer)

Coverage Selection:

Your non-medical group insurance program may not include all the benefits listed below. These benefits may be underwritten by Fort Dearborn Life Insurance Company or USAble Life. Ask your employer for the details about these carriers, the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

Life/AD&D ..... ☐ **Yes** ☐ **No**

Dependent Life..... ☐ **Yes** ☐ **No**

Weekly Disability..... ☐ **Yes** ☐ **No**

Long Term Disability..... ☐ **Yes** ☐ **No**

Supplemental Life/AD&D ..... ☐ **Yes** ☐ **No** **Amount:** _____

☐ **No Benefits Selected**

ENROLL2, 11/06

Application Continued on Next Page ⟶

Employee Name:

Employee's Annual Salary			
Primary Beneficiary Name **(required)**	Primary Beneficiary Address **(required)**		
Relationship	Date of Birth MM DD YYYY	Social Security Number	Percent[1]
Contingent Beneficiary Name **(required)**	Contingent Beneficiary Address **(required)**		
Relationship	Date of Birth MM DD YYYY	Social Security Number	Percent[1]

[1] NOTE: the primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I select any of the products listed above that I will be covered by Fort Dearborn Life Insurance Company or USAble at the discretion of the employer group (as indicated above).
- I understand that if I am not actively at work as defined in the policy(ies) (for the products selected above) on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

X Signature: _____ Date MM DD YYYY

G. STATEMENT OF UNDERSTANDING

I understand that the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina and/or the life insurance carrier contract and any changes provided for therein. I understand that BCBSNC and/or the life insurance carrier may, within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, BCBSNC may take legal action at any time.

BLUE OPTIONS HSA/HRA PLANS ONLY:

I understand that if I am applying for Blue Options HSA or Blue Options HRA, the HSA/HRA is provided to me directly by a separate administrator, unaffiliated with Blue Cross and Blue Shield of North Carolina (BCBSNC). BCBSNC is not responsible or liable for administration of the HSA/HRA. Detailed information regarding my HSA/HRA will be provided by that administrator. I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.

I understand that if my employer chooses select administrators for my HSA/HRA, my employer or their designees will share certain personal information about me with such administrators to facilitate the administrator's establishment of the HSA/HRA account. By signing this application, I authorize my employer or their designees to share pertinent information with these select administrators as applicable, which may include my name, address, social security number and my employer's name.

I understand that if issued a debit card in connection with my HSA/HRA, I agree that although BCBSNC's name and marks may be included on the face of the debit card for convenience, BCBSNC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.

HSA ONLY: If I am applying for Blue Options HSA, I understand that BCBSNC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my BCBSNC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.

I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.

X Signature: _____ Date MM DD YYYY

ENROLL2, 11/06

Sample ECR270 - EDI Services Batch Connectivity Request

EDI SERVICES BATCH CONNECTIVITY REQUEST

270/271 - Eligibility Inquiry / 276/277 - Claim Status Inquiry / 278 Authorization

Please complete the following information and fax the form to **EDI Services, (919) 765-7101**. A Connectivity Request form is required for each provider.

PROVIDER NAME		BCBSNC PROVIDER NUMBER
CONTACT NAME	TITLE	
MAIL ADDRESS	CITY / STATE / ZIP CODE	
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

VENDOR / CLEARINGHOUSE NAME	CONTACT NAME	TITLE
MAIL ADDRESS	CITY / STATE / ZIP CODE	
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

BILLING SERVICE NAME	CONTACT NAME	TITLE
MAIL ADDRESS	CITY / STATE / ZIP CODE	
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

Are you changing vendor/clearinghouse or billing service? ☐ Yes ☐ No **If so,** effective date of change:_____ /_____ /_____

Type of Transaction *(enter Effective Date and X12 Version for each applicable transaction)*		
Transaction Type	**Effective Date**	**X12 Version**
270/271 Eligibility Inquiry		
276/277 Claim Status Inquiry		
278 Authorization		

Type of Sender *(select one)*: ☐ Provider ☐ Clearinghouse ☐ Billing Service

ISA05 Interchange Sender ID Qualifier*:_____ ISA06 Interchange Sender ID*:_____

**As a business practice, BCBSNC defines the Sender ID Qualifier to be "30" and the Sender ID to be the "Federal Tax ID"*

Mode of Connectivity *(select one)*	**Complete for Asynchronous Connectivity Mode**	
☐ Async *(X, Y or Z Modem/Kermit)*	BAUD RATE	
☐ Secure FTP *(via Internet)*	COMMUNICATION PROTOCOL	PASSWORD *(8 CHARACTERS)*

X _____ **AUTHORIZED SIGNATURE OF PROVIDER**

_____ **PRINT NAME / TITLE OF AUTHORIZED SIGNER**

_____ **DATE OF AUTHORIZATION**

ECR270, 7/04

Sample ECR835 - EDI Services Batch Connectivity Request

EDI SERVICES BATCH CONNECTIVITY REQUEST

835 - PAYMENT/REMITTANCE ADVICE

Blue Cross and Blue Shield of North Carolina (BCBSNC) Remittance Advice will be sent for payments on: New Blue, PCP, PPO, Med*Point*, State Health Plan, FEP, NASCO, BlueCard and Traditional Blue Cross and Blue Shield Plans.

Please complete the following information and fax the form to **EDI Services, (919) 765-7101**. A Connectivity Request form is required for each provider.

PROVIDER NAME		BCBSNC PROVIDER NUMBER	
CONTACT NAME		TITLE	
MAIL ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	

VENDOR / CLEARINGHOUSE NAME		CONTACT NAME	TITLE
MAIL ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	

BILLING SERVICE NAME		CONTACT NAME	TITLE
MAIL ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	

Are you changing vendor/clearinghouse or billing service? ☐ Yes ☐ No **If so,** effective date of change:_____ /_____ /_____

Type of Receiver *(select one)*: ☐ Provider ☐ Clearinghouse ☐ Billing Service

ISA07 Interchange Receiver ID Qualifier*:_____ ISA08 Interchange Receiver ID*:_____

**As a business practice, BCBSNC defines the Receiver ID Qualifier to be "30" and the Receiver ID to be the "Federal Tax ID"*

X12 Version:

Mode of Connectivity *(select one)*

☐ Secure FTP *(via Internet)* ☐ Async *(X, Y, or Z modem/Kermit)* ☐ RealMed

Complete for Connectivity Selected *(not applicable for IBM Info Exchange or Other)*

BAUD RATE	
COMMUNICATION PROTOCOL	PASSWORD *(8 CHARACTERS)*

X _____ _____

AUTHORIZED SIGNATURE OF PROVIDER **DATE OF AUTHORIZATION**

_____

PRINT NAME / TITLE OF AUTHORIZED SIGNER

Sample ECR837 - EDI Services Batch Connectivity Request

EDI SERVICES BATCH CONNECTIVITY REQUEST

837 - Claim / Encounter

Blue Cross and Blue Shield of North Carolina (BCBSNC) accepts the following claims electronically: New Blue, PCP, PPO, Med*Point*, State Health Plan, FEP, BlueCard and Traditional Blue Cross and Blue Shield plans.

Please complete the following information and fax the form to **EDI Services, (919) 765-7101**. A Connectivity Request form is required for each provider.

PROVIDER NAME		BCBSNC PROVIDER NUMBER	
CONTACT NAME		TITLE	
MAIL ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	

VENDOR / CLEARINGHOUSE NAME	CONTACT NAME	TITLE
MAIL ADDRESS	CITY	STATE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

BILLING SERVICE NAME	CONTACT NAME	TITLE
MAIL ADDRESS	CITY	STATE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

Are you changing vendor/clearinghouse or billing service? ☐ Yes ☐ No **If so,** effective date of change:_____ /_____ /_____

Type of Transaction *(enter Effective Date and X12 Version for each applicable claim type)*		
Claim Type	**Effective Date**	**X12 Version**
837 Institutional		
837 Professional		

Type of Sender *(select one)*: ☐ Provider ☐ Clearinghouse ☐ Billing Service

ISA05 Interchange Sender ID Qualifier*: _____ ISA06 Interchange Sender ID*: _____

**As a business practice, BCBSNC defines the Sender ID Qualifier to be "30" and the Sender ID to be the "Federal Tax ID"*

Mode of Connectivity *(select one)*	**Complete for Async Connectivity Mode**	
☐ Async *(X, Y or Z Modem/Kermit)*	BAUD RATE	
☐ Secure FTP *(via Internet)*	COMMUNICATION PROTOCOL	PASSWORD *(8 CHARACTERS)*

Claims Flow:

☐ from Provider site – directly to BCBSNC
☐ from Provider site – to Billing Service – to BCBSNC
☐ from Provider site – to Clearinghouse – to BCBSNC
☐ from Provider site – to Billing Service – to Clearinghouse – to BCBSNC
☐ Other *(please specify)*_____

Electronic Audit Reports should be sent to *(select one)*: ☐ Provider ☐ Billing Service ☐ Clearinghouse

X _____
AUTHORIZED SIGNATURE OF PROVIDER

_____
PRINT NAME / TITLE OF AUTHORIZED SIGNER

_____
DATE OF AUTHORIZATION

Sample Member Appeal Representation Authorization Form

Date:

Name:
Address:
City/State/Zip Code:

Patient:
Date of Birth:
Date(s) of Service:
Provider:
Reference Inquiry:
Regarding:

I have given my permission for _____ to represent me, and act on my behalf

regarding the above referenced denial for the following services: _____ .

I authorized Blue Cross and Blue Shield of North Carolina "BCBSNC" to release any of my protected health information "PHI" to my representative named above for the purpose of resolving my appeal.

I understand that I may revoke this authorization at any time by mailing a written notice to BCBSNC at the address below. I understand that revoking this authorization will not affect my action that BCBSNC has taken prior to receiving my notice of revocation.

I further understand that BCBSNC will not condition the provision of my health plan benefits because of this authorization.

I further understand that the person(s) that I have given permission to receive my PHI may not be subject to receive my PHI may not be subject to federal health information privacy laws and that they may disclose my information and it may no longer be protected by federal health information privacy laws.

This authorization will expire upon resolution of this appeal.

Thank you,

_____ _____

Member Signature Date

PO Box 30055 • Durham, NC 27702-3055 • 919-489-7431

Sample S133 – Statement of Accommodation Charges

BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

STATEMENT OF ACCOMMODATION CHARGES

GENERAL ACCOMMODATIONS

CLASSIFICATION	# OF BEDS	CHARGE	UB-92 REV CODE
SP		$	0120
SP		$	0120
SP		$	
WARD		$	0130
WARD		$	
P		$	0110
P		$	0110
P		$	0110
P		$	0110

BCBSNC USE ONLY
MPSP001 $
AVSP002 $

NURSERY

	CHARGE	UB-92 REV CODE
ROUTINE	$	
PREMATURE	$	
	$	
	$	

NOTE: Do Not Include Intensive Care Nursery Her, But Rather In Critical Care Unit Section Below.

Licensed Beds (excl. Bassinets)
Bassinets

Name of Hospital
Blue Cross #
Medicare #
IRS #
Effective Date
Signature (Hospital CEO or CFO):
Date
Blue Cross Signature:
Date:

CLINICAL SPECIALTY

CLASSIFICATION PSYCHIATRIC	# OF BEDS	CHARGE	UB-92 REV CODE
ADULT SP		$	0124
ADULT P		$	0114
		$	
ADOL SP		$	
ADOL P		$	
		$	
CHILD SP		$	
CHILD P		$	
		$	
OBSTETRICAL		$	
SP		$	0122
P		$	0112
		$	
PEDIATRIC			
SP		$	0123
P		$	0113
		$	

BCBSNC USE ONLY
MPSP012 $
AVSP017 $
MPSP020 $
AVSP022 $
MPSP021 $
AVSP023 $
MPSP010 $
AVSP015 $
MPSP011 $
AVSP016 $

CLASSIFICATION ONCOLOGY	# OF BEDS	CHARGE	UB-92 REV CODE
SP		$	0127
P		$	0117
		$	
SUBSTANCE ABUSE			
SP		$	
P		$	
		$	
REHABILITATION			
SP		$	
P		$	
		$	
OTHER			
SP		$	
P		$	
		$	

BCBSNC USE ONLY
MPSP013 $
AVSP018 $
MPSP024 $
AVSP025 $
MPSP014 $
AVSP019 $
MPSP $
AVSP $

23-31

PLEASE LIST CRITICAL CARE UNITS ON REVERSE

S133 REV 3/01

BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

STATEMENT OF ACCOMMODATION CHARGES

CRITICAL CARE UNITS

UNITS	P/SP	# OF BEDS	UB-92 REV CODE ROOM	ROOM CHANGE	UB-92 REV CODE NURSING/EQUIP	NURSING/EQUIP CHARGE	TOTAL CHARGE
ICU			0200	$	0233	$	$
				$		$	$
				$		$	$
				$		$	$
				$		$	$
				$		$	$
				$		$	$
				$		$	$
				$		$	$
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				$		$	$
				$		$	$
				$		$	$

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S133 REV 3/01

Glossary of Terms

24. Glossary of Terms

Account - Includes any and all organized groups of individuals purchasing health insurance together, usually under employer sponsorship. Accounts are further defined as national, state, local and other.

Accreditation - The formal evaluation of an organization according to accepted criteria or standards. Accreditation may be rendered by a professional society, a non-governmental body or a government agency. National Committee for Quality Assurance "NCQA" accreditation is a nationally recognized evaluation that purchasers, regulators and consumers can use to assess HMO, POS and PPO plans.

Acute Care - Treatment for a short-term or episodic illness or health problem.

Admission - When a member enters any facility that files UB-04 claim forms and is registered as an inpatient.

Admission Certification - A procedure whereby the Plan determines, based on medically accepted criteria, whether an admission to a hospital as an inpatient is reasonable for the type of services to be received by a member. Non-maternity and non-emergency admissions must be certified prior to admission.

Administrative Costs - The costs assumed by a health care plan for administrative services, such as claims processing, billing and overhead costs.

Administrative Services Only "ASO" - An account that assumes full claims liability *(self-insured)* for funding the health benefits contract with a third party *(such as BCBSNC)* providing all or a portion of the administrative services that would be available under a regular health plan. Because the service company assumes no liability for health coverage, claim reserves normally are not required.

Allowable Charge/Amount - The maximum amount to be reimbursed to a provider as negotiated.

Allowed Amount - The charge that BCBSNC determines is reasonable for covered services provided to a member. This may be established in accordance with an agreement between the provider and BCBSNC. In the case of providers that have not entered into an agreement with BCBSNC, BCBSNC's methodology is determined based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.

Alpha Prefix - A letter code that precedes a member's identification number.

Alt Med Blue℠ - A comprehensive, complementary and alternative medicine discount program. Offers discounts for alternative treatments and therapies such as acupuncture, stress management, massage therapy/somatic education, fitness centers and personal trainers, spas, and nutritional counseling.

Ambulatory Care - Medical services that are provided on an outpatient *(non-hospitalized)* basis, including the office setting. Generally synonymous with outpatient; however, some outpatient services may be excluded.

Ambulatory Surgery - See outpatient surgery.

Ambulatory Surgical Center - a non-hospital facility with an organized staff of doctors, which is licensed or certified in the state where located, and which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
- provides nursing services and treatment by or under the supervision of doctors whenever the patient is in the facility
- does not provide inpatient accommodations
- is not other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other provider

Ancillary Providers - home health, home infusion, private duty nursing, dialysis facilities, hospice, durable medical equipment, skilled nursing facilities.

Ancillary Services - Facility services exclusive of room and board, such as supplies and laboratory tests.

ASO Pre-Existing Condition - A condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended during the six month period prior to the effective date of the member's coverage. Pregnancy variable is not considered a pre-existing condition.

Authorization - See certification.

Average Length of Stay "ALOS" - The number of inpatient days divided by the number of admissions for a given time period and a given population.

BCBSNC - Blue Cross and Blue Shield of North Carolina. BCBSNC may also be referred to as "we" or "us."

Beneficiary - A person who is eligible to receive insurance benefits. See member, dependent and subscriber.

Benefit Booklet - The document that contains a general explanation of the individual's benefits.

Benefits Package - Services an insurer, government agency or health plan offers to a group or individual under the terms of a contract. The components which make up a product's health benefit plan *(e.g., deductible, out-of-pocket limit, lifetime maximum, etc.)*.

Benefit Period - The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Billed Charge - The amount a physician, institution, pharmacy, suppliers of medical equipment or other practitioner bills a patient for a particular medical service or procedure. This is referred to as actual charge or public charge.

Billing - (a) An itemized account of subscriber dues owed to the Plan by a group or subscriber; (b) an itemized account of services rendered by a physician, provider or supplier.

Birthday Rule - A process under coordination of benefits clauses in a contract that determines which patient's coverage pays first when a dependent child has health insurance coverage through both parents. This rule states that the parent whose birthday falls first during the calendar year is primary *(his or her coverage pays first)*.

BlueCard® - A collection of programs and policies that enable members to receive health care services while traveling or living in another Plan's service area.

Blue Care® *(HMO)* - An open access HMO plan that allows the member to see any participating provider without a referral. There is no coverage for services received from a non-participating provider. Under Blue Care®, members are asked, but are not required, to select a primary care physician or provider.

Blue Cross and Blue Shield of North Carolina "BCBSNC" - A nonprofit hospital, medical and dental service corporation organized and operated under Chapters 55A and 58 of the North Carolina General Statutes. BCBSNC is an independent licensee of the Blue Cross and Blue Shield Association.

Blue Extras - Special program available to BCBSNC members as value-added services. These services are not covered benefits or otherwise a part of the member's health insurance contract.

Blue Options℠ "PPO" - A Preferred Provider Organization "PPO" plan that allows members the freedom to choose in-network or out-of-network providers; however, when members receive services from an out-of-network provider, there is more out-of-pocket expense to the member.

Brand Name - The proprietary name the manufacturer owning the patent places upon a drug product or on its container, label or wrapping at the time of packaging.

Bundling - The packaging of items or services containing defined elements grouped together in a global package.

Calendar Year - The period of time beginning January 1 and ending December 31 of a given year.

Carrier - An insurance company, pre-paid health plan or a government agency that underwrites and/or administers a range of health benefits programs and any claims submitted by or for plan members.

Carryover - A provision in health plans that allows individuals to apply expenses incurred in the last quarter of that calendar year to the next year's deductible. This does not apply to most health benefit plans.

Case Management - A program that is designed to assess the continuing needs of members with catastrophic or chronic health problems. Case managers assist physicians/providers in meeting an individual's health care needs through coordination of services and utilization of resources in order to promote high-quality, cost-effective outcomes.

CDW - Corporate Data Warehouse

Centers for Medicare and Medicaid Services "CMS" - A division of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.

Certification - Certification is the determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy our requirements for medically necessary services and supplies, appropriateness, health care setting, level of care and effectiveness.

Claim - A request for retrospective payment by a member or, on his/her behalf, by the provider for services or supplies rendered by an institution, provider or supplier of medical supplies and equipment. Each document or request for payment should be counted as one claim.

Classic Blue® "CMM" - An indemnity *(Comprehensive Major Medical)* plan. Unlike the other new Blue products, Classic Blue® members do not pay copayments for services provided in an office setting. Instead, all services are subject to a deductible and coinsurance. Members have the freedom to see any provider; however, when members receive services from a non-participating provider, payment is made to the member directly and they must reimburse the provider.

CMID - Common membership. Displays combined membership information from Legacy, State and New Blue products.

CMS-1500 Claim Form - Professional claim form which uses CPT codes and HCPCS codes to indicate procedures rendered for a member.

Coinsurance - The sharing of charges by BCBSNC and the member for covered services received by a member, usually stated as a percentage of the allowed amount.

Coinsurance Maximum - The maximum amount of coinsurance that a member is obligated to pay for covered services per calendar year/benefit period.

Complications of Pregnancy - Medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated as a hospital inpatient prior to the full term of the pregnancy *(except as otherwise stated below)*, including but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within seventy-two (72) hours of delivery; or, the following conditions occurring within ten (10) days of delivery: urinary tract infection, mastitis, thrombophlebitis and endometritis. Emergency cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

Complimentary and Alternative Medicine - See Alt Med Blue℠.

Comprehensive Major Medical - An indemnity policy characterized by a deductible amount, a coinsurance feature and maximum benefits.

Concurrent Review - Health coaching and intervention performed by a licensed nurse while a member is confined in an acute-care facility. Medical records are reviewed to determine if medical conditions and treatment continue to meet severity of illness and intensity of service requirements for continued inpatient care. If the member does not meet criteria for continued inpatient care, arrangements can be made with the attending physician to provide quality, cost-effective care in an outpatient setting. Records are also reviewed to ensure that the member is receiving quality care while in the facility.

Control Plan - A Plan that has responsibility for administering a national account normally headquartered in the Plan's service area.

Copayment - The fixed-dollar amount which is due and payable by the member at the time a covered service is provided.

Coordination of Benefits "COB" - A method of determining the primary payment source when a person is covered under more than one group medical program.

Cost Containment - A variety of activities directed at controlling the cost of medical care and reducing its rate of increase. Such activities include case management, concurrent review, etc.

Coverage - Benefits available to eligible members.

Covered Service(s) - A service, drug, supply or equipment specified in this benefit booklet for which members are entitled to benefits in accordance with the terms and conditions of this health benefit plan.

Credentialing - The process of licensing, accrediting, and certifying health care providers to ensure quality standards are met. Managed care companies often verify providers' credentials prior to allowing them to participate in a provider network.

Credentialing Application - The standardized credentialing application form developed by the North Carolina Department of Insurance.

Custodial Care - Care comprised of services and supplies, including room and board and other facility services, which are provided to the patient, whether disabled or not, primarily to assist him or her in the activities of daily living. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services and supplies are custodial as determined by BCBSNC without regard to the provider prescribing or providing the services.

Deductible - The specified dollar amount for certain covered services that the member must incur before benefits are payable for the remaining covered services. The deductible does not include copayments, member coinsurance, charge in excess of the allowed amount, amounts exceeding any maximum and expenses for non-covered services.

Dependent - A member other than the subscriber as specified in, When Coverage Begins and Ends. An individual who is eligible for health insurance through a spouse's, parent's or other family member's policy.

Dependent Child(ren) - The covered child(ren) of a subscriber, spouse or domestic partner up the the maximum dependent age, as specified in, When Coverage Begins And Ends.

Diagnosis-Related Groups "DRGs" - A system that reimburses hospitals fixed amounts for all hospital care given during a specific admission in connection with standard diagnostic categories. The standard diagnosis categorizes group services that are clinically related and/or on average, use the same amount of hospital resources.

Disease Management - The process of intensively managing a particular disease. This differs from large case management in that it goes well beyond a given case in the hospital or an acute exacerbation of a condition. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. Similar to case management, but more focused on a defined set of diseases.

Doctor - Includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or surgery by the board of medical examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice.

Durable Medical Equipment - Items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease and are appropriate for use in the patient's home.

Effective Date - The date on which coverage for a member begins in the member's booklet.

Emergency - The sudden or unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of emergencies.

Emergency Services - Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department.

Empty Suitcase - An ID card logo that indicates away from home care coverage that is administered through the BlueCard® system.

Endorsement - Optional coverage purchased by the group. Examples of endorsements are prescription drugs, mental health, substance abuse, chiropractor services and dental.

Exclusions - Specific conditions or services listed in the health benefit plan for which benefits are not available.

Experimental - See investigational.

Explanation of Benefits "EOB" - A statement to the subscriber that explains the action taken on each claim.

Explanation of Payment "EOP" - A statement to the provider that explains the action taken on each claim.

Facility Services - Covered services provided and billed by a hospital or non-hospital facility.

Family Deductible - A deductible that is satisfied by either the combined expenses of all family members or a certain number of family members.

Fee Schedule - Agreed upon reimbursement between a provider and BCBSNC.

Formulary - The list of outpatient prescription drugs and insulin that are available to members.

Generic - A non-brand name drug which has the same active ingredient, strength and dosage form, and which is determined by the FDA to be therapeutically equivalent to the drug product identified in the prescription.

Grievance - A written complaint submitted by a member about any of the following:

- Our decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.
- Claims payment or handling payment for services
- The contractual relationship between us and a member
- The outcome of an appeal of a non-certification under North Carolina General Statutes §58-50-61 or successor thereto.

Grievance and Appeals Process - The formal process described in this manual for the submission of Grievances or requesting review of denials of coverage or utilization review decisions. This process provides for expedited review in cases where the member's health would be detrimentally affected by a delay of care pending the standard review process.

Group - An employer or other entity that has entered into a contract for health care and/or administration of benefits for its eligible members.

Group Administrator - A representative of the group designated to assist with member enrollment and provide information to subscribers and members concerning the health benefit plan.

Group Contract - The agreement between BCBSNC and the group. It includes the master group contract, the benefit booklet(s) and any exhibits or endorsements, the group enrollment application and medical questionnaire when applicable.

Health Benefit Plan - The evidence of coverage issued to a group or individual by us or other Blue Cross and/or Blue Shield plans, that describes the scope of covered services and establishes the level of benefits payable, on an insured or administered basis, for such services rendered to members.

Health Maintenance Organization "HMO" - A plan which promises to deliver health services to an enrollee in exchange for the enrollee's prepayment of health care costs to the HMO. The enrollee has no liability to pay providers for health care services, other than copayments, coinsurance, and deductibles. The HMO enters into a direct contractual relationship with providers who promise to deliver all contractually promised health care services to the HMO's enrollees. See Blue Care®.

HIPAA - Health Insurance Portability and Accountability Act - Calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans and employer groups.

Hold Harmless - A contract provision whereby providers agree not to charge members more than the allowable charges for covered services and not to charge members for non-covered services. The subscriber's only liability would be the deductible, coinsurance, and/or copayment.

Homebound - A member who cannot leave their home or temporary residence due to a medical condition and a member's ability to leave is restricted due to a medical condition which requires the aid of supportive devices, the use of special transportation or the assistance of another person. A member is not considered homebound solely because the assistance of another person is required to leave the home.

Home Health/Home Care Agency - A non-hospital facility which is primarily engaged in providing home health care services, and which:

- Provides skilled nursing and other services on a visiting basis in the member's home
- Is responsible for supervising the delivery of such services under a plan prescribed by a doctor
- Is accredited and licensed or certified in the state where located
- Is certified for participation in the Medicare program
- Is acceptable to BCBSNC

Home Plan - The Blue Cross and/or Blue Shield Plan that carries the member's contract when the member receives services out-of-area.

Hospice - A non-hospital facility that provides medically-related services to persons who are terminally ill, and which:

- Is accredited, licensed or certified in the state where located
- Is certified for participation in the Medicare program
- Is acceptable to BCBSNC

Hospital - An accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located.

Hospital-Based Physician - A physician who is employed by or through a hospital or other facility and/or who provides services at the facility. Specialists which are designated hospital-based by BCBSNC are: emergency room physicians, pathologists, radiologists and anesthesiologists.

Host Plan - A Blue Cross and/or Blue Shield Plan participating in the *(Inter-Plan Service)* Benefit Bank that provides payment for medical care to a subscriber of another Blue Cross and/or Blue Shield Plan *(home)*. BCBSNC serves as the host Plan in the BlueCard® program.

IBO *(Individual)* is a twelve month look back and does include pregnancy. **Pre-Existing Condition -** A condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended during the twelve month period prior to the effective date of the member's coverage. Pregnancy/maternity related diagnoses are considered a pre-existing condition.

Identification Card *(ID Card)* - The card issued to our members upon approval of the request for enrollment application and change form.

IGO *(Insured Group)* and MEWA Pre-Existing Condition - A condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended during the six month period prior to the effective date of the member's coverage. Pregnancy, diabetes and genetic information is not considered as pre-existing conditions.

Incurred - The date on which a member receives the service, drug, equipment or supply for which a charge is made.

Indemnity *(Comprehensive Major Medical)* Plan - Traditional fee-for-service health insurance in which a subscriber has free choice of physicians / providers. The coverage usually includes a deductible and co-insurance. See Classic Blue®.

Infertility - The inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.

In-Network - Refers to participating providers.

In-Network Provider - A hospital, doctor, other medical practitioner or provider of medical services and supplies that has been designated as a Blue Care® provider by BCBSNC.

Inpatient - Pertaining to services received when a member is admitted to a hospital or non-hospital facility as a registered bed patient for whom a room and board charge is made.

Inpatient Days - The number of days for which inpatient services are provided, including the day of admission and excluding the day of discharge.

Inquiry - A request for information, action or a document from a subscriber, provider, account, another plan or the general public. Inquiries may be received in any area within a plan office.

Institutional Provider - A facility or entity other than a professional provider which is accredited and licensed or certified in the state where located to render covered services. Institutional providers may include general acute hospitals, ambulance companies, ambulatory surgical facilities, substance abuse treatment facilities, home health/home care agencies, hospices, skilled nursing facilities, etc. These typically bill on the UB-04 claim form.

Investigational *(Experimental)* - The use of a service or supply, including but not limited to treatment, procedure, facility, equipment, drug or device that BCBSNC does not recognize as standard medical care of the condition, disease, illness or injury being treated. The following criteria are the basis for BCBSNC's determination that a service of supply is investigational:

- Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration "FDA" for final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
- There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply.
- There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes.
- The service or supply under consideration is not as beneficial as other established alternatives.
- There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative nor conclusive.

ITS - Inter-Plan Teleprocessing Services. Allows plans to access, send, receive, and control claims information.

Licensed Practical Nurse "LPN" - A nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.

Lifetime Maximum - The maximum amount of covered services that will be provided to a member while they have coverage under this health benefit plan or any prior health benefit plan sponsored by the group in any member's lifetime.

Major Diagnostic Category "MDC" - A set of 23 broad diagnostic classifications, mainly according to organ system. Used as a first step in identifying DRGs *(Diagnostic Related Groups)*.

Managed Care - A health care delivery system, comprising a spectrum of financial and structural relationships among purchasers, insurers, providers and members, designed to favorably affect the balance of access, cost and quality of health care for a defined population of subscribers and members.

Medical Care/Services - Professional services provided by a doctor or another provider for the treatment of an illness or injury.

Medical Supplies - Health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.

Medically Necessary *(or Medical Necessity)* - Those covered services or supplies that are:

- provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury, or disease; and, except as allowed under North Carolina General Statute §58-3-255, not for experimental, investigational, or cosmetic purposes
- necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms
- within generally accepted standards of medical care in the community
- not solely for the convenience of the insured, the insured's family or the provider

For medically necessary services, BCBSNC may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Medical Policy - Medical policy consists of medical guidelines and payment guidelines. Medical guidelines detail when certain medical services are medically necessary, and whether or not they are investigational. *(For more information concerning medical necessity and investigational criteria, please see these specific policies.)* Our medical guidelines are written to cover a given condition for the majority of people. Each individual's unique, clinical circumstances may be considered in light of current scientific literature. Medical guidelines are based on constantly changing medical science, and we reserve the right to review and update our policies periodically. Payment guidelines provide (claims payment) editing logic for CPT, HCPCS and ICD-9-CM coding. Payment guidelines are developed by clinical staff, and include yearly coding updates, periodic reviews of specialty areas based on input from specialty societies and physician committees, and updated logic based on current coding conventions. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Therefore, medical policy is not an authorization, certification, explanation of benefits, or a contract. Benefits are determined by the group contract and the subscriber certificate that is in effect at the time services are rendered.

Medical Review - The process of determining the appropriateness of care or treatment. Usually part of claims adjudication.

Medicare - The program of health care for the aged, disabled and individuals with end-stage renal disease established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Crossover - Providers submit original claim to Medicare to receive payment first. The Medicare intermediary submits a tape to Blue Cross for secondary payment.

Medicare Participating Provider - A provider which has been certified by the Department of Health and Human Services of the United States for participation in the Medicare program. Medicare participation does not imply participation with BCBSNC.

Member - A subscriber or dependent, whose enrollment application and change form has been accepted and for whom premium is paid.

Mental Illness - Mental disorders, psychiatric illnesses, mental illnesses, mental conditions and psychiatric conditions *(whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement)*. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. *(This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC.)*

Most Prevalent Room Rate - The charge made for the majority of the rooms in a particular category where a hospital or non-hospital facility has more than one level of charges for rooms in the same category.

NCQA - The National Committee for Quality Assurance.

Network - A group of physicians, hospitals and other health care providers contracting with a health care plan to offer care at negotiated rates and at other agreed upon terms *(e.g., hold harmless, referrals only to other participating providers, etc.)*.

Newborn - Defined as five days or younger.

Non-Hospital Facility - An institution or entity other than a hospital which is accredited and licensed or certified in the state where located to render covered services and is acceptable to BCBSNC.

Non-Participating Provider - A provider that has not been designated as a Blue Care® provider by BCBSNC.

NPC Segment - The segment contains any special prefix information that needs to be attached to a group. If the NPC segment is blank, a default prefix will be assigned unless a program specifies otherwise.

Office Visit - Medical care, surgery, diagnostic services, short-term therapy services and medical supplies provided in a provider's office.

Open Enrollment - (a) A period during which subscribers in a health benefit program have an opportunity to make changes in their health coverage *(select an alternative program, for instance)*; or (b) a period when uninsured individuals can obtain coverage without presenting evidence of insurability *(health statements)*.

Other Professional Provider - A person or entity other than a doctor who is accredited and licensed or certified in the state where located to render covered services and which is acceptable to BCBSNC.

Other Provider - An institution or entity other than a doctor or hospital, which is accredited and licensed or certified in the state where located to render covered services and which is acceptable to BCBSNC.

Other Therapies - The following services and supplies, both inpatient and outpatient, ordered by a doctor or other provider to promote recovery from an illness, disease or injury when provided by a doctor, other provider or professional employed by a provider licensed in the state of practice.

- Chemotherapy *(including intravenous chemotherapy)* - the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the Food and Drug Administration "FDA."
- Dialysis Treatments - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- Radiation Therapy - the treatment of disease by X-ray, radium, or radioactive isotopes.
- Cardiac Rehabilitation - a multi-disciplinary approach to reconditioning of the cardiovascular system in order to help limit the physiologic and psychological effects of cardiac illness, reduce risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients. These programs may include exercise training, education, counseling, and cardiac risk factor modification.

Out-of-Area Benefits - Benefits that are available to individuals living or traveling outside a health plan's service area. Benefits may be somewhat less restrictive for enrollees living outside the service area.

Out-of-Network Services - Services performed by a provider who has not signed a contract with the member's health plan to be part of a provider network.

Outlier Certification - The approval of reimbursement for inpatient days beyond the assigned length of stay threshold. Certification must be requested prior to the days of service.

Outlier Cases - Services that are outside of the stated length of stay parameters or charge thresholds.

Outpatient - Pertaining to services received from a hospital or non-hospital facility by a member while not and inpatient.

Outpatient Surgery - Surgery performed in a setting that does not require an inpatient admission. Sometimes called ambulatory surgery.

Partial Hospitalization - A program that provides less than 24-hour care *(usually during the day)* for mental health care, rehabilitative care or other services, often for patients in transition from full-time inpatient care to outpatient care.

Participating Provider - A hospital, doctor, other medical practitioner or provider of medical services and supplies that has been designated as a Blue Care® provider by BCBSNC.

Peer Review - Evaluation by practicing physicians or other professionals on the effectiveness and efficiency of services ordered or performed by other members of the profession whose work is being reviewed *(peers)*. Peer review is the all-inclusive term for medical review efforts. Medical practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review and claims review all are aspects of peer review.

Per Diem Rate - A prospective payment methodology for facility inpatient service in which the allowance for covered services is a negotiated daily rate.

Per Visit Rate - A prospective payment methodology for home infusion therapy services in which the allowance for covered services is a negotiated daily rate.

Plan Profile - A tool that allows a plan to capture alpha prefix information. It defines the relationship between BCBS plans for the accounts BCBSNC serves.

Point Of Service "POS" - A plan line that combines the cost and care management strengths and comprehensive benefits of an HMO with the freedom of choice of a preferred provider organization. The member determines the benefit level by choosing the point-of-service — in or out-of-network.

Practitioner - Any practitioner of health care services who is duly licensed to administer such services by the state in which covered services are performed, subject to any licensure or regulatory limitation as to location, manner or scope of practice.

Preferred Provider Organization "PPO" - A hybrid of HMOs and traditional insurance plans, that contract with various physicians, providers and hospitals. Enrollees are offered a financial incentive to use providers on a preferred list, but may use out-of-network providers as well. See Blue Options℠.

Prescription - An order for a prescription drug issued by a doctor duly licensed to make such a request in the ordinary course of professional practice.

Prescription Drug - A drug that under federal law is required, prior to being dispensed or delivered, to be labeled, Caution: Federal law prohibits dispensing without prescription; or labeled in a similar manner, or injectable insulin, when ordered by a doctor as a prescription, and which is not entirely administered at the time and place where the prescription is dispensed.

Preventive Care - Medical services provided by or upon the direction of a doctor or other provider related to the prevention of disease.

Primary Care Provider - A participating provider from one of the following specialties: family practice/general practice, internal medicine, obstetrics and/or gynecology, physician's assistant, certified nurse practitioner, or pediatrics.

Primary Payer - When a member is covered by more than one insurance carrier, the primary payer is the carrier responsible for providing benefits before any other insurer makes payment.

Prior Plan Approval - The approval of specific medical services and/or supplies for BCBSNC members. Procedures included in the prior plan approval list include high cost and/or potentially abused services. Services are evaluated against severity of illness and intensity of service requirements such as BCBSNC medical policy and M & R criteria for approval.

Prior Review - Prior review is the consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of medical necessity of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in certification or non-certification of benefits.

Professional Provider - A physician or other practitioner or group of practitioners who is licensed, certified or approved by the appropriate agency to render covered services/supplies in their state of practice.

Prosthetic Appliances - Fixed or removable artificial limbs or other body parts, which replace absent natural ones.

Provider - A hospital, non-hospital facility, doctor, or other provider, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification.

Re-Admission - A repeat admission for the same diagnosis or condition occurring shortly after the previous admission.

Referral - The recommendation by a primary care physician or provider for a member to receive care from a participating specialist or facility. This is not a formal process and does not require interacting with BCBSNC.

Registered Nurse "RN" - A nurse who has graduated from a formal program of nursing education *(diploma school, associate degree or baccalaureate program)*, and is licensed by the appropriate state authority in the state of practice.

Resource Based Relative Value Scale "RBRVS" - A methodology introduced by Center for Medicare and Medicaid Services, "CMS" and Medicaid Services to create the Medicare fee schedule. The methodology incorporates factors such as the amount of time and resources expended in treating patients, overhead costs and geographical differences.

Retrospective Review - A manner of judging medical necessity and appropriate billing practices for services that have already been rendered.

Secondary Payer - When a member is covered by more than one insurance carrier, the secondary payer is the carrier responsible for providing benefits after the primary payer has provided benefits.

Short-Term Therapy - Services and supplies both inpatient and outpatient, ordered by a doctor or other provider to promote the recovery of the member from an illness, disease or injury when provided by a doctor, other provider or professional employed by a provider licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

- Physical therapy
- Occupational therapy
- Speech therapy
- Respiratory therapy

Skilled Nursing Facility - A non-hospital facility licensed under state law that provides skilled nursing, rehabilitative and related care where professional medical services are administered by a registered or licensed practical nurse.

Specialist - A doctor who is recognized by BCBSNC as specializing in an area of medical practice other than family practice, general practice, internal medicine, pediatrician, obstetrician, gynecologist or obstetrician/gynecologist.

Sub-Acute Care - A level of care for patients requiring some support services but not requiring the intensity of services of a hospital.

Subrogation - The substitution of one person for another who has a legal claim or right.

Subscriber - The person who is eligible for coverage under this health benefit plan due to employment or association membership and who is enrolled for coverage.

Surgery - The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures.

- The correction of fractures and dislocations
- Usual and related pre-operative and post-operative care
- Other procedures as reasonable and approved by BCBSNC

Transplants - The surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive surgery are not considered to be transplants.

UB-04 Claim Form - Institutional claim form which uses revenue codes to indicate procedures rendered for a member.

Underwriting - The process by which an insurer determines if, and on what basis, an application for insurance will be accepted.

Urgent Care - Services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Examples of urgent care include sprains, some lacerations and dizziness.

VRU - The VRU system is a voice response front end application that allows callers to access policy information and make selective changes to their policies *(e.g., address, phone number, new ID cards and claim forms)*. Callers can also check eligibility, claims and payment status for their individual accounts.

Waiting Period - See pre-existing condition.

We - BCBSNC will also be referred to as "we" or "us."

Workers' Compensation - Insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured on the job, and to pay benefits to dependents of employees killed in the course of or in circumstances arising from their employment.

Class Action Settlement Agreement (Settlement)

25. Class Action Settlement Agreement (Settlement)

25.1 Definitions Applicable Only To This Chapter 25

25.1.1 Billing Dispute Reviewer

Billing Dispute Reviewer shall have the meaning assigned to that term in the Settlement.

25.1.2 Billing Dispute

Billing Dispute shall have the meaning assigned to that term in the Settlement.

25.1.3 Independent Review Organization

Independent Review Organization shall have the meaning assigned to that term in the Settlement.

25.1.4 Physician

Physician shall have the meaning assigned to that term in the Settlement.

25.1.5 Physician Group

Physician Group shall have the meaning assigned to that term in the Settlement.

25.1.6 Physician Organizations

Physician Organizations shall have the meaning assigned to that term in the Settlement.

25.1.7 Settlement

Settlement means Love, et al. v. Blue Cross Blue Shield Association, et al., (formerly Thomas et al. v. Blue Cross Blue Shield Association, et al), Civil Action No. CV-03-21296-MORENO/SIMONTON in the United States District Court for the Southern District of Florida, Miami Division.

25.1.8 Termination Date

Termination Date shall have the meaning assigned to that term in the Settlement.

25.2 Applicability of this Chapter 25

Unless otherwise specified, the provisions of this Chapter 25 apply only to Physicians, Physician Groups, and Physician Organizations, shall commence once a Billing Dispute Reviewer has been selected, and shall expire upon the Termination Date.

25.2.1 Conflicts Between this Chapter 25 and Other Sections of this Manual

In the event of a conflict between term(s) in this chapter 25 and any other chapter of this Manual, the term(s) of this chapter 25 shall supersede such conflicting term(s) until the Termination Date.

25.3 Process for Submitting a Post-Service Level II Provider Appeal

The Level II post-service provider appeal request 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. Providers may reduce administrative cost associated with records submission by first verifying that the record document information is consistent with BCBSNC medical policy, payment policy and Clinical Edit Clarification guidelines.

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.

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.

You may access BCBSNC's Pricing and Adjudication Principles for Professional Providers at: ***https://www.bcbsnc.com/services/medicalpolicy/pdf/pricing_and_adjudication_principles_for_ professional_providers.pdf***.

If a Physician, Physician Group, or Physician Organization's Level I Post-Service Provider Appeal was completed by BCBSNC prior to November 21, 2008, and Level II Post-Service Provider Appeal rights are available, Physicians, Physician Groups, and Physician Organizations will have 90 calendar days from November 21, 2008 to submit a Level II Post-Service Provider Appeal.

Requests for Level II Post-Service Provider Appeals may relate to the following issues:

- Integral part of a primary service
- Mutually exclusive services
- Services not eligible for separate reimbursement
- Incidental procedures denials
- Surgical global period denials

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

The Level II Provider Appeal requests 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.

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 based on medical policy.

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.

You may access BCBSNC's Medical Policy at: ***http://www.bcbsnc.com/services/medical-policy***.

If a Physician, Physician Group, or Physician Organization's Level I Post-Service Provider Appeal was completed by BCBSNC prior to November 21, 2008, and Level II Post-Service Provider Appeal rights are available, Physicians, Physician Groups, and Physician Organizations will have 90 calendar days from November 21, 2008 to submit 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

25.4 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

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.