The Blue Book℠

Provider e-Manual

BlueCrossNC.com

BlueCross BlueShield of North Carolina

The Blue Book℠
Provider e-Manual

for Physicians, Ancillary Providers, Hospitals and Facilities

Please Note:

In the event of any inconsistency between information contained in this e-Manual and the agreement(s) between you and Blue Cross and Blue Shield of North Carolina (Blue Cross NC), the terms of such agreement(s) shall govern. Also, please note that Blue Cross NC, 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 Blue Cross NC 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 e-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 Blue Cross NC, however such person may be referred to or described in said policy.

Help is here!

To view pdf documents, you will need Adobe Acrobat Reader. If you do not have it already, you can access the website for Adobe directly at **Adobe.com/Acrobat.html**.

Introduction 1

Quick contact information 2

Health care – Benefit plans and member identification cards 3

Health care – Benefit plans and member identification cards 3

Federal Employee Program® (FEP) – Blue Cross and Blue Shield Service Benefit Plan 4

The BlueCard program

5

The BlueCard program 5

Medicare supplement products 6

Medicare supplement products 6

Care management 7

Care management 7

Case management 8

Claims, provider billing and reimbursement 9

Claims, provider billing and reimbursement 9

Physician's office

Ancillary providers

Hospitals and facilities

Ambulatory surgical centers – Grouper methodology

Claims, provider billing and reimbursement 9

Ambulatory surgical centers – Fee schedule methodology

Coordination of benefits 10

Coordination of benefits 10

eSolutions 11

Provider review 12

Quality improvement program 13

Quality improvement program 13

Provider data management and credentialing 14

Quality and credentialing programs for ancillary providers 15

Appeal and grievance procedures 16

Pharmacy and specialty networks 17

Brand regulations – How to use our name and logos 18

Health Insurance Portability and Accountability Act 19

Privacy and confidentiality 20

Forms 21

Glossary of terms 22

1

Introduction

1.1
About this e-Manual

We are pleased to provide you with a completely revised and comprehensive Blue Book Provider e-Manual, for providers participating in the Blue Cross NC Provider Network. This e-Manual has been designed to make sure that you and your office staff have the information necessary to effectively understand and administer Blue Cross NC insurance products, care management policies and procedures and the health care claims billing guidelines of Blue Cross NC.

This e-Manual contains information providers need to administer Blue Cross NC's Comprehensive Major Medical (CMM) plans and managed health care programs efficiently with regard to claims and customer service issues.

Website resource

Please note that Blue Cross NC will periodically update this e-Manual. The most current version of The Blue Book Provider e-Manual will be available in the *Providers* section of the Blue Cross NC website at BlueCrossNC.com/Providers.

Blue Cross NC health care benefit plans overview

Health care benefit plans can typically be categorized into five (5) basic plan types: Health Maintenance Organization (HMO), EPO (Exclusive Provider Organization), Point-of-Service (POS), Preferred Provider Organization (PPO) and Comprehensive Major Medical (CMM). Contracting providers with questions about plans(s) in which they participate should refer to their Network Participation Agreement (NPA) with Blue Cross NC, their North Carolina State Health Plan Network Participation Agreement (SHP-NPA)* or contact Provider Network for assistance. Provider Network contact information can be found in **Chapter 2** of this e-Manual. Except where otherwise indicated, this e-Manual refers to all of the following Blue Cross NC HMO, EPO, POS, PPO and CMM product offerings, including but not limited to the products indicated in the following chart:

Blue Cross NC Product Offerings

Blue Cross NC HMO Product	• **Blue Care** (HMO plan)
Blue Cross NC EPO Products	• **Blue Home** (EPO plan with deductible and coinsurance, or copayments purchased by individuals) • **BlueHPN**℠ (EPO plan) • **Blue Local** (EPO plan with deductible and coinsurance, or copayments purchased by individuals)**
Blue Cross NC POS Products	• **Blue Value** (POS plan with in-network and out-of-network benefits)
Blue Cross NC PPO Products	• **Blue Options** (PPO plan) – **Blue Options** (PPO plan with deductible and coinsurance plan) – **Blue Options** (PPO plan with in-network benefits only) • **Blue Options® 1-2-3**℠ (PPO plan with 3 benefit levels) • **Blue Options® HRA**℠ (high-deductible PPO may be paired with a health reimbursement account) • **Blue Options® HSA**℠ (high-deductible PPO may be paired with a health savings account) • **Blue Advantage®** (PPO plan purchased by individuals) • **State Health Plan** (PPO plan for State Health Plan membership)
Blue Cross NC CMM Products	• **Classic Blue** (CMM plan)

* Except where otherwise indicated, all references to "Network Participation Agreement" or "NPA" are, where applicable, inclusive of the State Health Plan Network Participation Agreement.

** Blue Local with Atrium Health, Blue Local with Wake Forest Baptist Health, and My Blue with Duke Health POS employer group products will be discontinued at the end of 2023

Please note the following:

- Information relative to the Federal Employee Program PPO plan can be found in **Chapter 4** of this e-Manual.
- Information relative to the Inter-Plan programs (including BlueCard) can be found in **Chapter 5** of this e-Manual.
- Information relative to Medicare and Medicare supplement programs (non-Medicare Advantage plans) can be found in **Chapter 6** of this e-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 Blue Cross NC can be found in **Chapter 2**.
- Health benefit plans and sample identification cards can be found in **Chapter 3**.
- Care management can be found in **Chapter 7**.

Network Participation Agreement

This e-Manual is intended as a supplement to your Agreement with Blue Cross NC, most commonly the NPA, the Agreement by which you as the provider participate in the Blue Cross NC network(s), the Agreement between you as the provider and Blue Cross NC. The NPA is the primary document controlling the relationship between provider and Blue Cross NC. Nothing contained in the e-Manual is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the NPA.

Sanctions: In the event of provider's non-compliance with the provider contract or with applicable Policies and Procedures as included or referenced in this e-Manual, Blue Cross NC may pursue any contractual right of redress including but not limited to practitioner suspension, service exclusion, termination of contract, and Blue Cross NC reserves all legal rights of redress in law or equity. Blue Cross NC 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 Blue Cross NC website to receive updates and information about issues affecting Blue Cross NC network participating providers, **BlueCrossNC.com/Providers**.

1.2
Provider e-Manual online

The Blue Book is maintained on the Blue Cross NC website for providers at **BlueCrossNC/Providers/**. The e-Manual is available to providers for download to their desktop computers for easy and efficient access. In addition to the *Providers* section of the site, the provider e-Manual is also available to providers having free **Blue *e*** connectivity. Whether accessing the provider e-Manual from the *Providers* section or from **Blue *e***, the process to view is the same.

Just click on The Blue Book hyperlink and select the option to open; it's that easy. If you want to save a copy of the e-Manual to your computer's desktop, open the e-Manual for viewing following the same instructions, and after you have opened the e-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 e-Manual on your computer, and click on the tab to save.

If you experience any difficulty accessing or opening The Blue Book from our website or **Blue *e*** and need assistance viewing, please contact Provider Network.

Important

Please note that providers are reminded that this e-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 e-Manual in the *Providers* section of the Blue Cross NC website at BlueCrossNC.com/Providers/, or by using Blue *e*SM.

1.3
Additional references

This e-Manual is your main source of information about Blue Cross NC's policies and procedures for providing and arranging services for our members. If you cannot find the specific information you need within the e-Manual, please utilize the following resources:

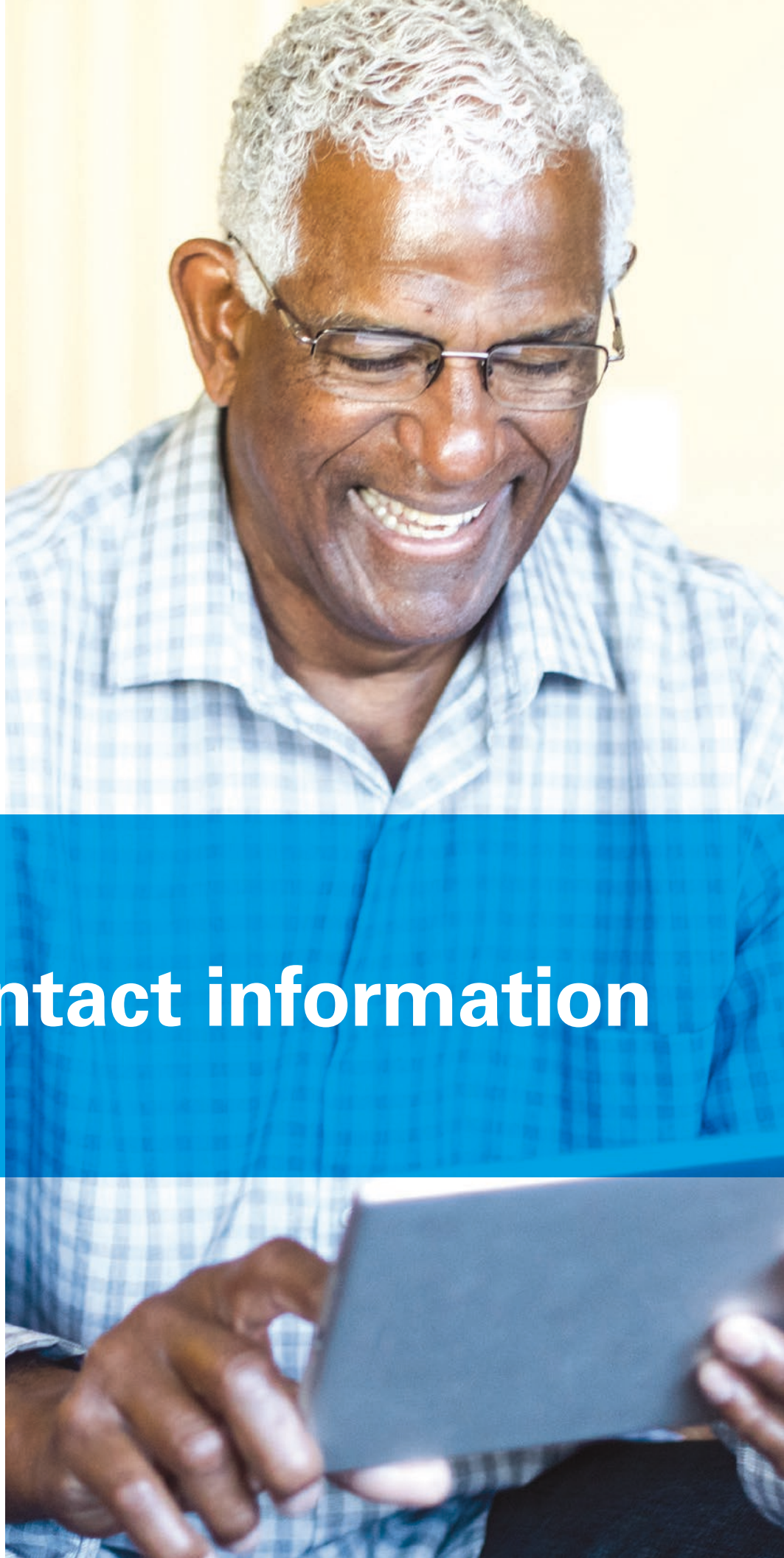
- Your health care business's Provider NPA with Blue Cross NC.
- The Important News page on our website **BlueCrossNC.com/Providers/Provider-News**.
- The pages for *Providers* on our website **BlueCrossNC.com**, located at **BlueCrossNC.com/Providers**.
- Blue Cross NC Provider Blue Line at **1-800-214-4844**.
- Your Provider Information Management team at **1-800-777-1643**.
- Blue Cross NC medical policies and guidelines, evidence-based guidelines, payment guidelines for providers, diagnostic imaging management policies and medical oncology program guidelines which can be accessed on our website at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes**.

Feedback

We value your feedback. Please direct comments regarding this e-Manual to your regional Strategic Provider Relationships representative.

2

Quick contact information



Carelon Medical Benefit Management
(formerly American Imaging Management)

Avalon Healthcare Solutions

Blue Cross NC

Health Network Solutions (HNS)

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

To find contact information for the Federal Employee Program, please refer to the corresponding plan-specific section that's contained within this e-Manual (see **Chapter 4** for **FEP**).

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 Blue Cross NC electronic solutions on the web at: **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries** or refer to **Chapter 11** of this e-Manual.

Blue *e* is quick and easy to use – plus, it's free to our network providers!

Helpful telephone numbers

2.1
Provider Blue Line 1-800-214-4844

For Blue Cross NC provider Customer Service, our Provider Blue Line is a one-stop shop. Providers only need to call one (1) 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

The Provider Blue Line 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; new requests for certification should be placed with Blue Cross NC health management

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 Blue Cross NC issued provider identification number)
- Patient's identification number and 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 (1) 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 speaker phone, 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.

Important

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*.

The Customer Service hours for the Provider Blue Line:

Days	Hours	Day	Hours
Monday – Thursday	8:00 a.m. – 5:00 p.m.	Friday	8:00 a.m. – 4:00 p.m.

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 should also be called for Care Management questions about other Blue Plan members. When calling, you will need to enter the three (3) letter prefix at the beginning of the member's identification number. Enter only the first three (3) characters and your call will be automatically routed to the member's Blue Plan.

Please Note: 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 Blue Cross NC 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 5** of this e-Manual.

2.3
Care management 1-800-672-7897

The Blue Cross NC Care Management department works with physicians and members to facilitate the most medically appropriate, cost-effective, quality care for our members. When you call **1-800-672-7897**, Care Management staff are available to assist with arranging care for our commercial and State Health Plan members. Care Management staff can assist with arranging:

- Certification
- Certification requests for members enrolled in the State Health Plan
- Prior review requests
- Discharge planning
- Transplants
- Medical director reviews
- Reconsideration requests of an initial medical necessity denial
- Peer-to-peer line
- The Blue Cross NC Pharmacy

Note: The following Utilization Management services are available:

- Staff members are available during normal business hours, excluding holidays. Call us at **1-800-672-7897** to discuss Utilization Management issues.
- After normal business hours, providers and members have access to a voice mail system by calling us at **1-800-672-7897**.
- Staff members will identify themselves by name, title and organization name when initiating and returning calls.
- TDD/TTY services are available at **1-800-442-7028** for members who need hearing assistance.
- Language assistance is also available for members who need to discuss Utilization Management issues by calling us at **1-800-678-7897**.

To learn more about Care Management services, processes or policies, please refer to **Chapter 7** of this e-Manual. Additionally, the Blue Cross NC Care Management department makes available electronic capability via **Blue *e*** for providers arranging member services and supplying Blue Cross NC requested documentation.

Care Management is available twenty-four (24) hours a day (to learn more, please see **Chapter 7** of this e-Manual).

Available support:

Representative
Monday – Friday
8:00 a.m. – 5:00 p.m.

Voice Mail System
Monday – Friday
Outside of regular business hours

2.4
Behavioral health services

The chart below displays the behavioral health services and the member plan exceptions that utilize Blue Cross NC (to learn more about these delegated activities, please refer to the specialty networks information located in **Chapter 17** of this e-Manual):

DELEGATED ACTIVITIES				
PLAN	**HMO**	**POS**	**PPO**	**CMM**
UTILIZATION MANAGEMENT PROGRAMS	Blue Cross NC	Blue Cross NC	Blue Cross NC	Blue Cross NC
QUALITY MANAGEMENT	Blue Cross NC	Blue Cross NC	Blue Cross NC	Blue Cross NC
CLAIMS PROCESSING	Blue Cross NC	Blue Cross NC	Blue Cross NC	Blue Cross NC
PROVIDER CONTRACTING AND PROVIDER NETWORK	Blue Cross NC	Blue Cross NC	Blue Cross NC	Blue Cross NC
CUSTOMER SERVICE	Blue Cross NC	Blue Cross NC	Blue Cross NC	Blue Cross NC
ELIGIBILITY AND BENEFIT VERIFICATION	Blue Cross NC	Blue Cross NC	Blue Cross NC	Blue Cross NC
FIRST LEVEL APPEALS	Blue Cross NC	Blue Cross NC	**Utilization first level appeals:** Blue Cross NC **Claims first level appeals:** Blue Cross NC	**Utilization first level appeals:** Blue Cross NC **Claims first level appeals:** Blue Cross NC

Blue Cross NC offers care management services for behavioral health.

Main telephone numbers

Behavioral health services are provided by Blue Cross NC.

- Utilization management
- Quality management
- Eligibility and member benefit verification

2.5
Avalon Healthcare Solutions

Blue Cross NC has partnered with Avalon Healthcare Solutions (Avalon), a Lab Insights company, to inform appropriate care, reduce costs and improve clinical outcomes. The Avalon program focuses on preservice (genetic test management) and post-service (routine test management) review, and couples test-specific scientific policy with a network of high-quality independent laboratories. This combination provides a comprehensive approach to managing appropriate utilization and costs of laboratory services.

Blue Cross NC members have in-network access to the Avalon network of independent laboratories. A current list of all participating laboratories is available in the Blue Cross NC provider directory. There is no change to the process followed by ordering physicians and members for accessing laboratory services through the Avalon network.

Participation status:

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

Health Network Solutions, Inc. (HNS) 1-704-895-8117

The below chart displays the intermediary, delegated activities for HNS (to learn more about these delegated activities, please refer to the specialty networks information located in **Chapter 17** of this e-Manual):

DELEGATED ACTIVITIES			
PLAN	**HMO/POS**	**PPO**	**CMM**
UTILIZATION MANAGEMENT PROGRAMS	Blue Cross NC	Blue Cross NC	Blue Cross NC
QUALITY MANAGEMENT	Blue Cross NC	Blue Cross NC	Blue Cross NC
CLAIMS PROCESSING	* Blue Cross NC	* Blue Cross NC	* Blue Cross NC
PROVIDER CONTRACTING AND PROVIDER NETWORK	HNS	HNS	Blue Cross NC
CUSTOMER SERVICE	Blue Cross NC	Blue Cross NC	Blue Cross NC
ELIGIBILITY AND BENEFIT VERIFICATION	Blue Cross NC	Blue Cross NC	Blue Cross NC
FINAL LEVEL APPEALS	Blue Cross NC	Blue Cross NC	Blue Cross NC

* Provider submits claims to HNS > HNS submits claim to Blue Cross NC > Blue Cross NC provides appropriate payment to HNS > HNS provides appropriate payment to provider.

Participation status:

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.

2.7

Carelon Medical Benefit Management (Carelon) 1-866-455-8414

Blue Cross NC requires that for non-emergency outpatient CT/CTA, MRI/MRA, PET, nuclear cardiology and echocardiography procedures performed in a physician's office, outpatient department of a hospital or freestanding imaging center, ordering physicians must obtain certification from Carelon. When contacting Carelon 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 Carelon in one (1) of the following ways:

- By logging in to the Carelon portal, accessed through **Blue *e***, available seven (7) days a week, 4:00 a.m. to 1:00 a.m. ET
- By calling Carelon, **1-866-455-8414** (toll free), Monday through Friday, 8:00 a.m. to 5:00 p.m. ET

Imaging service providers can also contact Carelon 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 **bluee.bcbsnc.com/providers/web**. Blue Cross NC provides **Blue *e*** to providers free of charge.

Please Note: Most Blue Cross NC member groups will be participating in the diagnostic imaging management program, however not all groups are participating. Blue Cross NC offers a web-based search tool that is available on the **BlueCrossNC.com** *Providers* section and on **Blue *e*** which will allow you to quickly determine whether an authorization is needed. Blue Cross NC 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 7** of this e-Manual.

2.8
Mailing addresses

Health Care Claims	
HEALTH CARE CLAIMS – BLUE CROSS NC **Exception(s):** The State Health Plan	**Blue Cross NC** **P.O. Box 35** **Durham, NC 27702**
HEALTH CARE CLAIMS – THE STATE HEALTH PLAN	**Blue Cross NC** **P.O. Box 30087** **Durham, NC 27702**

Mental Health and Substance Use Services Claims	
MENTAL HEALTH AND SUBSTANCE USE CLAIMS – BLUE CROSS NC **Exception(s):** The State Health Plan	**Blue Cross NC** **P.O. Box 35** **Durham, NC 27702**
MENTAL HEALTH AND SUBSTANCE USE CLAIMS – THE STATE HEALTH PLAN	**Blue Cross NC** **P.O. Box 30087** **Durham, NC 27702**

Chiropractic Services	
CHIROPRACTIC SERVICE CLAIMS: BLUE CROSS NC HMO, BLUE CROSS NC PPO **Exception(s):** CMM	**HNS/Blue Cross NC** **P.O. Box 2368** **Cornelius, NC 28031**

Level I Member Appeals	
LEVEL I MEMBER APPEALS INCLUDING A MEMBER SIGNED APPEAL AUTHORIZATION FORM	**Blue Cross NC** **Member Rights and Appeals** **P.O. Box 30055** **Durham, NC 27702-3055**

continued on following page

For fastest claims processing, file electronically!

Visit Blue Cross NC electronic solutions on the web at:
BlueCrossNC.com/Providers/Claims-Appeals-Inquiries

Level I Provider Appeals

LEVEL I PROVIDER APPEALS	**Blue Cross NC** **Provider Appeals** **P.O. Box 2291** **Durham, NC 27702-2291** (please use the Level I Provider Appeal Form located in **Chapter 21** of this e-Manual)

Level I Provider Appeals

OVERPAYMENTS – **Exceptions:** Blue Cross NC mental health and dental	**Blue Cross NC** **Financial Processing Services** **P.O. Box 30048** **Durham, NC 27702-3048** (please use the Provider Refund Return Form located in **Chapter 21** of this e-Manual)

2.9
Claim inquiries

If you have a question about a Blue Cross NC claim that has processed, the amount paid or disallowed or maybe you just want to ask about the status – **Blue *e*** can help. Providers with **Blue *e*** can find 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***, visit electronic solutions on the web at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries** or refer to **Chapter 11** in this e-Manual.

If you choose to send your claims question in writing, we offer a Provider/Doctor Claim Inquiry Form that can help. The form is available to be copied from **Chapter 21** of this e-Manual or can be printed from the Blue Cross NC website **BlueCrossNC.com/Providers/**.

The form is available to help you find the answers to questions pertaining to topics such as:

- 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
  - When using the form, supporting medical documentation should be submitted. Providers may reduce administrative costs associated with records submissions by first verifying that the records document information is consistent with Blue Cross NC medical policy, pricing and adjudication policy and Claim Check Clinical (C-3) edit rationale.

Find out what Blue *e* can offer you:
BlueCrossNC.com/Providers/

2.10
Online availability

The *Providers* section of our website, **BlueCrossNC.com**, contains a variety of helpful information. Some of the information available includes:

Provider Resources BlueCrossNC.com/Providers/

- Most current Blue Book Provider e-Manual
- *Provider eBriefs* (email communications)
- Most current prior authorization listing of certain medical services and medications
- Medical policies and guidelines
- Evidence-based guidelines
- Payment guidelines for providers
- Diagnostic imaging management policies
- Medical Oncology policies
- Sleep Study 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
- Educational courses
- And **much** more ...

Electronic Resources BlueCrossNC.com/Providers/Manage-Claims-and-Inquiries

- **Blue *e***
- Electronic solutions important news
- HIPAA information
- Electronic solutions
- Electronic solutions vendor list

Click on the *Providers* tab to access information pertaining to you. Make sure to access the website often to stay current on Blue Cross NC news and publications.

Provider/Doctor Claim Inquiry Form:

Blue Cross NC Provider Inquiry
Customer Service Department
P.O. Box 2291
Durham, NC 27702-2291

2.11

Electronic solutions customer support 1-888-333-8594

Blue Cross NC electronic solutions enables the transmission of electronic files for the business processing of health care information. Blue Cross NC 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 the web-based product **Blue *e*** for interactive inquiries about eligibility and claim status, admission notifications and claims entry. Blue Cross NC has developed electronic solutions that allow contracted health care providers to access detailed claim management information from Blue Cross NC, and customize that information to the workflows in their organizations. To find out more about Blue Cross NC electronic solutions, please refer to **Chapter 11** of this e-Manual, visit our electronic solutions website at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries** or contact your Strategic Provider Relationship Analyst.

Electronic solutions customer support is available to assist Monday through Thursday, 8:00 a.m. to 5:00 p.m., and Friday, 8:00 a.m. to 4:00 p.m. ET.

Need Help?

Electronic claims filing issues, Blue *e*

1-888-333-8594 Option 1

1-919-765-3514

Fax: **1-919-765-7101**

3

Health care – Benefit plans and member identification cards

3.1
Health care benefit plan types and provider participation

Blue Cross NC health care benefit plans can typically be categorized into five (5) basic plan types:

- Health Maintenance Organization
- Exclusive Provider Organization
- Point-of-Service
- Preferred Provider Organization
- Comprehensive Major Medical

Contracting providers with questions about in which plan types they participate should refer to their individual health care businesses Network Participation Agreement with Blue Cross NC, or contact the Provider Network for assistance. Contact information can be found in **Chapter 2** of this e-Manual.

Note: PPO and POS providers are in-network, and HMO and EPO providers are participating.

3.2
Health care benefit plans overview

Blue Cross NC 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 Blue Cross NC:

HMO product

- Blue Care (HMO plan)

EPO products

- BlueHPN (EPO plan)
- Blue Home with Novant Health (EPO plan with deductible and coinsurance, or copayments)
- Blue Home with UNC Health Alliance (EPO plan with deductible and coinsurance, or copayments)
- Blue Local with Atrium Health (EPO plan with deductible and coinsurance, or copayments)
- Blue Local with Wake Forest Baptist Health (EPO plan with deductible and coinsurance, or copayments)

POS products

- Blue Value (POS) with in-network and out-of-network benefits with deductible and coinsurance, or copayments)

Note: Blue Local with Atrium Health, Blue Local with Wake Forest Baptist Health, and My Blue with Duke Health POS employer group products will be discontinued at the end of 2023.

PPO products

- Blue Options (PPO plan)
  - Blue Options (PPO plan with deductible and coinsurance, or copayments)
  - Blue Options (PPO plan with in-network benefits only)
- Blue Options 1-2-3 (PPO plan with three [3] benefit levels)
- Blue Options HRA (High-deductible PPO plan may be paired with a health reimbursement account)
- Blue Options HSA (High-deductible PPO plan paired with a health savings account)
- Blue Advantage (PPO plan purchased by individuals)
- State Health Plan (PPO plan for State Health Plan membership)

CMM product

- Classic Blue (CMM plan)

Information relevant to each of these products, including sample member identification cards can be found within this section. Additional information about Blue Cross NC-offered health care plans is available on our website for members, located at **BlueCrossNC.com/shop-plans**. Health care providers should always (except in emergency situations) verify a member's individual health care benefits and coverage eligibility prior to providing services.

In addition to our health care benefits products, Blue Cross NC offers members local and national discounts via Blue365®, which offers a wide array of health and wellness products and services at no additional cost to members. Blue Cross NC members can sign up for weekly emails with featured deals at **BlueCrossNC.com/Blue365**.

Discounts offered:

- Gym memberships
- Eyeglasses and other vision care
- Hearing aids
- Family activities and travel
- Healthy foods and nutrition programs

Blue Cross NC also offers Medicare-related and Medicare Supplement programs, as well as COBRA and ancillary products including life, dental and disability insurance. Because Blue Cross NC continually reviews its products for members, new products may be developed and introduced or existing products may be removed from the market. Subsequently, the health care coverage products described within this e-Manual should not be considered inclusive of all products offered by Blue Cross NC. To find out more about Blue365 and other Blue Cross NC product offerings, please view information available on our website at **BlueCrossNC.com** or contact the Provider Network for assistance.

3.3
Determining eligibility

Blue *e* is the fastest and easiest way to obtain a member's eligibility and benefits information. With **Blue *e*** access, providers can verify a member's eligibility and benefits (including benefit accumulators). Providers and their office staff need only to access the member name search and/or member health eligibility search options to view a member's information in real-time from the provider's own computer screen. If your organization does not yet have access to **Blue *e***, find out more by visiting the Blue Cross NC electronic solutions page on the web at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**, or refer to **Chapter 11** of this e-Manual. **Blue *e*** and the Provider Blue Line are the most accurate and up-to-date sources for verifying 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 the Provider Blue Line at **1-800-214-4844**. When calling, please have a copy of 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. Providers are reminded to always verify a member's eligibility and complete benefits, as well as current remaining benefits, in advance of providing care.

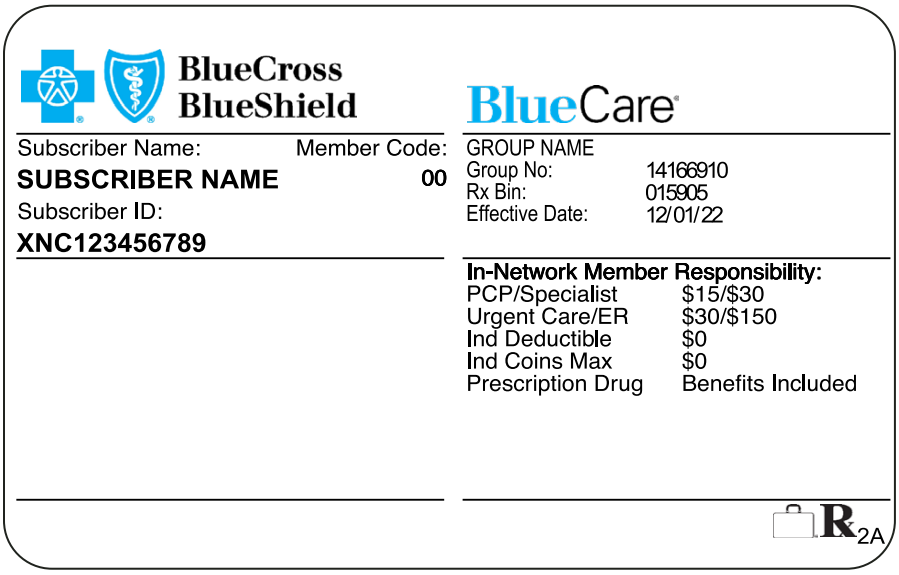
We suggest that you always request to see the member's most current Blue Cross NC ID card prior to providing service, and verify the member's ID number in your records. If a change has occurred, always update all your systems and records with the new identifying information. Inform any business partners or clearinghouses that you work with of the change.

When submitting claims or verifying eligibility and benefits always use the complete member ID number, including the complete prefix and member suffix without any special characters such as hyphens, spaces or dashes.

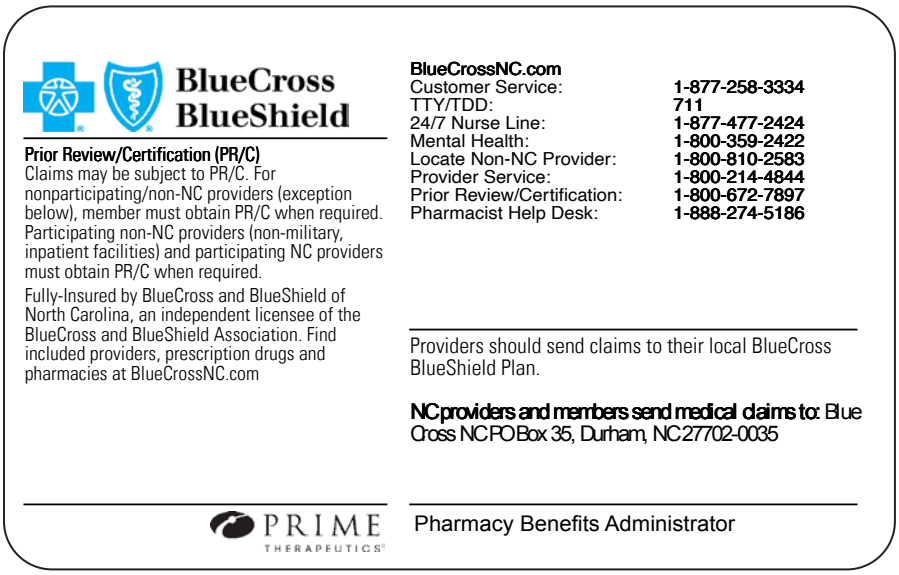
Here is a sample of how a Blue Cross NC member's identification card may appear:

When presented with a Blue Cross NC member ID card, always verify the member's other forms of identification to help prevent identity theft.

Sample identification card (front)



Sample identification card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

3.3.2
Member identification numbers

To protect our member's privacy, Social Security numbers are not included as part of the member's ID number. Blue Cross NC member ID numbers typically have a prefix in the first three (3) positions and are often followed by a "**W**" and six (6) randomly assigned numbers, which are followed by two (2) additional numbers that are displayed to the right of the subscriber's or dependent's name on the member's ID card (e.g., YPP**W**12345601).

As Blue Cross NC moves forward with migration to a new technology platform, members set up on the new system can be recognized by new prefixes:

- Most member ID numbers still consist of twelve (12) positions; a three (3) position prefix followed by numeric values.
- A "**W**" or "**J**" is not found in the fourth position of the ID number.

  Note: Members who have not yet migrated to the new platform will continue to have these prefix characters in the fourth position of their ID numbers.
- The "subscriber" suffix is "**00**," the "dependent" suffix is "**01**," and so forth.
- Identification numbers for FEP members have a single prefix beginning with "**R**" (e.g., **R**12345601).
- Member IDs for other Blue Plans will typically include a prefix in the first three (3) positions and can contain any combination of numbers and letters up to seventeen (17) characters.

Prefixes identify the Blue Cross and/or Blue Shield (BCBS) health care plan to which a member belongs. Prefixes should always be included when filing claims (if the member's ID includes a prefix). The prefix is necessary to accurately verify eligibility and benefits, as well as route claims to the appropriate Blue Cross and/or Blue Shield plan. Following is a list of the most commonly recognized prefixes for Blue Cross NC members.

Please Note: This list is not all-inclusive and may not include many of the customized employer group prefixes.

Prefix	Plan	
YPH	Blue Care	HMO
YPP	Blue Options	PPO
YPP YPS	Blue Options 1-2-3	PPO
YPD	Blue Options HSA	PPO
YPD	Blue Options HRA	PPO
YPP YPI YPN	Blue Advantage	PPO
YPY	State Health Plan	PPO
YPM	Classic Blue	PPO
YPW YPV	Blue Value	POS
YPN	Blue Advantage® Saver℠	PPO
Y2K Y2L	Blue Home with UNC Health Alliance	EPO
Y2P Y2Q	Blue Local with Wake Forest Baptist Health	EPO
Y2Y Y2Z	Blue Home with Novant Health	EPO
Y2U Y2V	Blue Local with Atrium Health	EPO
HPO	Blue HPN	EPO

Note: Employer group products sunsetting in 2023: Blue Local with Atrium Health POS (prefix NBQ), Blue Local with Wake Forest Baptist Health POS (prefix WVK), My Blue with Duke Health POS (prefix MDK)

3.3.3
Verification of Coverage form

Blue Cross NC makes every effort to provide ID cards prior to a member's effective date. Newly enrolled members or members with benefit plan changes may download and print a temporary Verification of Coverage form if they have not received a member ID card before the effective date of their coverage. The temporary Verification of Coverage form is available from Blue Connect℠ at **BlueConnectNC.com**.

3.3.4
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, Blue Cross NC 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
Preventive care services

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA) have designated certain clinical services as preventive benefits. When provided by an in-network provider, these services are available at no cost to eligible members.

In an effort to ensure our members receive the most out of their benefits for these services, we've developed a guide that outlines the various preventive care services in question. This guide will provide you with the correct coding: Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, diagnosis codes, information regarding the appropriate use of the codes, as well as any related explanatory comments for each service. It's important to remember that effective dates for the service categories included in the Preventive Services Guide apply to our members' benefits for these services on or after their respective plan renewal date.

The Health Care Reform Preventive Services Coding Guide is available to providers via **Blue *e*** under the *Related Links* section. As new national recommendations are published, we will update the online guide accordingly.

A list of preventive care services covered at 100% is available at **BlueCrossNC.com/Preventive**.

3.5
Blue Care, an HMO product

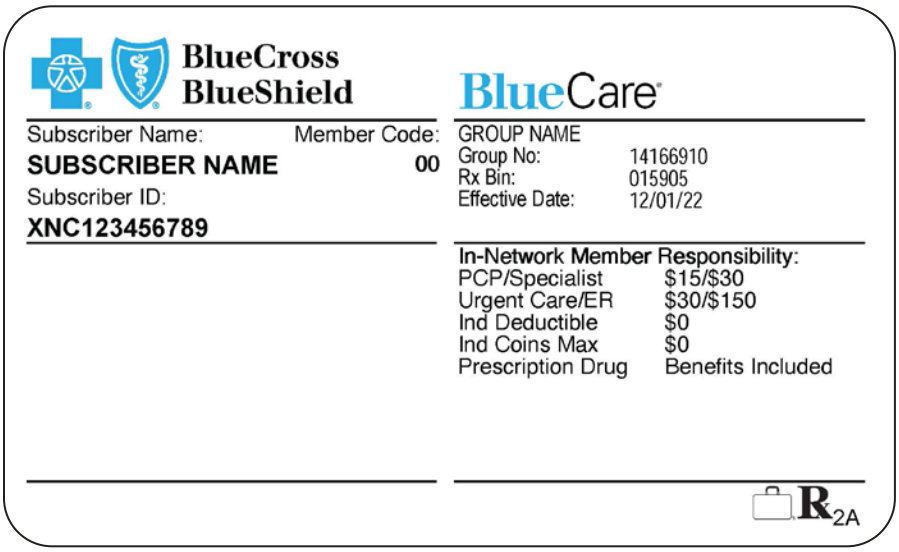
Blue Care is an open access HMO plan that gives employers simple and affordable health care options for their employees. Blue Care offers coverage for members when receiving care from participating providers, hospitals and clinics. Blue Care gives members the freedom to go directly to a participating Primary Care Provider (PCP) or specialist without a referral. Blue Care also provides an extensive wellness program to help keep our members healthy. Plus, members only pay a copayment when they receive office-based care.

3.5.1
Health benefit summary

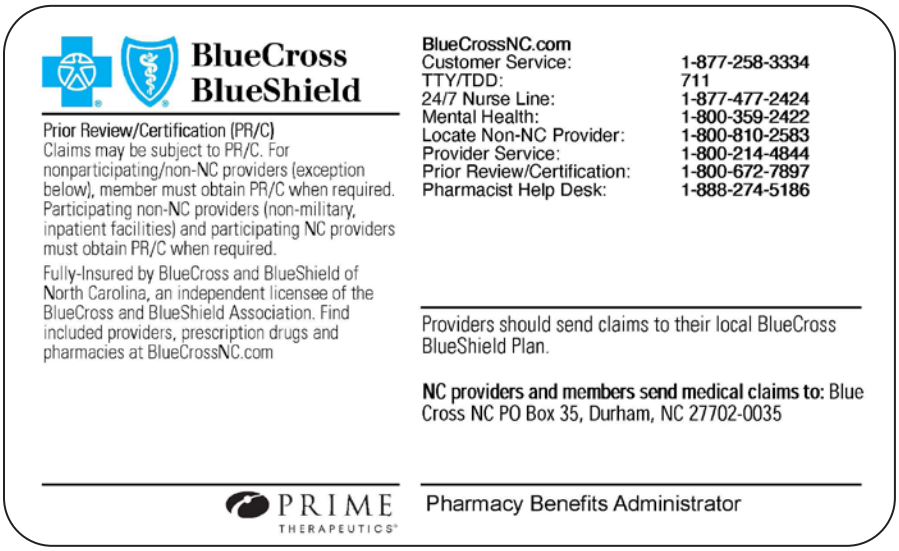
Blue Care is a traditional managed care plan where most services covered under a member's benefit plan include either a member copayment or coinsurance payment, when service is received within the HMO network. Benefits are available for covered services received from Blue Care in-network/participating providers. Blue Care members do not have out-of-network benefits unless approved in advance by Blue Cross NC or in cases of urgent or emergency care. The following summary of benefits describes basic fundamentals about how the HMO plan typically works, however eligible services and benefits can vary and providers should always verify a member's actual eligible services and coverage for benefits in advance of providing care (except when urgent or emergent conditions prevent):

- Member's benefits are available when services are received from Blue Cross NC HMO participating providers.
- Benefits are available from non-participating providers for emergency and urgent care services.
- Services received from non-participating providers that are not urgent or emergent, and are not approved by Blue Cross NC in advance of service, are not covered under Blue Care.
  - In specific situations, Blue Cross NC may approve coverage for certain services received from non-participating physicians or providers. This includes situations where continuity of care or network adequacy issues dictate the use of non-participating physician or provider.
- Members are encouraged, though not required, to select a primary care physician at the time of enrollment.
- 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 a change.
- Members are not required to have or obtain a referral from a primary care physician in order to see a specialist.
- The prior review list applies to Blue Care.
- Copayments typically apply when services are received within a provider's office, free-standing facility or hospital emergency room. Deductible and coinsurance amounts typically apply for outpatient and inpatient hospital care.

Sample Blue Care membership ID card (front)



Sample Blue Care membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Always verify the card holder's other forms of legal identification to help prevent identify theft.

3.6
Blue Value products

Blue Cross NC POS product is a type of HMO with in-network and out-of-network benefits. Blue Value offers a limited Provider Network and formulary. Blue Value is a plan that does not require a primary care provider or referrals for service.

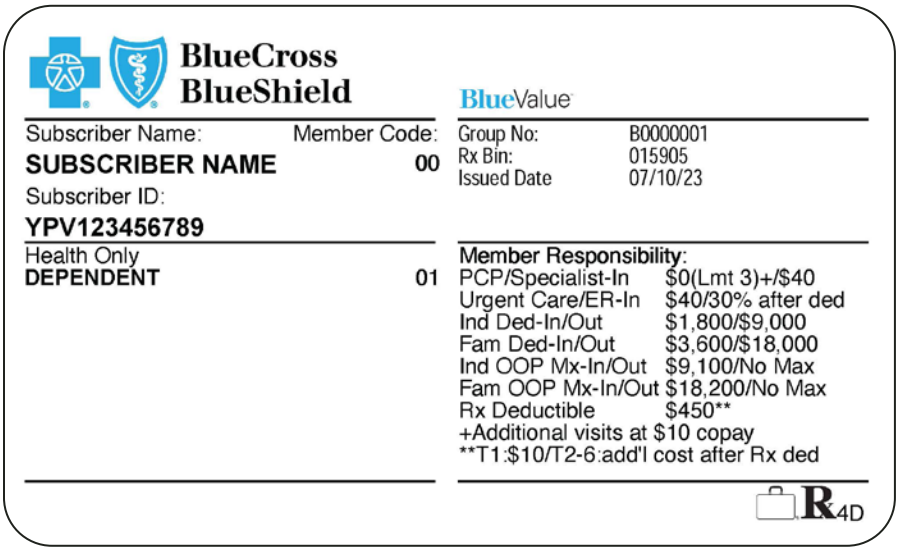
3.6.1
Health benefit summary

Blue Value is a POS plan where the member pays a copayment or deductible and coinsurance for provider visits. Members may have to pay additional for any tests, labs or other medical costs outside of the visit. After a member's prescription deductible is met, if applicable, the member pays a copayment for prescription drugs. Members pay toward the hospital costs until their deductible is met. After the deductible is met the member and Blue Cross NC share the medical costs until the member's out-of-pocket limit is met. After the member's out-of-pocket limit is met, Blue Cross NC pays for all covered medical expenses. Members locate participating Blue Value providers using the HealthNAV℠ suite of tools at **BlueConnectNC.com**.

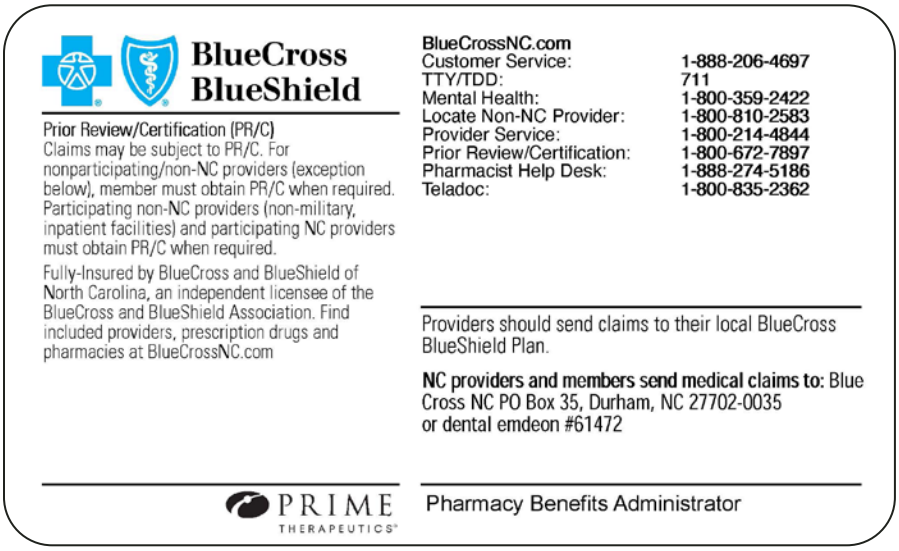
- Using an out-of-network provider results in higher out-of-pocket expenses for the member.
- Out-of-network claims will be paid to the member, who is responsible for paying the provider.
- If the member does not ensure the pre-authorization for out-of-network services is obtained, the claim will be denied.
- Members who need services not available in their network can apply for an exception for the service to be covered at the in-network level.

The full member ID begins with YPV for individual coverage and YPV for group coverage and is a total of twelve (12) characters, which includes nine (9) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the right of the subscriber's or dependent's name.

Sample Blue Value membership ID card (front)



Sample Blue Value membership ID card (back)

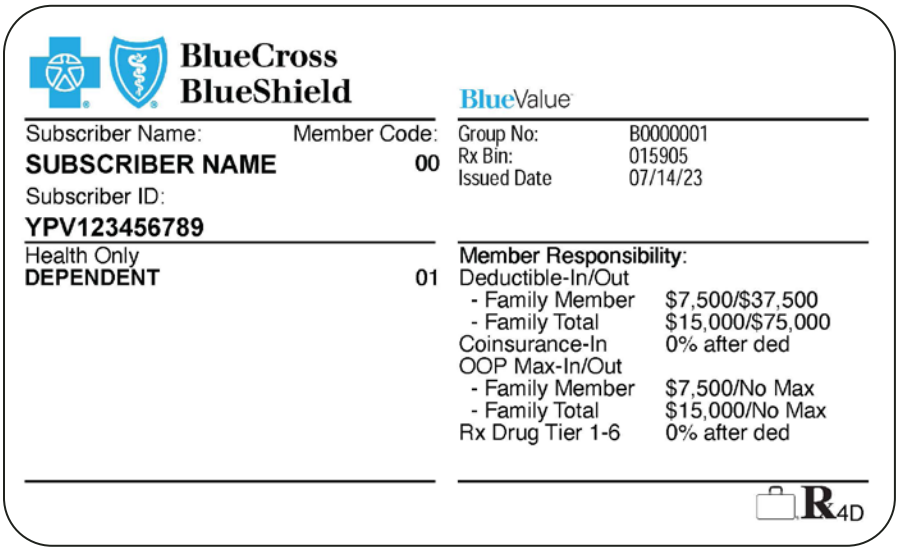


Always remember to make a copy of the front and back of the member's identification card and place that copy in the member's file for your records.

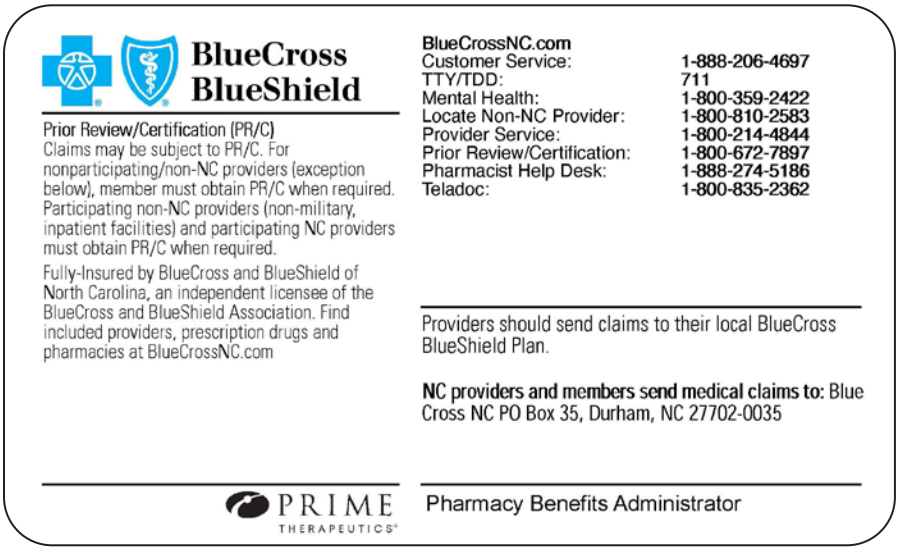
Please ensure that any discarded copies are properly destroyed to help protect the patient's identity.

Sample ID card for membership on Blue Cross NC's new technology platform

Sample Blue Value HSA membership ID card (front)



Sample Blue Value HSA membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

Remember, for membership on Blue Cross NC's new technology platform, there will not be a "**W**" in the fourth position of the ID number. See **Section 3.3.2** for applicable prefixes.

The "subscriber" suffix will be "**00**," the "dependent" suffix will be "**01**," and so forth.

ID cards for these members will be made out of hard plastic which is different from the paper ID cards generated today for members still on our legacy system.

3.7
Blue Home with UNC Health Alliance

Blue Home with UNC Health Alliance is a regionally-focused, exclusive provider organization plan with a local network built around the UNC Health Alliance system. The Blue Home with UNC Health Alliance product is available both on and off the North Carolina Health Insurance Marketplace (also referred to as the Exchange) to individual health care consumers under the age of sixty-five (65) and living in select counties within the Triangle including Nash County.

Blue Home members can be identified by the prefix on their Blue Cross NC ID cards. Members will need to be seen by in-network UNC Health Alliance providers in order to receive in-network benefits. There are no out-of-network benefits on this plan. If they are referred to other providers outside of the specific Blue Home network, they will not have benefit coverage and will be responsible for the total cost of care. Therefore, it is important for providers to be aware of which hospitals and providers are participating in the network for members to get the most out of their benefits when enrolled in these plans.

3.8
Blue Home with Novant Health

Blue Home with Novant Health is a regionally-focused, exclusive provider organization plan with a local network built around the Novant Health system. The Blue Home with Novant Health product is available both on and off the North Carolina Health Insurance Marketplace (also referred to as the Exchange) to individual health care consumers under the age of sixty-five (65) and living in select counties around Charlotte and Winston-Salem.

Blue Home members can be identified by the prefix on their Blue Cross NC ID cards. Members will need to be seen by in-network Novant Health providers in order to receive in-network benefits. There are no out-of-network benefits on this plan. If they are referred to other providers outside of the specific Blue Home network, they will not have benefit coverage and will be responsible for the total cost of care. Therefore, it is important for providers to be aware of which hospitals and providers are participating in the network for members to get the most out of their benefits when enrolled in these plans.

3.9
Blue Local

Blue Local is a regionally-focused, exclusive provider organization plan with a limited network built around select health care systems. The Blue Local product is available both on and off the North Carolina Health Insurance Marketplace (also referred to as the Exchange) to individual health care consumers under the age of sixty-five (65) and living in select counties. Blue Local is also available to some employer groups through the end of 2023.

There are two (2) separate products: Blue Local is sold in two (2) separate areas. In the Charlotte area, there is Blue Local with Atrium Health. In the Triad area, there is Blue Local with Wake Forest Baptist Health. These networks are not shared; however, since Atrium Health and Wake Forest Baptist Health's merger, hospital-owned providers affiliated with each system are in-network on both Blue Local Products. For instance, Wake Forest Baptist Health providers are in-network in the Blue Local with Atrium Health product. Atrium Health providers are in-network in the Blue Local with Wake Forest Baptist Health product. The networks in each Blue Local product are not identical.

Blue Local members can be identified by the prefix on their Blue Cross NC ID cards. Members will need to be seen by in-network Blue Local providers in order to receive in-network benefits. There are no out-of-network benefits on these plans. If they are referred to other providers outside of the specific Blue Local network, they will not receive benefit coverage and will be responsible for the total cost of care. Therefore, it is important for providers to be aware of which hospitals and providers are participating in the network for these regional products in order for members to get the most out of their benefits when enrolled in these plans. The Find a Doctor tool at **BlueCrossNC.com** can be used to determine if a hospital or provider is participating in the Blue Local with Atrium Health plan or in the Blue Local with Wake Forest Baptist Health plan.

Providers can recognize a Blue Local member by reviewing the member's ID card.

3.9.1
Health benefit summary

Blue Local and Blue Home offer a limited provider and pharmacy network to members living in select counties. Members are offered two (2) options to pay for medical expenses – deductible and coinsurance, or copayments.

Eligible services and benefits can vary. Therefore, providers should always verify a member's eligibility and coverage for benefits in advance of providing care (except when urgent or emergent conditions prevent).

Blue Local and Blue Home offer the following:

- Preventive care benefits covered at 100% when members go to an in-network provider.
- No lifetime dollar maximums – there is no lifetime dollar amount limit on benefits.
- Blue Local plans offer essential health benefits such as maternity, newborn care, and pediatric services, including dental and vision.
- Blue Local members should see an in-network urgent care provider when inside of the product service area. When outside of the product service area, urgent care is covered as in-network. Emergency services are always covered.

Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

3.10
My Blue with Duke Health

My Blue with Duke Health is a regionally-focused, point-of-service plan with a local network built around the Duke Health system. My Blue with Duke Health is a group only product (so it is not offered in the individual market).

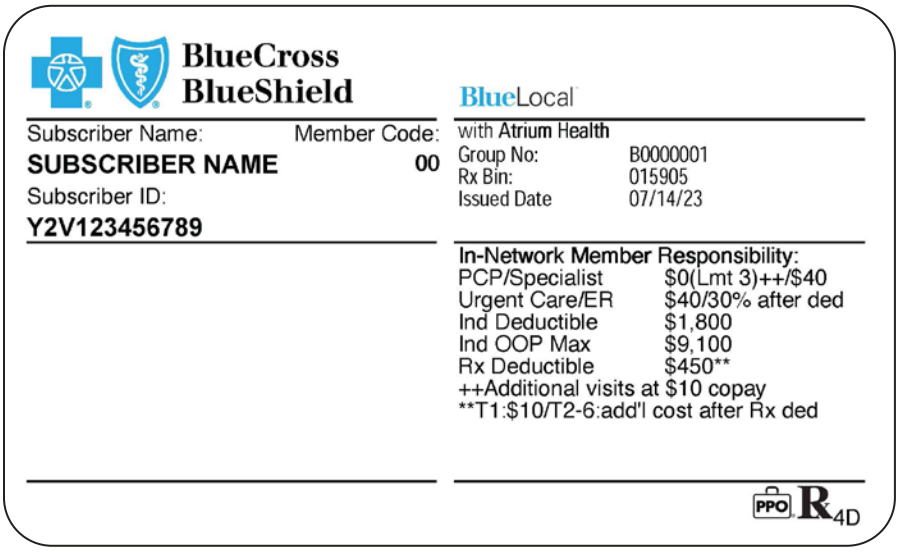
My Blue with Duke Health members can be identified by the prefix on their Blue Cross NC ID cards. Members will need to be seen by in-network Duke Health providers in order to receive in-network benefits. If they are referred to other providers outside of the specific My Blue with Duke Health network, they will be subject to lower, out-of-network benefits for services and higher out-of-pocket costs. Therefore, it is important for providers to be aware of which hospitals and providers are participating in the network for members to get the most out of their benefits when enrolled in these plans.

Members may choose to use out-of-network providers, but it is important they are aware of the potential for higher out-of-pocket expenses they may experience if they make such a decision. Providers should notify patients before rendering services if they are not an in-network provider for the specific benefit plan.

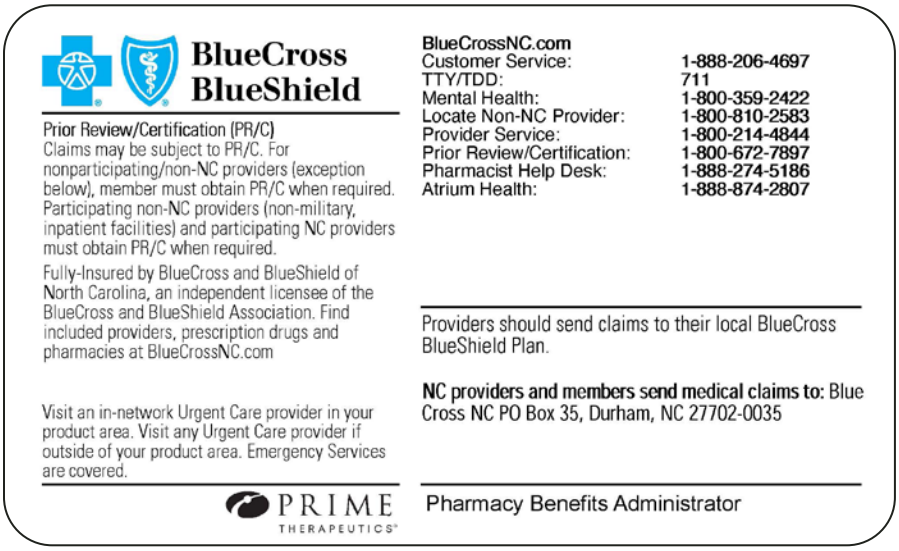
Sample ID card for membership on Blue Cross NC's new technology platform

Atrium Health

Sample Blue Local membership ID card (front)



Sample Blue Local membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

Remember, for membership on Blue Cross NC's new technology platform, there will not be a "**W**" in the fourth position of the ID number. See **Section 3.3.2** for applicable prefixes.

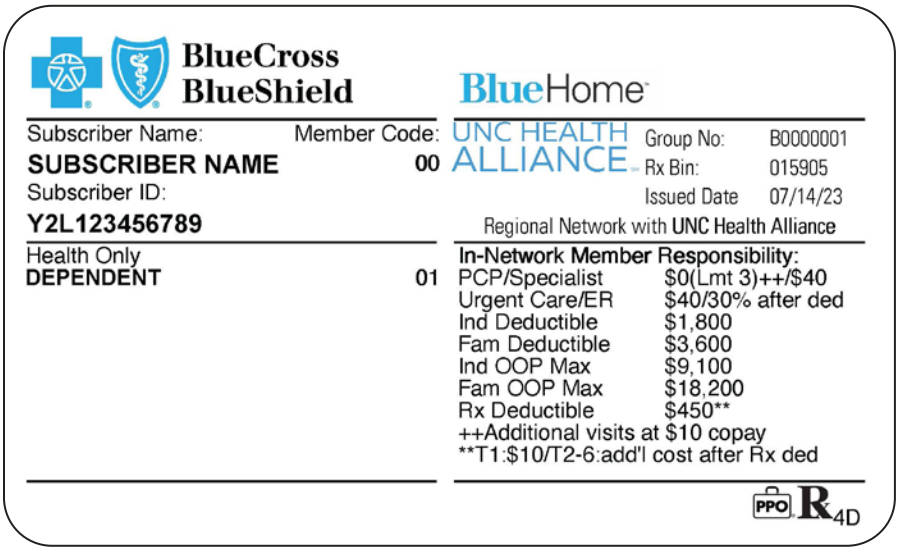
The "subscriber" suffix will be "**00**," the "dependent" suffix will be "**01**," and so forth.

ID cards for these members will be made out of hard plastic which is different from the paper ID cards generated today for members still on our legacy system.

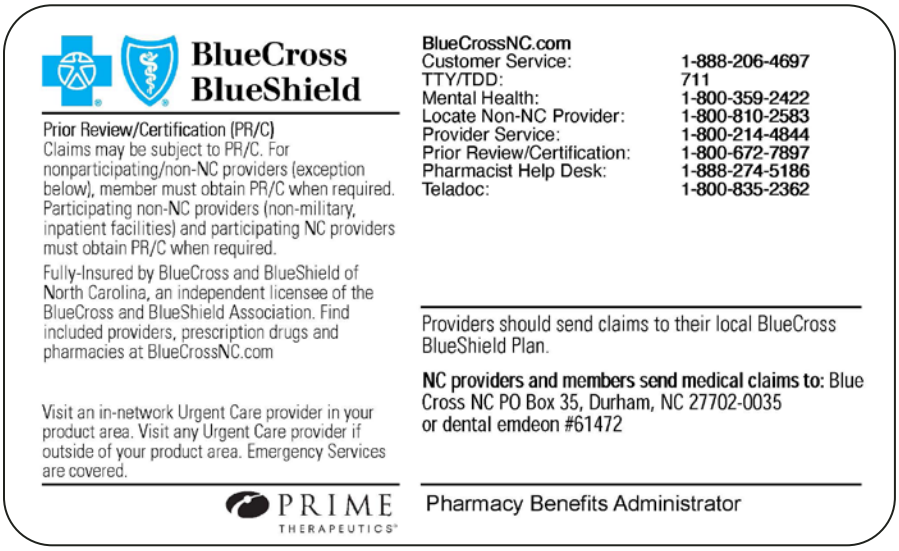
Sample ID card for membership on Blue Cross NC's new technology platform

UNC Health Alliance/UNC Health Care

Sample Blue Home membership ID card (front)



Sample Blue Home membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

Remember, for membership on Blue Cross NC's new technology platform, there will not be a "**W**" in the fourth position of the ID number. See **Section 3.3.2** for applicable prefixes.

The "subscriber" suffix will be "**00**," the "dependent" suffix will be "**01**," and so forth.

ID cards for these members will be made out of hard plastic which is different from the paper ID cards generated today for members still on our legacy system.

3.11

Blue Options plans, State Health Plan and Blue Advantage PPO products

Blue Cross NC PPO products offer coverage for members when receiving care from in-network/participating providers, hospitals and clinics. PPO plans also provide benefits for both in- and out-of-network services.

Please Note: Blue Options In-Network Only is a product available to ASO employer groups, and offers limited in-network benefits for their employees – with the exception of urgent and emergent services.

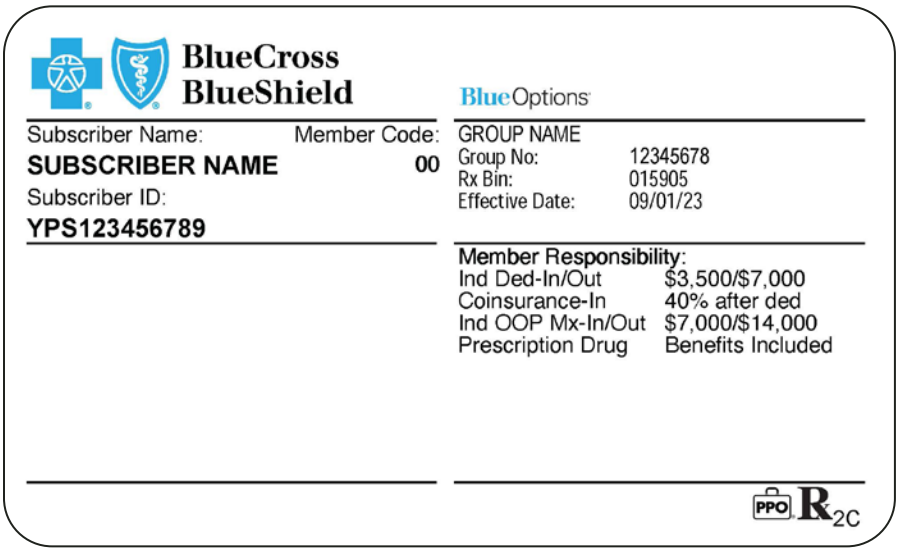
Members who have both in- and out-of-network benefits receive a higher level of benefits when services are received from in-network providers. Blue Cross NC PPO products include plans with copayments-only for certain services, copayments partnered with coinsurance and deductibles and only coinsurance and deductibles (non-copayment plans). Blue Cross NC PPO plans give members the freedom to go directly to participating PCPs or specialists without a referral. PPO plans provide access to extensive wellness programs to help keep our members healthy and are available to individual subscribers, employers purchasing coverage for their employees and State Health Plan members.

Sample PPO membership ID cards

BlueOptions®

The full member ID begins with "YPS" and is a total of twelve (12) characters, which includes nine (9) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the right of the subscriber's or dependent's name.

Sample Blue Options membership ID card (front)



Sample Blue Options membership ID card (back)

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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with three (3) prefix characters and is a total of twelve (12) digits, which includes the three (3) digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

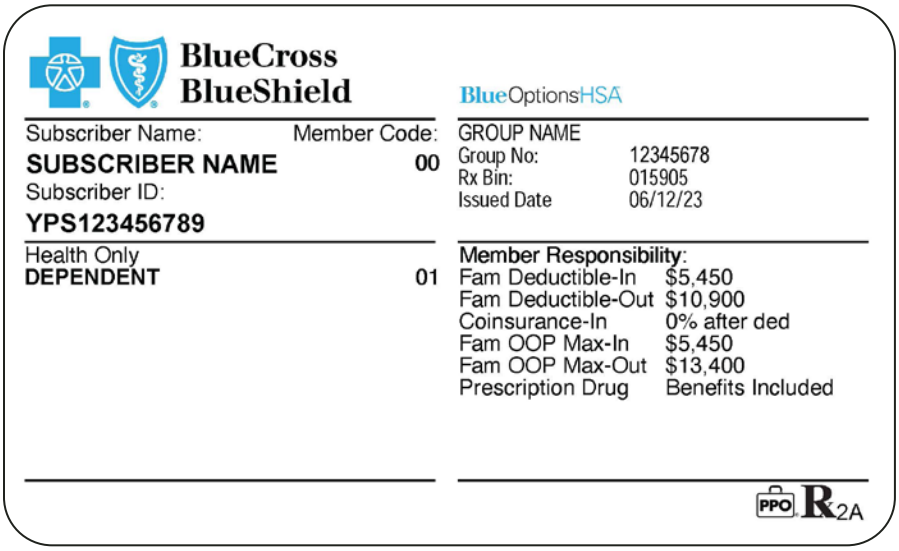
Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Always verify the card holder's other forms of legal identification to help prevent identity theft.

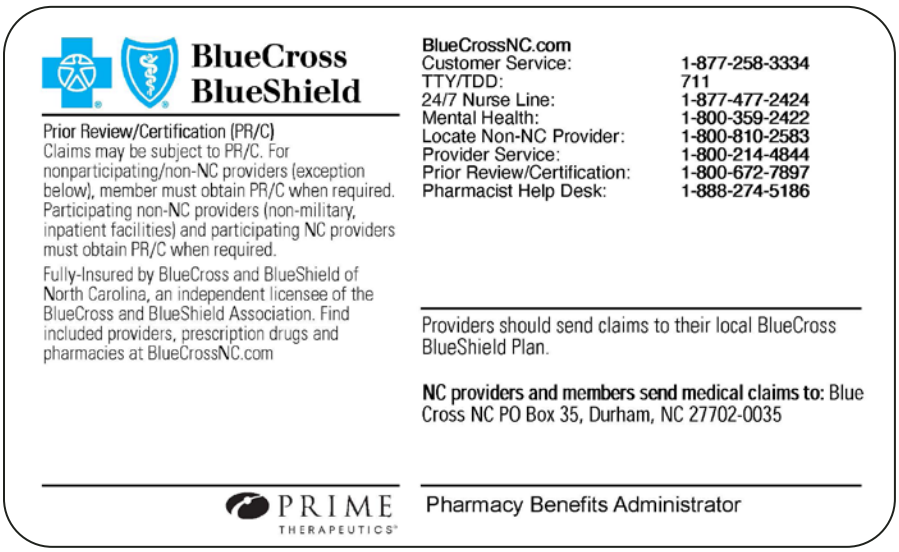
BlueOptionsHSA®

The full member ID begins with "YPS" and is a total of twelve (12) characters, which includes nine (9) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the right of the subscriber's or dependent's name.

Sample Blue Options HSA membership ID card (front)



Sample Blue Options HSA membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with three (3) prefix characters and is a total of twelve (12) digits, which includes the three (3) digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

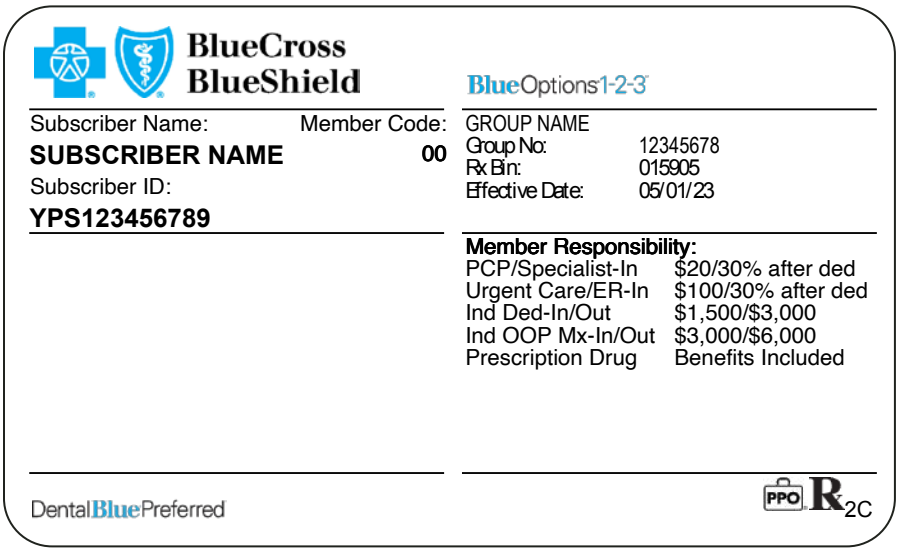
Always verify the card holder's other forms of legal identification to help prevent identity theft.

BlueOptions 1-2-3℠

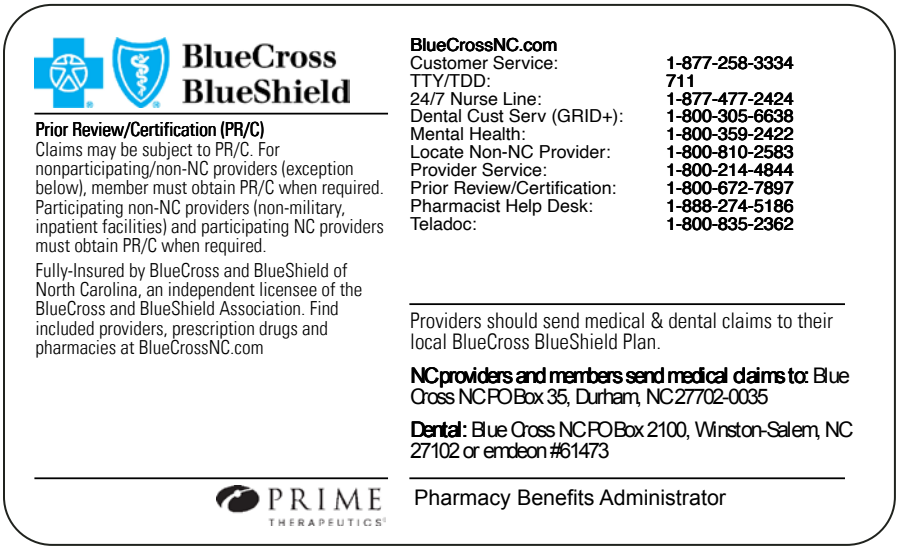
NC

The full member ID begins with "YPS" and is a total of twelve (12) characters, which includes nine (9) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the right of the subscriber's or dependent's name.

Sample Blue Options 1-2-3 membership ID card (front)



Sample Blue Options 1-2-3 membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with three (3) prefix characters and is a total of twelve (12) digits, which includes the three (3) digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

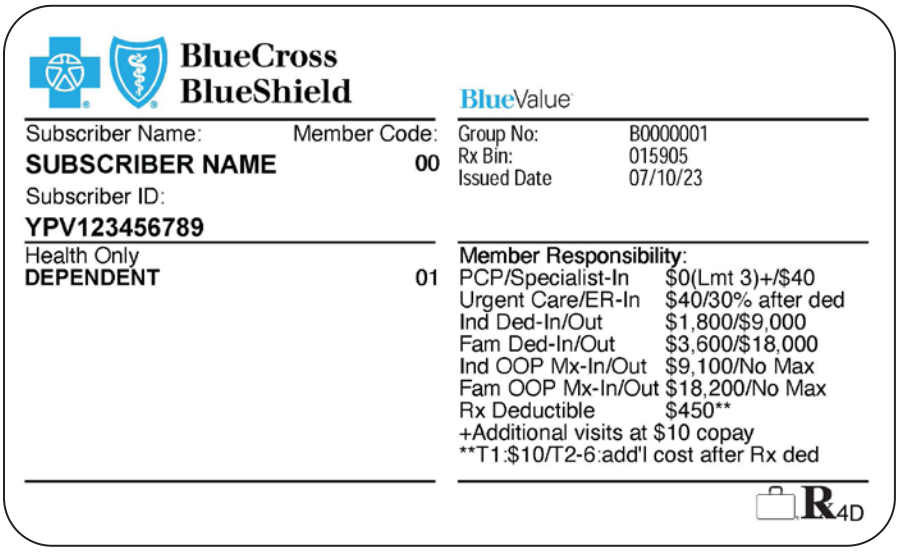
Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Always verify the card holder's other forms of legal identification to help prevent identity theft.

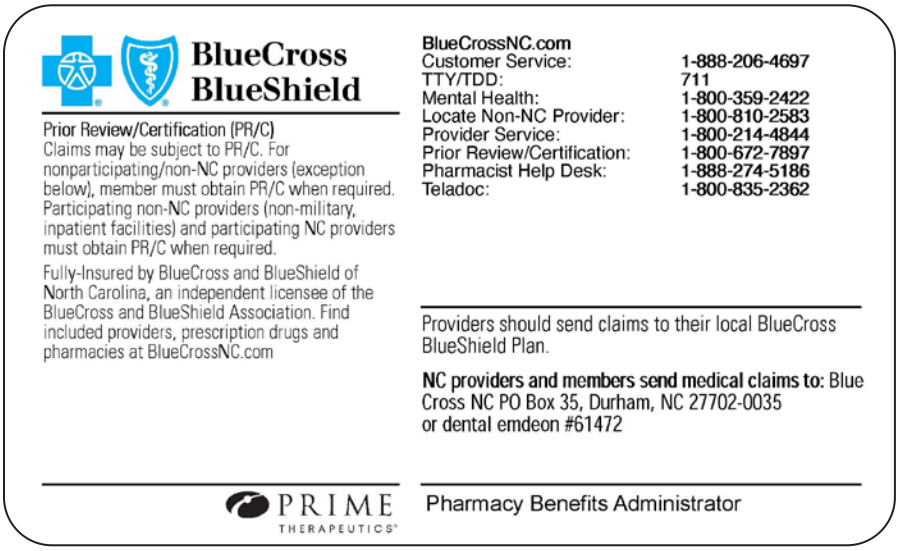
BlueAdvantage®

The full member ID begins with YPI and is a total of twelve (12) characters, which includes nine (9) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the right of the subscriber's or dependent's name.

Sample Blue Advantage membership ID card (front)



Sample Blue Advantage membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with three (3) prefix characters and is a total of twelve (12) digits, which includes the three (3) digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

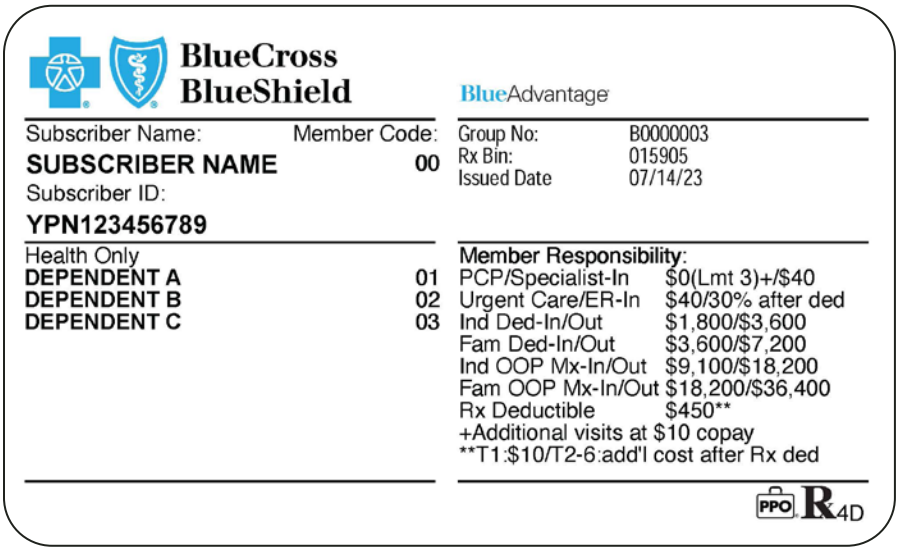
Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Always verify the card holder's other forms of legal identification to help prevent identity theft.

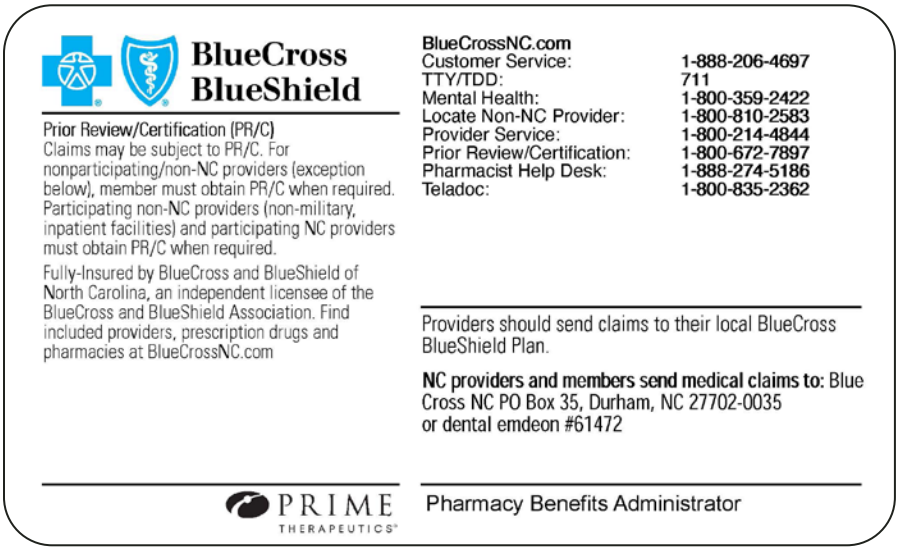
Blue Advantage HSA®

The full member ID begins with "YPN" and is a total of twelve (12) characters, which includes nine (9) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the right of the subscriber's or dependent's name.

Sample Blue Advantage HSA membership ID card (front)



Sample Blue Advantage HSA membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with three (3) prefix characters and is a total of twelve (12) digits, which includes the three (3) digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

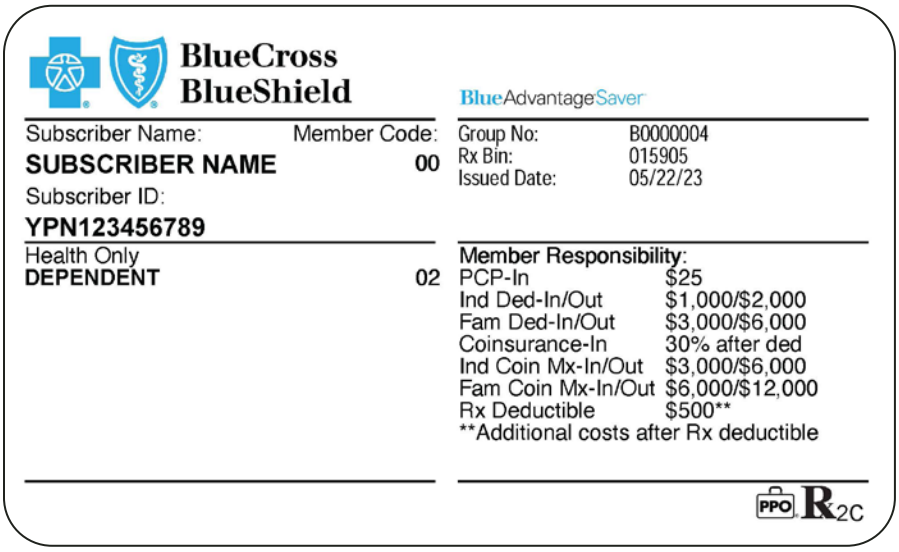
Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Always verify the card holder's other forms of legal identification to help prevent identity theft.

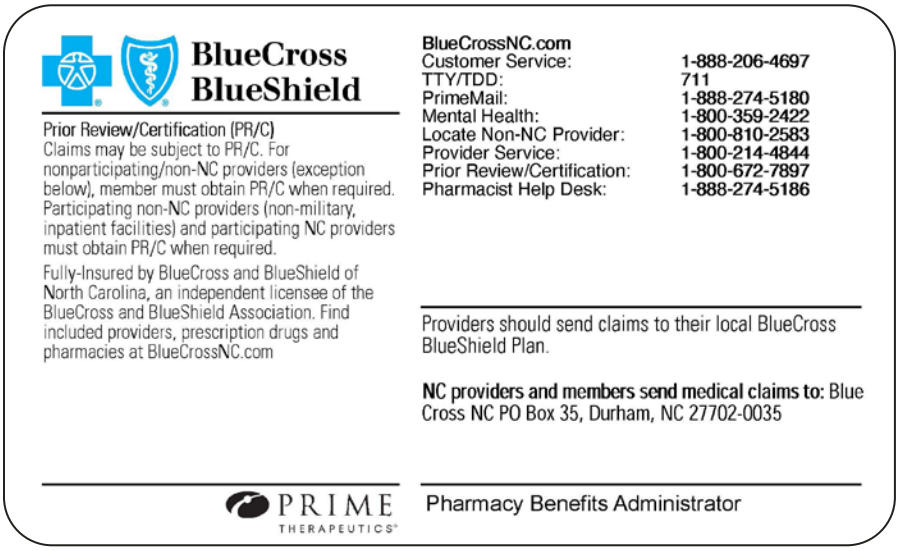
BlueAdvantage Saver℠

The full member ID begins with "YPN" and is a total of twelve (12) characters, which includes nine (9) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the right of the subscriber's or dependent's name.

Sample Blue Advantage Saver membership ID card (front)



Sample Blue Advantage Saver membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with three (3) prefix characters and is a total of twelve (12) digits, which includes the three (3) digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

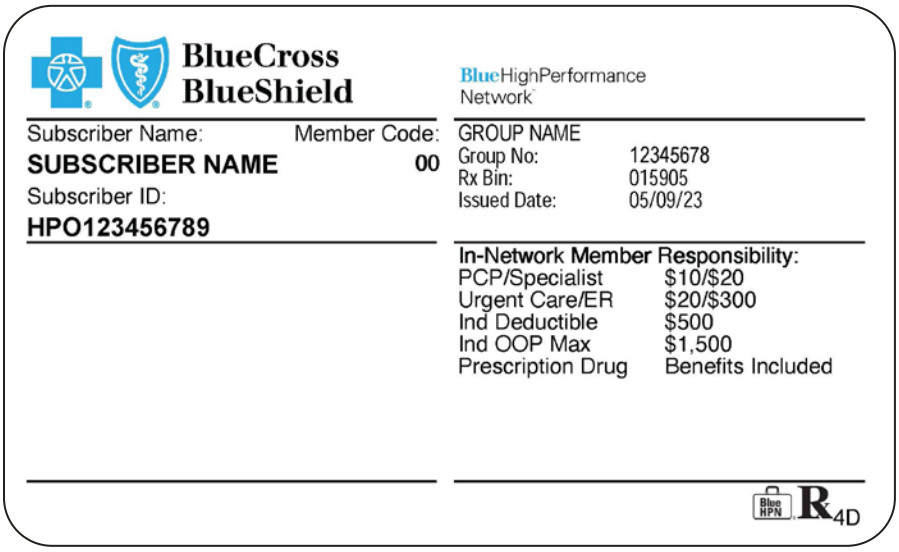
Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Always verify the card holder's other forms of legal identification to help prevent identity theft.

BlueHighPerformance

The full member ID begins with "YPN" and is a total of twelve (12) characters, which includes nine (9) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the right of the subscriber's or dependent's name.

Sample Blue High Performance Network membership ID card (front)



Sample Blue High Performance Network membership ID card (back)

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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with three (3) prefix characters and is a total of twelve (12) digits, which includes the three (3) digits that are displayed to the left of the subscriber's or dependent's name.

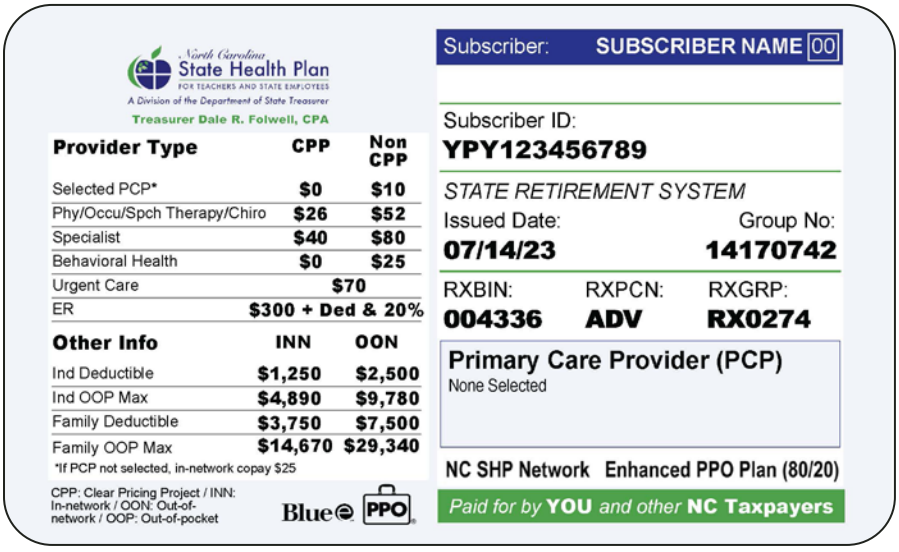
An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

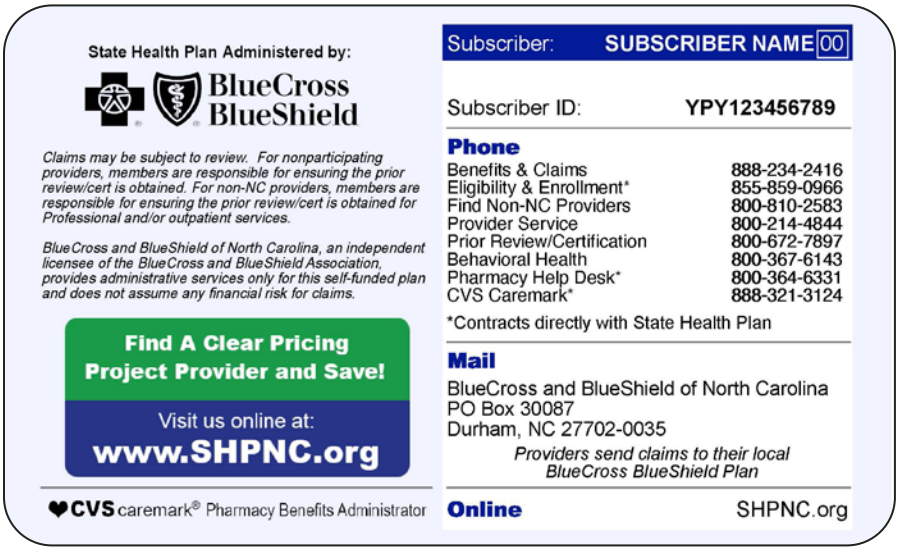
Always verify the card holder's other forms of legal identification to help prevent identity theft.

The State Health Plan

Sample of the State Health Plan membership ID card (front)



Sample of the State Health Plan membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with three (3) prefix characters.

An individual's possession of a SHP membership ID card is not a guarantee of eligibility or benefits.

Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Always verify the card holder's other forms of legal identification to help prevent identity theft.

3.11.1
Health benefit summary

Blue Cross NC offers PPO products for individual subscribers and for employer groups. Employer groups with more than one hundred (100) employees can customize a plan to help meet their company's individual needs. PPO products include traditional plans that include member copayments, coinsurance and deductibles. Blue Cross NC PPO products also offer High Deductible Health Plans (HDHP), where members pay deductible and coinsurance amounts but have no copays.

Benefits are available for covered services received from Blue Cross NC PPO in-network/participating providers. Additionally, most PPO members have the option to seek care out-of-network at a reduced benefit level (but not all PPO members and not for all services). If a member's PPO plan does not include out-of-network benefits, services must be approved in advance by Blue Cross NC (unless necessary due to an urgent or emergency health need).

The following summary of benefits describes basic fundamentals about how the PPO plans typically work, however eligible services and benefits can vary and providers should always verify a member's actual eligible services and coverage for benefits in advance of providing care (except when urgent or emergent conditions prevent):

- Member's benefits are available when services are received from Blue Cross NC PPO participating providers.
- Most PPO plans include benefits for services by non-participating providers (but not all plans and not all out-of-network services).
- Benefits are available from non-participating providers for emergency and urgent care services.
- Services received from non-participating providers that are not urgent or emergent, and are not approved by Blue Cross NC in advance of service, will not be covered if the PPO plan does not include out-of-network benefits.
  - In specific situations, Blue Cross NC may approve coverage for certain 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 provider.
- Members are encouraged, though not required, to select a primary care physician at the time of enrollment.
- 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 a change.
- Members are not required to have or obtain a referral from a primary care physician in order to see a specialist.
- The prior review list applies to PPO plans.
- For PPO plans that include copayments – copayments typically apply when services are received within a provider's office, free-standing facility or hospital emergency room. Deductible and coinsurance amounts typically apply for outpatient and inpatient hospital care.
- For PPO plans that do not include copayments, deductible and coinsurance typically apply when services are received within a provider's office, free-standing facility, hospital emergency room, outpatient and inpatient hospital care.

3.11.2
The State Health Plan for teachers and state employees

The SHP offers teachers, state employees and family members of state retirees of North Carolina the option to choose from multiple PPO health plans.

The PPO plans are based on different levels of physician office visit copays, different levels of coinsurance and different levels of deductibles.

The amount of money a state employee pays out-of-pocket for PPO benefits cost-sharing differs based on the option selected by the employee.

Under all SHP 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 when out-of-network care is obtained.

Blue Cross NC does not administer the Medicare Advantage business for SHP Medicare-primary retirees. As a result of the change, Medicare-primary SHP retirees may have split certificates with family members. Providers can expect the following as a result of this change:

- Family members (spouse and/or dependents) of Medicare-primary retirees that are under the age of sixty-five (65) and covered on the Medicare retiree's current SHP policy are issued their own individual ID cards with the State Health Plan administered by Blue Cross NC.
- Individual ID cards are issued to family members, regardless of age.
- Spouses and/or dependents on split certificates are listed as the subscriber on their individual ID card.
- Individual ID cards include the name of any chosen primary care physician or practice.

Important Note: Only family members on the same plan type are included in any family deductible and/or coinsurance accumulators.

Providers can recognize a SHP member by simply reading the member's ID card or by review of the member's prefix. SHP PPO members have a prefix of YPY.

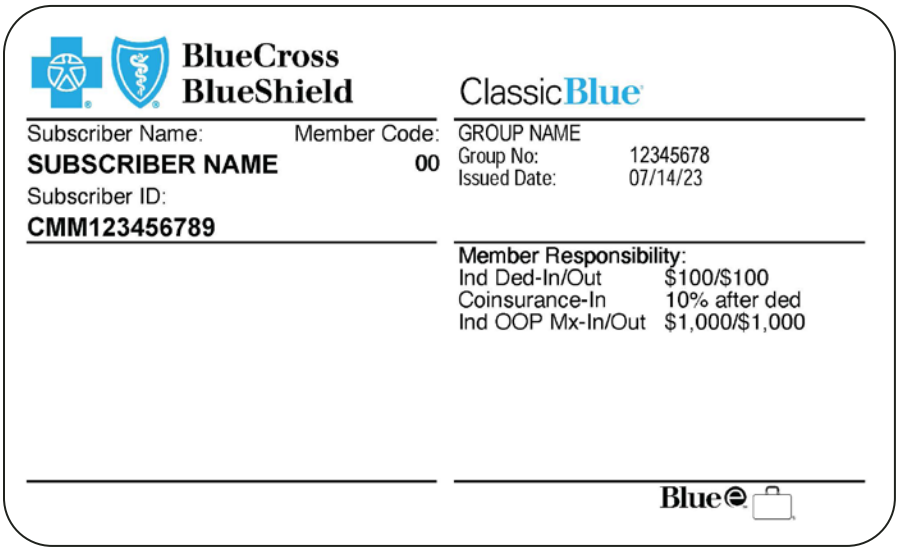
Member specific benefits and eligibility should be verified securely and electronically via **Blue *e*** or by calling the Provider Blue Line at **1-800-214-4844**. Sample summaries of benefits can be viewed and/or downloaded from the State Health Plan website located at **www.shpnc.org**.

3.12

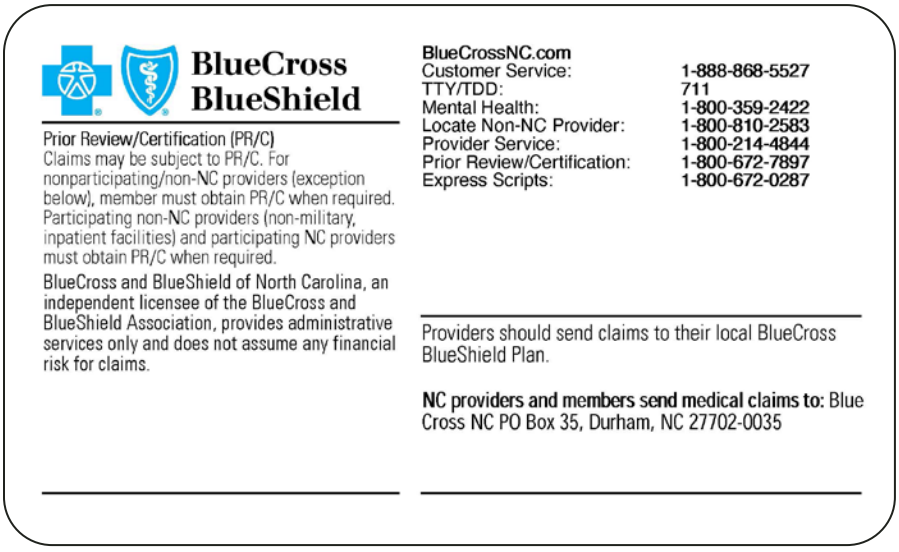
Classic Blue, an indemnity CMM product

Classic Blue is an indemnity CMM plan that gives employers a dependable and traditional health care option for their employees. Classic Blue offers coverage for members when receiving care from both in-network and out-of-network providers, hospitals and clinics. Classic Blue gives members the freedom to go directly to any provider without a referral.

Sample Classic Blue membership ID card (front)



Sample Classic Blue membership ID card (back)



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 ensure that any discarded copies are properly destroyed to help protect the patient's identity.

The full subscriber ID begins with YPMW and is a total of eleven (11) digits, which includes the two (2) digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services. Always verify the card holder's other forms of legal identification to help prevent identity theft.

3.12.1
Health benefit summary

Classic Blue is a traditional indemnity CMM plan where most services covered under a member's benefit plan include deductible and/or coinsurance payments. Benefits are available for covered services received from both in- and out-of-network providers. The following summary of benefits describes basic fundamentals about how the CMM plan typically works, however eligible services and benefits can vary and providers should always verify a member's actual eligibility and coverage for benefits in advance of providing care (except when urgent or emergent conditions prevent):

- Member's benefits are available when services are received from any providers.
- Members are encouraged, though not required, to select a primary care physician at the time of enrollment.
- Members are not required to have or obtain a referral from a primary care physician in order to see a specialist.
- The prior review list applies to certain services.
- Deductible and/or coinsurance amounts typically apply.

4

Federal Employee Program

Blue Cross and Blue Shield Service Benefit Plan

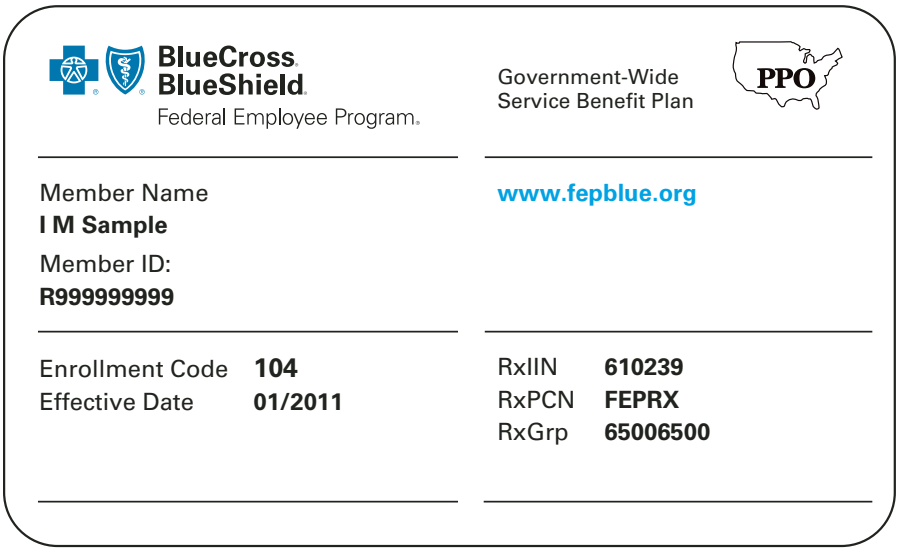
The FEP is also known as the Blue Cross and Blue Shield Service Benefit Plan. The Blue Cross and Blue Shield Association contracts with the United States Office of Personnel Management on behalf of the forty-seven (47) independent Blue Cross and Blue Shield plans to provide health care coverage to federal employees, postal employees and retirees who choose to enroll in this plan.

The Service Benefit Plan is a PPO plan. The plan has three (3) options – **Standard** option, **Basic** option and **FEP Blue Focus** option. The following information is only applicable to those members enrolled in the Federal Employee Program.

4.1
Identification cards

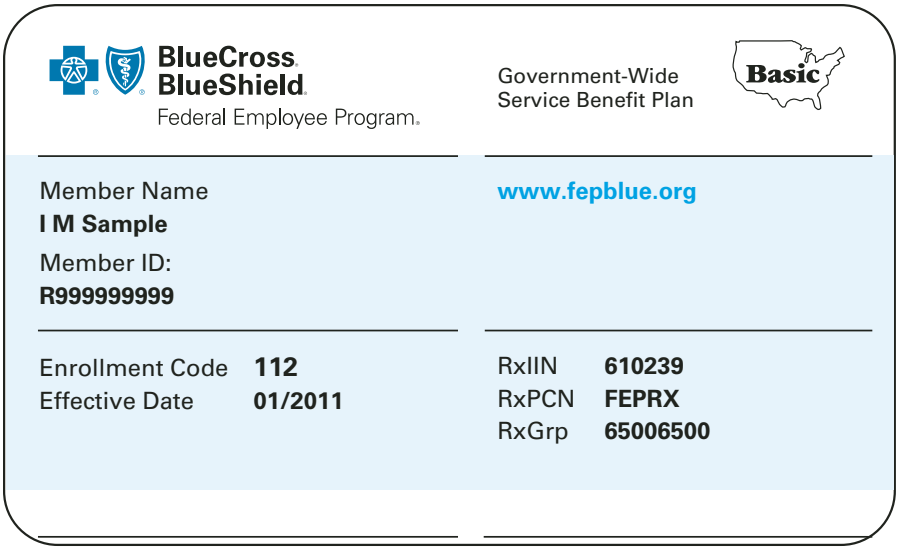
STANDARD OPTION: Enrollment codes (104, 105, 106)

Sample membership ID card (front)



BASIC OPTION: Enrollment codes (111, 112, 113)

Sample membership ID card (front)



ENROLLMENT CODES ARE:

104
Standard option - self only

105
Standard option - self and family

106
Standard option - self plus one

111
Basic option - self only

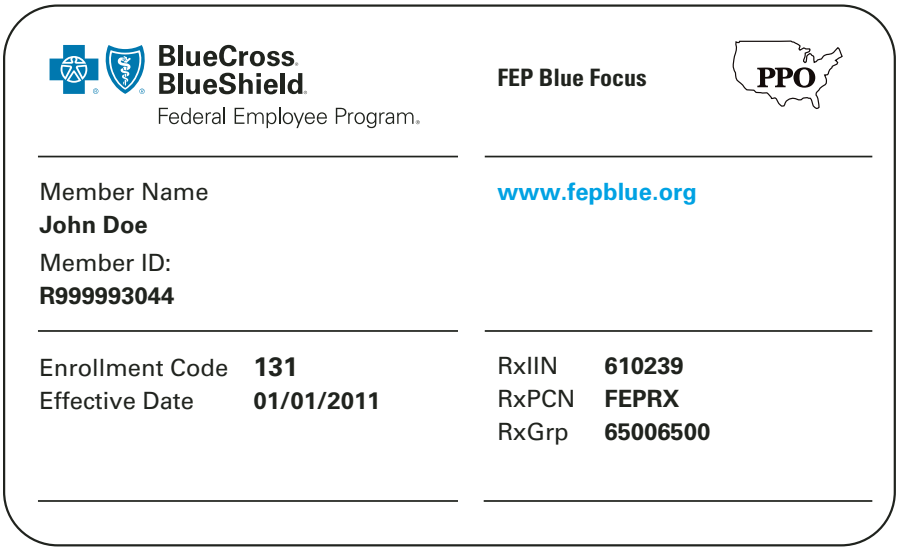
112
Basic option - self and family

113
Basic option - self plus one

Important telephone numbers are located on the back of each card

FEP BLUE FOCUS OPTION: Enrollment codes (**131, 132, 133**)

Sample membership ID card (front)



ENROLLMENT CODES ARE:

131
FEP Blue Focus - self only

132
FEP Blue Focus - self plus family

133
FEP Blue Focus - self plus one

Important telephone numbers are located on the back of each card

4.2
Blue Cross NC FEP contact information

BLUE CROSS NC FEP CUSTOMER SERVICE	
BENEFITS CLAIMS ELIGIBILITY	**1-800-222-4739**

FEP PRE-CERTIFICATION AND PRIOR APPROVAL	
CERTIFICATION Pre-certification for inpatient admission Prior review HOME HOSPICE CARE ORGAN AND TISSUE TRANSPLANTS CLINICAL TRIALS FOR CERTAIN ORGAN AND TISSUE TRANSPLANTS	**1-800-672-7897**

ADDITIONAL IMPORTANT NUMBERS	
FEP CARE MANAGEMENT (CASE MANAGEMENT)	**1-888-234-2415**
FEP HEALTHY ENDEAVORS (DISEASE MANAGEMENT)	**1-888-392-3506**
RETAIL PHARMACY INFORMATION	**1-800-624-5060** **1-877-727-3784** (prior approval)
MAIL SERVICE PHARMACY INFORMATION	**1-800-624-5060**
BLUE HEALTH CONNECTION INFORMATION	**1-888-258-3432**

continued on following page

For fastest claims processing, file electronically!

Visit Blue Cross NC electronic solutions on the web at:
BlueCrossNC.com/Providers/Claims-Appeals-Inquiries

Blue e℠

MAILING ADDRESSES	
CLAIMS PROCESSING	**Blue Cross NC P.O. Box 35 Durham, NC 27702**
CLAIMS REVIEW PROVIDER INQUIRY CORRESPONDENCE	**Blue Cross NC Customer Service P.O. Box 2291 Durham, NC 27702-2291**

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

For fastest claims processing, file electronically!

Visit Blue Cross NC electronic solutions on the web at: BlueCrossNC.com/Providers/Claims-Appeals-Inquiries

BlueSM

4.3
Certification for the Federal Employee Program

4.3.1
Inpatient pre-certification 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 pre-certification requirement:

1. Routine maternity admissions.
2. You are admitted to a hospital outside the United States; with the exception of admissions for gender reassignment surgery.
3. You have a group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender reassignment surgery.
4. Medicare Part A is the primary payor for the hospital stay; with the exception of admissions for gender reassignment surgery.

   Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you do need pre-certification.

Either the member, a representative of the member, the member's physician or the hospital may pre-certify the hospital stay utilizing one (1) of the following methods:

1. RightFax at **919-765-2081**
2. Calling the Blue Cross NC Federal Employee Program at **1-800-672-7897**
3. Provider Blue Line at **1-800-222-4739**
4. **Blue *e***

4.3.2
Flexible benefits options

Blue Cross NC has the authority to determine the most effective way to provide services. Blue Cross NC 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 FEP Health Management (case management) at **1-888-234-2415** for information.

4.3.3
Prior approval

The following services require prior approval before they are rendered:

You must obtain prior approval for these services under both Standard and Basic options. Pre-certification is also required if the service or procedure requires an inpatient hospital admission. All gender reassignment surgeries require prior approval; if inpatient admission is necessary, pre-certification is also required.

4.3.3.1

Outpatient sleep studies performed outside the home

Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, outpatient center, hospital, skilled nursing facility, residential treatment center and any other location that is not your home.

4.3.3.2

Applied Behavior Analysis (ABA)

Prior approval is required for ABA and all related services, including assessments, evaluations and treatments.

4.3.3.3

BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes

Prior approval is required for BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes whether performed for preventive or diagnostic reasons.

Note: You must receive genetic counseling and evaluation services before preventive BRCA testing is performed.

4.3.3.4

Surgical services

The surgical services on the following list require prior approval for care performed by preferred participating/member, and non-participating/non-member professional and facility providers:

- Outpatient surgery for morbid obesity.

  Note: Benefits for the surgical treatment of morbid obesity – performed on an inpatient or outpatient basis.
- Outpatient surgical correction of congenital anomalies.
- Outpatient surgery needed to correct accidental injuries (see definitions) to jaws, cheeks, lips, tongue, roof and floor of mouth.
- Gender reassignment surgery.

4.3.3.5

Outpatient Intensity-Modulated Radiation Therapy (IMRT)

Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, prostate or anal cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.

4.3.3.6

Hospice care

Prior approval is required for home hospice, continuous home hospice or inpatient hospice care services.

4.3.3.7

Organ/tissue transplants

Prior approval is required for both the procedure and the facility. If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits.

4.3.3.8

Inpatient mental health and substance use treatment – Standard, Basic and FEP Blue Focus options

The member or someone acting on their behalf should contact Blue Cross NC at **1-800-222-4739** to verify benefits for inpatient services and request prior approval. The provider must contact Blue Cross NC prior to services being rendered to obtain prior approval. When Blue Cross NC approves the plan of care, the provider will be given authorization for the length of stay. If the provider fails to contact Blue Cross NC, the Plan will not provide benefits for services. **Basic option members must use in-network providers.**

In cases of medical emergency or access, the member or someone acting on their behalf must contact Blue Cross NC at **1-800-222-4739**.

4.3.3.9

Residential treatment center (RTC)

Pre-certification prior to admission is required. A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider RTC and case manager in the local plan where the RTC is located prior to admission.

4.3.3.10

Morbid obesity surgery

Effective with the 2011 benefit period, prior approval is required for outpatient surgery for morbid obesity. FEP members must meet specific pre-surgical criteria before receiving surgery for morbid obesity.

FEP definition of morbid obesity:

A condition in which an individual has a Body Mass Index (BMI) of forty (40) or more, or an individual with a BMI of thirty-five (35) or more with one (1) or more co-morbidities; eligible members must be age eighteen (18) or over.

Note: Prior approval is required for outpatient surgery for morbid obesity. You must precertify your hospital stay and verify your facility's designation as a Blue Distinction Center.

Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the pre-surgical requirements listed below. **The member must meet all requirements.**

- Diagnosis of morbid obesity for a period of two (2) years prior to surgery.
- Participation in a medically supervised weight loss program, including nutritional counseling, for at least three (3) months prior to the date of surgery.

  Note: Benefits are not available for commercial weight loss programs.
- Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating and exercise.
- Evidence that attempts at weight loss in the one (1) year period prior to surgery have been ineffective.
- Psychological clearance of the member's ability to understand and adhere to the pre- and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner.
- Member has not smoked in the six (6) months prior to surgery.
- Member has not been treated for substance use for one (1) year prior to surgery and there is no evidence of substance use during the one (1) year prior to surgery.

Benefits for subsequent surgery for morbid obesity, performed on an inpatient or outpatient basis, are subject to the following additional pre-surgical requirements:

- All criteria listed above for the initial procedure must be met again.
- Previous surgery for morbid obesity was at least two (2) years prior to repeat procedure.
- Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure.
- Member complied with previously prescribed post-operative nutrition and exercise program.
- Claims for the surgical treatment of morbid obesity must include documentation from the member's provider(s) that all pre-surgical requirements have been met.

4.3.3.11

Gender reassignment

Gender reassignment surgery is limited to once per covered procedure, per lifetime.

Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements.**

- **Prior approval is obtained.** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **Member must be at least eighteen (18) years of age at the time prior approval is requested and the** treatment plan is submitted.
- Diagnosis of gender dysphoria by a qualified health care professional.
- New gender identity has been present for at least twenty-four (24) continuous months.
- Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender.
- Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality.
- Gender dysphoria causes clinical distress or impairments in social, occupational or other important areas of functioning.

Member must meet the following criteria:

- Living twelve (12) months of continuous, full-time, real life experience in the desired gender (including place of employment, family, social and community activities).
- Twelve (12) months of continuous hormone therapy appropriate to the member's gender identity.
- Two (2) referral letters from qualified mental health professionals – one (1) must be from the psychotherapist who has treated the member for at least twelve (12) continuous months. Letters must document: Diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery.
- If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled.

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 (2) steps, starting with an informal review by Blue Cross NC 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 patient, provider (authorized by member to appeal on behalf) or legal agent within 30 days of receiving the request for review. Note that if additional information is needed, this timeframe could be extended by up to 60 days.

4.4.3
OPM appeal

When the Plan affirms its denial of benefits, the patient or legal agent may send a written request to the 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 ninety (90) days of the date of the Plan's letter affirming its denial.

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 thirty (30) days of the date of the request.

4.5
Federal Employee Program covered professional providers

We provide benefits for the services of covered professional providers, as required by Section 2706 (a) of the Public Health Service Act. Covered professional providers within the United States, Puerto Rico and the U.S. Virgin Islands are health care providers who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the provider is licensed or certified. 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.); 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 an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the local 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 Registered Nurse (RN) 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 (2) 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.

4.5.14
Mental health and substance use professional

A professional who is licensed by the state where the care is provided to provide mental health and/or substance use services within the scope of that license.

4.5.15
Lactation consultant

A person who is licensed as a registered nurse in the United States (or appropriate equivalent if providing services overseas) and is licensed or certified as a lactation consultant by a nationally recognized organization.

4.6
Health benefits – Standard, Basic and FEP Blue Focus options

A copy of the current year *Standard and Basic Option Service Benefit Plan Summary* can be obtained by visiting the FEP website at **www.fepblue.org**. Providers are reminded to always verify a member's benefits and eligibility in advance of providing care. Member benefits and eligibility can be verified via **Blue *e*** or by calling Blue Cross NC FEP Customer Service at **1-800-222-4739**.

About the Blue Cross and Blue Shield Service Benefit Plan

The local Blue Cross and Blue Shield plans underwrite and administer the Blue Cross and Blue Shield Service Benefit Plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) program. 85% of all federal employees and retirees who receive their health care benefits through the government's FEHB program are members of the Service Benefit Plan. Any questions regarding benefit changes and any new programs should be directed to the Plan's provider contacts.

4.7
Preventive care screenings

Adult preventive care includes the following services when performed as part of a routine annual physical examination: Chest X-ray; general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for alcohol/substance use; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea and HIV; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings; and routine immunizations as licensed by the U.S. Food and Drug Administration.

4.8
Home health services

Home nursing care for two (2) hours per day, when:

- An RN or a Licensed Practical Nurse (LPN) provides the services.
- A physician orders the care.

Please Note: Benefits for home nursing care are limited to fifty (50) visits per person, per calendar year for Standard option benefits; twenty-five (25) visits per person, per calendar year for Basic option benefits; and for FEP Blue Focus, ten (10) visits per person, per calendar year.

4.9
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.
- Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age twenty-two (22), for up to one (1) year following the date of the initial prescription or physician order for the medical food (e.g., Neocate).
- Ostomy and catheter supplies.
- Oxygen.
- Blood and blood plasma except when donated or replaced, and blood plasma expanders.

4.10
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.
- Hearing aids for children up to age twenty-two (22), limited to $2,500 per calendar year.
- Hearing aids for adults age twenty-two (22) and over, limited to $2,500 every five (5) calendar years.
- Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to $5,000 per calendar year.
- Surgically implanted penile prostheses to treat erectile dysfunction.
- Wigs for hair loss due to chemotherapy for the treatment of cancer, limited to $350 for one (1) wig per lifetime. (This is for Standard and Basic option benefits. Wigs are not covered for FEP Blue Focus benefits.)

4.11
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.

1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:
   - Home dialysis equipment
   - Oxygen equipment
   - Hospital beds
   - Wheelchairs
   - Crutches
   - Walkers
   - Continuous Passive Motion (CPM) and Dynamic Orthotic Cranioplasty (DOC) devices
   - Speech-generating devices, limited to $1,250 per calendar year
   - Other items that we determine to be DME, such as compression stockings

4.12
Claims billing tips

4.12.1
Disputed claims

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: Charges are not billable to members for preferred or participating providers.

4.12.2
Preventive care children

Preventive care benefits for children are available under both Basic and Standard options for covered children up to age twenty-two (22). Basic option members must use preferred providers in order to receive benefits. We provide benefits for a comprehensive range of preventive care services for children up to age twenty-two (22), including the preventive services recommended under the Patient Protection and Affordable Care Act (the Affordable Care Act), and services recommended by the American Academy of Pediatrics (AAP).

4.12.3
Immunizations

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 (SL) for state supplied vaccine 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.

4.12.4
Timely filing requirements

Providers participating with Blue Cross NC are required to file FEP claims by December 31 of the calendar year, following the year in which the services were rendered or the date of discharge. Corrected claims must be submitted within three (3) years/thirty-six (36) months from the date the original claim was processed by Blue Cross NC.

4.12.5
Do not file the same claim multiple times

Instead of speeding up processing, filing the same claim multiple times, in fact, slows claims processing. If the FEP has not paid a claim within thirty (30) to forty-five (45) days, then you may contact us at **1-800-222-4739** to find out the status of the claim.

4.12.6
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 eight [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 NPI
- Missing primary payor's Explanation of Benefits (EOB)
- Missing dates and/or diagnosis code

4.12.7
Service edits

Effective May 2013, Blue Cross NC policies and procedures relating to claims editing, bundling, reimbursement policies and other provider-related policies associated with Blue Cross NC commercial products may apply to FEP.

4.13 Care coordination processes

4.13.1 Medical review

- A CNM or a Letter of Medical Necessity (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 **fepblue.org**.
- 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. 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

4.13.2 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 a 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**.

4.13.3
Healthy Endeavors

Healthy Endeavors is a chronic disease care management program for federal employees that have Service Benefit Plan and are enrolled in the FEP. Members identified with one (1) of the top five (5) chronic conditions: diabetes, coronary artery disease, congestive heart failure, asthma and chronic obstructive lung disease; are enrolled into the program; and may receive condition-specific educational materials at no charge. In addition, the enrolled members may work with a registered nurse on their goals and receive health coaching by phone for three to four (3-4) months until they are educated to manage their own conditions. The member's physician is notified when their patient is engaged in the Healthy Endeavors program. For information, call **1-888-392-3506**.

4.14
24/7 Nurse Line – twenty-four (24) hour nurse telephone service

Our registered nurses are available 24/7 by phone, online chat and email for general questions about health issues or where to go for care. This benefit is included with the membership at no cost. Help is available by phone at **1-888-258-3432** or online at **www.fepblue.org/myblue**.

4.15
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 **www.fepblue.org**.

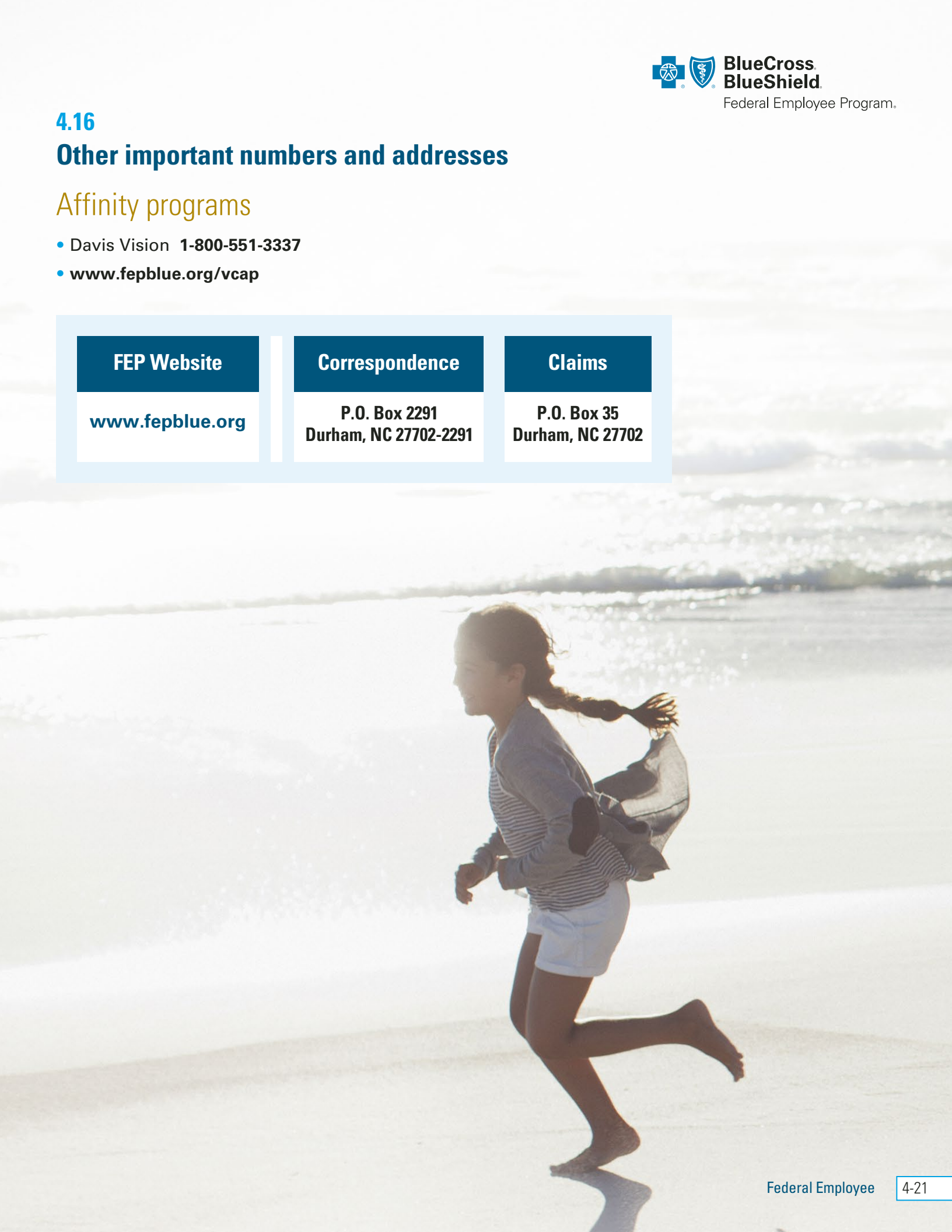
BlueCross BlueShield
Federal Employee Program®

4.16
Other important numbers and addresses

Affinity programs

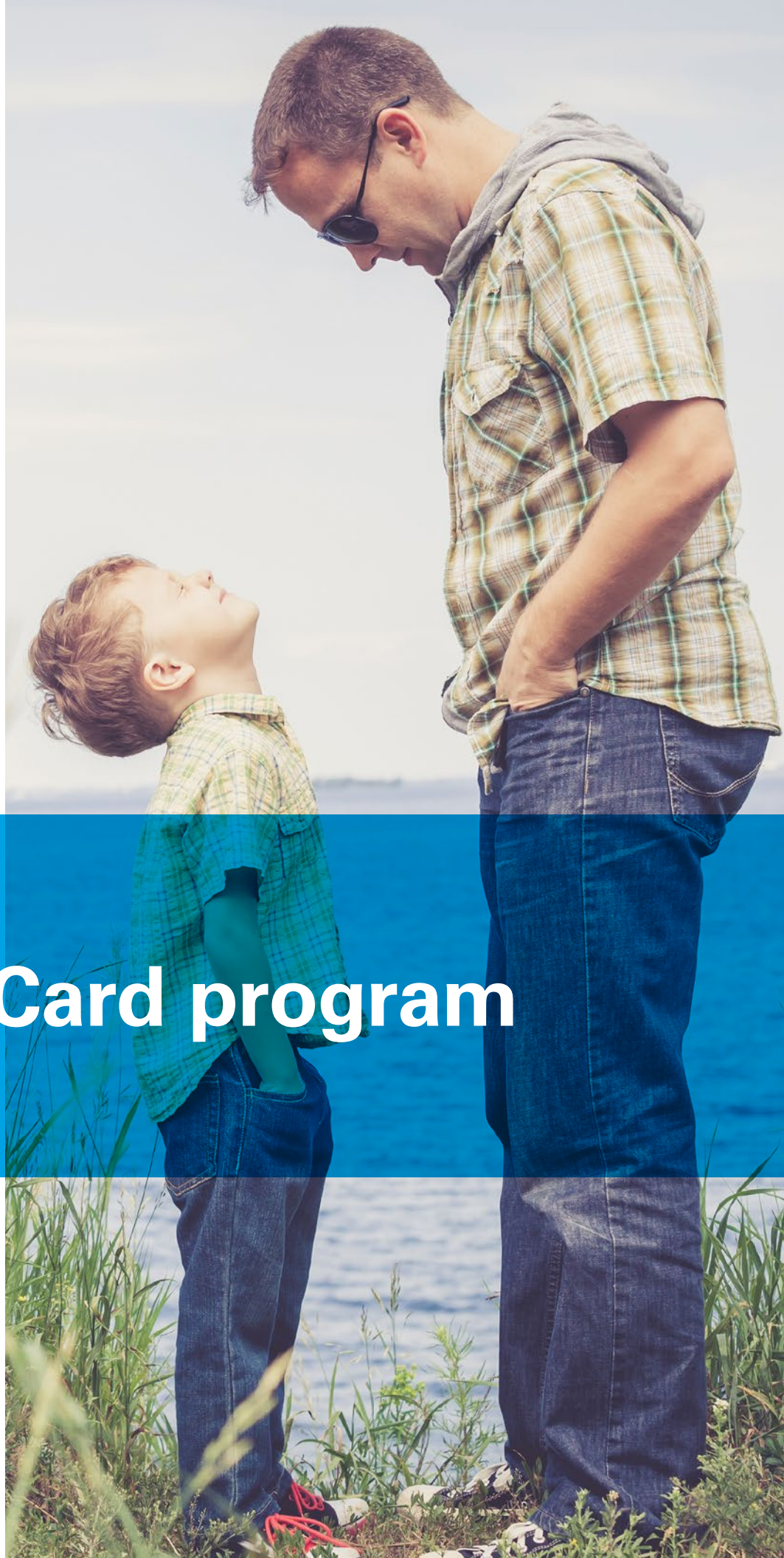
- Davis Vision **1-800-551-3337**
- **www.fepblue.org/vcap**

FEP Website	Correspondence	Claims
www.fepblue.org	P.O. Box 2291 Durham, NC 27702-2291	P.O. Box 35 Durham, NC 27702



5

The BlueCard program



5.1
BlueCard overview

BlueCard is a national program that enables members of one (1) Blue Cross and/or Blue Shield (Blue Plan) to obtain health care service benefits while traveling or living in another Blue Plan's service area. The program links participating health care providers with the independent Blue Plans across the country and in many foreign countries and territories worldwide, through a single electronic network for claims processing and reimbursement. Within North Carolina nearly 2,513,185 members of other Blue Plans are currently residing in the Blue Cross NC service area (at the time of this publication).

The BlueCard program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Blue Cross NC. Blue Cross NC is your single point of contact for BlueCard claims payment, problem resolution and adjustments.

Verification of an out-of-state member's eligibility and benefits can be obtained by calling BlueCard Eligibility at **1-800-676-BLUE (2583)**. Providers with **Blue *e*** can verify eligibility, benefits and claim status immediately and from the convenience of their web browsers. To find out more about signing up for **Blue *e***, visit Blue Cross NC electronic solutions on the web at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**, or refer to **Chapter 11** of this e-Manual.

Due to HIPAA privacy regulations, members from other Blue Plans must contact their Blue Plan directly for all inquiries and related issues.

All claims should be billed to Blue Cross NC unless otherwise noted on the back of the member's identification card.

The BlueCard Inter-Plan Programs department at Blue Cross NC is available to assist you with all your out-of-state Blue Plan member claims and claims questions by calling 1-800-487-5522.

5.1.1
BlueCard applicable services

The BlueCard program applies to all inpatient, outpatient and professional claims, including vision and hearing exams; excluding:

- Prescription drugs
- Standalone dental
- Standalone vision (i.e., hardware and contacts)
- Federal Employee Program
  - (Members who are part of the FEP will have the letter "**R**" in front of their member ID number. Please follow the Blue Cross NC and FEP billing guidelines contained within this e-Manual.) Claims for BlueCard excluded products and services should be filed to the address that is listed on the member's identification card.

5.1.2
Product types included in the BlueCard program

Product types administered through the BlueCard program include:

- BlueCard PPO®, which offers Blue Plan members the highest level of PPO benefits when services are obtained from a participating provider outside of their Blue Plan's service area. PPO coverage is the coverage type that most frequently applies for BlueCard eligible members from another Blue Plan's service area.
- BlueCard Traditional (also recognized as CMM or indemnity plans) offers Blue Plan members the traditional level of benefits when they obtain services from a physician or hospital outside their Blue Plan's service area.
- BlueCard HMO offers Blue Plan members the HMO level of benefits when they obtain emergency, urgent care and follow-up services from a physician or hospital outside their Blue Plan's service area.
- BlueCard Managed Care/POS is offered to members who reside outside their Blue Plan's service area and is similar to BlueCard Traditional and BlueCard PPO. Unlike other BlueCard programs, BlueCard POS members are actually enrolled in the Blue Cross NC network. Therefore, you should treat these members as you treat any other Blue Cross NC POS member, applying the same pre-authorization practices and network protocols.
- BlueCard eligible Medicare Supplement, Medicare Plus/Choice and Medicare Advantage plans (Blue Plan Medicare Advantage plans are offered to Medicare beneficiaries in product options that include: HMO, PPO, POS, Medical Savings Accounts [MSA] and Private Fee-For-Service [PFFS] plans).

5.2
Identifying BlueCard members

When members from other Blue Cross and/or Blue Shield plans arrive at your office or facility, be sure to ask for their most current Blue Plan membership identification card. New ID cards may be issued to members throughout the year; obtaining a copy of the newest ID card will help to ensure that you have the most up-to-date information in your patient's file. Specific data elements on Blue Plan membership ID cards will help you identify BlueCard members. It is very important to capture all ID card data at the time of providing service. Member ID card information is critical for verifying membership and coverage and accurately reporting claims.

We suggest that you make copies of the front and back of a member's ID card and pass needed information on to your billing staff.

When referencing a member's ID to verify eligibility and benefits, filing claims and arranging services, always report the ID exactly how it's listed on the member's ID card. Never add and/or delete characters or change the sequence of the characters following the prefix. Additionally, always include the prefix because it is necessary for identifying plans and electronic routing of specific HIPAA transactions to the appropriate Blue Plans.

All BlueCard eligible members have a prefix included as part of their member identification number (member identification numbers for BlueCard eligible members include a combination of both alpha and numeric characters).

Important:

Not all Blue Cross and/or Blue Shield PPO, HMO, POS, Medicare Advantage and CMM members are BlueCard eligible. Only a member who has an identification number that begins with a minimum of three (3) alpha characters and/or is carrying a membership ID card from a Blue Plan which displays the PPO in a suitcase logo or an empty suitcase logo (unless Medicare Advantage) is a BlueCard eligible member. Out-of-state Blue Plan member ID cards that do not have a prefix should be billed to the address listed on the member's identification card.

5.2.1
Member ID numbers for BlueCard eligible members

All out-of-state Blue Plan members who are enrolled in a benefit plan and eligible as part of the BlueCard program will have a prefix included as part of their member identification number (member identification numbers for BlueCard eligible members include a combination of both alpha and numeric characters). A correct member ID number includes a prefix in the first three (3) positions, followed by a combination of alpha and/or numeric characters. The combination of alpha and numeric characters can vary among the amount of letters and numbers used to compose a member's ID and can be up to seventeen (17) character positions in total. This means that you may see cards with ID numbers between six (6) and fourteen (14) (numeric/alpha) characters in length, in addition to the prefix (three [3] letter prefix + six to fourteen [6-14] additional characters = nine to seventeen [9-17] characters in total, depending on the ID given to a specific member).

Examples of member ID numbers:

ABC1234567
prefix

ABC1234H567
prefix

ABC12345678901234
prefix

5.2.2
Prefix

The three (3) character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan to which the member belongs. It is necessary for confirming a patient's membership and coverage. To ensure accurate claims processing, it is important to capture all ID card data. If the information is not captured correctly, you may experience a delay with claims processing. Never make up or guess a member's prefix or assume that the member's ID number is their social security number (all Blue Plans have eliminated use of social security numbers from member ID assignments).

5.2.3
Symbols

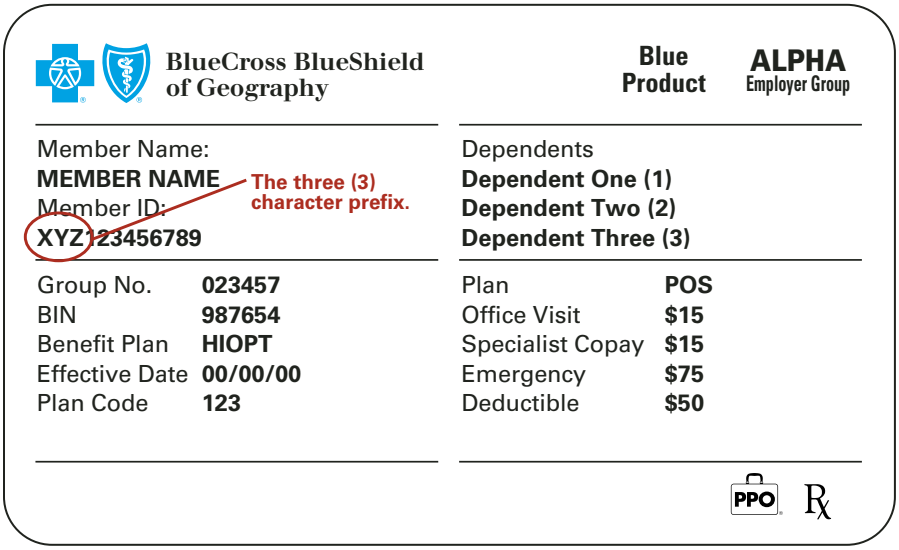
- PPO in a suitcase logo for eligible PPO members (BlueCard PPO members are uniquely identified by their Blue Cross and/or Blue Shield identification cards which display the PPO in a suitcase logo. Members traveling or living outside their plan's service area receive PPO level benefits when they obtain services from preferred providers.)
- MA PPO in a suitcase logo for eligible Medicare Advantage members (Medicare Advantage members eligible as part of the BlueCard program will not have the standard Medicare identification card, instead a Blue logo will be visible on the ID card.)
- Medicare Advantage logo with or without a suitcase logo (Medicare Advantage members eligible as part of the BlueCard program may be enrolled in plans in addition to PPO, which include but are not limited to HMO, POS, PFFS and MSA plan types. When a suitcase logo is not included on the member's identification card, BlueCard eligibility can be identified by verifying that a member's Blue Plan issued Medicare Advantage card also includes a prefix as part of the member's ID.)
- Blank suitcase logo (CMM, HMO and POS members will typically have an empty suitcase logo displayed on their cards, which signifies the coverage type is non-PPO.)

5.2.4

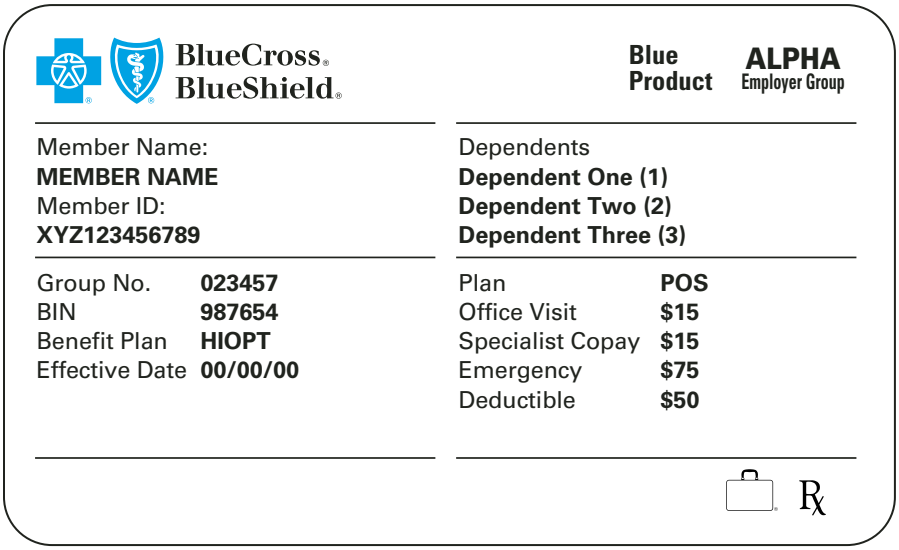
Sample ID cards

Blue Plan members who are enrolled in a benefit plan and eligible as part of the BlueCard program will have a prefix included as part of their member identification number (member identification numbers for BlueCard eligible members include a combination of both alpha and numeric characters). A correct member ID number includes a prefix in the first three (3) positions, followed by a combination of alpha and/or numeric characters. Additionally, most (but not all) BlueCard eligible members carry a membership ID card from a Blue Plan which displays the PPO in a suitcase logo or an empty suitcase logo.

Sample identification card (front)



Sample identification card (front)



5.2.5

How to identify international members

Occasionally, you may see identification cards from Blue Plan members residing abroad or members of foreign Blue Plans. These ID cards will also contain three (3) character prefixes. Please treat these members the same as domestic Blue Plan members and submit claims for services to Blue Cross NC.

Note: The Canadian Association of Blue Cross plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the United States. Claims for members of the Canadian Blue Cross plans are not processed through the BlueCard program. Please follow the instructions as listed on a member's ID card or contact the member's Canadian Blue Cross plan directly.

Sample international member card (front)

BlueCross & BlueShield de Uruguay

MEMBER NAME
Member Name
MEMBER ID
XYZ0123456789

Plan
1400
RPA PREMIUM
Expiration Date: May 31, 2017

Plan	**PPO**
GROUP	**URU038**
BC/BS Plan Codes:	**154/654**

CREDENCIAL PARA USO EXCLUSIVO
FUERA DE URUGUAY

PPO

Sample international member card (back)

BlueCross & BlueShield de Uruguay

www.bcbsu.com.uy

Clientes: Por beneficios consulte su contrato. La posesión de esta tarjeta no garantiza la elegibilidad de los beneficios.

Proveedores en Uruguay: Para verificar elegibilidad y beneficios, por favor llamar a nuestras oficinas. Dinija facturas por facturas por servicios médicos a nuestra dirección.

Providers in the United States: To verify membership eligibility, please call Eligibility line. Providers should file all claims to the local BlueCross and/or BlueShield plan in whose Service Area the member received services.

Uruguay
Atención al Cliente: **(598-2) 707-7575**

United States (E.E.U.U.)
Customer Service: **(598-2) 707-7575**
Provider Finder: **1-800-810-2583**
Eligibility: **1-800-675-2583**

BlueCross & BlueShield de Uruguay
Lord Ponsonby 2456
11600 Montevideo, Uruguay
An independent licensee of the BlueCross and BlueShield Association.

5.3
Coverage and eligibility verification

To verify coverage and BlueCard eligibility for members from other Blue Plans, submit an electronic inquiry (HIPAA 270 transaction) using **Blue *e*** or by calling BlueCard Eligibility at **1-800-676-BLUE (2583)**. You can receive real-time responses to your eligibility requests for out-of-area members between 6:00 a.m. and midnight, CT, Monday through Saturday (English and Spanish speaking phone operators are available to assist you). When calling the BlueCard Eligibility line, you will be asked for the prefix shown on the patient's ID card and then you will be connected directly to the appropriate membership and coverage unit at the member's Blue Cross and/or Blue Shield plan. Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than Blue Cross NC. Therefore, if calling after the out-of-area plan's regular business hours, you may be transferred to a voice response system linked to customer enrollment and benefits.

Please Note: The BlueCard Eligibility line is for eligibility, benefits and pre-certification/referral authorization inquiries only. It should not be used for claim status.

BlueCard Eligibility

1-800-676-BLUE (2583)

5.4
Inpatient pre-certification

Blue Cross NC participating providers, hospitals and facilities are responsible for the pre-certification for non-emergency inpatient admissions and related inpatient procedures/services for BlueCard members.

- Pre-certification requests are to be made in advance of a scheduled inpatient admission. Providers must notify the member's Home Plan within forty-eight (48) hours when a change to the original pre-service review occurs.
- Authorization or certification for emergency admissions must be obtained within twenty-four (24) hours after the emergency admission, or by the end of the next working day (not exceeding seventy-two [72] hours) if on a weekend or holiday.

> **Note:**
>
> **Pre-certification may also be referred to as prior review, prior plan approval, prior authorization or prospective review.**

- Providers are responsible for keeping the member's Home Plan informed of changes to a member's condition.
- Only inpatient services billed on a UB-04 Claim form are included. Outpatient services billed on UB-04 Claim forms and professional services billed on CMS-1500 Claim forms are excluded.
- BlueCard Worldwide/International members are excluded. The requirement only applies to inpatient admissions and related services for BlueCard members within the U.S.
- Some BCBS plans may allow their members to be held financially responsible when certification is denied and a member elects services and agrees to be financially responsible. In the event that an inpatient admission or inpatient service has been denied certification by a member's Home Plan, the member's potential financial responsibility should be discussed in advance with the member's Home Plan before deciding whether or not to proceed with inpatient services that have been denied certification, even if the member has agreed to pay.
- Inpatient providers and facilities that fail to obtain pre-certification from a member's Home Plan will be financially responsible for any covered services not paid and the member will be held harmless.

To determine if a member's inpatient stay or services requires certification from the member's Home Plan, providers can access a member's Home Plan's website to inquire about and make certification requests. Requests for pre-service review for BlueCard members (not Blue Cross NC members) can be routed to the member's Home Plan via an electronic provider access routing system accessed via **Blue *e***. Blue Cross NC providers can connect through **Blue *e*** to BlueCard members' Home Plans to request authorizations for inpatient stays, as well as approvals for inpatient procedures and services that require advanced certification.

5.4.1
Mental health and substance use services

Mental health and substance use services for BlueCard eligible members are coordinated by the member's out-of-state Home Plan. For information on these services or to obtain certification, call the number on the back of the member's ID card.

5.4.2
Radiology management services

BlueCard eligible members from another Blue Plan's service area are not included in the Blue Cross NC radiology management program administered through Carelon. However, it's important to always verify a member's eligibility and prior authorization requirements, as a member may be enrolled in a benefit coverage plan that requires authorization prior to receiving certain radiological services. To verify a member's prior authorization requirements for radiology management services, submit an electronic HIPAA 278 transaction using **Blue *e***, or call BlueCard Eligibility at **1-800-676-BLUE (2583)** and ask to be connected to the member's Home Plan's utilization review area.

5.5
Consumer directed health care and health care debit cards

BlueCard eligible members from another Blue Plan's service area who have consumer directed health care (CDHC) plans often carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). Some cards are "standalone" debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

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

Sample standalone health care debit card (front)

Sample standalone health care debit card (back)

This card issued by [bank name] pursuant to a license from Visa U.S.A., Inc.

MAGNETIC STRIP

By using this card, I agree to the terms and conditions of the [insert Bank Name]'s card holder agreement provided to me. I certify that it will be used only for qualified [medical or dependent care] expenses that qualify under my [insert plan name] plan.

For Customer Service: 800-000-0000

Authorized signature
Not valid unless signed

BlueCross BlueShield of [Geography] is an independent licensee of the Blue Cross and Blue Shield Association.

Sample combined health care debit card and member ID card (front)

BlueCross BlueShield of Geography

Blue Product ALPHA Employer Group

Member ID		Group No.	023457	Plan	PPO
XYZ123456789		BIN	987654	Office Visit	$15
		Benefit Plan	HIOPT	Specialist Copay	$15
		Effective Date	00/00/00	Emergency	$75
		Plan Code	123		

4000 1234 5678 9010

4000

VALID FROM 01/13 GOOD THRU 12/17

DEBIT

CARD HOLDER NAME

VISA

Sample combined health care debit card and member ID card (back)

000000ACB

www.BluePlan.com

By using this card, I agree to the terms and conditions of (Bank's name)'s card holder agreement provided to me. I certify that it will be used only for qualified medical or dependent care expenses.

Authorized signature
Not valid unless signed

Presentation of this card does not guarantee eligibility for benefits. Hospitals or physicians: file claims with your local BlueCross and/or BlueShield plan.

BlueCross and BlueShield of Geography
P.O. Box 01234, City, State 01234-1234
An independent licensee of the BlueCross and BlueShield Association.

Customer Service: 1-800-234-5678 x1234
Debit Card Administrator: 1-800-888-3456
Behavioral Health: 1-800-987-6541 x1234
Outside of Area: 1-800-810-2583 x1234
Eligibility: 1-800-676-2583 x1234
Pharmacy Benefits*: 1-800-888-1234

*BETA Pharmacy Management

Pharmacy benefits administrator: not a BlueCross BlueShield product.

PLUS

Important:

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.

Debit cards will have the nationally recognized Blue logos, along with the logo from a major debit card such as MasterCard® or VISA®.

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.

Helpful tips:

- Carefully determine the member's financial responsibility before processing payment. You can access a member's eligibility, benefits and accumulated deductible amounts by using **Blue *e*** or by contacting the BlueCard Eligibility line at **1-800-676-BLUE (2583)**.
- 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 prefix) and avoid unnecessary claims payment delays.
- If the member presents a debit card (standalone or combined), be sure to verify the member's out-of-pocket amounts before processing payment:
  - Many plans offer well-care services that are payable under a basic health care program. If you have any questions about the member's benefits or to request accumulated deductible information, please contact **1-800-676-BLUE (2583)** or verify using **Blue *e***.
  - You may use the debit card for member responsibility for medical services provided in your office.
  - You may choose to forego using the debit card and submit claims directly to Blue Cross NC for processing.

All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to Blue Cross NC for proper benefit processing.

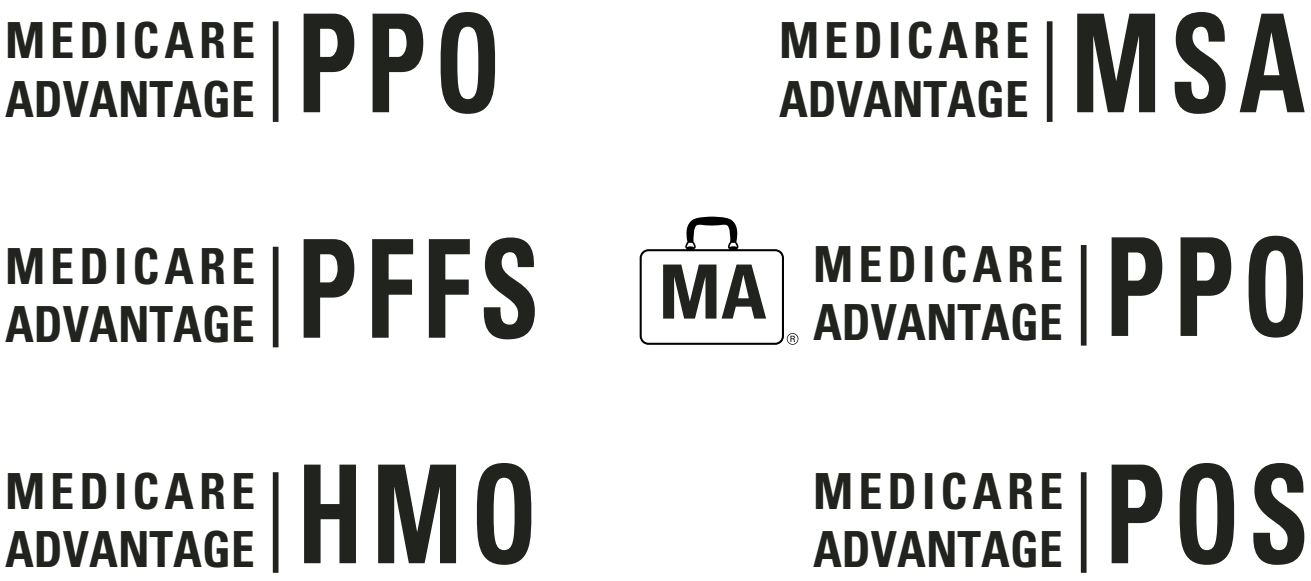
A member's debit card should not be used to process full payment upfront. If you have any questions about the member's benefits, please contact **1-800-676-BLUE (2583)**, or for questions about the health care debit card, processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

5.6

Providers serving out-of-state Blue Plan Medicare Advantage members

Medicare Advantage is an alternative coverage option to the standard Medicare Part A and Part B fee-for-service coverage, generally referred to as Original Medicare. Many Blue Plans offer Medicare Advantage products (within their service areas) for Medicare beneficiaries; product options include: HMO, PPO, POS and MSA products. Additionally, out-of-state Blue Plans offer PFFS plans. Medicare Advantage PFFS plans pay providers on a fee-for-service basis. There is no specific network that providers sign up for to service PFFS patients. Patients can obtain services from any licensed provider in the United States who is qualified to be paid by Medicare and accepts the Blue Plan's terms of payment. The Blue Plan must provide the same coverage as Medicare Part A and Part B, and may offer additional services.

Members enrolled in Blue Plan Medicare Advantage plans will not have a standard Medicare card; instead, a Blue logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:



The Blue Cross and Blue Shield Association and Blue Cross NC provide an online search tool that providers who accept Medicare can access in advance of providing services to patients who have a Medicare Advantage PFFS policy with another Blue Plan. This search tool allows providers to review the terms and conditions of participation that a provider must accept to see a patient with an out-of-state PFFS policy, as offered by another Blue Plan.

Blue Plan members enrolled in Medicare Advantage (MA) products may receive services out-of-network, when out-of-network benefits apply. Coverage rules will vary by MA product type and Blue Plan. When providing services to a Medicare Advantage member, providers should follow these steps:

1. Ask for the member's ID card. Members have been asked not to show their standard Medicare card when receiving services; instead, members should provide their Blue Plan member ID card. The Blue Cross and/or Blue Shield logo will be visible on the ID card along with a MA logo to designate the type of health plan in which the member is enrolled.

2. Verify eligibility electronically using the 270/271 HIPAA eligibility transactions, or by calling **1-800-676-BLUE (2583)** and providing the prefix. When calling, be sure to ask if Medicare Advantage benefits apply. For PFFS plans, you should review the member's Blue Plan's terms and conditions, which can be accessed from the Blue Cross NC website at **BlueCrossNC.com/Providers**.

3. Submit claims to Blue Cross NC. Do not bill Medicare directly for any services rendered to a Blue Plan Medicare Advantage member. Applicable payment will come to you from Blue Cross NC. In general, you may collect any applicable copayment amounts from members at the time of service, but may not otherwise charge or balance bill a member, except as indicated on the explanation of benefits for a processed claim.

   Note: Special rules may apply for MA PFFS plans that may allow balance billing under certain conditions, as reported in the Blue Plan's terms and conditions.

5.6.1
Medicare Advantage PPO network sharing

Medicare Advantage PPO network sharing allows MA PPO members from out-of-state Blue Plans to obtain in-network benefits when receiving care from another Blue Plan's contracted MA PPO providers. Blue Cross NC PPO-participating providers will recognize eligible MA PPO members by the "MA" in a suitcase logo displayed on Blue Plan issued member identification cards.

Medicare Advantage PPO logo

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

Blue Cross NC participating providers should verify eligibility and bill for services using the same methods as when arranging and providing services for any out-of-area Blue Plan's Medicare Advantage member.

5.6.2
Medicare Advantage deemed provider

Medicare Advantage PFFS plans offered by Blue Plans generally use the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage deemed provider concept, rather than direct contracts, to arrange for services to members. Providers of care are considered a deemed provider if each of the following three (3) criteria are met per episode of care:

- The provider is aware in advance of furnishing services that the person being treated is enrolled in a Medicare Advantage PFFS plan.
- The provider has accessed or has reasonable access to information about the Blue Plan's Medicare Advantage PFFS terms and conditions of payment (terms and conditions of payment are available on the Blue Cross NC website located at **BlueCrossNC.com/Providers**.
- The provider subsequently provides services to the member having Medicare Advantage PFFS health care coverage.

Providers electing not to be considered as deemed for providing care to Medicare Advantage PFFS members should not treat them unless in an emergency or urgent situation as appropriate.

5.6.3
Medicare Advantage PFFS PPO and providers participating in the Blue Medicare PPO Medicare Advantage products

Providers contracted to provide services to Medicare Advantage members enrolled in the Blue Medicare PPO plans are required to provide services to BlueCard eligible Medicare Advantage PPO members seeking care within North Carolina.

Blue Medicare PPO providers participating

In the event that a provider contracted to provide services to Medicare Advantage members enrolled in the Blue Medicare PPO plan is in disagreement with a processed claim for services provided to an out-of-state Blue Plan member, the *Network Provider Claim Appeal* must be submitted. The provider may submit a *Network Provider Claim Appeal* for one (1) of the following reasons:

- Payor allowance/pricing
- Incorrect payment/coding rules applied

Benefit determinations made by the member's Blue Plan in writing within ninety (90) days of claim adjudication and should be mailed to:

Blue Medicare PPO
Attention: IPP Provider Appeals
P.O. Box 17509
Winston-Salem, NC 27116-7509

Eligible network provider appeals concerning out-of-state Blue Plan members will be completed by the Plan within thirty (30) days of the Plan's receipt of all information.

5.7

Medicaid members – benefits administered by other Blue Plans

Blue Cross NC is a Host Plan for other Blue Plans' Medicaid members, and claims for services provided to these members should be filed to Blue Cross NC. When you see a BCBS member with Medicaid coverage from another state and submit the claim through Blue Cross NC to the member's BCBS Home Plan, you must accept the Medicaid fee schedule that applies in the member's home state.

BCBS Plans currently administer Medicaid programs in California, Delaware, Hawaii, Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Virginia and Wisconsin as a Managed Care Organization (MCO), providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state and each BCBS plan. Medicaid members have limited out-of-state benefits, generally only coverage for emergency situations. In some cases such as continuity of care, children attending an out-of-state college or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, which may require prior authorization.

If you provide services or supplies that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you follow the guidelines of the Hold Harmless provision (as outlined in **Section 9.17** of this e-Manual). You must tell the member in advance that the service or supply in question may not be covered, as well as get written approval from the member before the service or supply is provided.

Billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by federal regulations (42 CFR 447.15). However, in some circumstances, a state Medicaid program will have an applicable copayment, deductible or coinsurance applied to the member's coverage, which is typically based on the Medicaid fee schedule for a particular service or supply provided. A provider may collect this amount from the member as applicable.

5.7.1
Medicaid provider enrollment requirements

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state's Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from Blue Cross NC regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement.

The Blue Cross Blue Shield Plans in states that currently require Medicaid provider enrollment include:

State	Plan
Indiana	Anthem Blue Cross Blue Shield
Kentucky	Anthem Blue Cross Blue Shield
Pennsylvania	Independence Blue Cross
South Carolina	Blue Cross Blue Shield of South Carolina
Tennessee	Blue Cross Blue Shield of Tennessee
Virginia	Anthem Blue Cross Blue Shield

When you call about a member's eligibility and benefits, always confirm if enrollment is required as this list may change.

5.7.2
Blue Cross Blue Shield Medicaid member identification

Members enrolled in a Blue Cross Blue Shield Medicaid product are issued Blue Cross Blue Shield member identification cards, but these ID cards do not always display a member's Medicaid eligibility. However, there are some indications to look for when identifying Medicaid coverage:

- Medicaid cards do not include the suitcase logo seen on most Blue Cross and/or Blue Shield ID cards.
- There should be a disclaimer on the back of the member's ID card which provides information about benefit limitations. For example, the card may display:

  "This member has limited benefits outside of Tennessee. Providers should verify eligibility/benefit information."

Additionally, some members may have Medicaid benefits administered by a Blue Plan as well as Medicare coverage. These members are known as dual-eligible members and Medicare is generally the primary payor.

To obtain eligibility, benefits and prior authorization information, use the same tools used for BlueCard members:

- Submit an eligibility inquiry using **Blue *e***
- Request pre-service review via the web at **BlueCrossNC.com/members/health-plans/forms-resources/request-prior-review**
- Call the BlueCard Eligibility line at **1-800-676-BLUE (2583)**

5.7.3
Medicaid billing data requirements

When billing for a Medicaid member, remember to check the Medicaid website of the state where the member resides for information about their Medicaid billing requirements. Each state is different. Based on individual requirements, claims may pend or deny if required information is missing.

All required data elements need to be included on Medicaid claims so that BCBS MCOs are able to comply with encounter data-reporting requirements applicable in their respective states. Additional details about how to electronically submit the required data elements for Medicaid claims can be viewed on our website at **BlueCrossNC.com/Providers/About-Blue-e**.

5.8
Claims submission

Submit claims for services provided to BlueCard members to Blue Cross NC using your normal claims billing processes. Blue Cross NC will electronically route your claims to the member's Blue Cross and/or Blue Shield plans. A specific member's plan then applies benefits, processes the claim, approves or denies payment and routes the results back to Blue Cross NC for payment to (you) the provider.

Below is an example of how claims flow through BlueCard

1. Member of another Blue Plan receives services from you, the provider

2. Provider submits claim to the local Blue Plan

3. Local Blue Plan recognizes BlueCard member and transmits standard claim format to the member's Blue Plan

4. Member's Blue Plan adjudicates claim according to member's benefit plan

5. Member's Blue Plan issues an EOB to the member

6. Member's Blue Plan transmits claim payment disposition to your local Blue Plan

7. Your local Blue Plan pays (you,) the provider

You should always submit claims to Blue Cross NC.

To help ensure that claims are routed accurately and that the member's Blue Plan has all of the information needed to appropriately apply benefits, Blue Cross NC forwards to the member's Blue 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 the federal tax identification, member/patient services and medical conditions).

Following these helpful tips will improve your BlueCard experience:

- Ask members for their most current Blue Plan membership ID cards and regularly obtain new photocopies of cards (front and back). Having the current card enables providers to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Incorrect or missing prefixes and incorrect member identification numbers delay claims processing. Claims will be returned or denied if subscriber information is incorrect or invalid.
- Check eligibility and benefits electronically using **Blue *e*** by submitting an electronic HIPAA 278 transaction or by calling BlueCard Eligibility at **1-800-676-BLUE (2583)**.
- Verify the member's cost sharing amount before processing payment. Please do not request complete payment upfront, except for any applicable copayment (for members enrolled in a non-copayment plan [deductible and coinsurance only], providers may follow the Blue Cross NC member liability collection policy located in **Chapter 9** of this e-Manual).
- Indicate on the claim any payment that you collected from the patient. (On the 837 Electronic Claim Submission form, check field AMT01=F5 patient paid amount; on the CMS-1500 Locator 29 amount paid; on UB-04 Locator 53 prior payment.)
- Do not send duplicate claims. Sending another claim or having your billing agency resubmit claims automatically slows down the claims payment process and can create confusion for the member receiving multiple EOBs (Explanation of Benefits).
- Check claims status by submitting an electronic HIPAA 276 transaction, using **Blue *e*** or by contacting Blue Cross NC at **1-800-487-5522**.
- Blue Card members may read other members' reviews and write about their own personal experience with a provider.

5.8.1
Other party liability (OPL)

In cases where there is more than one (1) payor and a Blue Plan is the primary payor, submit OPL information with the Blue claim. Upon receipt, Blue Cross NC will electronically route the claim to the member's Blue Plan. The member's plan then processes the claim and approves the appropriate payment; eligible reimbursement will be sent to the provider of service by Blue Cross NC.

5.8.2
International claims

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

Exception: The Canadian Association of Blue Cross plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the United States. Claims for members of the Canadian Blue Cross plans are not processed through the BlueCard program. Please follow the instructions as listed on a member's ID card, or contact the member's Canadian Blue Cross plan directly.

5.8.3
Coding

Follow all Blue Cross NC claim submission instructions, except for the BlueCard specific instructions noted within this chapter (**Chapter 5**). Code claims, use appropriate forms and complete claim forms and/or electronic entry detail as you would for correctly filed Blue Cross NC claim submissions. Just like other claims filed to Blue Cross NC, BlueCard claims should never be split-billed or filed in partial increments:

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

5.8.4
Timely filing

Claims for professional services provided to BlueCard members having coverage with other Blue Plans (non-Blue Cross NC) must be submitted to Blue Cross NC within one hundred and eighty (180) days of providing service. Institutional/facility claims must be filed within one hundred and eighty (180) days of the member's discharge date.

Note: Providers contracted with Blue Cross NC are allowed one hundred and eighty (180) days for claim submissions to be eligible for benefits release. However, members from other Blue Plans may have shorter filing time limitations applied depending on their individual benefit structure or state legal requirements. Therefore, Blue Cross NC participating providers are encouraged to file claims for BlueCard patients without delay.

5.8.5
Chiropractic services for Blue members

If you're a chiropractic provider participating with both Blue Cross NC and HNS, you should file chiropractic claims for BlueCard eligible members who are enrolled in PPO or HMO plans to HNS using the HNS group number. Chiropractic services provided to members with out-of-state Blue Plan CMM coverage should be sent directly to Blue Cross NC. File chiropractic claims to:

- HNS for BlueCard PPO and HMO members
- Blue Cross NC for BlueCard CMM members

Chiropractic claims for out-of-state members not enrolled in BlueCard-eligible plans should be sent to the addresses listed on the member's ID cards.

5.8.6
Exceptions to BlueCard claims submission

Occasionally, exceptions may arise in which Blue Cross NC will require that a claim be filed directly to the member's Blue Plan; exception reasons can include:

- You contract with the member's Blue Plan located in a contiguous state
- The ID card does not include a prefix

5.8.7
Ancillary

Ancillary providers are typically recognized as independent clinical laboratories, durable/home medical equipment or supply providers and specialty pharmacies. Filing requirements for ancillary providers can vary depending on the type of services performed, where supplies are shipped or services ordered or performed, as well as a provider's participation status with a particular Blue Plan. Ancillary filing guidelines can affect where claims are to be submitted and how they are processed, and should be followed to ensure timely processing of claims.

Please use the examples below to determine where to file claims for ancillary services provided to BlueCard eligible members:

- Local ancillary providers should file directly to Blue Cross NC.
- If a remote provider contract is in place with the local plan, the claim must be filed to the local plan for services received in the local plan area, and it would be considered a participating provider claim.
- If a remote provider contract is not in place with the local plan, the claim must still be filed to the local plan, but it would be considered a non-participating provider claim.

Please use the examples below to determine where to file your claim to ensure timely processing.

Specialty Pharmacy

Specialty pharmacy claims must be filed to the Blue Plan in whose service area the ordering physician is located.

- The NPI of the referring provider is identified in Field **17B** (NPI of Referring Provider or Other Source)
- The NPI of the rendering provider is identified in Field **24J** (Rendering Provider ID Number)
- The NPI of the referring provider is populated in Loop **2310A**

Independent Clinical Laboratory (Lab) Claims

Lab claims must be filed to the Blue Plan in the service area the specimen was drawn. (Where the specimen was drawn will be determined by the state in which the specimen was drawn.)

- The NPI of the referring provider is identified in Field **17B** (NPI of Referring Provider or Other Source)
- The NPI of the rendering provider is identified in Field **24J** (Rendering Provider ID Number)
- If you are a reference laboratory participating with Avalon Healthcare Solutions, you should file claims for BlueCard eligible members to Avalon Healthcare Solutions

Durable/Home Medical Equipment (DME/HME) Claims

The NPI of the referring provider for the DME/HME claims must be filed to the Blue Plan in whose service area the equipment was shipped to or purchased at a retail store.

- The patient address where the DME/HME was shipped to in Field **5**
- The NPI of the referring provider is identified in Field **17B** (NPI of Referring Provider or Other Source)
- The Place of Service (POS) in Field **24B**
- The service facility location in Field **32** (for retail store information or location other than the patient address)
- The patient address is populated in Loop **2010CA**
- The NPI of the ordering provider is populated in Loop **2420E**
- The POS of the member is populated in Loop **2300**, sub-element **CLM05-01**
- The service facility location is populated in Loop **2310C**
- The NPI of the referring provider is populated in Loop **2310A**

5.8.8
Accounts exempt from the BlueCard program

Sometimes Blue Plan members will have identification numbers that include prefixes (member identification numbers for BlueCard-eligible members include a combination of both alpha and numeric characters) even though the members are not enrolled in BlueCard-eligible benefit plans (membership enrolled in non-BlueCard accounts). When a member belongs to an account that is exempt from the BlueCard program, Blue Cross NC will electronically forward those claims to the member's Blue Plan. This means you should not send claims to the member's Blue Plan. Instead, you should submit these claims to Blue Cross NC through your normal claims filing processes.

Submit claims with prefixes exempt from BlueCard directly to Blue Cross NC; we will forward to the member's Blue Plan on your behalf for processing. It's important for you to correctly capture on the claim the member's complete identification number, including the three (3) character prefix at the beginning. If you don't include this information, Blue Cross NC may return the claim to you and this will delay claims processing and payment.

A Blue Plan member's BlueCard-eligibility (and recognition of non-BlueCard eligibility) can be verified by calling **1-800-676-BLUE (2583)** or by submission of an Electronic Eligibility Request (270) with **Blue *e***.

5.9
Reimbursement

Reimbursement to Blue Cross NC participating providers for BlueCard-eligible services, for claims that are submitted to and processed by Blue Cross NC for BlueCard-eligible members from another Blue Plan's service area, are considered based upon the provider's Blue Cross NC contractual allowance appropriate to the member's coverage type (PPO* Blue Options, CMM Classic Blue or HMO Blue Care) in addition to the member's eligibility and available benefits.

Reimbursement for services provided to out-of-area members enrolled in BlueCard-eligible Medicare Advantage plans (including HMO, EPO, PPO, POS, MSA and PFFS plans) will be considered based upon Medicare allowances, in addition to the member's eligibility, available benefits, location where services are provided and the out-of-state Blue Plan's PFFS terms and conditions, as applicable**. Providers should access and review the terms and conditions of participation that a provider must accept to see a patient with an out-of-state PFFS policy, as offered by another Blue Plan. Terms and conditions for non-Blue Cross NC BlueCard PFFS members can be accessed online at: **BlueCrossNC.com/Providers**.

Additional information about reimbursement is available in **Chapter 9** of this e-Manual, located in your businesses participation agreement with Blue Cross NC, and from the Provider Network.

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* PPO members will typically have out-of-network benefits to see providers outside of their PPO network. If you are a non-PPO (CMM contracted only) provider and are presented with an identification card for a BlueCard-eligible PPO member (a card that displays the PPO in a suitcase logo), you should still provide service to the member and file a claim to Blue Cross NC. Payment will be considered based on the CMM allowance for that service in addition to the member's eligibility and available benefits.

** Providers accepting Medicare assignment and servicing Blue Cross NC PFFS Medicare Advantage members for whom they have an obligation to provide services under their Blue Cross NC agreement will be considered as in-network providers and be reimbursed per their individual Blue Cross NC contractual agreement. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Blue Cross NC contractual agreements. Providers who are participating with Blue Cross NC to provide services to Medicare Advantage members enrolled in the Blue Medicare PPO plan receive reimbursement based in accordance with their Blue Medicare PPO negotiated rate with Blue Cross NC.

5.10
Claim status inquiry

Blue Cross NC is your single point of contact for all claim inquiries. Claim status inquiries can be done by:

- Using **Blue *e*** to send a HIPAA transaction 276 (Claim Status Inquiry) to the appropriate Blue Plan
- Phone by calling Blue Cross NC for BlueCard Customer Service at **1-800-487-5522**

If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because they may receive multiple explanations of benefits. Blue Cross NC's standard time for claims processing is 5.5 (five and a half) days (for clean claims, inclusive of the time from when it is time-stamped coming in the door, to when we print the check and financial documentation is sent). However, claim processing times at various Blue Plans can vary.

The standard allowance for Blue Plans to complete BlueCard processing is thirty (30) days, as follows:

- Blue Cross NC receives and routes BlueCard claims to the appropriate Blue Plan within ten (10) days
- Blue Plan in another state makes member benefit decisions and processes claims within fifteen (15) days
- Blue Cross NC receives processing information back from other Blue Plans and pays claims within five (5) days

If you have not received your payment or a response regarding your payment, please call Blue Cross NC for BlueCard Customer Service at **1-800-487-5522** or review status on **Blue *e***. In some cases, a member's claim may be delayed because medical review or additional information is necessary. When resolution of a delayed claim requires additional information from you, Blue Cross NC will contact you for the additional detail.

5.10.1
Calls from members and others with claim questions

If a member contacts you with questions about a processed claim, advise them to contact their Blue Plan and refer them to their ID card for the Customer Service number. The member's plan should not contact you directly regarding claims issues. If the member's plan contacts you and asks you to submit a claim to them, please refer the requester back to Blue Cross NC.

Blue Cross NC is your central point of contact for most out-of-state and international Blue Plan patients receiving care within North Carolina. Contact us for claims processing, payment and claims adjustment questions. However, due to the HIPAA privacy regulations, members must contact their home Blue Plans for all inquiries and claims related issues. Under the HIPAA privacy regulations, we are required to verify a member's PHI before we can answer questions over the phone. Blue Cross NC cannot access an out-of-state member's PHI, as this is maintained with the member's home Blue Plan. If you are approached by an out-of-state member with questions about a claim and information is needed from any of the Blue Plans, please advise the member to contact their home Blue Plan where their PHI can be verified and their questions answered.

5.11
Claim adjustments

File a corrected BlueCard claim to Blue Cross NC whenever a claim adjustment is necessary. Follow Blue Cross NC standard requirements for filing a corrected claim, filing just as you would for a Blue Cross NC member. Once we receive a corrected claim, Blue Cross NC will work with the member's Blue Plan to make the adjustment.

Note: A claim that has been mailed back to a provider should not be submitted as a corrected claim. Claims are mailed back when we need to request that a provider make a correction to a submitted claim. When claims are mailed back they are not entered into our claim processing system for payment. Therefore, when we receive a claim that has been corrected because we had mailed it back to a provider, it's considered new once it's returned to Blue Cross NC. Claims are only eligible to be considered as corrected claims when they are resubmitted after being previously processed for payment. For additional information about how to correct a claim, see **Chapter 9** of this e-Manual or contact the Provider Network.

5.12
Appeals

Appeals for all BlueCard claims are handled through Blue Cross NC. We will coordinate the appeal process with the member's Blue Plan when needed. For additional information about how to submit an appeal, see **Chapter 16** of this e-Manual or contact the Provider Network.

5.13
Coordination of benefits (COB) claims

COB refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two (2) or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment. If you discover that a member is covered by more than one (1) health plan, and:

- Blue Cross NC or any other Blue Plan is the primary payor, submit the other carrier's name and address with the member's claim to Blue Cross NC. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment.

5.13.1
Coordination of benefits questionnaire

Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays. Providers can download and print a copy of the COB questionnaire from the Blue Cross NC website at: **BlueCrossNC.com/sites/default/files/document/attachment/common/pdfs/BCBSNCCOBquestion.pdf**.

The COB questionnaire has been designed to help reduce claims processing delays, and/or a denial, relating to a member's other insurance verification. All Blue Plans have placed on their websites COB questionnaire forms that may be printed and presented to members believed to have potential COB. When you see any Blue Cross and/or Blue Shield BlueCard member and you are aware that they might have other health insurance coverage, give a copy of the questionnaire to the member during their visit. Ask the member to complete the form and send it to the Blue Plan through which they are covered as soon as possible after leaving your office. A BlueCard member can find the address for sending the form on the back of their member identification card or by calling the Customer Service number listed on the back of the card.

Note: The COB questionnaire is only for the BlueCard member's completion and it is not for use by Blue Cross NC members when visiting in-state, North Carolina providers.

5.13.2
Medicare primary claims

Medicare primary claims should be filed with the Medicare contractor first. When filing, always include the complete Health Insurance Claim Number (HICN); the patient's complete Blue Cross and/or Blue Shield plan identification number including the three (3) character prefix; and the Blue Cross and/or Blue Shield plan name as it appears on the patient's ID card for their supplemental insurance. This will help ensure cross-over claims are forwarded appropriately. Additionally, you should never file claims to both the Medicare contractor and Blue Cross NC at the same time. Instead wait until the claim has processed and Medicare has provided you with an Explanation of Payment (EOP) or a payment advice. We request this because the member's benefits cannot be determined by the member's Blue Plan without knowing what Medicare has allowed. Once you receive the Medicare payment advice/EOP, determine if the claim was automatically crossed over to the supplemental insurer:

- Crossed over – If the claim was crossed over, the payment advice/EOP should typically have remark code "**MA**" eighteen (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 accept Medicare assignment. If you do not accept assignment, the member will be paid and you will need to bill the member.
- Not crossed over – If the payment advice/EOP does not indicate that the claim was crossed over and you accept Medicare assignment, file the claim to Blue Cross NC if the member's ID includes a prefix. If no prefix is included, file the claim to the address on the back of the member's Blue Plan ID card. Blue Cross NC or the member's Blue Cross and/or Blue Shield 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.

5.13.3
Coordination of benefits filing for secondary UB-04 claims to Medicare and other insurance

Blue Cross NC along with all BlueCard plans maintain HIPAA compliant software which allows plans to process all COB claims through the BlueCard ITS claims system. Providers should expect payment through the BlueCard program when following the instructions for electronic submission of UB-04 claims, when the member's Blue Plan coverage is secondary to Medicare or another payor. Submit claims electronically via 837 (HIPAA compliant software) for UB-04 hospital claims; file the Medicare COB data as follows:

- Medicare paid amount should be filed using an AMT segment in the 2320 Loop with a "**D**" 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 "**CO**," 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**," appropriate claim adjustment reason code **2** for deductible and the corresponding claim adjustment $ amount.

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, but rather use the CAS code segments as indicated. If you have questions, please contact Blue Cross NC Electronic Solutions by calling **1-888-333-8594**.

5.14
Medical records

Do not send medical records unless Blue Cross NC requests the records from you using a medical request letter. When medical records are requested by Blue Cross NC, send the records, including the medical request letter received from Blue Cross NC, to Blue Cross NC. Upon receipt of the medical records, Blue Cross NC will forward the records to the member's Home Plan. Blue Plans are able to send and receive medical records electronically between each other. This electronic method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records more than once and helps to eliminate lost or misrouted records.

Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim requiring medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records are still needed, please contact Blue Cross NC to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.

If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact Blue Cross NC to determine if the records are needed from your office.

Helpful ways you can assist in timely processing of medical records:

- If the records are requested following submission of a claim, forward all requested medical records to Blue Cross NC.
- Include the letter that you received from Blue Cross NC, which requested medical records be submitted, when sending the needed medical records to Blue Cross NC. Please place the Blue Cross NC medical records request letter on top of the records being submitted. The medical records request letter contains a bar code that helps ensure that the records are routed efficiently once received by Blue Cross NC.
- Submit the information to Blue Cross NC as soon as possible to avoid delay.
- Only send the information specifically requested. Complete medical records are not always necessary.
- Do not pro-actively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

5.14.1
Sending medical records to the member's Blue Plan

Providers should not send medical records to the member's Blue Plan. Requested medical records should always be sent to Blue Cross NC, unless the medical records have been requested by the member's Blue Plan as part of the pre-authorization process. If you receive requests for medical records from other Blue Plans prior to rendering services as part of the pre-authorization process, you may be requested to submit the records directly to the member's Blue Plan that requested them. This is the only circumstance where you would not submit them to Blue Cross NC.

When medical records are necessary as part of claim review and adjudication, the request for records will come from Blue Cross NC.

5.14.2
Provider Link users

Provider Link is an electronic method of requesting and sending medical records. If your health care operation uses Provider Link for medical records transmission and a medical request is submitted to you through Provider Link, the request should be returned through Provider Link and not by other methods.

5.15
Provider-initiated refunds for out-of-area members

When Blue Cross NC receives non-requested refunds for Blue Plan members, both Blue Cross NC and the member's out-of-state Blue 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 BlueCard members. Blue Cross NC will work with both you and the member's Blue Plan to process the returned payment and its associated claim in an accurate and timely manner.

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

- Provide the EOP documentation for all insurance carriers associated with the claim.
  Ensure that the EOP documentation details the following items (if available):
  a. Provider's name
  b. Provider's NPI (Level 1 and Level 2 if applicable)
  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
- Specify the reason for the refund. Provide the following support documentation (if available).
  a. Duplicate payment (requires both Blue Cross NC vouchers)
  b. Workers' Compensation (provide the date of onset)
  c. Medicare payment is primary (requires EOP)

d. Other carrier paid primary (requires EOP)

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 EOP)

i. Other carrier adjusted payment (requires EOP)

j. Not your patient

- If sending as a rebuttal to a payment issue previously discussed with Blue Cross NC, please attach a copy of the information described above, as well as a copy of the Blue Cross NC check voucher. Unfortunately, if we cannot accurately trace your returned payment to its appropriate claim, Blue Cross NC must return the payment to the provider. Submitting all necessary information will help ensure that your returned payment is processed appropriately.

6

Medicare supplement products

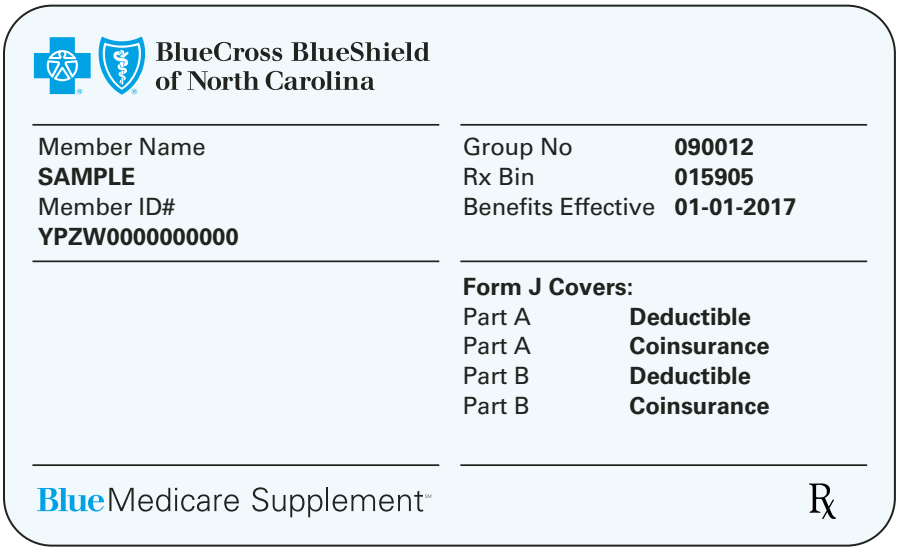
Blue Cross NC offers Blue Medicare Supplement℠ plans to help cover health care costs that Medicare does not cover alone, such as deductibles and coinsurance amounts. Blue Cross NC Blue Medicare Supplement products allow members to receive services from any Medicare participating doctor, hospital or clinic. Blue Medicare Supplement plans offer coverage options in addition to a member's Medicare plan and do not take the place of Original Medicare. Medicare is a federal health insurance program for people ages sixty-five (65) years or older, certain people with disabilities and people with permanent kidney failure treated with dialysis or a transplant. Medicare has four (4) parts: Part A, which is hospital insurance; Part B, which is medical insurance; Part C, which is Medicare Advantage plans; and Part D, which is prescription drug coverage.

Medicare supplement insurance policies are sometimes called Medigap plans. Medigap plans are private health insurance policies that cover some of the costs that Original Medicare (Parts A and B) does not cover. Some Medigap policies will cover services not covered by Medicare, such as preventive care. Medigap has nine (9) standard plans: Plan A through Plan N, which includes one (1) high deductible plan called High Deductible Plan G.

Please Note: Blue Cross NC Blue Medicare Supplement plans discussed within this chapter are not the same product as the Blue Medicare HMO℠ and Blue Medicare PPO products. Additional information about the Blue Medicare HMO and Blue Medicare PPO products is available in the Blue Book Provider Manual – Blue Medicare HMO and Blue Medicare PPO Guide, which is located on our website at **BlueCrossNC.com/Providers/Networks-Programs/Blue-Medicare**.

Sample Blue Medicare Supplement membership ID card:

Sample identification card (front)



Sample identification card (back)

The full member ID begins with YPZW or YPZJ and is a total of fourteen (14) characters, which includes eight (8) subscriber numbers followed by two (2) additional member identifying numbers that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a Blue Cross NC membership ID card is not a guarantee of eligibility or benefits.

Always verify a member's individual eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Always verify the card holder's other forms of legal identification to help prevent identity theft.

6.1
Available benefits

Medicare recipients will typically pay a portion of the costs not covered by Medicare, i.e., deductibles and coinsurance amounts. Medicare supplement plans help Medicare recipients to offset some of these costs and costs for services that aren't covered by Original Medicare by providing additional coverage. The health care financing administration has authorized the sale of nine (9) standard supplement plans (Plans A through N) with which individuals with Medicare coverage may supplement their benefits. Blue Cross NC offers five (5) of the standardized plans: A, G, High Deductible G, K and N. Benefits in these plans vary in both benefit levels and cost. With reference to hospital benefits, Blue Cross NC 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.

Services and Coverage Parts

Medicare Part A	Processes claims for: • Inpatient hospital • Skilled nursing facilities • Home health care • Hospice In North Carolina, the Intermediary is Palmetto GBA. Provider contact center: **1-877-567-9249**.
Medicare Part B	Processes claims for: • Physician charges • Medical and surgical services, including anesthesia • Treatment of mental illness • Diagnostic tests and procedures that are part of treatment (radiology and pathology services [inpatient and outpatient]) • Ambulance services • Ambulatory surgical centers • 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 Government Services. Provider customer service: **1-866-655-7996**.
Medicare Part D	Processes claims for: • Prescription drugs • Certain vaccines (not all vaccines are covered) • Insulin • Certain medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs and gauze)

6.1.1
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. The following description of benefits is offered as an example of typical benefit options, not a guarantee of benefits, eligibility or coverage. Always verify a member's actual eligibility and benefits prior to providing services.

6.1.1.1
Hospital

Basic benefits available for each benefit period:

- Member has coverage for the first sixty (60) days at 100% of all covered services except for the Medicare Part A inpatient hospital deductible of $1,556 for 2022 (changes January 1st yearly).
- Member has coverage for days sixty-one (61) to the ninetieth (90th) day and pays a daily coinsurance amount of $389 for 2022 (changes January 1st yearly).
- Member has coverage for days ninety-one (91) to the hundred and fiftieth (150th) day and pays a daily coinsurance amount of $778 for 2022 (changes January 1st yearly).

For hospital services after the ninety (90) basic days available each benefit period, your patients are eligible for lifetime reserve days equaling sixty (60) days at 100% of all covered services except for any applicable daily coinsurance amount. 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.

6.1.1.2
Skilled nursing facility (SNF)

Basic benefits available each benefit period:

- Member has coverage for the first twenty (20) days at 100% of all covered services.
- Member has coverage for days twenty-one (21) to the one hundredth (100th) day and pays a daily coinsurance amount of $194.50 for 2022 (changes January 1st yearly).
- Coverage is not available for days beyond the maximum one hundred (100) days allowed.

6.1.1.3
Hospital and post-hospital skilled nursing 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 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 sixty (60) days in a row. Benefits also end 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 at the facility for sixty (60) consecutive days.

If a patient is readmitted as a hospital inpatient after the sixty (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 that a patient can have for hospital and skilled nursing facility care.

6.1.1.4
Part A deductible and coinsurance amounts

INPATIENT HOSPITAL		
Part A deductible	Per benefit period in 2022	$1,556.00
Coinsurance	Days 1-60 in year 2022	$ 0.00
Daily coinsurance	Days 61-90 in year 2022	$ 389.00
Daily coinsurance	Days 91-100 in year 2022	$ 778.00
Lifetime reserve days	Days 101-150 in year 2022	All costs

6.1.2
Medicare Part B benefits

Medicare Part B helps cover medical services that typically includes coverage for: Professional services, outpatient hospital care, physical and occupational therapists and home health care. Members are responsible for the first $233 (for 2022) Medicare Part B deductible amount plus 20% of the balance of any approved amounts (Medicare pays 80% less the member's $233 [for 2022] deductible).

6.1.3
Medicare Part D benefits

Medicare Part D covers prescription drugs, medical supplies associated with the injection of insulin (syringes, needles, alcohol swaps and gauze) and certain vaccines. 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. Claims for Part D vaccines that cannot be filed on a CMS-1500 under the member's medical benefits can be submitted using eDispense™ (for additional details about eDispense see **Chapter 9** of this e-Manual or contact the Provider Network).

6.1.4
Supplement plans

Supplement plans are offered through nine (9) standard plans: Plan A through Plan N, including one (1) high deductible plan called High Deductible Plan G. Supplement plans help pay the member's deductible and coinsurance amounts not covered by Original Medicare.

6.1.5
Blue Medicare Rx

Blue Cross NC offers two (2) Blue Medicare Rx plans for Medicare recipients to choose from. Our Standard Plan meets and exceeds Medicare's minimum benefit requirements. Additionally, we offer an even more comprehensive plan in the Enhanced Plan. Additional information about the Blue Medicare Rx plans can be found on our website, **BlueCrossNC.com**.

6.2
Medicare secondary payor

Medicare secondary payor refers to situations of Medicare acting as the secondary payor on health care claims. Mandates from the CMS require that providers identify and report situations where Medicare should be the secondary payor. Three (3) 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)
- COBRA
- Retiree health plans

Accident/injury related insurance:

- No-fault
- Liability
- Workers compensation

Other government sponsored health plans:

- Veterans Administration (VA)
- Black lung

6.3
Fraud, waste and abuse

Any of the following violations should be reported to the carrier or intermediary immediately:

- The performance of an unnecessary or inappropriate service
- Billing a service that was not received or a misrepresented service
- Charges in excess of the limiting charge
- Violation of the assignment agreement with Medicare
- A provider who accepts referral fees
- Misrepresentation of the reason for ambulance transportation
- A provider who collects payments from Medicare recipients (except for deductible amounts, coinsurance amounts and any appropriate payment for non-covered items)
- A Medicare beneficiary who misrepresents a condition to get Medicare to pay for a service
- A Medicare beneficiary who misuses a Medicare card

7

Care management

7.1
Overview

In an effort to work with physicians and members to facilitate the most medically appropriate, cost effective quality care, the Care Management department has designed comprehensive processes to administer Blue Cross NC benefit plans.

As your partner in managing care, Blue Cross NC 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 Care Management department administers the following processes:

- Prospective/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 health care management guidelines. You are responsible for contacting Blue Cross NC to obtain all necessary certifications when a Blue Cross NC member seeks care from you.

Medical decisions are based on MCG Care Guidelines and Blue Cross NC medical policy. You may request a copy of a specific criteria set or medical policy by calling the Care Management department at **1-800-672-7897**. Medical policy is also available on the Blue Cross NC website at **BlueCrossNC.com**.

For information pertaining to health coaching and intervention for the FEP, see **Chapter 4**.

For information pertaining to health coaching and intervention for inter-plan programs, see **Chapter 5**.

7.2
Contacting Care Management

The Care Management department is available as follows:

- Monday through Friday, 8 a.m. – 5 p.m. ET 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**.
- Care Management may also be accessed via the **Blue *e*** electronic network. See **Chapter 11** for more detailed information.

Contact information for discharge services can be found in **Section 7.7** of this e-Manual.

7.3
Services not requiring prior review

Emergency department services and urgent care center services

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 twenty-four [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 Blue Cross NC 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 admitting physician should provide notification for any inpatient admission following an emergency service as soon as possible, but no later than two (2) business days after the admission. The admitting physician should obtain certification for any inpatient hospital admission that is the result of an unplanned direct admission (i.e., member did not enter through the emergency room), or complication related to pre-planned outpatient services, within two (2) business days after the admission.

Please reference **Section 7.5.1.1** for additional information about emergency inpatient admissions.

7.3.1
Observation

Observation stay is a period not to exceed forty-eight (48) hours.

Blue Cross NC does not require notification for hospital observations for our HMO, POS, EPO or PPO plans. Blue Cross NC encourages providers to notify us of a patient's observation admission if the patient will have discharge needs.

Notification to Blue Cross NC will facilitate the coordination and authorization of discharge related services (i.e., home health, home IV therapy and DME related services that may require prior review for our HMO, EPO, POS and PPO members).

7.4
If appropriate participating physician is not available

It is the policy of Blue Cross NC 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 Blue Cross NC to certify coverage for a non-participating provider before services are provided. Reasonable access is defined by Blue Cross NC's access to care standards, which are available at **BlueCrossNC.com** or by contacting Customer Service.

The following standards apply to HMO, EPO, POS and PPO products:

- No benefits are available to HMO/EPO members for care from non-participating providers except in emergencies or with certification from Blue Cross NC. If an HMO/EPO 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 7.14.3** of this chapter for more information about continuity of care).

If you have questions about a provider's participation in our HMO, EPO, POS or PPO networks, visit our website at **BlueCrossNC.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 Care Management at **1-800-672-7897**.

7.5
Certification and prior review

7.5.1
Certification

Certification is the determination by Blue Cross NC 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 • EPO • 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 Blue Cross NC prospective review process, certification is required prior to delivery of certain outpatient services such as home health, home infusion therapy, private duty nursing, durable medical equipment and certain surgical procedures. A list of services requiring certification has been included in this section for your convenience. This list is reviewed quarterly at this time. Please check at website **BlueCrossNC.com** for the current up-to-date list. This list is current as of the date of publication of this e-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 Blue Cross NC. Failure to obtain certification for services will result in reduction or denial of payment for charges, both institutional and professional.

7.5.1.1
How to request certification

All certification requests for services should be made directly to Blue Cross NC.

To request certification:

- Utilize the **Blue *e*** Care Affiliate Authorization Portal
- Call Care Management at **1-800-672-7897**

OR

- Mail a completed Blue Cross NC Certification Request form to:
  Blue Cross and Blue Shield of North Carolina
  Attention: Care Management
  P.O. Box 2291
  Durham, NC 27702-2291

Inpatient admissions:

- Hospitals and facilities may notify Blue Cross NC via the admission notification application on **Blue *e***. If your organization does not have access to **Blue *e***, please refer to **Chapter 11**.

Provide the following information when submitting a request:

- Provider/group practice name NPI.
- Contact name, phone number and fax number.
- Patient's name, Blue Cross NC member ID number and date of birth.
- Attending physician's name, NPI 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 may also be asked to provide the ordering practitioner's name, phone number and fax number.

You will be contacted if additional clinical information is required and will be notified of decisions within three (3) business days of our receipt of all necessary information.

URGENT REQUESTS WEEKEND OR HOLIDAY:

Providers making an urgent authorization request on a weekend or holiday for a service or services requiring prior authorization should utilize the Blue *e* Care Affiliate Authorization Portal as a primary means of notification.

Phone (**800-672-7897**) is available if you do not have **Blue *e*** access.

For urgent requests, Blue Cross NC will notify the requesting provider (hospital or facility) within twenty-four (24) hours of receiving the request. This includes weekends and holidays.

- Providers will then have twenty-four (24) hours to submit the supporting clinical information to Blue Cross NC for review and determination
- Blue Cross NC will provide notification of the decision within seventy-two (72) hours of receipt of the initial request
- Once an admission is approved, Blue Cross NC may follow up about the patient's discharge planning and length-of-stay (concurrent review) needs

If all clinical information needed to support the emergency inpatient admission authorization request is received at the time of the initial request, Blue Cross NC will notify you of the decision within twenty-four (24) hours of receipt of the request.

If all required clinical information is not available at the time of the initial request, Blue Cross NC will notify the requesting provider (hospital or facility) within twenty-four (24) hours of receiving the request. This includes weekends and holidays. Providers will then have twenty-four (24) hours to submit the supporting clinical information to Blue Cross NC for our review and determination. Once we receive the requested clinical information, Blue Cross NC will provide notification of the decision within seventy-two (72) hours of our receipt of the initial request.

As part of the health care reform guidelines, urgent requests are defined as requests for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function; or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

7.5.1.2
Certification decisions

We agree to use our best efforts to notify you as soon as possible of our decisions regarding prior review and/or certification or non-certification of services as set forth in our Care Management programs. This will occur within no more than three (3) business days following our receipt of all necessary information.

Certification is required for appropriate claims payment but does not guarantee claim payment. Blue Cross NC 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 their 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 MCG 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. Blue Cross NC will issue written notification of the decision within applicable regulatory time frames of our receipt of all necessary information. If you feel a non-certification is in error, you may request a courtesy review.

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 some instances.

7.5.1.3
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 Blue Cross NC to be avoidable are not eligible for reimbursement
- Members cannot be billed for avoidable days

7.5.1.4
Non-participating providers for HMO/EPO, POS and PPO members

- No benefits are available to HMO/EPO members for care from non-participating providers except in emergencies or with certification from Blue Cross NC. If an HMO/EPO 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, Blue Cross NC 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 7.14.3** in this e-Manual).
- Services received from a non-participating physician or provider that are not urgent or emergent and are not approved by Blue Cross NC in advance will not be paid at the in-network benefit level.
- If you have a question about participation in our HMO/EPO networks, visit our website at **BlueCrossNC.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 Care Management at **1-800-672-7897** or visit the **Blue *e*** portal.

7.5.1.5
Certification list

Blue Cross NC requires certification for certain services, procedures, inpatient admissions and pharmaceuticals. The prior review list is updated every quarter with new service codes, and/or deletion of service codes that are no longer effective. If changes are made to the prior review list, our website at **BlueCrossNC.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 Care Management 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. If the process for obtaining certification changes, Blue Cross NC will notify you in accordance with your contract.*

Please Note: Any services, durable medical equipment, procedures or medications listed on the Prior Review Code List require authorization for ALL places of service, including when performed during any prior approved inpatient admission, including both planned inpatient admissions and emergent inpatient admissions.

Helpful tips:

- If the member's physician certifies in writing to Care Management 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.
- Blue Cross NC's drug-specific fax forms are available online at **BlueCrossNC.com**. The only time a general fax form is acceptable to submit to Blue Cross NC is if it's indicated as the correct fax form to use for requesting prior review of a specific drug.
- PPO products offer out-of-network benefits. Members should refer to their member guide for their responsibilities when seeking services from out-of-network providers.
- Some large groups have special benefits and benefit exclusions.
- Blue Cross NC may authorize out-of-network/non-participating services at a member's in-network benefit level if a service is not available in-network or if there is a qualifying continuity of care issue.
- Certain non-emergency, outpatient, high-tech diagnostic imaging services as defined by our diagnostic imaging management program require certification. Please see **Section 7.9** for additional detail, or visit our website at **BlueCrossNC.com/Providers/Prior-Authorization/Services-Requiring-PPA**.
- Sleep study reviews are performed to determine medical necessity, as well as, ensure the service is rendered in the most appropriate place of service.
- Carelon Medical Oncology performs clinical appropriateness reviews for chemotherapy regimens and supportive drugs.

QUICKLY ACCESS PROVIDER PRIOR APPROVAL LIST!

- On the web at **BlueCrossNC.com/Providers**
- In Blue e℠
- Call Care Management **1-800-672-7897**

* Services on the Prior Review Code List that are rendered emergently or urgently during an inpatient admission are still subject to medical necessity criteria.

7.5.2
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 the certification or non-certification of benefits.

7.5.3
Guidelines for obtaining durable medical equipment and home health services (applies to HMO, EPO, PPO, POS and some CMM plans)

7.5.3.1
Durable medical equipment services

- Prior review/authorization is required for specific DME codes (whether purchased or rented). Refer to **BlueCrossNC.com** for the most current DME service code list under prior review.
  - *Only home durable medical equipment (HDME) suppliers that meet Blue Cross NC 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 21**).

7.5.3.2
Home health services

Home health services include skilled nursing visits, non-routine medical supplies and home infusion therapy.

- Prior review/authorization is required for skilled nursing visits and some home infusion services. 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 website at **BlueCrossNC.com**.

See **Chapter 4** for requirements for FEP members.

7.5.4
Certification list for ancillary services

Blue Cross NC requires certification for certain services and procedures. The following chart indicates when certification is required.

SERVICES/PROCEDURES/ADMISSIONS				
TYPE	**HMO**	**POS**	**PPO**	**CMM**
HOME HEALTH	Certification[1]	Certification for RN/LPN only[1]	Certification[2]	Not applicable
CERTAIN HOME INFUSION THERAPY DRUGS	Refer to specific DME service code list at **BlueCrossNC.com** under prior review	Certification[1]	Certification[2]	Not applicable
PRIVATE DUTY NURSING	Certification[1]	Certification[1]	Certification	Certification
HOME DURABLE MEDICAL EQUIPMENT	Refer to specific DME service code list at **BlueCrossNC.com** under prior review	Refer to specific DME service code list at **BlueCrossNC.com** under prior review	Refer to specific DME service code list at **BlueCrossNC.com** under prior review	Not applicable
HOSPICE – OUTPATIENT	Not applicable[1]	Not applicable	Not applicable	Not applicable
DIALYSIS	Not applicable[1]	Not applicable	Not applicable	Not applicable

1 Some CMM plans require prior review for home health, home infusion and home durable medical equipment. Verify member benefits.

2 Applies to Blue Options, State Health Plan and Classic Blue only.

- 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.

7.5.5
Hospital observation

(Applicable for all Blue Cross NC products and lines of business)

Observation services (not to exceed forty-eight [48] hours) 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 (rule out 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 (rule out 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, Blue Cross NC 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 a continued hospital stay, coverage for a continuing inpatient stay will be denied. The Care Management coordinator will notify the requesting provider of the denial via telephone or fax within applicable regulatory time frames.
- 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 time frames.
- For information on appeals, refer to **Chapter 16**.

Prior review

Services and procedures received in an observation setting may be subject to prior review. Blue Cross NC requires that prior review be obtained from Blue Cross NC by a health care provider on behalf of a Blue Cross NC member, in advance of their providing any service that requires prior review as applicable to the member's benefit plan.

Services requiring prior review from Blue Cross NC must receive advance approval from us regardless if the services in question requiring prior review are scheduled to be performed in a physician's office, outpatient or observation setting at a facility of care or inpatient setting.

- Prior review of services is not required when provided during an emergency room encounter and administered to a patient with a possible emergent or life-threatening condition.
- Diagnostic imaging radiological services that are subject to prior review as part of Blue Cross NC's diagnostic imaging management program administered by Carelon Medical Benefit Management are exempt from prior review requirements when the imaging services are performed during observation care (up to forty-eight [48] hours), and when they are performed as inpatient services.
- Services requiring prior review can vary depending on the Blue Cross NC product in which a member is enrolled. Health care providers are encouraged to verify a member's individual benefits and prior review requirements in advance of providing non-emergency services.

7.6
Peer-to-peer review

Blue Cross NC medical directors are available to discuss clinical problems 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 Blue Cross NC 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**, x**51910**.
- A peer-to-peer review may also be requested by a Blue Cross NC 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.

7.7
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, SNF, 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 Blue Cross NC members. Services include:

- DME – Specific DME code listed at **BlueCrossNC.com** under prior review and/or prior plan approval
- Home health, including IV therapy
- SNF placement
- Rehabilitative admissions

Requests for discharge services may be made to discharge services twenty-four (24) hours a day, seven (7) days a week by submitting request via the **Blue *e*** Care Affiliate Authorization Portal.

All requests/messages should contain the following information:

- Physician's name and phone number, including area code
- Physician's NPI
- Subscriber's name and ID number
- Brief description of the needed services

7.8

Transfer to long-term acute care (LTAC) facilities

Requests for transfer to a 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/EPO) may not have a benefit for the LTAC. Other members in PPO/POS plans may incur a significant financial obligation for care in these facilities that they would not if they received their care in-plan.

When Care Management 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, a 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 Blue Cross NC review process. A discussion between physicians may help clarify the situation and reach the best decision for the patient. A Blue Cross NC medical director is available during regular business hours and can be reached at **1-800-672-7897**, x**51910**.

To refer a member to case management, call **1-800-672-7897**. Referrals can be made by:

- Consulting specialist
- Member or the member's family
- Employer

7.9
Diagnostic imaging management program

Carelon administers the diagnostic imaging management program for Blue Cross NC for the management of outpatient high-tech diagnostic imaging services.

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
- Positron emission tomography (PET) scans

Requests involving multiple examinations of contiguous body parts that are not approved prior to physician review will be subject to a mandatory peer-to-peer conversation. If the Carelon physician reviewer cannot reach the ordering provider, none of the multiple exams requested will be approved. Coverage of services will continue to be subject to all of the terms and conditions of the member's health benefit plan and applicable law.

Ordering physicians must contact Carelon via the web or by phone to obtain a certification prior to scheduling an imaging exam for these outpatient diagnostic non-emergency services. Hospitals and freestanding imaging centers that perform imaging services cannot obtain the certification.

The exceptions to this policy are as follows:

- An ordering physician has diagnostic imaging equipment in their office and the ordering physician will be filing the claim for the technical component (or billing globally) for the service.
- The servicing physician is an interventional radiologist, as established by Blue Cross NC's credentialing department.

As part of the diagnostic imaging management program, Blue Cross NC prohibits the following:

- A servicing location to market or offer Blue Cross NC referring providers their services in obtaining the certification from Carelon on behalf of the referring physician.
- A referring physician to allow the servicing location to contact Carelon on their behalf to request the certification for diagnostic imaging management 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.

Ordering physicians can obtain and confirm certification by contacting Carelon in one (1) of the following ways:

1. By logging in to the provider portal through **Blue *e***.
2. By calling Carelon: **1-866-455-8414** (toll free), Monday through Friday, 8 a.m. to 5 p.m. ET. Imaging service providers can also contact Carelon, 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 Carelon to change the date of service on the certification, change the location of the service or request add-on procedures.

Neither Carelon nor Blue Cross NC will issue retroactive certification. However, if the requested scan is of an urgent nature, the ordering physician can request the certification within forty-eight (48) hours of the procedure.

If you are not currently registered to use **Blue *e***, you will need to register online at **BlueCrossNC.com/Providers/About-Blue-e**. Blue Cross NC provides **Blue *e*** to providers free of charge.

7.9.1
The diagnostic imaging prior review code list

The diagnostic imaging prior review specific code list is available on the **BlueCrossNC.com** website at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/cpt-Service-Codes**. This list is subject to change once per quarter. Changes will be posted to **BlueCrossNC.com** by the tenth (10th) day of January, April, July and October. Diagnostic imaging management policies and medical policies are also available, located on the web at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes**.

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

7.9.2
Medical oncology program

Carelon administers the Medical Oncology Program for Blue Cross NC for the medical management of outpatient medical oncology drug administration. The program promotes the use of evidence-based treatment guidelines and quality outcomes by efficient use of chemotherapy and supportive agents.

The program has two (2) components:

1. Prior review of a subset of medical oncology and oncology supportive drugs.
2. Carelon Cancer Treatment Pathway recommendations.

Requesting Prior Approval for Medical Oncology

The Medical Oncology Program prior review code list requires prior authorization through the Carelon Provider Portal or by phone.

Ordering physicians can obtain and confirm certification by contacting Carelon in one (1) of the following ways:

1. By logging in to the ProviderPortal through **Blue *e***.
2. By calling Carelon at **1-866-455-8414** (toll free) Monday through Friday, 8:00 a.m. to 5:00 p.m. ET.

If you are not currently registered to use **Blue *e***, you can register at **BlueCrossNC.com/Providers/About-Blue-e**. Blue Cross NC provides **Blue *e*** to providers free of charge.

A list of medical drugs requiring prospective review through AIM Provider Portal is available on the **BlueCrossNC.com** website at **BlueCrossNC.com/Providers/Prior-Authorization**. Medical oncology program policies and other medical policies can be located on the web at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes**.

Keep in mind that certain drugs may require prior review through the member's pharmacy benefit manager or from Blue Cross NC Utilization Management. Please refer to the member's benefit booklet for availability of benefits.

7.10
Specialty Care Shopper program

This program provides real-time cost transparency information to ordering physicians with site-of-service options for lowest-cost, in-network CT/CTA and MRI/MRA diagnostic imaging sites. In addition, when available, quality information is taken into account such as staff certifications, accreditation by recognized organizations, equipment used (e.g., magnet strength) and services offered by the practice. Imaging providers must supply quality information to the Specialty Care Shopper program in order to be incorporated into the program.

In cases where the ordering provider does not elect the most optimal site for this care, Carelon will make a courtesy call to the member to make them aware of their options for their imaging exam(s), but the provider and/or member is not required to schedule the exam at a specific facility.

Members will be contacted only if they meet the following criteria:

- Request is for a CT or MRI
- There is a $300 cost differential between the originally selected site and the optimal site when both sites have high quality ratings
- There is cost savings if the originally selected site has lower quality while the optimal site has a high-quality rating
- Member is over eighteen (18) years of age
- Exam is for a non-cancer diagnosis

Note: The Specialty Care Shopper program only works when a member also has the Diagnostic Imaging Program.

7.11
Sleep study program

This program is part of Blue Cross NC's prior review programs that will require prior approval of sleep studies.

- This program seeks to manage costs by ensuring that these studies are medically necessary and provided in the appropriate setting (e.g., at home versus at a sleep center/facility).

Laboratory Management

Avalon Healthcare Solutions provides access to a laboratory network designed to meet the clinical requirements of Blue Cross NC's network of providers and the patients they serve.

The Avalon program consists of three (3) separate components:

- **Network management.** Since 2017, Avalon has managed Blue Cross NC's independent lab network. Only laboratories contracted with Avalon will be eligible to provide in-network laboratory services and receive payments under our members' in-network benefits. Through this arrangement, we can better offer our members access to high-quality laboratory services at the most affordable cost.
- **Genetic test management.** Laboratory services that require medical record review to determine clinical compliance and appropriateness with policy are managed through the Avalon test management program. Avalon delegates Prior Plan Approval (PPA) for existing laboratory related medical necessity reviews and a portfolio of procedures recommended for prior approval.

  Note: Emergency room and hospital stays (urgent/emergent situations) do NOT require PPA.

  – Impacts any procedure on the PPA list for Blue Cross NC's under-65 underwritten and Administrative Services Only (ASO) products, including but not limited to the SHP and under 65 members eligible through the BlueCard program. This change does not impact any laboratory's existing participation in Blue Cross NC's Medicare Advantage products or the FEP.
- **Routine test management.** Routine lab services evaluated for clinical compliance and appropriateness with policy are managed through Avalon's Automated Policy Enforcement Application (APEA) tool. APEA automates the enforcement of medical policies by applying claims edits to evaluate laboratory claims. The APEA result may be applied to the claim to 1) pay as is, 2) reduce units or 3) deny the laboratory service based on those edits.

  Note: The application reviews for reimbursement only, not for medical necessity.

APEA impacts any claim with a qualifying lab service for Blue Cross NC's FEP under-65 underwritten and ASO products, including but not limited to the SHP and under 65 members eligible through the BlueCard program. Routine test management does not impact any laboratory's existing participation in Blue Cross NC's Medicare Advantage products.

7.12
Carelon program employer group participation

Most Blue Cross NC employer groups are participating in one of the Carelon programs. However, not all employer groups are participating, so member verification should be completed via Carelon's portal to determine whether an authorization is needed. Carelon will update their portal as new employer groups enter or leave this program, so it is important that you confirm participation in advance of providing services. These programs are offered to our individual, fully insured and select ASO groups that opt in for the specific programs. ASO groups may opt in only at renewal.

7.13
Health coaching/case management

Health coaching and case management are voluntary programs. Condition Care health coaches and case managers are all 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.

7.13.1
About Healthy Outcomes health coaches and case managers

A Blue Cross NC Condition Care 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 individual's health care needs and treatment options. Health coaches 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 Blue Cross NC benefits, incorporate and direct members to online decision support tools and initiate members into other Healthy Outcomes Condition Care programs and 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 Blue Cross NC continues until the member's condition is stabilized, the need for care ends or the member is no longer enrolled with Blue Cross NC.

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

7.13.2
Referrals to case management

Members can be referred from the following sources:

- Blue Cross NC staff
- Health Line Blue (twenty-four [24] hour health information line)
- Hospital discharge planner or case manager
- Condition Care health coach
- Primary care physician
- Client or clinic
- Member self-referral
- Employer group vendors

7.13.3
State Health Plan (SHP) health care support program

The SHP Health Care Support Program provides members with an integrated approach of supporting members' health by providing them the opportunity to work with a nurse on managing their health issues. Disease and case management services are available for members to help take the stress out of dealing with:

- Managing chronic conditions
- Complex health conditions
- Newly diagnosed illnesses
- Multiple providers and/or medications
- Lifestyle changes that lead to better health
- Following provider instructions
- Short-term disability
- Injuries from an accident

Participation in the program is part of the SHP benefits. This program helps connect members with a team of dedicated medical professionals – nurses, social workers, nutritionists, pharmacists and others who care and are here to help. Dedicated staff assist members with making informed decisions about their care, while working with their providers and others to coordinate their needs.

Staff help members understand their condition, treatment options and provider's treatment plan.

- They help the member make informed decisions about care based on what's important
- They work with providers and others on the medical team to coordinate needs
- They explain health insurance benefits
- They connect members to community resources for even more support when available

Members and providers can reach the program by calling **1-833-298-1069**.

- Monday – Friday: 8 a.m. – 7:30 p.m. ET
- Saturday: 9 a.m. – 1 p.m. ET

7.13.4
Transplant management program

Our transplant program includes pre-authorization, a transplant network and a case management component.

- Requires pre-authorization for all lines of business.
- HMO and POS members must use participating providers in the Blue Cross NC transplant network.
- PPO and CMM members can maximize their benefits by using the Blue Cross NC 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 Care Management department at **1-800-672-7897**.

After your patient is assigned a transplant care manager, you can help facilitate a more coordinated care program and make the administrative processes associated with transplant services more efficient by:

- Collaborating with the patient's Blue Cross and/or Blue Shield Care Manager to identify and note the patient's specialty pharmacy information
- Notifying the patient's Blue Cross and/or Blue Shield Care Manager when the patient is admitted
- When a global period applies to the transplant care, notifying the patient's Blue Cross and/or Blue Shield Care Manager of the date the global period began
- Placing a hold on all claims associated with a patient's transplant that are part of the global package

Effective January 1, 2020, Blue Cross NC manages all aspects of behavioral health and substance use disorder services for HMO, EPO, POS, PPO and CMM members (including certification, concurrent review, discharge planning and case management).

Utilization Management services will include:

- **Commercial members (including the State Health Plan):** Inpatient psychiatric and substance use treatment (including residential treatment centers);"Electro-Convulsive Therapy (ECT); Transcranial Magnetic Stimulation (TMS); and Applied Behavioral Analysis for the treatment of autism.
- **FEP members:** Inpatient psychiatric and substance use treatment (including residential treatment centers); Applied Behavioral Analysis for the treatment of autism.
- **Blue Medicare℠ members:** Inpatient psychiatric and substance use treatment; ECT; and TMS.

7.14
Third party health coaching and intervention agreements

7.14.1
Delegation of services

Blue Cross NC reserves the right to outsource additional Care Management services at its discretion.

7.14.2
Hold harmless agreement

Hold harmless is a contractual agreement between Blue Cross NC 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 Blue Cross NC and/or deemed not medically necessary by Blue Cross NC. Additional information about hold harmless is located in **Chapter 9** of this e-Manual (see **Section 9.17**.

7.14.3
Continuity of Care (CoC)

CoC is a process that allows members with ongoing special conditions to continue receiving care from a provider who becomes an out-of-network provider. CoC is available to all members across all lines of business in certain situations according to the benefit design as outlined in the member benefit booklet. Benefits may vary regarding the CoC offering when a member or employer changes plans or products.

Provider Termination

- CoC is offered when a practitioner is no longer in the Blue Cross NC network due to the termination of the contract between Blue Cross NC and the provider.
- Notification of a provider termination is sent to eligible members at least thirty (30) calendar days prior to the effective termination date of provider. If a practitioner notifies Blue Cross NC of termination less than thirty (30) days prior to the effective date, Blue Cross NC shall notify the affected members as soon as possible, but no later than thirty (30) calendar days after receipt of the notification.
- Members must request CoC within forty-five (45) days of the provider termination date or within 45 days of the effective date for members new to the Blue Cross NC plan.

New Plan or Product

- CoC is not offered when the member electively changes plans (e.g., Affordable Care Act [ACA] individual plans where members have a variety of offerings).
- CoC is offered for groups when the employer changed health benefit plans, and the provider is no longer in-network.
  - A member is eligible for CoC if during open enrollment, the group has only one offering.
  - If the group offers dual options, and the member can choose to stay on a plan with their provider being in the PPO/POS network, the member is not eligible for CoC.

When a provider is terminated for cause the organization is not required to provide continued access if:

- The practitioner is unwilling to continue to treat the member or accept the organization's payment or other terms.
- The member is assigned to a practitioner group, rather than to an individual practitioner, and has continued access to practitioners in the contracted group.
- The organization discontinued a contract based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.).

To be eligible for CoC, the member must be actively being seen by an out-of-network provider for an ongoing special condition. In addition, the provider must also agree to the following terms and conditions in order for a member to elect continuation of coverage of treatment.

Once written notification of a provider termination is received by Blue Cross NC, we are required to notify members that are being seen on a regular basis by letter at least thirty (30) days prior to the termination effective date if notified in advance of termination or within thirty (30) days of notification. CoC requests must be submitted to Blue Cross NC within forty-five (45) days of the provider termination date or within forty-five (45) days or effective date for members new to the Blue Cross NC plan.

A new member has forty-five (45) days from their effective date to request a review for CoC. An ongoing special condition means:

- Serious and complex condition
  - Acute illness (required specialized medical treatment to avoid death or permanent harm)
  - Chronic illness (life threatening, degenerative, potentially disabling, or congenital requiring treatment over a prolonged period of time)
- Course of institutional or inpatient care
- Scheduled to undergo non-elective surgery, including receipt of postoperative care with respect to such a surgery (i.e., necessary at the time but could be delayed; determined on a case-by-case basis depending on facts and circumstances)
- Pregnant and undergoing a course of treatment for the pregnancy (i.e., from initially visiting doctor through the pregnancy, including postpartum care)
- Terminally ill

The allowed transitional period shall extend up to ninety (90) days, although some exceptions may apply.

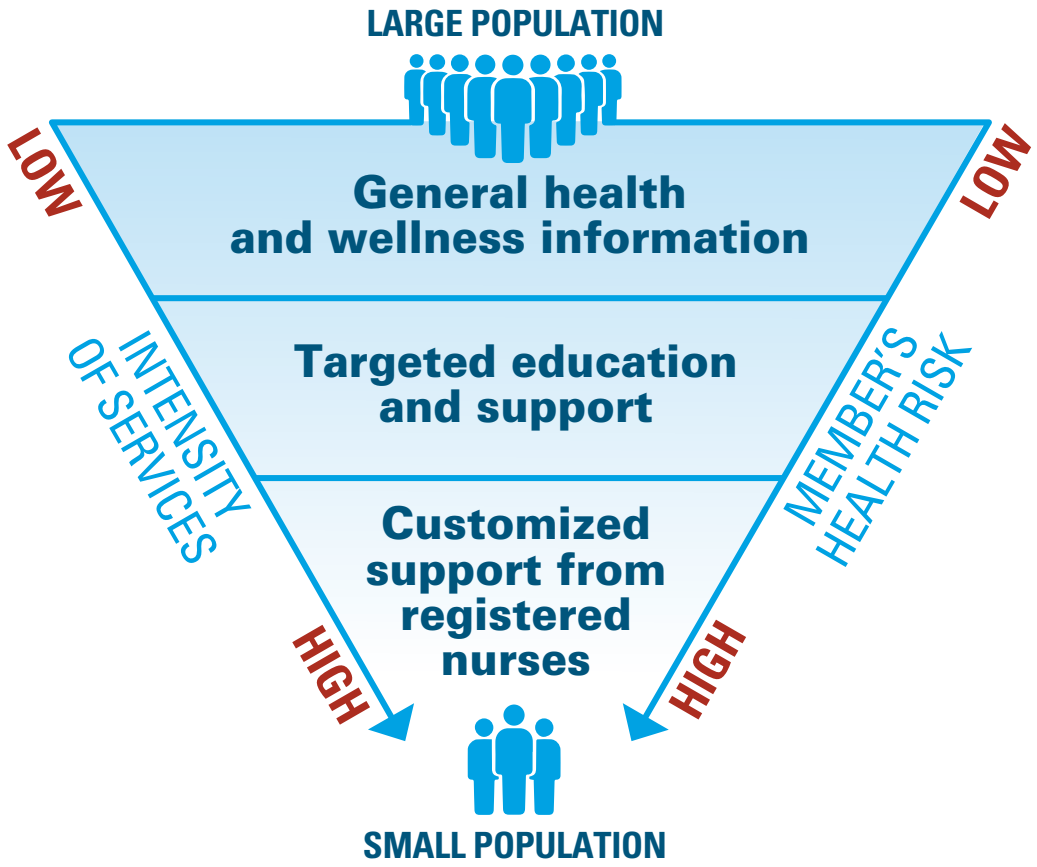
CoC requests will be reviewed by a medical professional based on the information provided about specific medical conditions. CoC will not be provided when the provider's contract was terminated for reasons relating to quality of care or fraud. To request a continuity of care review, call Care Management at **1-800-672-7897**.

8

Case management

8.1
Case management overview

The goal of case 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.



8.2
Case management

Case management is an integral part of Blue Cross NC's health and wellness 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 7**.

8.3
Health management program

Blue Cross NC offers a health management program called Healthy Outcomes Condition Care (HOCC) to members who have select health conditions. This confidential program is offered at no additional cost and is designed to provide members with targeted information and services to help them manage their specific health care needs.

HOCC is available to PPO members. The program is also available to members enrolled in Consumer Driven Health Plan (CDHP) products, though benefits are not part of the first dollar preventive care and subject to deductible and coinsurance for those with high deductible plans. Certain employer groups may choose not to offer this program to their employees. Members eligible for the HOCC program are identified based on medical and pharmaceutical claims data, health assessment results, provider referrals, calls to Health Line Blue and self-referrals for some programs.

Conditions addressed include:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive heart failure
- Coronary Artery Disease (CAD)
- Depression
- Diabetes
- Maternity
- Pain management

Members participating in HOCC program receive:

- Comprehensive educational materials which are consistent with nationally-accepted evidence-based standards of medical care. Materials are available in English and Spanish.
- The opportunity to work with a condition care coach to learn more about their condition and how to manage it.
- Access to our digital Care Management app with bidirectional secure messaging.
- Access to a wealth of information and tools through a personalized online health portal through Blue Connect.

HOCC is an opt-out program. Members are identified and contacted about the program and considered enrolled unless they choose to opt out. The maternity program is available to members who identify themselves as pregnant – these members are not identified through claims data. Providers may encourage members who have not been identified for a condition care program but may benefit from the services to call to speak to an engagement specialist at **1-800-260-0091**.

Members enrolled in condition care programs receive personalized support through telephonic coaching and targeted educational materials, which are available both in paper and through varied media including web, text and email. Materials are available in English and Spanish. Condition-specific books and access to self-management tools are available to members to educate them on how to manage conditions, identify triggers of symptoms and work with health care providers to treat their conditions appropriately. Members also have access to Blue Cross NC's online interactive health portal through Blue Connect. This online portal provides a comprehensive library of tools and resources to assist members in self-managing their care.

Additional benefits and waivers for eligible members include diabetes, deductible waivers and asthma copay reductions on select asthma medication. (Members should consult their benefit booklet for eligibility.) Eligible 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.

8.3.1
Provider reports

Blue Cross NC provides the following reports to providers as part of our Care Management programs.

Patient Care Summary

With our Patient Care Summary (PCS), you get a more complete picture of your patients' health. The patient care summary for Blue Cross NC members brings you essential information that helps you deliver the care most appropriate for your patients. You will be able to review a three (3) year history of your patients' medical care – including who they saw, where they were seen and the diagnosis code or codes for the visit. And you'll also have a twelve (12) month record of your patients' prescription history, including refills.

One of the critical functions of the patient care summary is helping make sure that your patients get the care they need when they need it. So you'll see at a glance if your patient has an overdue screening, a missed lab test or an unfilled prescription based on evidenced-based and nationally recognized guidelines.

Conditions monitored for overdue screenings/tests or prescriptions include:

- Asthma
- Behavioral health
- Congestive heart failure
- COPD
- Diabetes
- Heart disease
- Hyperlipidermia
- Medications and drug safety
- Migraines
- Preventive screenings

The summary helps providers coordinate care and includes comprehensive information in an easy-to-follow format. The report includes a summary page with detailed information for all medical claims within the past thirty-six (36) months, and pharmacy claims for the past twelve (12) months. The pharmacy section alerts you as to medications that were ordered but not filled and medications that have generics available. The PCS also alerts you if we are actively trying to enroll that member/patient in one (1) of our case management programs.

Access to the PCS from Blue Cross NC is fast and easy. The report is available through **Blue *e***. Your **Blue *e*** administrator can assign PCS access to your staff who manage PHI, assist in treatment and care coordination. Your staff can access the PCS via the **Blue *e*** health eligibility transaction. You'll be able to view, download and print the report. For questions on how to access the PCS, contact the eSolutions help desk at **1-888-333-8594**.

You'll find a range of valuable information that can help you provide the best care possible. The summary is compliant with HIPAA and all other applicable laws. Your patients' privacy is protected.

Patient Care Summary

BlueCross BlueShield of North Carolina

NOTICE: The following includes confidential personal health information that is subject to the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, North Carolina Consumer and Customer Information Privacy Act and all other applicable laws and regulations.

Patient Care Summary

04/18/2014 10:58 AM

Last Name	First Name	DOB	Gender	Subscriber ID
PUBLIC	JOHN	01/01/1957	M	YPPW0123456701

The Patient Care Summary contains Blue Cross NC medical care and prescription claims only. Claims information is updated weekly, and potential gaps in care are updated monthly.

Potential Gaps in Evidence Based Care: Identified as past due

Condition	Potential Gap	Months Overdue
Diabetes	Diab: Retinal Eye Exam	17
Diabetes	Diab:Medical Attention for nephropathy	17
Preventive	Colorectal Cancer Screen	16

Prescriptions: Ten most recent unique medications in the last 12 months.

Latest Fill	Prescriber	Medication	Dose	Days Supply (#)
02/11/2012	Ralph P. Sample, M.D.	GEMFIBROZIL	600 MG	30 (60)
02/11/2012	Ralph P. Sample, M.D.	VITAMIN D	50000 UNIT	4 (4)
12/09/2011	Ralph P. Sample, M.D.	LIPITOR (generic available)	20 MG	30 (30)
12/05/2011	Ralph P. Sample, M.D.	APAP/HYDROCODONE BITARTRATE	7.5-500 MG	30 (90)
12/05/2011	Ralph P. Sample, M.D.	CEPHALEXIN (Rx not picked up)	500 MG	0 (0)
09/15/2011	Sarah T. Example, M.D.	TRAMADOL HYDROCHLORIDE	50 MG	10 (40)
09/02/2011	Ralph P. Sample, M.D.	PREDNISONE	10 MG	8 (20)
06/23/2011	Ralph P. Sample, M.D.	AZITHROMYCIN	250 MG	5 (6)

Medical care: Claims identified up to a maximum of 10 over the past 36 months - substance use disorder claims protected by 42 CFR Part 2 have been omitted. Labs, DME, radiology, anesthesiology, and pathology claims appear on subsequent pages.

Date of Visit	Provider	Specialty	Place of Service	Diagnosis Codes
12/09/2011	Ralph P. Sample, M.D.	INTERNAL MEDICINE	OFFICE	250.00
12/05/2011	Ralph P. Sample, M.D.	INTERNAL MEDICINE	OFFICE	250.00
09/21/2011	Leanne K. Test, M.D.	NEUROLOGY	OUTPATIENT HOSPITAL	355.5
09/21/2011	FACILITY	GENERAL ACUTE CARE HOSPITAL	OUTPATIENT HOSPITAL	729.5 825.25
09/02/2011	Ralph P. Sample, M.D.	INTERNAL MEDICINE	OFFICE	724.3
06/23/2011	Ralph P. Sample, M.D.	INTERNAL MEDICINE	OFFICE	466.0
05/09/2011	Ralph P. Sample, M.D.	INTERNAL MEDICINE	OFFICE	250.00
01/17/2011	Ralph P. Sample, M.D.	INTERNAL MEDICINE	OFFICE	466.0
10/22/2010	Ralph P. Sample, M.D.	INTERNAL MEDICINE	OFFICE	250.0
08/13/2010	Lawrence A. Quiz, M.D.	UROLOGY	OFFICE	592.1

Provider Alerts

BCBSNC is actively trying to reach this patient for Care Management assistance. Please encourage this patient to contact us at 1-800-218-5295 x55547.

This patient may have the opportunity to save out-of-pocket costs by switching to a generic medication.

8.4
Medical nutrition therapy benefits

Blue Cross and Blue Shield of North Carolina began covering medical nutrition therapy in 2005. The nutrition counseling benefit is available to members who have Blue Care, Blue Options, Blue Value or Blue Advantage. This benefit was previously available only to members participating in HOCC programs, but now all members whose employer offers HOCC are eligible regardless of their participation in a program. This benefit is not available to National Carolinas Program or CMM product lines. The State Health Plan and FEP provide some coverage. If a member is enrolled in the Blue Options HSA plan, they may be subject to a deductible and coinsurance.

Please Note: Some self insured employer groups may choose to omit medical nutrition therapy from coverage for their employees. For this reason, always verify a member's eligibility before the member's first visit.

Coverage guidelines and verifying eligibility

Members covered under Blue Cross NC commercial products whose employer offers HOCC programs may have benefits for six (6) medical nutritional therapy visits. Members with a diagnosis of diabetes may exceed six (6) medical nutritional therapy visits per year. Members diagnosed with diabetes, whose employer does not offer HOCC, may be responsible for paying a copayment during the initial six (6) visits. Visits exceeding the sixth (6th) visit may be subject to copayments even if the member's employer offers HOCC. Providers are reminded to always verify a member's eligibility and medical nutrition therapy benefits prior to providing treatment.

8.5
Verifying eligibility

Before seeing a Blue Cross NC 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 Blue Cross NC electronic solutions on the web at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**, or refer to **Chapter 11** of this e-Manual.

Please verify that the member's employer group offers the Healthy Outcomes program, that the member has no current pre-existing condition(s) 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.

A medical nutritional therapy encounter may include one-on-one or group therapy.

8.6
Health Line Blue – twenty-four (24) hour health information line

Blue Cross NC 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.

Nurses also have insight into whether or not the member is involved in a health management program and which nearby urgent care centers or providers are in-network. 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.

8.6.1
On the phone – toll free at 1-877-477-2424

Members can call Health Line Blue twenty-four (24) hours a day, seven (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.

8.6.2
Online – BlueCrossNC.com

Members have the ability to chat online with a Health Line Blue nurse through Blue Connect. Members can also search the online library of current health information, track symptoms and medications and use tools that guide them through important health care decisions.

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* Health Line Blue is a service provided for members of Blue Care, Blue Options and Blue Advantage plans. Health Line Blue is not available to Individual Under 65 (IU65) members.

9

Claims, provider billing and reimbursement

9.1
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 (1) of six (6) actions within thirty (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 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 eighteen percent (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 thirty (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 ninety (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 (1) 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 Care Management or medical necessity standard is not satisfied, the notice must contain the decision's 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 NCGS §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 sixty (60) days. A status report must be sent to the insured and the claimant every thirty (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
- FEP

If you are interested in learning more about the prompt payment mandate and how it affects you, please contact the Provider Network (see **Chapter 2**).

9.2
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 (1) of these members is treated by a provider and Medicaid pays as primary payor in error, Blue Cross NC 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 Blue Cross NC 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 Blue Cross NC will reimburse the provider for the difference between Blue Cross NC's payment to Medicaid and the contracted amount, less member liabilities. If Blue Cross NC owes the provider less than the amount Medicaid paid the provider, then Blue Cross NC is obligated only to reimburse Medicaid for the amount that Blue Cross NC owes under the provider contract.

9.3

Disclosure of claim submission and reimbursement policies

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 FEP, the State of North Carolina Teachers' and State Employees' CMM (indemnity) plan, Inter-Plan Programs (BlueCard host) or Medicare Supplement.

The provisions apply to the following lines of group business administered on Blue Cross NC's Facets and/or PowerMHS claims adjudication systems:

- Blue Care
- Blue Home
- Blue HMO℠
- Blue Local
- Blue Options
- Blue Select®
- Blue Value
- Classic Blue
- My Duke
- The State Health Plan

In addition, the provisions apply to our individual lines of business including:

- Access℠
- Blue Advantage
- Blue Assurance℠
- Blue Value
- Short-Term

The statute does not apply to third parties which directly contract with providers and manage the Provider Networks for certain specialized services.

Methods of disclosure

Blue Cross NC uses the following primary means of communicating our claim submission policies:

1. *The* Blue Book *Provider e-Manual*: This provider e-Manual provides comprehensive information to assist Blue Cross NC network participating health care providers with effectively administering our Blue Cross NC products. The e-Manual is given to providers when they join a Blue Cross NC network and is maintained on the Blue Cross NC website for providers at **BlueCrossNC.com/Providers/**. The e-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 e-Manual is also available to providers having free **Blue *e*** connectivity. Providers are reminded that this e-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 e-Manual in the *Providers* section of the Blue Cross NC website at **BlueCrossNC.com/Providers/**, or by using **Blue *e***. In the event that a provider experiences difficulty accessing or opening the Blue Book from our website, or if the provider is a **Blue *e*** user and needs assistance with the Blue Book viewing, providers are requested to please contact the Provider Network (contact information is available in **Chapter 2** of this e-Manual). Additionally, providers without access to the Blue Cross NC website or **Blue *e*** are requested to contact the Provider Network to receive a copy of the e-Manual in another format.

2. *Provider eBriefs*: Provider communications sent directly to email addresses that have been registered with the Blue Cross NC registry; provides real-time information posted on the provider news and information home page.

3. **BlueCrossNC.com**: The provider home page on our website offers access to a news and information link that provides updates on policies and procedures, benefit plans, changes to medical policies, Blue Cross NC initiatives and general updates. We encourage our participating providers to view this news and information page often as articles are posted that may affect their business interactions with us. Providers can also access the Clear Claim Connection (C3) portal through **Blue *e*** which provides a better understanding of how claims are generally adjudicated on the PowerMHS system.

4. *Provider notice:* As outlined in our provider agreements, Blue Cross NC may send written proposed amendments such as changes in law, benefit plans and changes in fee schedules.

Disclosure Type	Blue Cross NC Policy	Policy Availability
General claim submission	The Blue Book Provider e-Manual: • **Chapter 5** • **Chapter 9**	The Blue Book Provider e-Manual available on the Blue Cross NC website at **BlueCrossNC.com/Providers/**. If you need assistance obtaining it from the website, please contact the Provider Network. For contact information, please see **Chapter 2** of this e-Manual.
Electronic claims	HIPAA companion guide	The *Providers* section of the Blue Cross NC website, **BlueCrossNC.com**, under electronic solutions and HIPAA at **BlueCrossNC.com/providers/network-participation/hipaa**.

continued on following page

Disclosure Type	Blue Cross NC Policy	Policy Availability
Electronic claims	**Blue *e*** instructions	The *Providers* section of the Blue Cross NC website, **BlueCrossNC.com**.
Claims Bundling and Other Claims Editing Processes	Reimbursement policy: • Bundling guidelines	The *Providers* section of our website, **BlueCrossNC.com** under medical policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes**. If you need assistance obtaining it from the website, please contact the Provider Network. For contact information, please see **Chapter 2** of this e-Manual.
	The Blue Book Provider e-Manual: • **Chapter 9**	The Blue Book Provider e-Manual available on the Blue Cross NC website at **BlueCrossNC.com/Providers/**. If you need assistance obtaining it from the website, please contact the Provider Network. For contact information, please see **Chapter 2** of this e-Manual.
	C3* (for CMS-1500 professional claims)	Through the **Blue *e*** portal, available free to Blue Cross NC contracting providers at **bluee.bcbsnc.com/providers/web/login**. Providers not already signed up for **Blue *e*** are encouraged to sign up through the web at **BlueCrossNC.com/Providers/About-Blue-e**. If you need assistance obtaining it from the website, please contact the Provider Network. For contact information, please see **Chapter 2** of this e-Manual.
Recognition or Non-Recognition of CPT Modifiers	Reimbursement policy: • Modifier guidelines	The *Providers* section of our website, **BlueCrossNC.com** under medical policies at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes**. If you need assistance obtaining it from the website, please contact the Provider Network. For contact information, please see **Chapter 2** of this e-Manual.
Payment Based on Relationship of Procedure Code to Diagnosis Code	The Blue Book Provider e-Manual: • **Chapter 9**	The Blue Book Provider e-Manual available on the Blue Cross NC website at **BlueCrossNC.com/Providers/**. If you need assistance obtaining it from the website, please contact the Provider Network. For contact information, please see **Chapter 2** of this e-Manual.

continued on following page

Disclosure Type	Blue Cross NC Policy	Policy Availability
Administrative Policies	Blue Cross NC medical policies (including but not limited to the following): • Clinical trial services for life threatening conditions • Investigational (experimental) services • Medical necessity • Place of service for medical infusions	The *Providers* section of our website, **BlueCrossNC.com** under medical policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes**. If you need assistance obtaining it from the website, please contact the Provider Network. For contact information, please see **Chapter 2** of this e-Manual.

* C3 is a web-based code auditing reference tool designed to mirror how the McKesson code auditing process, used by Blue Cross NC, evaluates code combinations during the auditing of claims. C3 is a tool that indicates only:

1. How combinations of codes (including modifiers) will be bundled and/or unbundled.
2. Whether the codes are in conflict with the age and gender information that is entered. Edits that occur in the Facets system, outside of ClaimCheck and are not disclosed by C3. For more information on the additional edits, see Blue Cross NC's Reimbursement Policies at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

Additionally, C3 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 Blue Cross NC's Care Management program, the provisions of the provider's contract with Blue Cross NC and the interaction in the claims adjudication process between the services billed on any particular claim with services previously billed and adjudicated.

9.4
Health coaching and intervention requirements

Please refer to **Chapter 7** for instructions on certifications and prior review for Blue Cross NC membership.

Please note the following exception:

- 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 5** of this e-Manual

9.5
Mental health and substance use services claims

Note to the Reader: Providers are encouraged to review information about our mental health and substance use management programs located in **Chapter 7** of this e-Manual in advance of providing services.

Federally assisted providers of substance use services that are subject to 42 CFR Part 2 **must** obtain consent from the member prior to submitting claims to Blue Cross NC and/or its delegates. The consent should reference that the disclosure is for the purpose of **payment and health care operations**.

Claims for HMO, PPO, POS and CMM members: Blue Cross NC processes mental health and substance use claims. All claims should be submitted to Blue Cross NC according to the guidelines provided in **Chapter 2**.

Providers servicing members in the Federal Employee Program can find additional information about mental health and substance use administration in **Chapter 4** of this e-Manual.

9.6
Short-term physical therapy, occupational therapy and speech therapy

9.6.1
Definition

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. Short-term therapies include:

- Physical therapy
- Occupational therapy
- Speech therapy

9.6.2
Verifying benefits and eligibility

Providers are reminded to always verify a member's eligibility and short-term therapy benefits, both inpatient and outpatient, prior to providing treatment. Benefits will vary by employer group and a member's coverage plan type. Verification of benefits will determine applicable copayment, coinsurance or deductible that may apply for these visits. Most short-term therapies are limited to a maximum number of visits per benefit period per therapy combination (i.e., occupational and physical therapies are combined).

9.7
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:

- If you do not file your claims electronically, please visit Blue Cross NC electronic solutions at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**, and find out how to register.
- Submit all claims within one hundred and eighty (180) days.
- If Blue Cross NC is secondary and you need to submit the primary payor 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*** 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 Blue Cross NC electronic solutions on the web at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**, or refer to **Chapter 11** of this e-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 3**.
- 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 Blue Cross NC for your health care business.
- Please notify Blue Cross NC if there are any changes to your NPI. Do not file any claims with your new NPI until that number is effective in our system and you have received confirmation from us.
- Terminated NPIs cannot be filed on claims after the assigned end date.
- Blue Cross NC cannot correct claims when incorrect information is submitted. Claims will be mailed back.

For fastest claims processing, file electronically!

Visit Blue Cross NC electronic solutions on the web at:
BlueCrossNC.com/Providers/Manage-Claims-and-Inquiries

Blue e℠

- You are required to follow Blue Cross NC's claim filing guidelines stated in this provider e-Manual. In the absence of specific Blue Cross NC 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.
- Blue Cross NC does not cover investigational (or cosmetic) services and will not reimburse for any services, procedures or supplies associated with those investigational (or cosmetic) services.
- Claims submitted by professional providers and facilities (institutional providers) for services deemed investigational or cosmetic, as well as all services, procedures or supplies associated with those services, will be denied.

Requirements for professional CMS-1500 claim forms

- All professional claims must be filed on a CMS-1500 claim form or the equivalent.
- If filing on paper, you must use the red and white CMS-1500 claim form (version 2/12).
- Once you have registered your NPI with Blue Cross NC, you must include your NPI on each subsequent claim submission to us.
- If your NPI changes, please use your new NPI on your claims on or after the date your NPI is registered and effective with Blue Cross NC.
  - The tax ID number must correspond to the NPI filed in field 33.
- Once a provider has registered their NPI with Blue Cross NC, and they have received confirmation from us with the effective date, claims must be filed with the assigned NPI and corresponding tax ID number only.
- When submitting an accident diagnosis, include the date that the accident occurred in field 15.
- 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, National Drug Classification (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:** Fields 21 and 24e of the CMS-1500 claim form (version 2/12) are designated for diagnosis codes and pointers/reference numbers. Twelve (12) diagnosis codes may be entered into Block 21a-l. Any paper CMS-1500 claim form submitted with more than twelve (12) diagnosis codes or pointers/reference numbers will be mailed back to the submitting provider.
- **Please Note:** Certain filing requirements may vary for providers who participate in the State Health Plan Network. You should carefully review the State Health Plan Network Participation Agreement and the State Health Plan Pricing Policy to ensure awareness of all applicable requirements.

Requirements for institutional UB-04 claim forms

- All claims must be filed electronically using the HIPAA 837 transaction.
  - If filing on paper, the red and white printed version must be used.
- For outpatient therapies and treatment 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).
- When billing inpatient claims, submit the claim for the entire length of stay from admission date through discharge date. Do not submit an interim bill except under the following circumstances:
  - The claim is from a skilled nursing facility or hospice
  - The claim was split intentionally by the hospital due to partial authorization
  - The claim was split intentionally by the hospital for maternity/initial newborn charges within forty-eight (48)/ninety-six (96) hours
- Do not file new charges until the new rates have been accepted by Blue Cross NC.
  - 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 Blue Cross NC. 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 Blue Cross NC.
- Intensive care unit (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.
- Providers are required to bill their retail charges and not their Blue Cross NC allowed rates.
- The primary surgical procedure code must be listed in the principle procedure Field Locator 74.
  - International Classification of Diseases (ICD)-10 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***.
  - Providers must allow thirty (30) days before inquiring on claim status via **Blue *e***.
  - Please allow forty-five (45) days before checking claim status through the Provider Blue Line.
- 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; FEP claims are excluded.
  - You will be notified via the HIPAA 835 ERA that ER services should be submitted using a bill type 13J.

9.8
Electronic claims filing

The best way to submit claims to Blue Cross NC 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 11** of this e-Manual, or visit Blue Cross NC eSolutions on the web at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**.

9.9
Claims filing addresses

Please see **Chapter 2** of this e-Manual for mailing instructions for medical health care claims, mental health/substance use service claims and chiropractic care claims.

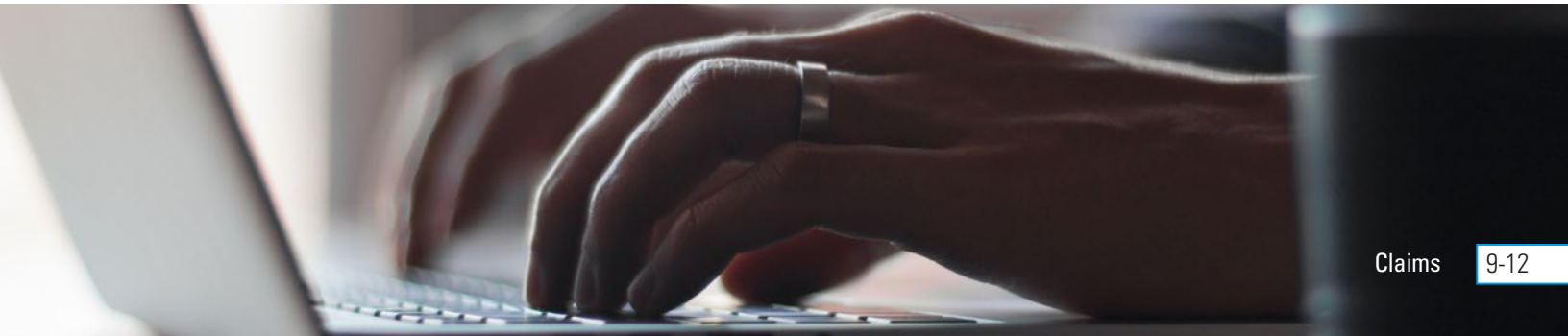
9.10
Claim filing time limitations

File all claims within one hundred and eighty (180) days of the date of service. Institutional/facility claims must be submitted within one hundred and eighty (180) days of the discharge date. Corrected claims must be submitted within twenty-four (24) months following the last date of service or the discharge date that is listed on the original claim.

9.11
Verifying claim status

You can inquire about the status of a claim in one (1) of the following ways:

1. Check claim status from your desktop computer using the HIPAA 276 Inquiry or **Blue *e***. **Blue *e*** enables users to verify the status of all claims, including BlueCard and FEP claims. Providers without **Blue *e*** access can call the Provider Blue Line at **1-800-214-4844**. To find out more about **Blue *e*** and other electronic options, visit Blue Cross NC electronic solutions on the web at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**, or refer to **Chapter 11** of this e-Manual.
2. Complete a Provider Claim Inquiry form, (see **Chapter 21**), and mail it to:
   Blue Cross and Blue Shield of North Carolina
   Customer Service Department
   P.O. Box 2291
   Durham, NC 27702-2291



9.12
Incomplete claims

If information necessary to process a claim is missing from the claim form, we will request additional information or you will receive a Provider Claim Mailback form (see **Chapter 21**) 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 submitted electronically but 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 submitted electronically but 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 resubmit 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.

9.13
Corrected claims and mailbacks

9.13.1
Definitions

Corrected claim

In general, a corrected claim is any claim for which you have received a HIPAA 835 ERA 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. Blue Cross NC only accepts claims submitted with the correct submission type noted on the claim. These claim types should appear in Box 22 for professional claims and as the last digit in Box 4 for institutional claims. Blue Cross NC allows twenty-four (24) months for the filing of corrected or adjusted claims following the date a service, supply or procedure was provided. Blue Cross NC will not accept a corrected or adjusted claim for payment review that's aged up to twenty-four (24) months following the last date of service or the discharge date that's listed on the original 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 FACETS Codes	
W17	Mailback additional information
X89	Mailback – split authorization/no authorization
Z13	Mailback – split authorization/no authorization
WI9	Newborn – need split/resubmit
Z12	Deny all lines for newborn authorization split
WP7	Mailback narrow network – OON provider split authorization
ZBY	Inconsistent with the place of service
W47	Invalid procedure disallow
W48	Invalid procedure disallow
WE0	Invalid code for timed anesthesia
WA5	Servicing provider ID is required
ZZ6	Provider not eligible on this date

An EOP with any of these codes requires a new claim be submitted.

The 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	Miscellaneous mailback, add to CL1083 why claim mailed back, and print a copy of claim image using Document Control Number (DCN) query. Complete appropriate mail-back form, attach to claim and return to responsible party.
M4	Need valid NPI.
M5	Split days for approved/non-approved authorizations.
M6	Split 48/96 hours newborn.
M8	Provider not linked with vendor.
M9	Incorrect bill type for service(s). Resubmit with correct bill type.

An EOP with any of these codes requires a new claim be submitted.

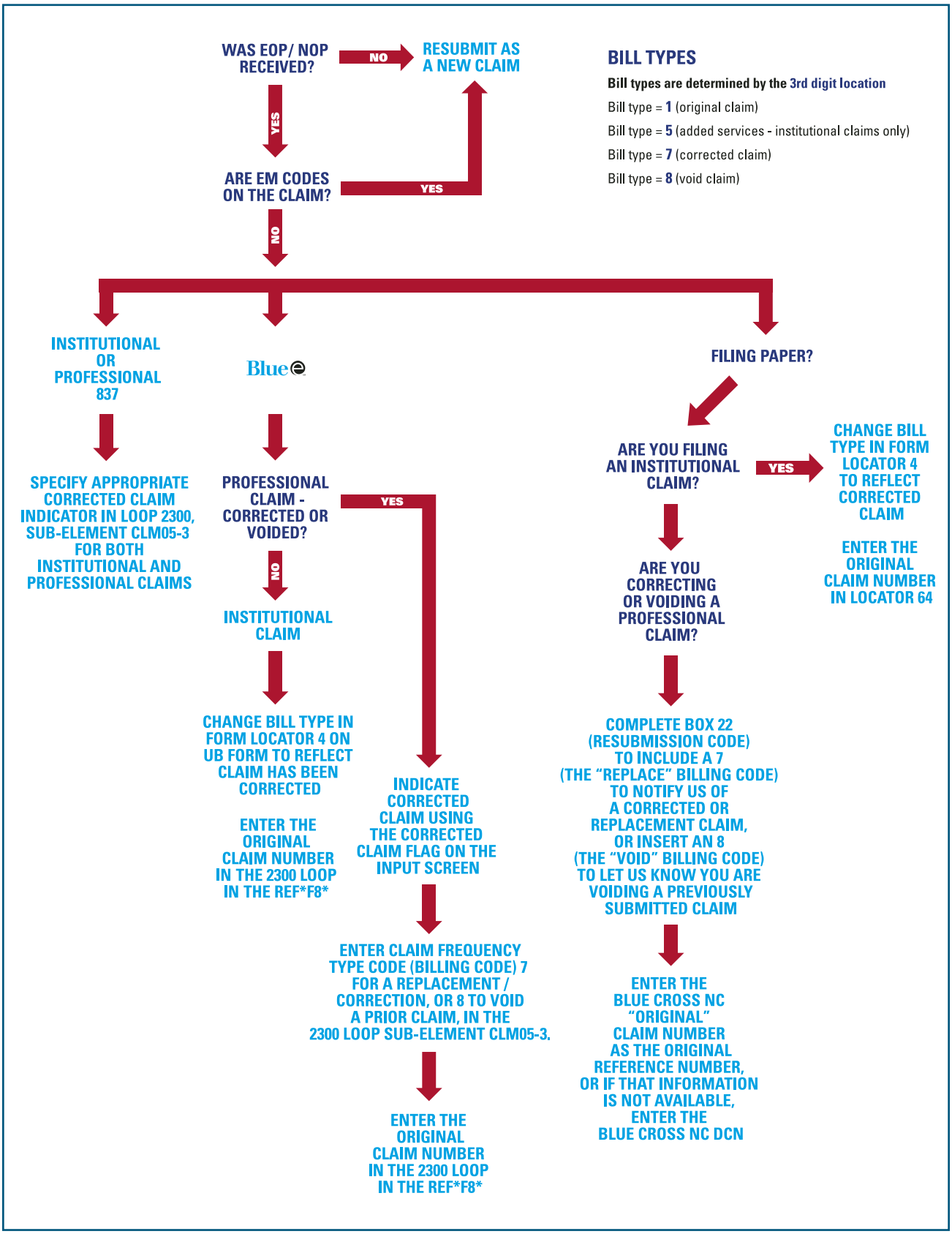
Mailback

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, sub-element CLM05-3. • 837 professional claim Specify appropriate corrected claim indicator* 2300, sub-element CLM05-3. ** 837 corrected claim indicators:* **5** – Late charges only (5 is only valid for institutional corrected claims) **7** – Replacement of a prior claim **8** – Void or cancel claim	If your claim is returned with a mailback form, check to see if you received a Notification of Payment (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.
Electronic Blue *e* – institutional only • Change bill type in Form Locator 4 on the UB claims entry screen to reflect that it is a corrected claim. • Enter the original claim number in the 2300 Loop in the REF*F8*. **Electronic Blue *e* – professional only** Correcting or voiding claims • Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in sub-element CLM05-3. • Enter the original claim number in the 2300 Loop in the REF*F8*. Paper • Facility paper claim – change bill type in Form Locator 4 to reflect claim has been corrected. Enter the Blue Cross "ORIGINAL" DCN in Form Locator 64. • Professional paper claim – correcting or voiding – complete box 22 (resubmission code) to include a **7** (the "REPLACE" billing code) to notify us of a corrected or replacement claim, or insert an **8** (the "VOID" billing code) to let us know you are voiding a previously submitted claim. Enter the Blue Cross NC "ORIGINAL" claim number as the Original Reference Number, or if that information is not available, enter the Blue Cross NC DCN.	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.

9.13.2

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 the 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.

9.13.3
Tips for corrected claims

- You can correct a claim in one (1) of the following ways:
  1. File a corrected facility claim electronically, or key the corrected UB-04 claim via **Blue *e***, being sure to change the bill type in Form Locator 4 and give the original claim number in form locator 64.
  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 4 and give the original claim number in form locator 64. Do not use a highlighter on any portion of the re-filed claim.
  4. File a corrected professional claim by marking box 22 correctly and keying in the original claim number on the CMS-1500 claim via **Blue *e***.
  5. For CMS-1500 forms – 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 (1) 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 (**0**) 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.
- When correcting or voiding electronic CMS-1500 claims, enter Claim Frequency Type code (billing code) **7** for a replacement/correction, or **8** to void a prior claim, in the 2300 loop in sub-element CLM05-3. Also, enter the original claim number in the 2300 loop in the REF*F8*.
- When correcting or voiding paper CMS-1500 claims, complete box 22 (resubmission code) to include a **7** (the "REPLACE" billing code) to notify us of a corrected or replacement claim, or insert an **8** (the "VOID" billing code) to let us know you are voiding a previously submitted claim. Also, enter the Blue Cross NC 'original' claim number as the Original Reference Number, or if that information is not available, enter the Blue Cross NC DCN.
- Do not mark claim "corrected" if additional information is requested, such as medical records or primary carrier EOB, UNLESS a change is made to the original claim submission.
- When changing a member ID number (base 9) or date of service for a processed claim:
  - Submit a corrected claim canceling charges for the original claim.
  - Submit a new claim with the correct member ID number or date of service.

9.13.4
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.

9.13.5
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 provider/group NPIs
- Invalid accommodation rate
- Missing primary payor's 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.

9.13.6
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.

9.14
Billing Blue Cross NC members

Participating providers agree not to bill Blue Cross NC members for services until receipt of the Blue Cross NC HIPAA 835 ERA for a processed claim, barring the following exceptions:

- Members enrolled in products that include copayments as part of the benefit design are required to pay any applicable copayment amount at the time of service (except if urgent or emergent conditions prevent collection at the time of care).
- Applicable deductible and coinsurance amounts listed as the member's responsibility on the HIPAA 835 ERA for a processed claim are owed by the member. Deductible and coinsurance amounts may only be collected from the member after your receipt of the HIPAA 835 ERA from Blue Cross NC (except when a member's coverage type is a deductible and coinsurance-only product).
  - Members enrolled in deductible and coinsurance-only products (products without copays) are responsible for payment of eligible deductible and coinsurance amounts as specified in **Section 9.16** of this chapter.
- A service that Blue Cross NC verifies as non-covered for a specific member may be billed to the member only when the provider advises the member in advance of providing the service. When so advised, the member must agree to pay the provider for non-covered service(s). Please see the "hold harmless" provision of your Agreement with Blue Cross NC and **Section 9.17** of this chapter to ensure correct compliance.

Note: Blue Cross NC members receiving services from a non-participating ancillary provider may cause an increase in member liability or services to be considered non-covered under the member's benefit plan. Participating network providers have contractually agreed that when a patient is to receive other professional services – such as a referral for reference laboratory services, specialty pharmacy services or durable medical equipment rental/purchase – you will refer Blue Cross NC members to other participating network providers.

- In accordance with Section 13405, *Restrictions on Certain Disclosures and Sales of Health Information, of the Health Information Technology of Economic and Clinical Health Act*, (as incorporated in the American Recovery and Reinvestment Act of 2009 [ARRA] and any accompanying regulations), you may bill, charge, seek compensation or remuneration or collection from the member if the member requests that you do not disclose personal health information to us, and provided the member has paid out-of-pocket in full for such services or supplies. Unless otherwise permitted by law or regulation, the amount that you charge the member for services or supplies in accordance with Section 13405 of ARRA may not exceed the allowed amount for such service or supply. Additionally, you are not permitted to **(i)** submit claims related to, or **(ii)** bill, charge, seek compensation or remuneration or reimbursement or collection from us for services or supplies that you have provided to a member in accordance with Section 13405 of ARRA.

Any amounts collected erroneously by you from a member, for any reason, must be refunded to the member within forty-five (45) days of receipt of the HIPAA 835 ERA from Blue Cross NC, your discovery of the error or other form of notification.

9.14.1
Items for which providers cannot bill members

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

Providers may not balance bill Blue Cross NC members for the difference between billed charges and the amount allowed by Blue Cross NC, 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 Blue Cross NC to be out of compliance with Blue Cross NC Care Management programs and policies or medical necessity criteria or are otherwise non-covered, except as outlined within this chapter's (**Chapter 9**) instructions for billing members as a non-network provider.

Providers may not seek payment from either members or Blue Cross NC if a proper claim is not submitted to Blue Cross NC within one hundred and eighty (180) days of the date a service is rendered.

9.14.2
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 Blue Cross NC. 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 Blue Cross NC.

A provider may charge a fee for administrative services related to, but not limited to, filling out forms and preparation for Family and Medical Leave Act (FMLA) leave, disability or services not related to Blue Cross NC benefit plans.

9.14.3
Billing members as a non-network provider

Providers who contract with Blue Cross NC for in-network participation for some, but not all, Blue Cross NC commercially offered products must wait to receive payment notification from Blue Cross NC prior to billing the member any coinsurance or deductible amounts. This applies even if the member is enrolled in a Blue Cross NC commercially offered coverage product, which is a different product type from the product in which the provider participates. Additionally, the member may only be billed for the difference between the amount paid by Blue Cross NC and a Blue Cross NC out-of-network allowable fee for the service provided to that member. Blue Cross NC participating providers may not bill members charges in excess of Blue Cross NC's allowable amounts for an individual member's specific services.

9.14.4
Billing members for non-covered services

A provider may be asked to provide a service to a member that is not covered by the member's benefit plan with Blue Cross NC. If you elect to provide the member requested non-covered service, payment may only be collected from the member when all of the conditions specified within the hold harmless provision are followed. These conditions include that a provider must inform the member in advance of providing service via written notification that the specific service might not be covered by Blue Cross NC. The member signs a written acknowledgment/waiver that they received such notification prior to receiving the specific service at issue. The member acknowledges in advance and in writing that they have chosen to have the service at issue, and if the service is not covered when the claim is processed, the member is responsible for the expense and will pay the provider directly, regardless of the denial stating the provider has to write off the changes. Providers must maintain copies of the waiver as Blue Cross NC may request a copy of the signed/dated service-specific waiver. The written acknowledgment must be specific to a particular service and define 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 a member's obligations to pay for non-covered services (see **Section 9.17** for additional details about the hold harmless provision or refer to your provider agreement with Blue Cross NC). A waiver of non-covered services must be in writing and include the following information:

- Indication that the beneficiary is enrolled in Blue Cross NC coverage
- Reference to the specific non-covered service or procedure that is not covered
- If an appropriate CPT code exists that covers several procedures rendered, the provider must use the all-inclusive procedure code and not bill for each procedure separately
- Notice that the service or procedure is not covered
- A written agreement that the member is to be financially responsible for non-covered services prior to the date of service
- Member's signature
- Date signed

Service-specific waivers may not be utilized as a method to request payment from members for services that require prior authorization from Blue Cross NC, or as an alternative to making the request for prior authorization.

Providers billing PPO and/or CMM members for non-covered services may bill up to the provider's Blue Cross NC CMM allowance, when the provider is participating in both the CMM and PPO networks.

Providers can inquire about a member's eligibility and benefits using **Blue *e*** or by calling the Provider Blue Line at **1-800-214-4844** (see **Chapter 2**). Confirmation of benefit eligibility does not guarantee payment as other factors may affect payment (e.g., Blue Cross NC Care Management programs and/or medical necessity).

9.15
Copayments

9.15.1
Services covered with an office visit copayment

- For Blue Cross NC products that include a copayment as part of the member's benefit design, all covered services rendered during the course of an office visit are subject to one (1) copayment, if an evaluation and management (CPT E/M coded) service was performed.
- Office visit copayments do not apply to deductible and coinsurance-only products. For Blue Cross NC deductible and coinsurance-only products, all services are subject to deductible and coinsurance amounts as specified in **Section 9.16** of this chapter.

9.15.2
When to collect an office visit copayment

- A copayment is collected when you charge for an office visit using an E/M code, surgery in the office, second surgical opinion or consultation service.
- The patient is seen by a physician, physician's assistant, clinical nurse practitioner, nurse midwife, physical therapist, occupational therapist or speech therapist.
- Collection of any applicable copayment, when appropriate to the member's plan, may be made at the time of providing service. Providers should always verify if a member's benefit plan includes a copayment and if applicable, the copay amount, in advance of requesting payment from a member. Applicable copayment information can typically be found listed on the front of a member's ID card, by accessing **Blue *e*** or by calling the Provider Blue Line at **1-800-214-4844**.

9.15.3
When not to collect an office visit copayment

- No E/M service code for an office visit is billed or allowed (e.g., when not billing an E/M service code because the member received an allergy injection or lab service only).
- The patient is being seen for a second surgical opinion or consultation and surgery, in addition to the same-day 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.

9.15.4

Note the following with respect to office visit copayments

- Only one (1) copayment per visit date can be collected from a member. If a patient is seen by multiple providers within the same office, on the same date, only one (1) copay may be collected by the practice for that day's E/M services.

  Claims for E/M services provided in the same office by more than one (1) provider, on the same date of service, must be filed as a single claim and not split into two (2) separate claim submissions.
- OB/GYNs should always collect the primary office visit copayment for Blue Cross NC copayment products.

9.16

Upfront collection for deductible and coinsurance-only products

For any Blue Options deductible and coinsurance-only product (non-copayment products), Blue Cross NC'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 the member's out-of-pocket costs, as described within this section. Providers are requested that as a courtesy to members enrolled in HRA and HSA products, to wait until receipt of Blue Cross NC's EOP for services provided, when services are provided during the first quarter of a new year, as many employer groups make their annual contributions to employees' health reimbursement and savings accounts during this period. To determine whether a product is covered under these provisions, check the member's ID card to make sure that 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.
2. Check that the card indicates that the product is a Blue Options deductible and coinsurance-only product (including Blue Options HRA and Blue Options HSA).
3. Verify that the member's ID card does not list a copay amount. If the card indicates a copayment for physician services, the product is not a deductible and coinsurance-only product.

In-network providers and hospitals are required to check for a member's remaining deductible or coinsurance amounts using sources such as the HIPAA 270 inquiry, **Blue *e*** or Blue Cross NC Customer Service.

Please Note: These sources provide the most accurate information available at the time provided. Actual deductible and/or coinsurance amounts for a processed claim may differ based on other claims received or adjusted in-between the time that benefits were verified and Blue Cross NC's receipt and processing of the claim.

9.16.1

Guidelines for upfront collection of member liability (deductible and coinsurance products)

Collection of a member's estimated patient responsibility may be collected at the time of service when the member is enrolled in one (1) of the Blue Cross NC Blue Options deductible and coinsurance-only products (products without copayments) and the participating provider agrees to:

- Establish and maintain a policy and process for collection of estimated patient financial responsibility, and the provider assists the member with payment plan options in the event that a member cannot pay the complete estimated patient responsibility in advance of receiving service. If a member is unable to pay at the time of service, the provider should not refuse to provide necessary treatment to the member.
- Inform the member in advance that the amount being collected is an estimated amount.
- Request a payment amount according to the provider's negotiated Blue Cross NC network fee schedule, which is effective at the time of service, and appropriate to that member's particular coverage plan type.
- Provide their collecting staff access to the current fee allowances (Blue Cross NC allowable reimbursements for billed charges), a listing of specific services to be delivered to a member that includes CPT codes and applicable allowances for those CPT codes, accompanied with the codes/charges to be billed to Blue Cross NC for the member's incident of care.
- Calculate the member's out-of-pocket costs based on the lesser of the allowable reimbursement amount or billed charges, taking into account the member's benefit year-to-date deductible or coinsurance benefit status (amount met).
- Collect only an amount determined to be accurate with reasonable certainty through the provider's validation of the member's estimated liability using tools such as **Blue *e***.
- Utilize and take into consideration C3 bundling logic and Blue Cross NC policies addressing: medical, payment and evidence-based guidelines before requesting payment from a member.
- Final determination of what the member owes will be based on the claim that is submitted to Blue Cross NC, and only amounts reflected on the final HIPAA 835 ERA from Blue Cross NC as member responsibility.
- Any applicable refund for overpayment owed to a member will be issued as soon as identified, but no later than forty-five (45) days after payment was received for the service.

Special instructions

Emergency room

Members enrolled in non-copayment plans seeking care at the ER cannot be required to pay any charges until the Blue Cross NC HIPAA 835 ERA is received. However, when following these guidelines, payment of estimated patient responsibility may be requested for ER services (but is not required until receipt of the Blue Cross NC ERA).

- Members enrolled in copayment plans can be requested (and are required) to pay applicable copayments at the time of service or following treatment; however, treatment cannot be denied prior to payment. Following these guidelines, payment of estimated patient responsibility may be requested for ER services but is not required (other than applicable copayments) until receipt of the Blue Cross NC ERA.

Urgent care

Urgent care providers have the option to follow these guidelines and bill members enrolled in non-copayment plans an estimated patient responsibility at the time of service or following treatment. Urgent treatment should not be denied prior to payment.

- Members enrolled in copayment plans can be requested (and are required) to pay applicable copayments at the time of service or following treatment. Urgent care providers following these guidelines can request payment of estimated patient responsibility; however, members are required to pay copays only. Urgent treatment should not be denied prior to payment.

Hospital and freestanding facilities

Hospitals and freestanding facilities cannot require payment from the member beyond any applicable copayment. Members enrolled in both copayment plans and non-copayment plans can be requested to pay an estimated patient responsibility or enter into a payment plan, but are not required to pay until after receipt of the Blue Cross NC EOP. Additionally, members should not be sent a final bill until after receipt of the Blue Cross NC EOP.

If a member is unable to pay at the time of service, providers should not refuse to provide necessary treatment to a member.

Members enrolled in HSA and HRA plans can use funds from their HSA or HRA to pay for services. Providers should be aware of the tax implications if funds are withdrawn for non-qualified 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 the 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 to their account.

Some groups may have specific requirements around upfront member collections. This information is typically found on the member ID card. Blue Cross NC requests participating providers to honor these special requests and collect according to the specified amounts.

Blue Cross NC policy for all other products prohibits participating providers from requiring upfront payment from a member (other than applicable copayments) until the EOP for the member's claim is received from Blue Cross NC indicating the correct amount to be collected. However, providers following the guidelines contained here **(Section 9.16.1)** may elect to request estimated amounts from members not enrolled in the Blue Cross NC Blue Options deductible and coinsurance-only products, as long as payment is not required or a prerequisite for receiving service.

9.17
Hold harmless provision

Provider agrees not to bill or otherwise hold members, Blue Cross NC 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 Blue Cross NC Care Management programs and policies, and/or not eligible under the member's benefit plan except when the following conditions have been met:

- The provider obtained prior authorization or prior certification by Blue Cross NC 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 Blue Cross NC under the member's benefit plan; and the member signed a written authorization stating that:
  1. The member received from the provider notification that the specific services and/or supplies may not be covered by his or her benefit plan.
  2. The member received the notification prior to receiving the specific services and/or supplies.
  3. The notification informed the member that the particular services and/or supplies, if not covered by Blue Cross NC 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.
  4. The provider obtained the member's written authorization prior to rendering the specific services and/or supplies.
  5. 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.
  6. 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 Blue Cross NC with a copy of any and all such written authorizations upon request.

Refer to your health care businesses' contractual agreement with Blue Cross NC 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 the Provider Network (see **Chapter 2**) for more information.

9.17.1

Provisions for the protection of members eligible for both Medicare and Medicaid (dual eligibles)

- Blue Plan members eligible for both Medicare and Medicaid (dual eligibles) are not to be held liable for Medicare Part A and Part B cost sharing when a state is responsible for paying such amounts. Provider agrees to accept the Medicare Advantage Plan payment as payment in full or bill the appropriate state Medicaid agency for such amounts.

9.18

Payment guidelines

You are notified of payment guidelines via special messages on the HIPAA 835 ERA. 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 the providers reimbursement section of their agreement, as a participating provider, provider shall be paid by Blue Cross NC only for medically necessary covered services to members which are in compliance with Blue Cross NC's Care Management programs.

Nonpayment for serious adverse events (Never Events)

Never Events are injuries caused by medical management rather than by the underlying disease or condition of the patient. The Centers for Medicare and Medicaid Services and the National Quality Forum (NQF) have identified fourteen (14) categories of hospital acquired conditions that should not occur in a hospital setting. Any professional provider associated with a wrong surgery Never Event (surgeon, anesthesiologist, radiologist, etc.) is not eligible for reimbursement. Reimbursement is also not provided for any services in the operating or procedure room where the wrong surgery error occurs. Members will be held harmless for any services related to wrong surgery Never Events. Providers are required to report Never Events to Blue Cross NC and are not reimbursed for services associated with Never Events. Services associated with Never Events should not be submitted on any claim submitted to Blue Cross NC. If services associated with a Never Event are submitted to Blue Cross NC, a corrected claim without the services should be submitted.

Service edits

Blue Cross NC reserves the right to implement service edits to apply correct coding guidelines for CPT, HCPCS and ICD-10 diagnosis and procedure codes. Service edits are in place to enforce and assist in a consistent claim review process. The coding edits reflect Blue Cross NC medical coverage guidelines, benefit plans and/or other Blue Cross NC policies. Unbundling, mutually exclusive procedures, duplicate, obsolete or invalid codes are identified through the use of coding edits.

Manner of payment – general

As a participating provider, provider agrees to accept as full and final payment by Blue Cross NC for medically necessary covered services to members which are in compliance with Blue Cross NC's health coaching and intervention programs either:

1. the allowed amount, minus deductible, coinsurance and/or copayment amounts, or
2. provider's requested 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.

Blue Cross NC is establishing reimbursement rates for a limited group of service/procedure codes (primarily supply and drug codes). These codes were previously unpriced by Blue Cross NC 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, Blue Cross NC has notified providers of the application of a pricing procedure that will price these codes consistent with the reimbursement level for codes in the same range.

Blue Cross NC makes revisions to the reimbursement for the above-referenced service/procedure codes according to the methodology listed in the following section of this e-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 the Provider Network.

9.19

Blue Cross NC policy for pricing professional claims billed on form CMS-1500 (how to identify the correct policy for your professional charges)

Blue Cross NC policy for pricing claims can vary depending upon a provider's individual or group affiliated agreement with Blue Cross NC, under which payment consideration is made for a particular claim for service. Participating providers can identify the pricing policy that applies for their professional services by referencing their individual health care business's participation agreement with Blue Cross NC.

Unless your contract agreement or terms specify otherwise, one (1) of the following policies applies to Blue Cross NC contracted providers for procedure/service codes billed on a CMS-1500 or successor claim form. Please reference the Reimbursement Exhibit of your agreement to determine the applicable policy:

- DME providers of ancillary services participating in the Blue Cross NC networks under a *Network Participation Agreement-Ancillary contract* should refer to the DME pricing development and maintenance policy (see **Section 9.19.2** of this e-Manual).
- If you're participating with Blue Cross NC under a Network Participation Agreement that includes 2008 North Carolina Medicare Part B based reimbursement as part of the agreement's reimbursement exhibit, the pricing policy titled *"Pricing development and maintenance policy for network fee schedules based upon 2008 North Carolina Medicare"* applies to the processing of your professional charges when billed to Blue Cross NC on the CMS-1500 Claim form (see **Section 9.19.3** of this e-Manual).
- If your Network Participation Agreement with Blue Cross NC does not include 2008 North Carolina Medicare Part B based rates as part of the reimbursement exhibit, you should reference the pricing policy titled *"Pricing policy for procedure/service codes"* to review the policy that applies to your professional charges when billed to Blue Cross NC on the CMS-1500 Claim form (see **Section 9.19.4** of this e-Manual).
- If you're participating with Blue Cross NC under a Network Participation Agreement that includes BETOS CCS (*Berenson-Eggers Type of Service [BETOS] and Clinical Classification Software [CCS])* based reimbursement as part of the agreement's reimbursement exhibit, the pricing policy titled "Pricing Development and Maintenance Policy BETOS/CCS" applies to the processing of your professional charges when billed to Blue Cross NC on the CMS-1500 Claim form (see **Section 9.19.5** of this e-Manual).
- **North Carolina State Health Plan Network**

  Please Note: To review the details of the pricing policies applicable to your contract for participation with the North Carolina State Health Plan Network, please refer to **BlueCrossNC.com/Providers/Network-Participation/Fee-Schedules**.

9.19.1
Fee schedules

Blue Cross NC provides fee schedule information to participating physicians electronically. Participating physicians with access to **Blue *e*** have the ability to view their fee schedule through the fee schedule transaction located in **Blue *e***. Participating physicians who do not have internet access, or who wish to view a special or supplemental fee schedule, may contact the Provider Network to request either a CD or hard copy of the fee schedule. Blue Cross NC currently offers the fee schedule transaction to all Blue Cross NC participating physicians, physician groups or physician organizations who are duly licensed by a state licensing board as a medical doctor or as a doctor of osteopathy. If you are a participating provider other than a Blue Cross NC contracted medical doctor or doctor of osteopathy, you can contact the Provider Network to obtain a current copy of your fee schedule.

Providers not yet signed up for **Blue *e*** access will not be able to view their fee schedule information via **Blue *e*** until they are enrolled in **Blue *e***. **Providers are encouraged to sign up today!** Enrollment is **easy**; just visit **BlueCrossNC.com/Providers**. Providers who are already enrolled with **Blue *e*** and have questions about their fee schedule should contact the Provider Network for assistance.

If after review of your participation agreement with Blue Cross NC and your fee schedule information in **Blue *e***, you are unsure about which pricing policy applies to your professional charges, please contact the Provider Network for assistance.

9.19.2

DME pricing development and maintenance policy

Unless your contract agreement or terms specify otherwise, the following policy applies to Blue Cross NC providers participating under a *Network Participation Agreement-Ancillary* contract.

This pricing development and maintenance policy applies to Blue Cross NC's calculations of contractual allowances (fees) for services billed on a CMS-1500 or successor claim form. Each uniquely identifiable service is assigned a service category, based upon the HCPCS Level I (CPT) or Level II code. Fee calculations applicable to each service category are described below, including the external pricing source. Blue Cross NC will update annually those service categories based on current year pricing source as listed below. The annual updates will be made based on pricing sources in effect on January 1. Fees based on current year Medicare are determined by the first Medicare file published in the Federal Register, post Congressional Review, designated to be effective on January 1. Quarterly updates as indicated below will be made based on pricing source in effect the last month of the preceding quarter. Blue Cross NC will not adjust pricing once established for the year until the following calendar year.

Reimbursement is based upon the hierarchy listed below. Rates are based on current calendar year and will be updated on an annual basis. The first of the following criteria that can be used to establish a price will be the applicable source:

1. 75% current year CMS NC Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) (not based upon competitive bid allowance).
2. 75% current year OptumInsight, as licensed by Blue Cross NC.
3. 75% of the following fee: The national 60th percentile of billed charges for the applicable code provided by FAIR Health Benchmarks HCPCS product, as reported through Optum's EncoderPro or through successor product licensed by Blue Cross NC.

If none of the above sources contains a price for the applicable code, the contractual allowance for reimbursement will be based on:

4. Individual consideration or if no price can be determined;
5. 75% of your reasonable charge.

Fee determination based on a percentage of your reasonable charge

When application of the hierarchy and criteria for the determination of contractual allowances results in a fee for a given service based upon a percentage of the charge, providers are obligated to ensure that: **(1)** all charges billed to Blue Cross NC are reasonable; **(2)** all charges are consistent with the fiduciary duty to the patient and Blue Cross NC; **(3)** no charges are 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.

Fee determination based on individual consideration

- If a general code (e.g., A9999 or E1399, miscellaneous DME supply) is filed because a code specific to the service or procedure is non-existent, or if a pricing source in the pricing hierarchy is for any reason otherwise unavailable, Blue Cross NC will assign a fee to the service which will be a reasonable fee established by Blue Cross NC using a methodology chosen by Blue Cross NC in its reasonable discretion, utilizing one (1) or more available sources. These sources may include, but are not limited to, reimbursement levels for similar or analogous equipment, national average pricing or other available pricing information.

- Some codes that are listed as specific codes in the CPT/HCPCS manuals relate to services that can have wide variation in the type and/or level of service provided. These codes will be treated by Blue Cross NC in the same manner as general codes, as described in the above paragraph.
- DMEPOS services that are filed using general or unlisted codes must include the applicable manufacturer's invoice, and will be priced at 10% above your acquisition cost supported by your invoice and any other pertinent pricing-related information. Blue Cross NC may reimburse a higher price for customized items, as specifically agreed by Blue Cross NC in writing. Blue Cross NC will not allow more than 75% of your charge for these services.
- If a general or unlisted code is filed despite the existence of a code specific to the service or procedure, Blue Cross NC will assign the more specific code to determine the fee under Blue Cross NC's applicable reimbursement policies.
- Blue Cross NC's assignment of a fee for a given general or unlisted code does not preclude Blue Cross NC from assigning a different fee for a subsequent service or procedure under the same code. Blue Cross NC's determination of a fee for a service billed for a given general or unlisted code may vary from a previously determined fee based on new analysis, or new or additional information that subsequently becomes available regarding the service in question or other similar services.

Additional fee determinations

- Fees based on current year Medicare are determined by the first Medicare file published in the Federal Register, post Congressional Review, designated to be effective on January 1. Blue Cross NC will make such fee adjustment within thirty (30) days of such first published Medicare file. Blue Cross NC will apply the adjusted fees to claims paid after such date of Blue Cross NC adjustment, with no obligation to adjust claims already paid. Additionally, Blue Cross NC has no obligation to adjust rates due to new rates or rate adjustments published by CMS after such first published Medicare file.
- Blue Cross NC reimburses the lesser of your charge or the applicable fee in accordance with your contract and this pricing policy.
- Nothing in this pricing policy will obligate Blue Cross NC 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 determination of a code-specific fee does not guarantee payment for the service.
- In the event that any external pricing source reference listed below changes (e.g., a new Medicare intermediary is selected), references in this pricing policy will be deemed to refer to the superseding source.
- Fees for services represented by CPT/HCPCS codes that are introduced after the effective date of this pricing policy will be determined based upon the hierarchy and criteria applicable to the service category of the new code.

External pricing sources

All references in this pricing policy to external pricing sources refer to the following:

- NC DMEPOS fee schedule
  - **www.CMS.HHS.gov/DMEPOSFeeSched/**
- OptumInsight *The Essential RBRVS*
  - **www.OptumInsight.com**
- FAIR Health, Inc.
  - **www.FairHealthUS.org/Products/Data-Products**

Other general/billing DME requirements

General requirements

- Always refer to and follow the policies and procedures that are documented in the appropriate DME section(s) of The Blue Book Provider e-Manual.

Billing

Provider agrees to:

- Bill using the CMS-1500 claim form.
- Use your appropriate NPI.
- Bill maintenance and repair modifier codes first after the procedure code.
- Submit claims with miscellaneous codes (i.e., A9999, E1399) with a complete description of the item, a factory invoice and documentation of medical necessity with the initial claim for each patient.
- Use a *Miscellaneous* code only if no suitable HCPCS billing code is available and appropriate documentation is included.
- Submit all claims for repairs with a complete description of services provided.
- Bill your typical retail charges.
- Comply with specific billing requirements related to HCPCS E0784 (external ambulatory infusion pump, insulin).

Payment – Rentals

- Rental prices include all equipment, accessories, delivery, shipping and handling, labor, set-up, visits, education, maintenance, repairs and replacement parts of DME on a monthly basis.
- Always include rental modifier code on rental claim forms.
- Bill each thirty (30) days of rental as one (1) unit. Rental claims that are ongoing will only be processed at the end of each month of service.
- Items filed without the rental modifier and rental dates are assumed to be purchases and are paid accordingly.

Payment – Repairs

- Use standard HCPCS codes when submitting maintenance/repair claims.
- Warranty repairs are not eligible for reimbursement.
- The labor component of the repair should be billed under the appropriate repair code.
- All replacement parts should be billed separately under the appropriate HCPCS code(s).
- Repairs may only be billed on purchased items.
- Repairs may not be billed on rented equipment.
- Submit the complete description of services provided when billing a repair code.
- Bill the repair or maintenance modifier code first after the procedure code, when submitting with other modifier codes.

9.19.3

2008 pricing development and maintenance policy

This pricing development and maintenance policy applies to Blue Cross NC's calculations of contractual allowances (fees) for services billed on a CMS-1500 or successor claim form. Each uniquely identifiable service is assigned a service category, based upon the HCPCS Level I (CPT) or Level II code. Fee calculations applicable to each service category are described below, including the external pricing source. Annual updates will be based upon the applicable pricing and category sources published for January 1 and will be effective for dates of service on and after April 1,* the year of the update. Quarterly updates as indicated below will be made based on the applicable pricing source in effect for the preceding quarter. New codes established on current year Medicare are determined by the 1st published Medicare file and will be effective for dates of service on and after April 1. New codes will be priced at 60% of charge from January 1 to March 31. Blue Cross NC will not adjust pricing once established for the year until the following calendar year.

Drug services

1. Drug service fees will be updated on a quarterly basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 100% of Blue Cross NC specialty pharmacy drugs**
   b. If option 'a.' is not available, 110% of Centers for Disease Control and Prevention (CDC) private sector price[1]
   c. If option 'b.' is not available, 100% of NC Medicare Part B drug fee schedule
   d. If option 'c.' is not available,* 105% wholesale acquisition cost
   e. If option 'd.' is not available, 95% of average wholesale price

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

   f. Individual consideration
   g. If no price can be determined, 75% of your reasonable charge

Blue Cross NC specialty pharmacy drugs***

1. Specialty pharmacy drug source discount will be updated on an annual basis.
2. Source pricing will be updated on a quarterly basis.
3. New and replacement codes will be updated on a quarterly basis.

* 1st published Medicare file to be effective on April 1.

** The percent amount varies by drug and is provided in the specialty pharmacy drug list.

*** The specialty pharmacy drug list with drug class (category) is available on the **BlueCrossNC.com** website on the following link: **BlueCrossNC.com/Providers/Networks-Programs/Pharmacy**.

1 All vaccines contained on the CDC price list will be cross-walked to a CPT code. If more than one CDC listed brand/trade name vaccine maps to a single CPT code, Blue Cross NC will apply the mean (average) private sector cost/dose price as the fee for the applicable CPT code. If the CDC vaccine price list contains more than one (1) private sector cost/dose price for a particular brand/trade name vaccine, Blue Cross NC will apply the lowest private sector cost/dose price when determining the fee.

4. Fees will be determined by each specialty pharmacy drug listed on the specialty pharmacy drug list and based on a set percent of the following hierarchy:
    a. Percentage of Average Sales Price (ASP).*
    b. If ASP does not contain a price for the applicable code, the allowed amount will be based upon percentage of Average Wholesale Price (AWP)*.
    c. If option 'b.' is not available, individual consideration.
    d. If no price can be determined, 75% of your reasonable charge. Blue Cross NC will not allow more than 75% of your charge for these services.
5. For any new drug that is not yet listed on the specialty pharmacy drug list, is considered a specialty medication as defined by Blue Cross NC and is added mid-year, the default allowed amount will be ASP +12% or AWP -14% as applicable per hierarchy above. All new drugs may be added mid-year and updated accordingly, pursuant to this policy.
6. Any AWP priced drug that receives an ASP source mid-year will be updated to the ASP default base rate amount implemented until it is listed on the specialty pharmacy drug list and may be updated accordingly, pursuant to this policy.

DMEPOS services

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
    a. 75% of CMS North Carolina DMEPOS fee schedule* (not based upon competitive bid allowance).
    b. If option 'a.' is not available, 75% of OptumInsight, as licensed by Blue Cross NC.
    c. If option 'b.' is not available, 75% of the following fee: The national 60th percentile of billed charges for the applicable code provided by FAIR Health Benchmarks HCPCS product, as reported through Optum's EncoderPro or through successor product licensed by Blue Cross NC.

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

    d. Individual consideration.
    e. If no price can be determined, 75% of your reasonable charge. Blue Cross NC will not allow more than 75% or your charge for these services.

* 1st published Medicare file to be effective on April 1.

DMEPOS services

Vision

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
    a. 100% of provider's reasonable billed charges for lenses and frames including contact lenses
    b. 100% of North Carolina Medicare DMEPOS fee schedule*****
    c. If option 'b.' is not available, 100% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

    d. 103% of invoice cost

DMEPOS services

Hearing

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
    a. 100% of North Carolina Medicare DMEPOS fee schedule*
    b. If option 'a.' is not available, 100% of OptumInsight as licensed by Blue Cross NC
    c. If option 'b.' is not available, 75% of national average billed (Optum)

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

    d. 100% of invoice cost

* 1st published Medicare file to be effective on April 1.

In-office laboratory services

1. In-office laboratory service fees will be updated on an annual basis.
2. Except for services identified by Medicare as Clinical Lab Improvement Amendments (CLIA)-excluded or CLIA-waived, in-office laboratory service fees will be limited to those services for which you have provided Blue Cross NC with evidence of your CLIA certification. Any changes to your CLIA certification will be updated upon notification to Blue Cross NC but will not be retroactively effective.
3. Fees for CLIA-excluded, CLIA-waived or provider performed microscopy procedure services will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 100% of North Carolina medical clinical lab fee schedule*
   b. If option 'a.' is not available, 100% of North Carolina Medicare Part B physician fee schedule*
   c. If option 'b.' is not available, 100% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   d. Individual consideration
   e. If no price can be determined, 75% of your reasonable charge

4. Fees for panels and chemistry services will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 45% of North Carolina Medicare clinical lab fee schedule*
   b. If option 'a.' is not available, 45% of North Carolina Medicare Part B physician fee schedule*
   c. If option 'b.' is not available, 45% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

   d. Individual consideration
   e. If no price can be determined, 75% of your reasonable charge

5. Fees for hematology and immunology services will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 60% of North Carolina Medicare clinical lab fee schedule*
   b. If option 'a.' is not available, 60% of North Carolina Medicare Part B physician fee schedule*
   c. If option 'b.' is not available, 60% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

   d. Individual consideration
   e. If no price can be determined, 75% of your reasonable charge

* 1st published Medicare file to be effective on April 1.

6. Fees for pathology services will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
    a. 90% of North Carolina medical clinical lab fee schedule*
    b. If option 'a.' is not available, 90% of North Carolina Medicare Part B physician fee schedule*
    c. If option 'b.' is not available, 90% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

    d. Individual consideration
    e. If no price can be determined, 75% of your reasonable charge

Ophthalmologic exam services

1. Ophthalmologic exam service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
    a. 80% of North Carolina Medicare Part B physician fee schedule*
    b. If option 'a.' is not available, 80% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

    c. Individual consideration
    d. If no price can be determined, 75% of your reasonable charge

3. The following service codes (and their successor codes) are considered routine vision codes and are excluded: S0620 – S0621, 92002, 92012, 92004 and 92014.
4. Evaluation & Management-Diagnosis Combinations – Codes 99202-99205 and 99211-99215 when filed in combination with the following diagnosis codes (or applicable successor codes).

Diagnosis Codes:

H52.00	H52.03	H52.12	H52.221	H52.229	H52.201	H52.209	H52.32	H52.7
H52.01	H52.10	H52.213	H52.222	H52.31	H52.202	H52.211	H52.4	Z01.00
H52.02	H52.11	H52.219	H52.223	H52.13	H52.203	H52.212	H52.6	Z01.01

Other ophthalmologic services

1. The following service codes (and their successor codes) are considered routine vision codes and are excluded: S0620 – S0621, 92002, 92012, 92004 and 92014.
2. Evaluation & Management-Diagnosis Combinations – Codes 99202-99205 and 99211-99215 when filed in combination with the following diagnosis codes (or applicable successor codes).

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Diagnosis Codes:

H52.00	H52.03	H52.12	H52.221	H52.229	H52.201	H52.209	H52.32	H52.7
H52.01	H52.10	H52.213	H52.222	H52.31	H52.202	H52.211	H52.4	Z01.00
H52.02	H52.11	H52.219	H52.223	H52.13	H52.203	H52.212	H52.6	Z01.01

Chiropractic services

1. Chiropractic service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 80% of North Carolina Medicare Part B physician fee schedule*
   b. If option 'a.' is not available, 80% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   c. Individual consideration
   d. If no price can be determined, 75% of your reasonable charge

Physical, occupational, speech therapy (PT/OT/ST) services

1. PT/OT/ST service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 70% of North Carolina Medicare Part B physician fee schedule*
   b. If option 'a.' is not available, 70% OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   c. Individual consideration
   d. If no price can be determined, 75% of your reasonable charge

Behavioral health services

1. Behavioral health service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:

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a. 100% of North Carolina Medicare Part B physician fee schedule for physician*

b. If option 'a.' is not available, 100% of North Carolina Medicare Part B clinical psychologist fee schedule for clinical psychologists

c. If option 'b.' is not available, 100% of North Carolina Medicare Part B clinical social worker fee schedule for non-physician/non-clinical psychologist*

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

d. 100% of OptumInsight as licensed by Blue Cross NC

e. If option 'd.' is not available, individual consideration

f. If no price can be determined, 75% of your reasonable charge

Other tests and miscellaneous services

1. Other tests and miscellaneous service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:

   a. 100% of North Carolina Medicare Part B physician fee schedule*

   b. If option 'a.' is not available, 100% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

c. Individual consideration

d. If no price can be determined, 75% of your reasonable charge

Hearing services

1. Service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:

   a. 100% of North Carolina Medicare fee schedule*

   b. If option 'a.' is not available, 100% of OptumInsight as licensed by Blue Cross NC

   c. If option 'b.' is not available, 75% of national average billed (Optum)

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

d. 100% of invoice cost

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All other services

1. All other service fees will be reviewed and/or updated on a periodic basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. Percentage of 2008 North Carolina Medicare Part B physician fee schedule*
   b. If option 'a.' is not available, percentage of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   c. Individual consideration
   d. If no price can be determined, 75% of your reasonable charge

Fee determination based on a percentage of your reasonable charge

- When application of the hierarchy and criteria for the determination of contractual allowances results in a fee for a given service based upon a percentage of your charge, you are obligated to ensure that: (1) all charges billed to Blue Cross NC are reasonable; (2) all charges are consistent with your fiduciary duty to your patient and Blue Cross NC; (3) no charges are 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.

Fee determination based on a general or unlisted code/individual consideration

- If a general code (e.g., 21499, unlisted musculoskeletal procedure, head) or unlisted code because a code specific to the service or procedure is non-existent, or a code where no pricing source is available is filed, Blue Cross NC will assign a fee to the service which will be a reasonable charge established by Blue Cross NC using a methodology which is applied to comparable providers for similar services under a similar health benefit plan and/or applying a twelve (12) month claims review to determine average allowed or applying a twelve (12) month claims review to determine average allowed or 75% of a reasonable charge. Blue Cross NC's methodology is based on several factors including Blue Cross NC's payment guidelines and reimbursement policy as described in The Blue Book, and pricing and adjudication principles for professional providers as described in the medical policy section of the Blue Cross NC website. Under these guidelines, some procedures charged separately may be combined into one (1) procedure for reimbursement purposes. Blue Cross NC may use clinical judgment to make these determinations, and may use medical records to determine the specific service(s) rendered.

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- Some codes that are listed as specific codes in the CPT/HCPCS manuals relate to services that can have wide variation in the type and/or level of service provided. These codes will be treated by Blue Cross NC in the same manner as general codes, as described in the preceding paragraph.
- Blue Cross NC reserves the right to price drug services using the national drug code for drugs that are filed using general or unlisted codes, or codes that may be used for multiple drugs.
- DMEPOS services that are filed using general or unlisted codes must include the applicable manufacturer's invoice, and will be priced at 10% above the invoice price. Blue Cross NC will not allow more than 100% of your charge for these services.
- If a general or unlisted code is filed despite the existence of a code specific to the service or procedure, Blue Cross NC will assign the fee for the more specific code to determine the fee under Blue Cross NC's applicable reimbursement policies.
- Blue Cross NC's assignment of a fee for a given general or unlisted code does not preclude Blue Cross NC from assigning a different fee for a subsequent service or procedure under the same code. Blue Cross NC's determination of a fee for a service billed for a given general or unlisted code may vary from a previously determined fee based on new or additional information that subsequently becomes available regarding the service in question or other similar services.

Additional fee determinations

- Blue Cross NC reimburses the lesser of your charge or the applicable fee in accordance with your contract and this pricing policy.
- Outpatient Prospective Payment System (OPPS) pricing will apply to the technical component of certain diagnostic imaging services and the technical component portions of the global diagnostic imaging services in accordance with Section 5102(b) of the Deficit Reduction Act of 2005.
- Nothing in this pricing policy will obligate Blue Cross NC 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 determination of a code-specific fee does not guarantee payment for the service.
- In the event that any external pricing source reference listed below changes (e.g., a new Medicare intermediary is selected), references in this pricing policy will be deemed to refer to the superseding source.
- Fees for services represented by CPT/HCPCS codes that are introduced after the effective date of this pricing policy will be determined based upon the hierarchy and criteria applicable to the service category of the new code.

- For all new other services codes, the year in which the code was first introduced will be substituted for the applicable 2008 external pricing source. (E.g., if a new CPT code is introduced in 2009, the 2009 North Carolina Medicare Part B physician fee schedule will be the primary external pricing source.)
- The fee for any code not previously determined based upon a source established within our hierarchy will be recalculated as if it were a new code if the fee can then be determined based upon the applicable source within the hierarchy.

External pricing sources

All references in this *2008 Pricing Policy to External Pricing Sources* refer to the following:

- NC Medicare Part B physician fee schedule*
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html**
  - **www.PalmettoGBA.com/Palmetto/Fees_Front.nsf/Fee_Main?OpenForm**
- NC Medicare Part B drug fee schedule*
  - **www.ReimbursementCodes.com/**
- NC Medicare Part B clinical lab fee schedule*
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Laboratory-Fee-Schedule-Files.html**
- NC ambulance fee schedule*
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html**
- NC DMEPOS fee schedule*
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html**
- Blue Cross NC physician specialty pharmacy
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the Blue Cross NC specialty pharmacy criteria.
- CDC private sector price
  - **www.CDC.gov/Vaccines/Programs/VFC/Awardees/Vaccine-Management/Price-List/Index.html**

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- Average sales price
  - **www.ReimbursementCodes.com**
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the average sales price criteria.
- Wholesale acquisition cost
  - **www.ReimbursementCodes.com**
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the wholesale acquisition cost or average wholesale price criteria.
- Average wholesale price
  - **www.ReimbursementCodes.com**
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the wholesale acquisition cost or average wholesale price criteria.
- OptumInsight *The Essential RBRVS*
  - **www.OptumInsight.com**
  - Please contact your local Network Management office to obtain the fee for any service category code, which was determined by the OptumInsight criteria.
- FAIR Health, Inc.
  - **www.FairHealthUS.org/Products/Data-Products**

9.19.4

Non-2008 pricing development and maintenance policy

The following policy applies to Blue Cross NC'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/HCPCS codes are published, and an external pricing source exists for such codes, Blue Cross NC will price those 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.
- Annual updates will be based upon the applicable pricing and category sources published for January 1 and will be effective for dates of service on and after April 1,* the year of the update. Quarterly updates as indicated below will be made based on the applicable pricing source in effect for the preceding quarter. New codes established on current year Medicare are determined by the 1st published Medicare file and will be effective for dates of service on and after April 1. New codes will be priced at 60% of charge from January 1 to March 31. Blue Cross NC will not readjudicate or adjust affected claims based upon NC 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 Blue Cross NC's loading of your revised fee.
  - If NC Medicare pricing is unavailable, Blue Cross NC will apply the most current OptumInsight as licensed by Blue Cross NC Relative Value Unit (RVU) pricing, using the same methodology described above, to establish your fee schedule.
- Drug CPT and HCPCS codes will be priced as outlined below.
- Upon initial pricing of a code as described above, 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 one hundred and twenty (120) days of the publishing of each new external source pricing, Blue Cross NC will repeat the above procedure for previously unpriced codes.
- Blue Cross NC reimburses the lesser of your charge or the applicable pricing in accordance with your contact and this policy.
- Nothing in this policy will obligate Blue Cross NC 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.

* 1st published Medicare file to be effective on April 1.

Durable medical equipment, prosthetics, orthotics and supplies services

For durable medical equipment, prosthetics, orthotics and supplies, the NC DMEPOS fee schedule will be used in place of the above-referenced external pricing sources.

Durable medical equipment, prosthetics, orthotics and all other medical supplies services – effective January 1, 2015

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 75% of CMS North Carolina DMEPOS fee schedule* (not based upon competitive bid allowance)
   b. If option 'a.' is not available, 75% of OptumInsight, as licensed by Blue Cross NC
   c. If option 'b.' is not available, 75% of the following fee: The national 60th percentile of billed charges for the applicable code provided by FAIR Health Benchmarks HCPCS product, as reported through Optum's EncoderPro or through successor product licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   d. Individual consideration
   e. If no price can be determined, 75% of provider's reasonable charge; Blue Cross NC will not allow more than 75% of provider charge for these services

Durable medical equipment services:

Vision

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 103% of invoice cost for eyeglass frames
   b. If option 'a.' is not available, 100% of North Carolina Medicare DMEPOS fee schedule*
   c. If option 'b.' is not available, 100% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   d. 103% of invoice cost

* 1st published Medicare file to be effective on April 1.

Durable medical equipment services:

Vision – Effective January 1, 2015

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 100% of provider's reasonable billed charges for lenses and frames including contact lenses
   b. If option 'a.' is not available, 100% of North Carolina Medicare DMEPOS fee schedule*
   c. If option 'b.' is not available, 100% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   d. 103% of invoice cost

Durable medical equipment services:

Hearing

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 100% of North Carolina Medicare DMEPOS fee schedule*
   b. If option 'a.' is not available, 100% of OptumInsight as licensed by Blue Cross NC
   c. If option 'b.' is not available, 75% of national average billed (Optum)

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

   d. 100% of invoice cost

Ophthalmologic exam services

1. Ophthalmologic Exam Service fees will be updated on an annual basis based on applicable pricing source.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source going forward for items not based on current year rates:
   a. 80% of North Carolina Medicare Part B Physician Fee Schedule* or if not available;
   b. 80% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the Allowed Amount will be based upon:

   c. Individual Consideration or if no price can be determined;
   d. 75% of your Reasonable Charge
3. The following service codes (and their successor codes) are considered routine vision codes and are excluded: S0620 – S0621, 92002, 92012, 92004 and 92014.

* 1st published Medicare file to be effective on April 1.

4. Evaluation & Management-Diagnosis Combinations – Codes 99202-99205 and 99211-99215 when filed in combination with the following diagnosis codes (or applicable successor codes).

Diagnosis Codes:

H52.00	H52.03	H52.12	H52.221	H52.229	H52.201	H52.209	H52.32	H52.7
H52.01	H52.10	H52.213	H52.222	H52.31	H52.202	H52.211	H52.4	Z01.00
H52.02	H52.11	H52.219	H52.223	H52.13	H52.203	H52.212	H52.6	Z01.01

Other ophthalmologic services

1. Ophthalmologic Exam Service fees will be updated on an annual basis based on applicable pricing source.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source going forward for items not based on current year rates:
   a. 80% of North Carolina Medicare Part B Physician Fee Schedule* or if not available;
   b. 80% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the Allowed Amount will be based upon:

   c. Individual Consideration or if no price can be determined;
   d. 75% of your Reasonable Charge

3. The following service codes (and their successor codes) are considered routine vision codes and are excluded: S0620 – S0621, 92002, 92012, 92004 and 92014.
4. Evaluation & Management-Diagnosis Combinations – Codes 99202-99205 and 99211-99215 when filed in combination with the following diagnosis codes (or applicable successor codes).

Diagnosis Codes:

H52.00	H52.03	H52.12	H52.221	H52.229	H52.201	H52.209	H52.32	H52.7
H52.01	H52.10	H52.213	H52.222	H52.31	H52.202	H52.211	H52.4	Z01.00
H52.02	H52.11	H52.219	H52.223	H52.13	H52.203	H52.212	H52.6	Z01.01

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 the charge or the NC statewide average charge (if available) for a given code. The NC statewide average charge will be determined and updated annually, using the most recent twelve (12) month period for which complete data has been received and entered into Blue Cross NC's claim system. If an NC statewide average charge cannot be determined due to limited claims data, Blue Cross NC will assign

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a fee to the service that will be the lesser of the charge or a reasonable charge established by Blue Cross NC using a methodology that is applied to comparable providers for similar services under a similar health benefit plan. Blue Cross NC's methodology is based on several factors including Blue Cross NC's *Payment Guidelines and Reimbursement Policy* as described in The **Blue** Book, and the *Pricing and Adjudication Principles for Professional Providers* medical policy. Under these guidelines, some procedures charged separately may be combined into one (1) procedure for reimbursement purposes.

Drug CPT and HCPCS codes

These codes are priced based on a percentage of 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 1, April 1, July 1 and October 1) based on national vendor data.

In the event that new external source pricing generally acceptable in the industry and acceptable to Blue Cross NC becomes available (e.g., average sales price to determine reimbursement for drug CPT and HCPCS codes), such external source pricing may be incorporated by Blue Cross NC into this procedure.

The specialty pharmacy drugs are priced according to the standard fee schedule as outlined below.

Blue Cross NC specialty pharmacy drugs**

1. Specialty pharmacy drug source discount will be updated on an annual basis.
2. Source pricing will be updated on a quarterly basis.
3. New and replacement codes will be updated on a quarterly basis.
4. Fees will be determined by each specialty pharmacy drug listed on the specialty pharmacy drug list and based on an set percent of the following hierarchy;

   a. Percentage of ASP*

If ASP does not contain a price for the applicable code, the allowed amount will be based upon:

   b. Percentage of AWP*

   c. If option 'b.' is not available, individual consideration

   d. If no price can be determined, 75% of your reasonable charge; Blue Cross NC will not allow more than 75% of your charge for these services

5. For any new drug that is not yet listed on the specialty pharmacy drug list, is considered a specialty medication as defined by Blue Cross NC and is added mid-year, the default allowed amount will be ASP +12% or AWP -14% as applicable per hierarchy above. All new drugs may be added mid-year and updated accordingly, pursuant to this policy.

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** The percent amount varies by drug and is provided in the specialty pharmacy drug list.

6. Any AWP priced drug that receives an ASP source mid-year will be updated to the ASP default base rate amount implemented until it is listed on the specialty pharmacy drug list and may be updated accordingly, pursuant to this policy.

Policy on payment based on charges (applies to all products)

When application of Blue Cross NC'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 Blue Cross NC are reasonable; (2) all charges are consistent with your fiduciary duty to your patient and Blue Cross NC; (3) no charges are 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/individual consideration (applies to all products)

If a general code (e.g., 21499, unlisted musculoskeletal procedure, head) or unlisted code because a code specific to the service or procedure is non-existent or a code where no pricing source is available is filed, Blue Cross NC will assign a fee to the service which will be the lesser of the charge or a reasonable charge established by Blue Cross NC using a methodology which is applied to comparable providers for similar services under a similar health benefit plan or applying a twelve (12) month claims review to determine average allowed. Blue Cross NC's methodology is based on several factors including Blue Cross NC's *Payment Guidelines and Reimbursement Policy* as described in The Blue Book, and the *Pricing and Adjudication Principles for Professional Providers* medical policy. Under these guidelines, some procedures charged separately may be combined into one (1) procedure for reimbursement purposes. Blue Cross NC 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/HCPCS manuals relate to services that can have wide variation in the type and/or level of service provided. These codes will be treated by Blue Cross NC in the same manner as general codes, as described in the above paragraph.

DMEPOS 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. Blue Cross NC 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, Blue Cross NC will apply the more specific code to determine payment under Blue Cross NC's applicable reimbursement policies.

Blue Cross NC's assignment of a fee for a given general or unlisted code does not preclude Blue Cross NC 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.

External source pricing

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

- NC Medicare Part B physician fee schedule*
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html**
  - **www.PalmettoGBA.com/Palmetto/Fees_Front.nsf/Fee_Main?OpenForm**
- OptumInsight *The Essential RBRVS*
  - **www.OptumInsight.com**
  - Please contact your local Network Management office to obtain the fee for any service category code, which was determined by the OptumInsight criteria.
- NC DMEPOS fee schedule*
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html**
- Wholesale acquisition cost
  - **www.ReimbursementCodes.com**
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the wholesale acquisition cost or average wholesale price criteria.
- Average sales price
  - **www.ReimbursementCodes.com**
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the average sales price criteria.
- FAIR Health, Inc:
  - **www.FairHealthUS.org/Products/Data-Products**

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 Blue Cross NC becomes available, such external source pricing may be incorporated by Blue Cross NC into this policy.

* 1st published Medicare file to be effective on April 1.

9.19.5

Pricing development and maintenance policy BETOS/CCS

This pricing development and maintenance policy applies to Blue Cross NC's calculations of contractual allowances (fees) for services billed on a CMS-1500 or successor claim form. Each uniquely identifiable service is assigned a service category. Service categories have been created using a combination of BETOS and CCS published by Agency for Healthcare Research and Quality (AHRQ). Categories and assigned codes will be published at **BlueCrossNC.com/Providers/Network-Participation/Fee-Schedules/**.

Fee calculations and the external pricing sources applicable to service categories are described below. Blue Cross NC will review the percentages, pricing sources and category assignments annually. Annual updates will be based upon the applicable pricing and category sources published for January 1 and will be effective for dates of service on and after April 1,* the year of the update. Quarterly updates as indicated below will be made based on the applicable pricing source in effect for the preceding quarter. New codes established on current year Medicare are determined by the 1st published Medicare file and will be effective for dates of service on and after April 1. New codes will be priced at 60% of charge from January 1 to March 31. Blue Cross NC will not adjust pricing once established for the year until the following calendar year.

Pricing hierarchy

1. Service fees will be reviewed and/or updated on an annual basis. Blue Cross NC will implement such pricing effective for dates of service on and after April 1st of each year for annual updates and effective for dates of service on and after January 1st for new codes.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. Percentage of Current North Carolina Medicare Part B physician fee schedule*
   b. If option 'a.' is not available, percentage of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   c. Individual consideration
   d. If no price can be determined, 75% of the reasonable charge

The pricing hierarchy will be applied to all categories with the exceptions of the following categories:

In-office laboratory services BETOS/CCS categories: 200, 205, 206, 233, 234, 235, T1A

1. In-office laboratory service fees will be updated on an annual basis.

* 1st published Medicare file to be effective on April 1.

2. Except for services identified by Medicare as CLIA-excluded or CLIA-waived, in-office laboratory service fees will be limited to those services for which you have provided Blue Cross NC with evidence of your CLIA certification. Any changes to your CLIA certification will be updated upon notification to Blue Cross NC but will not be retroactively effective.

3. Fees for laboratory services will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. Percentage of North Carolina Medicare clinical lab fee schedule*
   b. If option 'a.' is not available, percentage of North Carolina Medicare Part B physician fee schedule
   c. If option 'b.' is not available, percentage of OptumInsight as licensed by Blue Cross NC

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

   d. Individual consideration
   e. If no price can be determined, 75% of your reasonable charge

Drug services BETOS/CCS Categories 228 and 240

1. Drug service fees will be updated on a quarterly basis.

2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 100% of Blue Cross NC specialty pharmacy drugs**
   b. If option 'a.' is not available, 110% of CDC Private Sector Price[1]
   c. If option 'b.' is not available, 100% of NC Medicare Part B drug fee schedule
   d. If option 'c.' is not available, 105% wholesale acquisition cost
   e. If option 'd.' is not available, 95% of average wholesale price

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

   f. Individual consideration

Blue Cross NC specialty pharmacy drugs**

1. Specialty pharmacy drug source discount will be updated on an annual basis.

2. Source pricing will be updated on a quarterly basis.

* 1st published Medicare file to be effective for dates of service on and after April 1.

** The specialty pharmacy drug list with drug class (category) is available on the **BlueCrossNC.com** website on the following link: **BlueCrossNC.com/Providers/Networks-Programs/Pharmacy**.

1 All vaccines contained on the CDC price list will be cross-walked to a CPT code. If more than one CDC listed brand/trade name vaccine maps to a single CPT code, Blue Cross NC will apply the mean (average) private sector cost/dose price as the fee for the applicable CPT code. If the CDC vaccine price list contains more than one (1) private sector cost/dose price for a particular brand/trade name vaccine, Blue Cross NC will apply the lowest private sector cost/dose price when determining the fee.

3. New and replacement codes will be updated on a quarterly basis.
4. Fees will be determined by each specialty pharmacy drug listed on the specialty pharmacy drug list and based on a set percent of the following hierarchy:
    a. Percentage of ASP*

If ASP does not contain a price for the applicable code, the allowed amount will be based upon:

    b. Percentage of AWP*
    c. If option 'b.' is not available, individual consideration
5. For any new drug that is not yet listed on the specialty pharmacy drug list and is considered a specialty medication as defined by Blue Cross NC, and is added mid-year, then the default allowed amount will be ASP +12% or AWP -14% as applicable per hierarchy above. All new drugs may be added mid-year and updated accordingly, pursuant to this policy.
6. Any AWP priced drug that receives an ASP source mid-year will be updated to the ASP default base rate amount implemented until it is listed on the specialty pharmacy drug list and may be updated accordingly, pursuant to this policy.

DMEPOS
BETOS/CCS Category 243 and 243V**

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
    a. 80% of CMS North Carolina DMEPOS fee schedule* (not based upon CMS competitive bid allowance)
    b. If option 'a.' is not available, 80% of OptumInsight, as licensed by Blue Cross NC
    c. If option 'b.' is not available, 80% of the following fee: the national 60th percentile of billed charges for the applicable code provided by FAIR Health Benchmarks HCPCS product, as reported through Optum's EncoderPro of through successor product licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

    d. Individual consideration.
    e. If no price can be determined, 75% of the reasonable charge. Blue Cross NC will not allow more than 75% or the charge for these services.

* 1st published Medicare file to be effective on April 1.

** Service codes classified as 243V require that the provider have DME licensure.

Durable medical equipment, vision services (DMEPOS) BETOS/CCS Category 241

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 100% of providers reasonable billed charges for lenses and frames including contact lenses
   b. If option 'a.' is not available, 100% of North Carolina Medicare DMEPOS fee schedule*
   c. If option 'b.' is not available, 100% of OptumInsight as licensed by Blue Cross NC

If none of the above sources contains a price for the applicable code, the allowed amount will be based upon:

   d. 103% of invoice cost

Durable medical equipment, hearing services (DMEPOS) BETOS/CCS Category 242

1. DMEPOS service fees will be updated on an annual basis.
2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 100% of North Carolina Medicare DMEPOS fee schedule*
   b. If option 'a.' is not available, 100% of OptumInsight as licensed by Blue Cross NC
   c. If option 'b.' is not available, 75% of national average billed (Optum)

If none of the above sources contain a price for the applicable code, the allowed amount will be based upon:

   d. 100% of invoice cost

Fee determination for general or unlisted code and codes designated individual consideration

- If a general code (e.g., 21499) or unlisted code is submitted because a code specific to the service or procedure is non-existent, or a code is submitted where no pricing source is available, Blue Cross NC will assign a fee to the code. Pricing will be based upon fee paid to comparable providers for similar services under a similar health benefit plan and/or by applying a twelve (12) month claims review to determine average allowed or 75% of the reasonable charge.

* 1st published Medicare file to be effective on April 1.

- If a general or unlisted code is filed despite the existence of a code specific to the service or procedure, Blue Cross NC will assign the fee for the more specific code to determine the fee under Blue Cross NC's applicable reimbursement policies.
- Blue Cross NC's assignment of a fee for a given general or unlisted code does not preclude Blue Cross NC from assigning a different fee for a subsequent service or procedure under the same code. Blue Cross NC's determination of a fee for a service billed for a given general or unlisted code may vary from a previously determined fee based on new or additional information that subsequently becomes available regarding the service in question or other similar services.
- Blue Cross NC's methodology is based on several factors including Blue Cross NC's payment guidelines and reimbursement policy as described in The **Blue** Book, and *Pricing and Adjudication Principles for Professional Providers* as described in the medical policy section of the Blue Cross NC website. Under these guidelines, some procedures charged separately by you may be combined into one (1) procedure for reimbursement purposes. Blue Cross NC may use clinical judgment to make these determinations, and may use medical records to determine the specific service(s) rendered.
- Some codes that are listed as specific codes in the CPT/HCPCS manuals relate to services that can have wide variation in the type and/or level of service provided. These codes will be treated by Blue Cross NC in the same manner as general codes.
- Blue Cross NC reserves the right to price drug services using the national drug code for drugs that are filed using general or unlisted codes, or codes that may be used for multiple drugs.
- DMEPOS services that are filed using general or unlisted codes must include the applicable manufacturer's invoice, and will be priced at the lesser of your reasonable charge or 10% above the invoice price.

Fee determination based on a percentage of your reasonable charge

When application of the hierarchy and criteria for the determination of contractual allowances results in a fee for a given service based upon a percentage of the charge, you are obligated to ensure that: (1) all charges billed to Blue Cross NC are reasonable; (2) all charges are consistent with your fiduciary duty to your patient and Blue Cross NC; (3) no charges are 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.

Additional fee determinations

- Blue Cross NC reimburses the lesser of your charge or the applicable fee in accordance with your contract and this pricing policy.

- OPPS pricing will apply to the technical component of certain diagnostic imaging services and the technical component portions of the global diagnostic imaging services in accordance with Section 5102(b) of the Deficit Reduction Act of 2005.
- Nothing in this pricing policy will obligate Blue Cross NC 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 determination of a code-specific fee does not guarantee payment for the service.
- In the event that any external pricing source reference listed below changes (e.g., a new Medicare intermediary is selected), references in this pricing policy will be deemed to refer to the superseding source.
- Fees for services represented by CPT/HCPCS codes that are introduced after the effective date of this pricing policy will be determined based upon the hierarchy and criteria applicable to the service category of the new code.
- The fee for any code not previously determined based upon a source established within our hierarchy will be recalculated as if it were a new code if the fee can then be determined based upon the applicable source within hierarchy.

External pricing sources

All references in this pricing policy to external pricing sources refer to the following:

- NC Medicare Part B physician fee schedule*****
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html**
  - **www.PalmettoGBA.com/Palmetto/Fees_Front.nsf/Fee_Main?OpenForm**
- NC Medicare Part B drug fee schedule*****
  - **www.ReimbursementCodes.com/**
- NC Medicare Part B clinical lab fee schedule*****
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Laboratory-Fee-Schedule-Files.html**
- NC ambulance fee schedule – rural rate*****
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html**
- NC DMEPOS fee schedule*
  - **www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html**

* 1st published Medicare file to be effective on April 1.

- Blue Cross NC physician specialty pharmacy
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the Blue Cross NC specialty pharmacy criteria.
- CDC private sector price
  - **CDC.gov/Vaccines/Programs/VFC/Awardees/Vaccine-Management/Price-List/Index.html**
- Average sales price
  - **www.ReimbursementCodes.com**
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the average sales price criteria.
- Wholesale acquisition cost
  - **www.ReimbursementCodes.com**
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the wholesale acquisition cost or average wholesale price criteria.
- Average wholesale price
  - **www.ReimbursementCodes.com**
  - Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the wholesale acquisition cost or average wholesale price criteria.
- OptumInsight *The Essential RBRVS*
  - **www.OptumInsight.com**
  - Please contact your local Network Management office to obtain the fee for any service category code, which was determined by the OptumInsight criteria.
- FAIR Health, Inc.
  - **www.FairHealthUS.org/Products/Data-Products**

9.20
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.

- For all non-grandfathered plans, select diagnostic services will be denied when they are filed with a wellness diagnostic code. This includes:
  - Urinalysis testing
  - Thyroid function testing
  - Vitamin D serum testing
  - EKGs
  - Testosterone level testing
  - Vitamin B serum testing
  - Albumin (urine) testing
  - Iron level testing
  - Chest X-rays

These services will be covered if filed as diagnostic.

- 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 (1) of the three (3) 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.
- Administrative charges including, but not limited to: charges for failure to keep a scheduled visit, completion of claim forms, obtaining medical records, late payments, telephone charges, shipping and handling and taxes.
- 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.
- Some treatment and studies leading to or in connection with gender affirmation or modifications and related care are not covered.
- 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.

- 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.
- ***Medical*** care provided by more than one (1) 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.

9.21
Medical records

At times, it is necessary for Blue Cross NC to request medical records from you in order to determine appropriate claims payment, ensure contractual compliance or perform quality improvement activities. Generally, under federal privacy regulations, patient authorization is not needed when medical records are requested for these purposes as they fall within Blue Cross NC's payment and health care operations as those terms are defined in the HIPAA privacy rule.* For ACA products, CMS requires retention of medical record information for a minimum of 10 years.

Contracting providers have agreed to provide Blue Cross NC with medical records as requested without further payment or authorization from the member or Blue Cross NC unless required by law.*

Blue Cross and Blue Shield of North Carolina will accept the upfront submission of medical records for specific codes to help support the medical necessity of services for our commercially insured membership, including administrative-only (ASO) groups and State Health Plan. Providers should always reference the list of ***"Codes by Procedure Types Requiring Medical Record Submissions"*** before submitting medical records as **medical records submitted for codes not included in the listing will process as unsolicited medical records**. The listing of codes can be accessed on our website at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries/Medical-Record-Submission**. Additional resources for medical record submissions are also available on our website at **BlueCrossNC.com**.

Before sending medical records to Blue Cross NC, please consider if the records are required and if the documentation will be sufficient to meet criteria for a given service. These criteria are outlined on Blue Cross NC's online medical policies website for Blue Cross NC's commercially insured members. Blue Cross NC's medical guidelines are written to cover a given condition for the majority of people. However, each individual's unique clinical circumstances may be considered in light of current scientific literature, as well as an individual member's coverage and eligibility for a particular service or supply.

Examples when medical records are typically needed by Blue Cross NC for the following:

- To review the medical necessity of a specified CPT, HCPCS or revenue code.
- To determine unlisted services.
- To identify a durable medical equipment price from the invoice.
- To determine the name of a physician who has ordered labs.
- To determine a member's benefit.
- To identify an NDC for a medication.
- To ensure complete and accurate diagnostic data submissions to CMS for risk adjusted products.

When medical records are needed to support a medical necessity review, and records were not received by Blue Cross NC before the claim is processed, the member will receive an explanation of benefits and the provider will receive an explanation of payment showing the specific reason(s) for the claim denial. The denial letter will provide reference to the criteria on which the claim denial decision was based, and it will inform the member and provider of their rights and ability to appeal the decision.

Important Note: The above information does not apply to Federal Employee Program members, Blue Cross and/or Blue Shield members eligible through the BlueCard program and members enrolled in Blue Cross NC's Medicare Advantage plans.

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* Member authorization is required to disclose psychotherapy notes or any documentation that would identify a member as having a substance use disorder. Providers should not send this type of information to Blue Cross NC unless it has been specifically requested and you have obtained the appropriate authorization.

9.22
Individual three (3) month grace period

Under the ACA, members who receive a premium subsidy from the government and are delinquent in paying their portion of their premium are given a three (3) month grace period. This federally mandated grace period applies as long as the individual has previously paid at least one (1) month's premium within the benefit year. The grace period starts with the first day of the month after the paid-through date and ends on the last day of the third month. Claims with dates of service within the first month of the grace period will be processed as normal. However, insurers may pend claims for services rendered during the second and third months of the grace period. **Blue *e*** health eligibility inquiries will identify ACA Exchange members, and provide an ***"Alert"*** notice if they are within the grace period for the date of service requested. The notice advises of the exact paid-through dates, as well as the start and end dates of the member's grace period. An ***"Additional Information"*** message advises providers that received payments may not display in **Blue *e*** for up to four (4) days, and that Blue Cross NC Customer Service professionals cannot discuss member payment with providers.

9.23
Electronic Remittance Advice (ERA)

Blue Cross NC offers an electronic remittance using the standard HIPAA 835 transaction to participating providers. See **Chapter 11** for information regarding the HIPAA 835.

9.24
Overpayments

In the event of any overpayment, duplicate payment or other payment by us in excess of the member's benefits payable according to the member's benefit plan (overpayment) and all Blue Cross NC policies, you shall promptly remit the overpayment to Blue Cross NC. In addition to other remedies, if within forty-five (45) days of a request for refund by us, the requested refund has not been made we may recover the overpayment amount by offset of future amounts payable to you. Neither Blue Cross NC nor you may initiate recovery of overpayments or underpayments, respectively, any later than twenty-four (24) months***** after the date of the original claim payment with the following exceptions:

- Fraud, misrepresentations and other intentional misconduct
- Contractual requirements of self-funded groups
- Contractual requirements of certain provider contracts
- Statutory or regulatory compliance
- Unsolicited or self-reported refunds

***** Thirty-six (36) months for FEP Health Benefit claims.

9.24.1
When you notice an overpayment

Complete Form G252 – Refund of Overpayment Form (see **Chapter 21**).

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
- NPI 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.

9.24.2
When we notice an overpayment

If we discover an overpayment, an invoice will be sent requesting payment within forty-five (45) days. Please return the invoice with your payment. If payment is not received after forty-five (45) days of our notification to you, we will deduct the amount owed from future payments to you, and indicate the member's identification number, date of service and a message indicating the reason on the HIPAA 835 ERA.

9.25
Enterprise business continuity (EBC)

1. **Executive summary**
   Blue Cross NC has established an enterprise business continuity program, its mission to enhance the overall protection of:

   a. Employees

   b. Customers and service activities

   c. Property and other assets

   d. Brand, image and reputation

2. An EBC governance committee has been formed to ensure Blue Cross NC's enterprise business continuity methodology is derived from and executed according to industry best practices and provides for the specific needs of Blue Cross NC and its customers. Moreover, the EBC governance committee is responsible for the confluence and oversight of all related business continuity efforts and programs.

3. **Pay providers recovery plan**
   In the event of catastrophic systems loss preventing the electronic submission and processing of claims, Blue Cross NC will implement a plan to pay most participating providers on an interim basis for up to ninety (90) days. Providers meeting a pre-designated level of claims over the most recent three (3) month period will receive 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 Blue Cross NC systems are back in operation.

9.26
Using the correct NPI

The NPI is a HIPAA mandate for electronic transactions. The NPI is a ten (10) digit unique health care provider identifier, which replaces the Blue Cross NC Proprietary Provider Number (PPN) on electronic transactions. Additional information about NPI is located in **Chapter 19** of the e-Manual and on the CMS website at **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 the provider/group practice NPI

There are two (2) types of NPI that are assigned via the CMS 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 (1) 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.

9.26.1
NPI – Facility type code (FTC) billing

If your health care business files both UB-04 Facility Claims and CMS-1500 Professional Claims and uses only one (1) 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 NPI.

Blue Cross NC accepts NPI on transactions, maps the NPI submission to the appropriate Blue Cross NC PPN, and 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 (1) NPI is requested, Blue Cross NC will use a facility type code (filter) to differentiate between two (2) 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 (1) NPI but has two (2) Blue Cross NC 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.

9.26.2
NPI – PA and nurse practitioner

If your office staff includes physician assistants (PAs) or advanced practical nurse practitioners, you may have applied for and received NPIs for them. Only use PA or advanced practice nurse practitioners NPIs when reporting services through claim submissions to Blue Cross NC if the PA or advanced nurse practitioner has been approved by Blue Cross NC for inclusion as part of your organization's practitioner roster.

Please Note: Generally, Blue Cross NC does not directly reimburse PAs or advanced practice nurse practitioners for services provided in a physician's office, and filing claims using the NPIs of non-rostered PAs or registered nurses can delay claims processing which can also delay payment to your practice.

9.27

Using the correct claim form for reporting your health care services

Blue Cross NC recognizes and accepts the CMS-1500 claim form (version 2/12) 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 NPI as the replacements of the forms' predecessors CMS-1500 (version 08/05) and UB-92.

Most providers, billing agencies or computer vendors file claims to Blue Cross NC 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
Home durable medical equipment	Form CMS-1500
Reference lab	Form CMS-1500
Licensed registered dietitian	Form CMS-1500
Specialty pharmacy	Form CMS-1500
Ambulance provider	Form CMS-1500
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

Please Note: 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. It is important to remember that while Blue Cross NC encourages providers to file claims electronically, there may be exceptions when a paper claim is required. In this case, Blue Cross NC reserves the right to require the submission of a paper claim and any additional supporting documentation.

For more information on the CMS-1500 claim form, visit the NUCC website at **www.NUCC.org**. For more information on the UB-04 claim form, visit the NUBC website at **www.NUBC.org**.

CMS-1500 claim filing instructions

Field Number	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 (this includes any alphanumeric prefix) and the 2-digit suffix listed next to the member's name on the ID card. This field accepts alpha and numeric characters.
2	**The patient's name** should be entered as last name, first name and middle initial as shown on the member ID card.
3	**Enter the patient's birth date and sex.** The date of birth should be eight (8) positions in the MM/DD/YYYY format. Use one (1) 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 (1) 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 (1) 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.**
9d	**Enter the other insured's insurance company name.**

continued on following page

Field Number	Description
10 a-c	Use one (1) character (X) to mark "Yes" or "No" to indicate whether employment, auto accident or other accident involvement applies to services in Item 21 (diagnosis).
11	Enter member's policy or group number.
11a	Enter member's date of birth (MM/DD/YYYY) and sex.
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, 9a and 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 appropriate qualifier followed by 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.
16	Enter the from and to dates the patient is unable to work.
17	Enter the appropriate qualifier followed by name of referring physician, supervising provider, or ordering provider.
17b	Enter NPI of referring provider, ordering provider or supervising provider.
18	If services are provided in the hospital, give hospitalization dates related to the current services.
19	If you are a Part 2 provider and the claim is for Substance Use Disorder enter **42 CFR PART 2 PROHIBITS UNAUTHORIZED DISCLOSURE OF THESE RECORDS**; otherwise leave blank.
20	Complete this block to indicate billing for clinical diagnosis tests.

continued on following page

Field Number	Description
21	**Enter the ICD indicator** to identify the version of ICD codes being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes left justified on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than twelve (12) ICD-10-CM diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. **Use the greatest level of specificity. Do not provide narrative description in this field.** The *Diagnosis of Nature of Illness or Injury* is the sign, symptom, complaint or condition of the patient relating to the service(s) on the claim. This field allows for the entry of a one (1) character indicator and twelve (12) diagnosis codes at a maximum of seven (7) characters in length. Example: 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. 0139 B. O6012x0 C. J0190 D. E. F. G. H. I. J. K. L.
22	**Use when correcting, replacing or voiding a claim. Choose appropriate resubmission code for corrected or voided claim. Also provide Blue Cross NC original claim number.**
23	**Enter certification of prior review number here if services require it.**
24	The six (6) service lines in Section 24 have been divided horizontally to accommodate **submission of both the NPI number and Blue Cross NC identifier during the NPI transition, and to accommodate the submission of supplemental information to support the billed service**. The top area of the six (6) service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of twelve (12) lines of service. **Use of the supplemental information fields should be limited to the reporting of NDC codes and unspecified code descriptions.** 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). If reporting unspecified code descriptions, report a 'ZZ' qualifier folllowed by the actual description. **Note:** The Blue Cross NC identifier is no longer required. Example: 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER; E. DIAGNOSIS POINTER; F. $ CHARGES; G. DAYS OR UNITS; H. EPSDT Family Plan; I. ID. QUAL.; J. RENDERING PROVIDER ID. # N400026064871 Immune Globulin Intravenous UN2 1B 12345678901 10 01 05 10 01 05 11 J1563 13 500 00 20 N NPI 0123456789
24a	**Enter the month, day and year (6 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 (4) 2-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., A, B, C or D, or multiple letters if the service relates to multiple diagnosis from Field 21). The field accommodates up to four (4) letters with no commas between numbers.

continued on following page

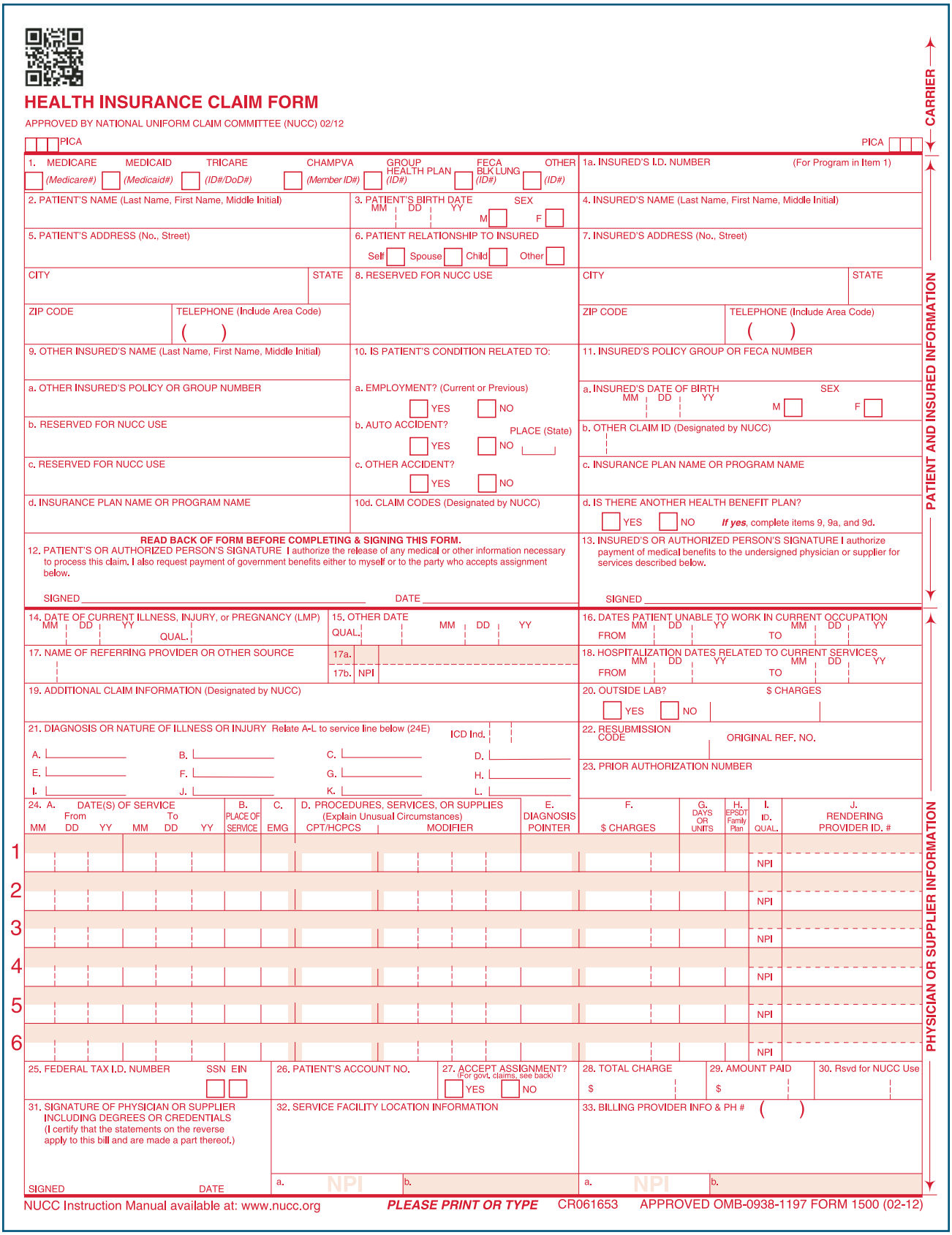
Field Number	Description
24f	**Enter the total charges for each line item in the unshaded area.** Enter up to six (6) numeric positions to the left of the vertical line two (2) positions to the right. Dollar signs are not required.
24g	**Enter days/units in the unshaded area.** This item is most commonly used for units of supplies, anesthesia units, etc. Anesthesia units should be one (1) unit equals a one (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	Leave blank.
24j	**Enter the NPI number of the rendering 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: 
25	**Enter federal tax identification number:** X 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:** X **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 seven (7) numeric positions can be entered to the left of the vertical lines and two (2) positions can be entered to the right. Dollar signs are not required.
29	**Enter the amount paid by the primary insurance carrier.** (Reminder: Only copayments may be collected at time of service.)
30	**Enter total amount due – charges minus any payments received.**
31	**Signature and date of the physician/provider/supplier.** (Stamped signatures are accepted.)
32	**Enter the name and address of the facility site where services on the claim were rendered.** This field is especially helpful when this address is different from billing address in Item 33.

continued on following page

Field Number	Description
32a	Enter the NPI number of the service facility.
32b	Leave blank.
33	Enter the name, address and phone number for the billing provider or group.
33a	Enter the NPI of the billing provider or group.
33b	Leave blank.

9.27.1

Sample CMS-1500 claim form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. 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. Rsvd for NUCC Use

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.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of the CMS-1500 claim form

9.28
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 Code
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 (0) • 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.

continued on following page

Form Locator Number	Description of Content
5	Provider's federal tax identification number.
6	From and through 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.
9d	Patient's address – ZIP Code.
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

continued on following page

Form Locator Number	Description of Content
14	Type of admission or 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 payor For newborns 1. Normal delivery 2. Premature birth 3. Sick baby 4. Extramural birth
16	Discharge hour Code Time AM — Code Time PM 00 12:00-12:59 midnight — 12 12:00-12:59 noon 01 01:00-01:59 — 13 01:00-01:59 02 02:00-02:59 — 14 02:00-02:59 03 03:00-03:59 — 15 03:00-03:59 04 04:00-04:59 — 16 04:00-04:59 05 05:00-05:59 — 17 05:00-05:59 06 06:00-06:59 — 18 06:00-06:59 07 07:00-07:59 — 19 07:00-07:59 08 08:00-08:59 — 20 08:00-08:59 09 09:00-09:59 — 21 09:00-09:59 10 10:00-10:59 — 22 10:00-10:59 11 11:00-11:59 — 23 11:00-11:59

continued on following page

Form Locator Number	Description of Content
17	Patient discharge status **01** – Discharged to home/self-care (routine discharge). **02** – Discharged/transferred to hospital. **03** – Discharged/transferred to skilled nursing facility. **04** – Discharged/transferred to an intermediate care facility. **05** – Discharged/transferred to another type of institution. **06** – Discharged/transferred to home under care of home health. **07** – Left against medical advice. **20** – Expired. **30** – Still patient. **43** – Discharged/transferred to a federal health care facility. **50** – Hospice – home. **51** – Hospice – medical facility (certified) providing hospice level of care. **61** – Discharged/transferred to a hospital based Medicare approved swing bed. **62** – Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital. **63** – Discharged/transferred to a Medicare certified long-term care hospital (LTCH). **64** – Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare. **65** – Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital. **66** – Discharged/transferred to a critical access hospital (CAH).
18–28 *(as applicable)*	Condition codes 09 – Neither patient nor spouse is employed. 11 – Disabled beneficiary but no LGHP. 71 – Full care in unit. C1 – Approved as billed. C5 – Post payment review applicable. C6 – Admission pre-authorization. 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.

continued on following page

Form Locator Number	Description of Content
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 payor. 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.
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

continued on following page

Form Locator Number	Description of Content
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).
44	HCPCS/Health Insurance Prospective Payment System (HIPPS) rates • The Level I (CPT) or Level II (HCPCS) is required for outpatient claims. • The accommodation rate for inpatient bills. • HIPPS are required for SNF claims.
45	Service date (MMDDYY) • Applies to Lines 1-22.
46	Unit of service.
47	Total charges for each line (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 (payor) • Line A – Primary payor. • Line B – Secondary payor. • Line C – Tertiary payor.
51	Health plan identification number (leave blank until mandated).

continued on following page

Form Locator Number	Description of Content
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 payor. • B – Secondary payor. • C – Tertiary payor.
55 (A, B, C)	Estimated amount due (not required).
56	NPI – billing provider.
57 (A, B, C)	Leave blank.
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's identification number.
61 (A, B, C)	Subscriber's/insured's group name.
62 (A, B, C)	Subscriber's/insured's group number.

continued on following page

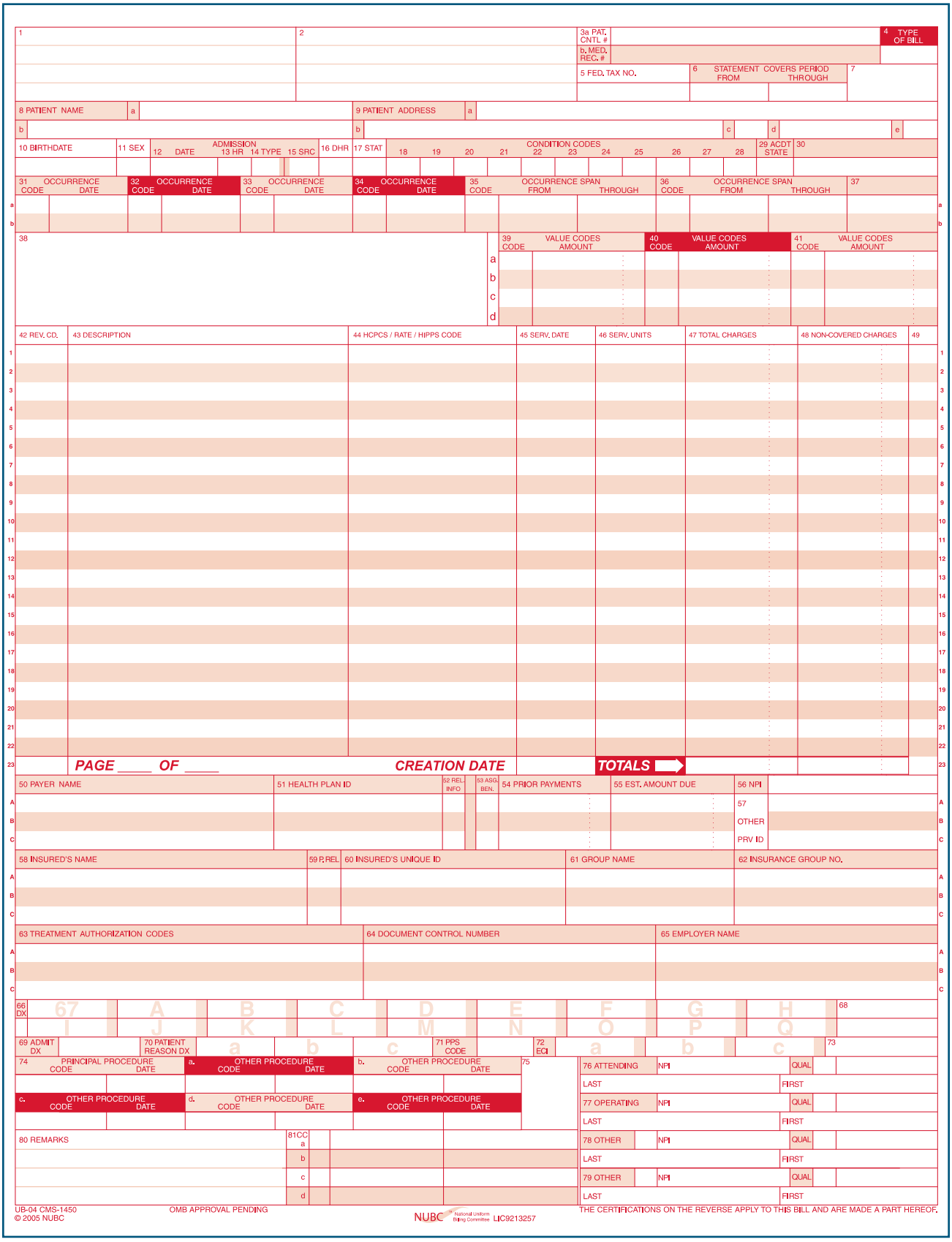
Form Locator Number	Description of Content
63 (A, B, C)	Treatment authorization code.
64 (A, B, C)	DCN [leave blank unless submitting a corrected claim].
65 (A, B, C)	Subscriber's/insured's employer name.
66	Diagnosis and procedure code qualifier (ICD version indicator).
67	Principal diagnosis code "ICD-10" (do not enter decimal, it is implied). • Eighth position indicates Present on Admission indicator (POA) – required for inpatient claims. Y = Yes N = No U = No information in the record W = Clinically undetermined
67	Other diagnosis codes "ICD-10." • Eighth position indicates POA – required for inpatient claims. Y = Yes N = No U = No information in the record W = Clinically undetermined
68	Leave blank.
69	Admitting diagnosis (inpatient only).
70 (A, B, C)	Patient's reason for visit (outpatient only).
71	Prospective Payment System code (PPS) [not required].
72 (A, B, C)	External cause of injury code "E-Code."
73	Leave blank.
74	Principal procedure code and date • ICD-10 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.

continued on following page

Form Locator Number	Description of Content
74 (A – E)	Other procedures codes and dates (procedures performed during the billing period other than those coded in FL74). • ICD-10 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).
77	Operating physician (NPI, last name and first name).
78-79	Other physician (NPI, last name and first name).
80	If you are a Part 2 provider and the claim is for Substance Use Disorder enter **42 CFR PART 2 PROHIBITS UNAUTHORIZED DISCLOSURE OF THESE RECORDS**; otherwise leave blank.
81 (A – D)	Code – Code Field (overflow field to report additional codes).

9.28.1

Sample UB-04 claim form



Sample of the UB-04 claim form

9.29
Split claim guidelines

Blue Cross NC 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	Blue Cross NC HMO, POS, PPO and CMM (includes fully insured, state PPO and ASO)	Medicare Supplement (CMM legacy)	Federal Employee Program PPO
1	For calendar year split	No	No	No
2	For hospital contract changes	No	Yes	Inpatient = No Outpatient = Yes
3	For hospital contract change with room rate changes	No	No	No
4	If the member's policy terms while inpatient	Yes	Yes	No
5	When the patient is admitted from the ER without an inpatient authorization	Yes	No	No
6	When authorized and non-authorized days are in the same admission and reimbursement is percent of charge	Yes	No	No
7	When authorized and non-authorized days are in the same admission and reimbursement is diagnosis-related group (DRG) (case pay)	Yes	No	No
8	When authorized and non-authorized days are in the same admission and reimbursement is DRG (percent of charge)	Yes	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; 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 (1) 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.)
- **DRGs:** A system that reimburses hospitals fixed amounts for all hospital care given during a specific admission in connection with standard diagnostic categories.
- **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 Blue Cross NC-approved inpatient day.)
- **Percent of approved charges:** A payment methodology in which the allowance for covered services is calculated on Blue Cross NC approved charges.

Please Note: Blue Cross NC reserves the right to request a split claim where necessary to support correct adjudication of the claim.

9.30
Maternity claims

In accordance with Healthcare Effectiveness Data and Information Set (HEDIS) guidelines, Blue Cross NC requires that claims outside of the global billing claim be submitted with both the date of the first prenatal visit and the date of the postpartum visit.

For guidance on maternity related services, please refer to Blue Cross NC Reimbursement Policy on our website at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.31
Filing immunizations

Vaccines for immunizations can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered. Blue Cross NC members are not to pick up vaccines from the pharmacy for transport to a provider's office, as this may result in unsafe temperature changes. Vaccines may only be obtained by the administering provider and never by a Blue Cross NC member. Providers with questions are encouraged to contact the Provider Network.

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 Blue Cross NC's quality improvement staff to monitor the immunization status of our members for HEDIS reporting. Blue Cross NC submits immunization data concerning its members to the National Committee for Quality Assurance (NCQA) and the North Carolina Department of Insurance (NCDOI).

Use the following guidelines when filing immunizations:

- When filing immunizations, each immunization given must be filed on a single line of the CMS-1500 using one (1) CPT-4 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.
- **Blue Cross NC HMO, POS, PPO and CMM products:**
  Submit state-supplied vaccines with the immunization code and a zero (0) charge amount. Claims for vaccines that are not supplied by the state should indicate the cost of the vaccine.

Blue Cross NC preventive care guidelines are updated regularly and available to providers on the **BlueCrossNC.com** website for providers at: **BlueCrossNC.com/Providers/Network-Participation/Resources**. 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.

9.31.1
State-supplied immunization reimbursement

Claims reported for HMO, PPO and CMM members for the administration of a state-supplied vaccine, filed with the appropriate immunization CPT code and a SL-modifier, are considered for reimbursement according to the providers contracted fee schedule. This reimbursement method does not apply to Federal Employee Program products.

9.31.2
Vaccines and Medicare Part D coverage

Vaccines considered as a prescription drug benefit under a member's Medicare Part D coverage vs. a member's medical benefit cannot be reported to Blue Cross NC on a CMS-1500 claim form. Claims for vaccines eligible under a member's Part D benefit should be reported to the member's Part D payor for processing and payment. Additionally, because vaccines for immunizations can be temperature-sensitive and should be monitored for temperature increases and decreases until they are administered, Blue Cross NC members are not to pick up vaccines from the pharmacy for transport to a provider's office. This may result in unsafe temperature changes. Vaccines may only be obtained by the administering provider and never by a Blue Cross NC member.

Medicare Part D vaccine manager for claims filing

Participating providers have an easy online option to submit Medicare Part D vaccine claims to Medco® Health Solutions, Inc. (Medco) through eDispense. eDispense Part D vaccine manager, a product of Dispensing Solutions, Inc. (DSI), is a web-based application that offers a solution for the submission and adjudication of claims for physician-administered Part D vaccines covered by a member's Medicare Part D pharmacy benefits (vaccination claims that cannot be submitted on a standard CMS-1500 medical claim form).

eDispense makes real-time claims processing for in-office administered Medicare Part D vaccines available through its secure online access. Services offered with eDispense allow providers to quickly and electronically verify member's Medicare Part D vaccination coverage and submit claims to our pharmacy benefits manager, Medco, directly from your in-office internet connection.

eDispense offers providers the ability to:

- Verify members' Medicare Part D vaccination eligibility and benefits in real time
- Advise members of their appropriate out-of-pocket expense for Medicare Part D vaccines
- Submit Medicare Part D vaccine claims electronically to Medco

Enrollment is an easy two (2) step process:

- Step 1 – Select an authorized staff member who is most likely to be the primary user of the system to enroll the practice. This person should be prepared to provide the following information about the practice:
  - Tax identification number
  - NPI
  - Medicare ID number
  - Drug Enforcement Administration (DEA) number
  - State medical license number
- Step 2 – Go to Dispensing Solutions' website and complete a one (1) time online enrollment application at **Enroll.eDispense.com**.

Providers can contact Dispensing Solutions directly for assistance with enrollment and claims by calling their Customer Support Center at **1-888-522-EDVM** (**3386**).

Provider enrollment in eDispense vaccine manager and eDispense facilitated transactions between Medco and providers is a voluntary option for providers. Medicare Part D vaccine claims eligible for electronic processing with eDispense Part D vaccine manager are reimbursed according to the Medco allowance, less member liability. Blue Cross NC offers network providers access to eDispense vaccine manager for Medicare Part D transactions through our pharmacy benefits manager, Medco, by agreement between Medco and DSI.

9.32
Venipuncture and handling fee

Blue Cross NC has established allowances for laboratory services inclusive of venipuncture and usual supplies.

Blue Cross NC's reimbursement policy does not allow separate reimbursement for venipuncture and handling. For more information, please see reimbursement policies at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.33
Intensive outpatient service

Intensive outpatient service is a treatment alternative to a hospital admission or partial hospitalization. An intensive outpatient service must provide a multi-modal and multi-disciplinary structured outpatient program. Intensive outpatient services are indicated for Members, often in crisis, which require structured, multi-modal treatment (individual, group, family, multi-family as appropriate, and psycho- education) to achieve alleviation of symptoms and improved level of functioning which must be furnished by or under the supervision of registered or licensed personnel and under the direction of a North Carolina licensed physician credentialed by Blue Cross NC. The service will have a variable length of treatment (generally two [2] to three [3] hours per day, three [3] to five [5] times per week) and will have the ability to reduce each member's frequency of attendance as symptoms are alleviated and the member is able to resume more of his/her usual life obligations.

Billing guidelines

- Bill on a CMS1500 or successor claim form consistent with CMS implementation date, using only those HCPCS codes indicated in the table below.
- The member must require intensive psychiatric and/or chemical dependency services for the care to be considered as a covered service for intensive outpatient services. The specific determination of covered services is made by Blue Cross NC or its designee in accordance with the member's benefit plan.
- Only one (1) unit of IOP (on a facility or professional claim), is allowed per date of service as these services are defined as per diem. PHP and IOP services are mutually exclusive (not eligible) on the same date of service.
- IOP services are allowed on facility or professional claims as a per diem and includes all facility, professional, ancillary and other services rendered to the member.

Description	HCPCS Code	Unit
Intensive outpatient services – psychiatric	S9480	Per diem
Intensive outpatient services – chemical dependency	H0015	Per diem

Intensive outpatient services include but are not limited to the following components:

- Assessing the total needs of the member.
- Planning and managing of a member treatment plan involving services where specialized health care knowledge must be applied to attain the desired result.
- Observing and monitoring the member's response to care and treatment.
- Teaching, restoring, and retraining the member.
- Provide services to members that require specialized education and skills.

9.34
Participating labs and billing

Avalon, a lab insights company, provides contracted reference laboratory services for Blue Cross NC members through their network of high-quality independent laboratories. A current list of all participating laboratories is available in the Blue Cross NC provider directory. There is no difference in the process followed by ordering physicians or members for accessing laboratory services through the Avalon network.

A contracting physician's office or hospital laboratory may provide laboratory services for all Blue Cross NC lines of business. The physician office should not bill for the lab services they have submitted to a contracted reference lab.

CLIA

Payment for in-office laboratory services for providers are limited to those for which the practice has provided Blue Cross NC with evidence of CLIA certification. The exception are those services identified by Medicare as CLIA-excluded or CLIA-waived. Evidence of CLIA certification must be provided ***prior*** to receipt of the claim for in-office labs performed in the provider's office.

The current CLIA service codes by categories can be obtained by visiting the CMS website at: **www.CMS.gov/Regulations-and-Guidance/Legislation/CLIA/Categorization_of_Tests.html**.

Referrals

Blue Cross NC participating providers and facilities have a contractual obligation to refer laboratory services to Blue Cross NC participating laboratory providers through Avalon Healthcare Solutions. To confirm if a laboratory is participating with Blue Cross NC, simply access the *Find a Doctor or Facility* tool available online at **BlueCrossNC.com,** or contact the Provider Blue Line at **1-800-214-4844**.

9.35
Hearing aid screenings

See **Section 9.62** for details relating to hearing services.

9.36

Network for Blue Cross NC routine vision services and vision hardware

Community Eye Care (CEC) network serves as the exclusive eye care network for routine vision services and vision hardware provided to Blue Cross NC's commercial members. Only optometric, ophthalmologic and multi-specialty providers who participate on the CEC panel can be considered in-network routine vision providers for Blue Cross NC's commercially underwritten and ASO products.

Participation in CEC's Provider Network is at the group level. In order to render routine vision care as an in-network provider for Blue Cross NC commercially insured, ASO and commercial BlueCard members, providers must have an active agreement with CEC. To initiate the credentialing and contracting process, contact CEC at **1-888-254-4290**.

Routine vision claims for Blue Cross NC commercial members should be filed with Blue Cross NC for processing under the terms of your participation agreement with CEC. Providers should use **Blue *e*** or the Provider Blue Line at **1-800-214-4844** to check the status of a claim filed with Blue Cross NC.

Claims Filing Guidelines		
Product	**Routine Vision Network**	**Routine Vision Claims**
Blue Cross NC Commercial (HMO, POS*, EPO* and PPO)	CEC**	Blue Cross NC
CEC Vision Plans	CEC	CEC
Product	**Medical/Surgical Network**	**Medical/Surgical Claims**
Blue Cross NC Commercial (HMO, POS*, EPO* and PPO)	Blue Cross NC	Blue Cross NC

* Varying participation status for POS and EPO product lines such as Blue Local, Blue Value, and BlueHPN.

** FEP and other government employer groups use different routine vision carriers.

Providers can contact CEC at **1-888-254-4290, x213**, with questions about the Blue Cross NC routine vision program.

9.37
Anesthesia services

Blue Cross NC policy guidelines state the anesthesia benefit includes coverage for general, regional and monitored anesthesia care (MAC) ordered by the attending doctor and administered by or under the supervision of an anesthesiologist. There are no additional benefits for local anesthetics or anesthesia administered by the attending physician.

In accordance with the North Carolina Medical Board Position Statement entitled Office Based Procedures, *"Anesthesia should be administered by an anesthesiologist or a CRNA supervised by a physician. The physician who performs the surgical or special procedure should not administer the anesthesia. The anesthesia provider should not be otherwise involved in the surgical or special procedure."*

The following anesthesia services may be considered medically necessary:

- General anesthesia
- Regional block anesthesia (nerve trunk block and IV anesthesia proximal to elbow and knee, spinal anesthesia and epidural anesthesia)
- 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 following components are considered an integral part of the anesthesia service and additional reimbursement is not available when billed separately from the anesthetic:

- Pre-anesthesia evaluation
- 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
- Services administered in recovery room

When anesthesia services are <u>not</u> 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, *Bundling Guidelines*.)
- Monitoring of IV sedation by an anesthesiologist for gastrointestinal endoscopy, arteriograms, CT scans, MRIs, cardiac catherizations and percutaneous coronary intervention (PTCA) is generally considered not medically necessary. Please review the medical policy for anesthesia services and separate evidence-based guidelines, Monitored Anesthesia Care at **BlueCrossNC.com**.

All anesthesia services are subject to Blue Cross NC bundling guidelines. For further information on reimbursement guidelines, please see administrative policies on the Blue Cross and Blue Shield of North Carolina website at **BlueCrossNC.com**. They are listed in the *Category Search* on the *Medical Policy* search page.

Please Note: If service begins on one (1) day and ends on another day, provider must bill based upon the beginning service date.

9.37.1
Certified Registered Nurse Anesthetists (CRNAs)

Blue Cross NC secondary to Medicare

Blue Cross NC provides benefits for CRNAs (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 Blue Cross NC for processing of secondary benefits.

9.37.2
Anesthesia time

Anesthesia time must be reported in one (1) 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 (1) unit for each minute of anesthesia time. Anesthesia base units and the anesthesia provider's conversion factor (CF) are adjusted by Blue Cross NC (internally) relative to this one (1) minute time unit, i.e., the base unit value is multiplied by fifteen (15), and the CF is divided by fifteen (15).

Blue Cross NC considers the following list of codes to be non-timed procedures, which differs from the American Society of Anesthesiologists (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 fifteen (15) minute increments. For example, in a procedure with an anesthesia base unit value of four (4) requiring two (2) hours and twelve (12) minutes of anesthesia time (properly reported as one hundred and thirty-two [132] in the claim's units field): The time units (one hundred and thirty-two [132]) are added to the base unit value of sixty (60), (or four [4] x fifteen [15]), producing a total unit value of one hundred and ninety-two (192) units for this anesthesia service.

This total unit value is then multiplied by the provider's CF (CF divided by fifteen [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)

Calculation:	
Allowance:	= ($CF/15) x ([base unit x 15] + min) = ($30.00/15) x ([4 x 15] + 132) = $2.00 x (60 + 132) = $2.00 x 192 = **$384.00**

9.37.3
Anesthesia modifiers

All anesthesia services are reported by use of the anesthesia five (5) 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 in the first position after the procedure code, before other non-anesthesia modifiers. Physical status modifiers must be listed before other modifiers on the anesthesia claim. Please include all modifiers for a procedure code on one (1) 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 (4) concurrent procedures
   - **"QK"** Medical direction of two (2), three (3) or four (4) concurrent anesthesia procedures involving qualified individuals
   - **"QS"** Monitored anesthesiology care services
   - **"QX"** CRNA with medical direction by a physician
   - **"QY"** Medical direction of one (1) CRNA by an anesthesiologist
   - **"QZ"** CRNA without medical direction by a physician

2. **Physical status modifiers:** When filed with a five (5) 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 after the procedure, listed before other modifiers reported on the anesthesia claim.

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 (6) 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.

9.38
Transplant donor claims (professional services)

All claims reporting the medical services provided to a donor as part of a member's transplant procedure must be submitted on paper. Paper claim submissions allow us the ability to process a member's medical benefits for the payment of medical services provided to a donor. Paper claims reporting a donor's medical services are manually entered into our claims systems under the recipient member's name and date of birth, which allows us to document the services provided to a donor and enables the claim to pass through our membership validation and claim adjudication systems. To help facilitate this process, Blue Cross NC requires transplant donor claim cover sheets to be submitted with claims that report services provided to donors.

Transplant donor claim cover sheet

Transplant donor claim cover sheets can be created using your organization's standard stationary for correspondence and should contain the following information:

- **Subject:** Transplant donor claim
- The provider's name and NPI/Provider ID
- The patient's name could be recipient or donor
- The recipient's ID number (including the prefix and suffix, e.g., YPPW1234567801)
- The recipient's date of birth
- The patient's date of service
- Provider contact information (Blue Cross NC will contact the individual listed if we have any questions about the received information)
- Address for mail-back (practice name, contact and address)

Transplant donor claim

The following information must be included on the CMS-1500 professional claim form:

- Write "Donor" in large letters on the claim form
- Patient (Box 2) = Donor's name
- Insured's unique ID (Box 1a) = Recipient
- Patient relationship (Box 6) = Other and (Box 19) = Organ donor
- The donor diagnosis (Box 21) = V59.X (ICD-9) / Z52.X (ICD-10)

Submit the transplant donor claim to the dedicated Blue Cross NC transplant claim P.O. Box:

Blue Cross NC
Attention: Transplant Coordinator
P.O. Box 1972
Durham, NC 27702

Incomplete donor claims missing any of the above listed criteria will be mailed back to obtain the necessary information.

9.39
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. The assistant surgeon benefit for a covered procedure will be 16% of the maximum amount allowed for the procedure. Applicable modifier is eighty (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. Blue Cross NC corporate reimbursement policy regarding assistant surgeons may be viewed online at **BlueCrossNC.com**.

9.40
Physician assistant/assistant-at-surgery

An assistant-at-surgery may be a PA acting under the direct supervision of a physician, where the physician acts as the surgeon and the assistant-at-surgery as an assistant. The physician assistant 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. Benefits are allowed when medical necessity and appropriateness of assistant surgeon services are met, and when the physician assistant is under the direct supervision of a physician. Separate benefits will not be allowed for the hospital-employed physician assistant. The physician assistant benefits for a covered procedure is 13.6% of the maximum allowed for the procedure. Applicable modifier for surgical assistant is "AS."

Please refer to our online corporate reimbursement policy on co-surgeon, assistant surgeon, team surgeon and assistant-at-surgery guidelines for complete details.

9.41
Telehealth

Telehealth is the use of medical information exchanged from one (1) site to another via electronic communications to improve a patient's clinical health status. Telehealth includes a growing variety of applications and services using two (2) way video, email, smartphones, wireless tools and other forms of telecommunications. Blue Cross NC recognizes telehealth as a potentially useful tool that, if employed appropriately, can provide important benefits to patients. When used in accordance with Blue Cross NC's guidelines, telehealth can be an effective method for providers to communicate directly with their patients as a means of delivering health care to our members. Facilities are not eligible for telehealth reimbursement.

Blue Cross NC's telehealth policy explains guidelines for when using telemedicine technologies between a provider in one (1) location and a patient in another location may be appropriate and eligible for reimbursement by Blue Cross NC. Services that may be eligible for coverage include:

- Psychiatric services
- Psychotherapy
- Health behavior assessments
- Diabetic counseling
- Inpatient and outpatient counseling
- Online evaluations for common health concerns
- Consultations with new and existing patients

Providers offering telehealth services to their patients or considering telehealth as an option for providing patient care should review Blue Cross NC's online *Telehealth Corporate Reimbursement Policy*.

9.42
Retainer practices

A retainer practice is a provider practice model whereby patients pre-pay a fixed yearly or monthly fee for various services, which might include: Comprehensive primary care and/or "add-on" components such as immediate 24/7 access to the physician, prolonged visits, telephone and email contact as well as physician accompaniment to specialist appointments (thus the name "concierge practice").

In addition to primary care visits, services often cited as provided under the retainer fee may include:

- 24/7 physician access by cell phone or pager
- Immediate appointment access
- No wait time in office
- Care coordination between specialists, including referral coordination
- Email and telephone communication
- Form completion (school, camp, employment, disability, etc.)
- Extended office visits
- "Executive physicals" (comprehensive exams that often include additional screening tests that are not recommended based on age/risk factors in evidence-based practice guidelines like U.S. Preventative Services Task Force)
- Wellness programs and nutritional counseling, risk appraisals and wellness plans
- Weight management
- House calls or place of business call
- Newsletters
- Physician escorts to specialists or hospitals

Blue Cross NC will permit retainer practices to participate in our Provider Networks if the following requirements are met:

1. Retainer fee must be voluntary for members.
2. Services provided under the retainer fee must be clearly separate and distinct from covered services under Blue Cross NC member contracts.
3. Non-retainer patients must not be discriminated from retainer patients with regard to reasonable access to appointments and after-hours coverage (as per Blue Cross NC access and coverage policies).
4. Non-retainer patients must not be discriminated from retainer patients with regard to quality or comprehensiveness of care services. Patients who would benefit from appropriate preventative care or wellness counseling should receive those services within the context of usual covered office visits, written handouts, nurse counseling, etc.
5. Non-retainer patients should not be charged for copies of medical records, no-shows, completion of forms, phone or email contact unless the practice has standard office charges for these services and patients are notified in advance in writing of these charges. As a value-added service, it is permissible for retainer practices to offer these additional services at no charge to retainer patients under their pre-paid fees.

6. The following services are considered part of patient management for established patients within a practice and cannot be considered to be "added value" services under the concierge fee:
   - Referrals to specialists, appropriate coordination of care with specialists and/or for hospital admissions
   - Refills or prescription changes
   - Pre-authorizations
   - Routine preventive care
   - Wellness, nutrition and weight management counseling, if offered in the context of a physician office visit, or by nutritionists when covered under Blue Cross NC member benefits
   - Extended office visits for the purpose of providing wellness counseling, when medically appropriate for a particular patient
   - Timely reporting of lab, imaging and other test results
   - Same day appointments when medically indicated
   - Other alternative visit channels if covered by Blue Cross NC
7. Practices that wish to change from a traditional practice model to a retainer practice, and already participate in Blue Cross NC networks, must notify Blue Cross NC one hundred and twenty (120) days prior to any planned change. Blue Cross NC will evaluate the services offered under the retainer relationship for compliance with the above policy, communication planned for existing patients being seen within the practice and the retainer contract, and validate if the fee will be voluntary for Blue Cross NC members. If the practice meets all requirements for continued participation, Blue Cross NC will notify impacted members of their rights with regard to continuing care within this practice, and the voluntary nature of the fee. If the practice does not meet continued participation requirements, it will be allowed to voluntarily withdraw from Blue Cross NC networks (with ninety [90] days notice) and will be considered in violation of their Blue Cross NC contract if they require payment of any additional fees for Blue Cross NC members during that period of time.
8. The same requirements must be met by de novo retainer practices; except that these requirements will be ascertained for any new practice wishing to join the Blue Cross NC network before contracting is performed.
9. Retainer practices that are permitted to remain within the Blue Cross NC network will be indicated as such within the Blue Cross NC online Provider Directory, with active links to the member information about retainer practice and patients rights in that regard.
10. All retainer practices must assure that they are compliant with any and all state and federal regulatory requirements that apply.

Blue Cross NC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

9.43
Billing for missed appointments

Blue Cross NC 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.

9.44
e-Visits (online medical evaluations)

e-Visits (email, online medical evaluations) refer to the ability for health providers to interact with patients through a secured electronic channel. e-Visits are typically member-initiated and used to address non-urgent ongoing or new symptoms, although there may be an evolving role for the use of e-Visits in management of chronic health conditions such as diabetes.

Sample CMS-1500 Claim Form

Physician's Office

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): YPPW12345678
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Last Name, First Name	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): Last Name, First Name
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. RESERVED FOR NUCC USE	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 X NO	a. INSURED'S DATE OF BIRTH MM DD YY: 02 08 1919 SEX M ☐ F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): First Bank
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield - NC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES X NO *If yes*, complete items 9, 9a, and 9d.

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: 10/01/2015

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 01 2015 QUAL.	15. OTHER DATE QUAL. MM DD YY: 10 01 2015
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 1234567890
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. E11.9 Diabetes B. C. D. E. F. G. H. I. J. K. L.	22. 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 01 15 10 01 15	11		99214			50 00	1		1B NPI	0123456789
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)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
56-9876543 ☐ X	987654321	X YES ☐ NO	$ 50 00	$ 0 00	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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (704) 555-1111
Signature of Claim Preparer SIGNED DATE	Regis Medical Center 999 Event Drive Charlotte, NC 28220 a. 0123456789 b.	Regis Medical Center 999 Event Drive Charlotte, NC 28220 a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PHYSICIAN'S OFFICE

9.45

Licensed dietitian nutritionist services

Eligible providers enrolled with Blue Cross NC can provide nutritional counseling services that are considered for member's in-network benefits. It is important to always verify a member's eligibility and medical nutrition therapy benefits prior to providing treatment. Educational materials are not separately billable as they are considered routine supplies and services for which payment is included in the reimbursement.

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
- Bill us your retail charges
- File claims within one hundred and eighty (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 min	1 unit (1 unit = 15 min)
97803	Re-assessment and intervention, individual, face-to-face with the patient, each 15 min	1 unit (1 unit = 15 min)
97804	Group (2 or more individual[s]), each 30 min	1 unit (1 unit = 30 min)
S9465	Diabetic management program, dietitian visit	Per visit
S9470	Nutritional counseling, dietitian visit	Per visit

Sample LDN Claim CMS-1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): XXXW12345678
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Last Name, First Name	3. PATIENT'S BIRTH DATE MM DD YY: 04 15 1970 SEX M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Last Name, First Name
5. PATIENT'S ADDRESS (No., Street): 123 Any Street	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street): 123 Any Street
CITY: City STATE: NC	8. RESERVED FOR NUCC USE	CITY: City STATE: NC
ZIP CODE: 12345 TELEPHONE (Include Area Code): (000) 111-2222		ZIP CODE: 12345 TELEPHONE (Include Area Code): (000) 111-2222
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 ☒ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): Working Group
c. RESERVED FOR NUCC USE	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. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☒ NO ☐ *If yes*, complete items 9, 9a, and 9d.

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 10/01/2015

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 01 2015 QUAL.	15. OTHER DATE QUAL. MM DD YY: 10 01 2015	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. 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.: A. E11.9 Diabetes B. C. D. E. F. G. H. I. J. K. L.		22. 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 01 15	10 01 15						20 00			NPI	0123456789
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 00-0000000 ☒	26. PATIENT'S ACCOUNT NO.: 00-0000000	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☒	28. TOTAL CHARGE $	29. AMOUNT PAID $: 20 00	30. Rsvd for NUCC Use
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.		

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PHYSICIAN'S OFFICE

9.46
Participating reference labs and billing

Definition

Laboratory services – Reference laboratory testing services as may be requested by Blue Cross NC participating providers. This would include, but not be limited to, consulting services 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
- Do not submit claims for CPT codes 99000 and 99001
- 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

Please Note: It is important to remember that Blue Cross NC participating providers and facilities have a contractual obligation to refer all lab services to Blue Cross NC in-network laboratory providers. To confirm if a laboratory is participating with Blue Cross NC, access the *Find a Doctor or Facility* tool, available online at **BlueCrossNC.com** or contact the Provider Blue Line at **1-800-214-4844**.

Sample Reference Laboratory Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): XXXW12345678
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Last Name, First Name	3. PATIENT'S BIRTH DATE MM 04 DD 15 YY 1970 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Last Name, First Name
5. PATIENT'S ADDRESS (No., Street): 123 Any Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 123 Any Street
CITY: City STATE: NC	8. RESERVED FOR NUCC USE	CITY: City STATE: NC
ZIP CODE: 12345 TELEPHONE (Include Area Code): (704) 111-2222		ZIP CODE: 12345 TELEPHONE (Include Area Code): (704) 111-2222
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 10 DD 01 YY 2003 SEX M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): Working Group
c. RESERVED FOR NUCC USE	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. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.

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 10/01/2015

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM 10 DD 01 YY 2015 QUAL.	15. OTHER DATE QUAL. MM 10 DD 01 YY 2015	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. 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. E11.9 Diabetes B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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 15 10 01 15			82131						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.: 00-0000000	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
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: Any Lab Name 1234 Street Name Any City, NC USA a. 0123456789 b.		33. BILLING PROVIDER INFO & PH # ( ) Any Lab Name 1234 Street Name Any City, NC USA a. 0123456789 b.		

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9.47
Birthing center services

Definition

The birthing center is a health care facility for childbirth where care is provided in the midwifery and wellness model. The birthing center is freestanding and not a hospital.

Birthing center inclusive rate includes all services provided during delivery. No other facility services are separately billable.

Interim labor facility global includes all services provided during labor but not resulting in actual delivery. No other facility services are separately billable.

Billing

Submit reasonable charges on a UB-04 or successor claim form.

Submit only those codes for services indicated as billable birthing center services.

Billable Birthing Center Services	Revenue Code	CPT/HCPCS Code
Birthing Center Inclusive Rate	0724	59409
Interim Labor Facility Global	0724	S4005

The following services are not considered birthing center services and must be billed by a provider contracted with Blue Cross NC:

- Medical care rendered by a professional provider

9.48
Licensed laboratory services

Definition

Reference clinical laboratory testing services as may be requested by Blue Cross NC participating providers. This would include, but not be limited to, consulting services provided by a 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.

Laboratory will submit performance standard reports to Blue Cross NC on a routine basis (monthly, quarterly or semi-annually). Blue Cross NC will review performance standards for two (2) performance periods each year as defined as:

- **Performance Period 1:** January 1 through June 30
- **Performance Period 2:** July 1 through December 31

Blue Cross NC will determine if performance penalties are applicable for each performance period and will submit an invoice to the laboratory. Laboratory agrees to remit any applicable penalty payments within thirty (30) days of invoice receipt. Laboratory agrees to provide claims data on applicable health measures as determined by Blue Cross NC.

General billing guidelines

- Bill on CMS-1500 claim form using appropriate health service codes
- Specify services provided and include all of the statistical and descriptive medical, diagnostic and patient data
- Use appropriate NPI
- File claims after complete services have been provided
- Laboratory procedure reimbursement includes the collection, handling and conveyance of the specimen

Billable Laboratory Services		
Service Code	**Service Description**	**Category**
80000–84999	Scheduled pickup completion rate >99%	Specimen handling
85000–85999	Received by but lost by the Lab .025%	Specimen handling
86000–86999	Initial accuracy >99%	Reporting
All Other Services		

9.49
Home health billing and reimbursement

Home health services are included in Blue Cross NC's prior review requirements. Please refer to **Chapter 7** in this e-Manual to learn more about prior review for Blue Cross NC members, and see our most current prior review listing available on the Blue Cross NC website at **BlueCrossNC.com/Providers/Prior-Authorization**.

9.49.1
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
PT	Licensed physical therapist or licensed physical therapist assistant
OT	Licensed occupational therapist
ST	Licensed speech pathologist
Medical Social Service	Medical social worker (MSW)
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 forty-eight (48) hours for a normal vaginal delivery or ninety-six (96) hours for a cesarean section, provider may bill a skilled nursing visit if rendered no later than seventy-two (72) hours following discharge. Prior review must be obtained for this service.

9.49.2
Billing codes and unit definitions

Revenue Codes	Services	Units
0551	Skilled nursing (RN/LPN)	Visit
0421	Physical therapy	Visit
0441	Speech therapy	Visit
0431	Occupational therapy	Visit
0561	Medical social services	Visit
0571	Home health aide	Visit
0272, 0279	See **Section 9.48.3**	Unit of Supply

Home health billing

Provider agrees:

- To bill Blue Cross NC for professional home health services and non-routine home health supplies subject to the terms of the agreement and all applicable Blue Cross NC programs, policies and procedures as set forth in the agreement, including those policies and rules set forth in this provider e-Manual and Blue Cross NC billing, claims submission, reimbursement and medical policies.
- To bill Blue Cross NC your reasonable charges for each member health benefit plan.

Home health services not billable as separate services (integral part of home health visit)

- Services and supplies which are not an integral part of a home health visit are not billable as separate services and are set out in this manual and Blue Cross NC's policies and procedures – any of which may be enacted and revised from time to time, including but not limited to, Blue Cross NC billing, claims submission, reimbursement and medical policies.

9.49.3
Billable non-routine home health supplies

The following 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 Blue Cross NC.

Billable Non-Routine Home Health Services The following services are to be billed using the applicable Revenue and HCPCS Codes		
Description	**Revenue Code**	**HCPCS Code**
Insertion tray without drainage bag and without catheter (accessories only)	0272	A4310
Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way latex with coating	0272	A4311
Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way, all silicone	0272	A4312
Insertion tray without drainage bag with indwelling catheter, Foley type, 3-way, for continuous irrigation	0272	A4313
Insertion tray with drainage bag with indwelling catheter, Foley type, 2-way latex with coating (teflon, silicone, silicone elastomer orhydrophilic, etc.)	0272	A4314
Insertion tray with drainage bag with indwelling catheter, Foley type, 2-way, all silicone	0272	A4315
Insertion tray with drainage bag with indwelling catheter, Foley type, 3-way, for continuous irrigation	0272	A4316
Irrigation tray with bulb or piston syringe, any purpose	0272	A4320
Male external catheter with integral collection chamber, any type, each	0272	A4326
Female external urinary collection device, metal cup, each	0272	A4327
Female external urinary collection device, pouch, each	0272	A4328
Perianal fecal collection pouch with adhesive, each	0272	A4330
Extension drainage tubing, any type, any length, with connector/ adaptor, for use with urinary leg bag or urostomy pouch, each	0272	A4331
Lubricant, individual sterile packet, each	0272	A4332
Urinary catheter anchoring device, adhesive skin attachment, each	0272	A4333
Urinary catheter anchoring device, leg strap, each	0272	A4334

continued on following page

Billable Non-Routine Home Health Services The following services are to be billed using the applicable Revenue and HCPCS Codes		
Description	**Revenue Code**	**HCPCS Code**
Male external catheter with integral collection chamber, any type, each	0272	A4326
Female external urinary collection device, metal cup, each	0272	A4327
Female external urinary collection device, pouch, each	0272	A4328
Perianal fecal collection pouch with adhesive, each	0272	A4330
Extension drainage tubing, any type, any length, with connector/ adaptor, for use with urinary leg bag or urostomy pouch, each	0272	A4331
Lubricant, individual sterile packet, each	0272	A4332
Urinary catheter anchoring device, adhesive skin attachment, each	0272	A4333
Urinary catheter anchoring device, leg strap, each	0272	A4334
Incontinence supply, miscellaneous	0272	A4335
Intermittent urinary catheter, with insertion supplies	0272	A4353
Insertion tray with drainage bag but without catheter	0272	A4354
Irrigation tubing set for continuous bladder irrigation through a 3-way indwelling Foley catheter, each	0272	A4355
External urethral clamp or compression device (not to be used for catheter clamp), each	0272	A4356
Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each	0272	A4357
Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each	0272	A4358
Ostomy faceplate, each	0272	A4361
Skin barrier; solid, 4 x 4 or equivalent; each	0272	A4362
Ostomy clamp, any type, replacement only, each	0272	A4363

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Adhesive, liquid or equal, any type, per ounce	0272	A4364
Adhesive, remover wipes, any type, per 50	0272	A4365
Ostomy vent, any type, each	0272	A4366
Ostomy belt, each	0272	A4367
Ostomy filter, any type, each	0272	A4368
Ostomy skin barrier, liquid (spray, brush, etc.), per ounce	0272	A4369
Ostomy skin barrier, powder, per ounce	0272	A4371
Ostomy skin barrier, solid 4 x 4 or equivalent, standard wear, with built-in convexity, each	0272	A4372
Ostomy skin barrier, with flange (solid, flexible or accordian), with built-in convexity, any size, each	0272	A4373
Ostomy pouch, drainable, with faceplate attached, plastic, each	0272	A4375
Ostomy pouch, drainable, with faceplate attached, rubber, each	0272	A4376
Ostomy pouch, drainable, for use on faceplate, plastic, each	0272	A4377
Ostomy pouch, drainable, for use on faceplate, rubber, each	0272	A4378
Ostomy pouch, urinary, with faceplate attached, plastic, each	0272	A4379
Ostomy pouch, urinary, with faceplate attached, rubber, each	0272	A4380
Ostomy pouch, urinary, for use on faceplate, plastic, each	0272	A4381
Ostomy pouch, urinary, for use on faceplate, heavy plastic, each	0272	A4382
Ostomy pouch, urinary, for use on faceplate, rubber, each	0272	A4383
Ostomy faceplate equivalent, silicone ring, each	0272	A4384
Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each	0272	A4385

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Ostomy pouch, closed, with barrier attached, with built-in convexity (1 piece), each	0272	A4387
Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each	0272	A4388
Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each	0272	A4389
Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each	0272	A4390
Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each	0272	A4391
Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each	0272	A4392
Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each	0272	A4393
Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce	0272	A4394
Ostomy deodorant for use in ostomy pouch, solid, per tablet	0272	A4395
Ostomy belt with peristomal hernia support	0272	A4396
Irrigation supply, sleeve, each	0272	A4397
Ostomy irrigation supply, cone/catheter, including brush	0272	A4399
Ostomy irrigation set	0272	A4400
Lubricant, per ounce	0272	A4402
Ostomy ring, each	0272	A4404
Ostomy skin barrier, non-pectin based, paste, per ounce	0272	A4405
Ostomy skin barrier, pectin-based, paste, per ounce	0272	A4406
Ostomy skin barrier, with flange (solid, flexible, or accordian), extended wear, with built-in convexity, 4 x 4 inches or smaller, each	0272	A4407

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Ostomy skin barrier, with flange (solid, flexible or accordian), extended wear, with built-in convexity, larger than 4 x 4 inches, each	0272	A4408
Ostomy skin barrier, with flange (solid, flexible or accordian), extended wear, without built-in convexity, 4x4 inches or smaller, each	0272	A4409
Ostomy skin barrier, with flange (solid, flexible or accordian), extended wear, without built-in convexity, larger than 4 x 4 inches, each	0272	A4410
Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, with built-in convexity, each	0272	A4411
Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each	0272	A4412
Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each	0272	A4413
Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each	0272	A4414
Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 inches, each	0272	A4415
Ostomy pouch, closed, with barrier attached, with filter (1 piece), each	0272	A4416
Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each	0272	A4417
Ostomy pouch, closed, for use on barrier with non-locking flange, with filter	0272	A4419
Ostomy pouch, closed, for use on barrier with locking flange (2 piece), each	0272	A4420
Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each	0272	A4422
Ostomy pouch, closed, for use on barrier with locking flange, with filter (2 piece), each	0272	A4423
Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each	0272	A4424
Ostomy pouch, drainable, for use on barrier with non-locking flange, with filter (2 piece system), each	0272	A4425

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Ostomy pouch, drainable, for use on barrier with locking flange (2 piece system), each	0272	A4426
Ostomy pouch, drainable, for use on barrier with locking flange, with filter (2 piece system), each	0272	A4427
Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each	0272	A4428
Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	0272	A4429
Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	0272	A4430
Ostomy pouch, urinary, with barrier attached, with faucet-type tap with valve (1 piece), each	0272	A4431
Ostomy pouch, urinary, for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each	0272	A4432
Ostomy pouch, urinary, for use on barrier with locking flange (2 piece), each	0272	A4433
Ostomy pouch, urinary, for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each	0272	A4434
Adhesive remover or solvent (for tape, cement or other adhesive), per ounce	0272	A4455
Enema bag with tubing, reusable	0272	A4458
Surgical dressing holder, non-reusable, each	0272	A4461
Surgical dressing holder, reusable, each	0272	A4463
Tracheostoma filter, any type, any size, each	0272	A4481
Tracheostomy, inner cannula	0272	A4623
Tracheostomy care kit for new tracheostomy	0272	A4625
Tracheostomy cleaning brush, each	0272	A4626
Ostomy pouch, closed, with barrier attached (1 piece), each	0272	A5051

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Ostomy pouch, closed, without barrier attached (1 piece), each	0272	A5052
Ostomy pouch, closed, for use on faceplate, each	0272	A5053
Ostomy pouch, closed, for use on barrier with flange (2 piece), each	0272	A5054
Stoma cap	0272	A5055
Ostomy pouch, drainable, without barrier attached (1 piece), each	0272	A5062
Ostomy pouch, drainable, for use on barrier with flange (2 piece system), each	0272	A5063
Ostomy pouch, urinary, with barrier attached (1 piece), each	0272	A5071
Ostomy pouch, urinary, without barrier attached (1 piece), each	0272	A5072
Ostomy pouch, urinary, for use on barrier with flange (2 piece), each	0272	A5073
Continent device, plug for continent stoma	0272	A5081
Continent device, catheter for continent stoma	0272	A5082
Continent device, stoma absorptive cover for continent stoma	0272	A5083
Ostomy accessory, convex insert	0272	A5093
Bedside drainage bottle with or without tubing, rigid or expandable, each	0272	A5102
Urinary suspensory with leg bag, with or without tube, each	0272	A5105
Urinary leg bag, latex	0272	A5112
Leg strap, latex, replacement only, per set	0272	A5113
Leg strap, foam or fabric, replacement only, per set	0272	A5114
Skin barrier, wipes or swabs, each	0272	A5120
Skin barrier, solid, 6 x 6 or equivalent, each	0272	A5121
Skin barrier, solid, 8 x 8 or equivalent, each	0272	A5122
Adhesive or non-adhesive, disk or foam pad	0272	A5126

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Appliance cleaner, incontinence and ostomy appliances, per 16 ounces	0272	A5131
Collagen based wound filler, dry foam, sterile, per gram of collagen	0272	A6010
Collagen based wound filler, gel/paste, sterile, per gram of collagen	0272	A6011
Collagen dressing, sterile, pad size 16 square inches or less, each	0272	A6012
Collagen dressing, sterile, pad size more than 16 square inches but less than or equal to 48 square inches each	0272	A6022
Collagen dressing, sterile, pad size more than 48 square inches	0272	A6023
Collagen dressing wound filler, sterile, per 6 inches	0272	A6024
Wound pouch, each	0272	A6154
Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 square inches or less, each dressing	0272	A6196
Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, each dressing	0272	A6197
Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 square inches, each dressing	0272	A6198
Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches	0272	A6199
Composite dressing, sterile, pad size 16 square inches or less, with any size adhesive border, each dressing	0272	A6203
Composite dressing, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, with any size adhesive border, each dressing	0272	A6204
Composite dressing, sterile, pad size more than 48 square inches, with any size adhesive border, each dressing	0272	A6205
Contact layer, sterile, 16 square inches or less, each dressing	0272	A6206
Contact layer, sterile, more than 16 square inches but less than or equal to 48 square inches, each dressing	0272	A6207

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Contact layer, sterile, more than 48 square inches, each dressing	0272	A6208
Foam dressing, wound cover, sterile, pad size 16 square inches or less, without adhesive border, each dressing	0272	A6209
Foam dressing, wound cover, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	0272	A6210
Foam dressing, wound cover, sterile, pad size more than 48 square inches, without adhesive border, each dressing	0272	A6211
Foam dressing, wound cover, sterile, pad size 16 square inches or less, with any size adhesive border, each dressing	0272	A6212
Foam dressing, wound cover, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, with any size adhesive border, each dressing	0272	A6213
Foam dressing, wound cover, sterile, pad size more than 48 square inches, with any size adhesive border, each dressing	0272	A6214
Foam dressing, wound filler, sterile, per gram	0272	A6215
Gauze, non-impregnated, sterile, pad size 16 square inches or less, with any size adhesive border, each dressing	0272	A6219
Gauze, non-impregnated, sterile, pad size more than 16 square inches, but less than or equal to 48 square inches, with any size adhesive border, each dressing	0272	A6220
Gauze, non-impregnated, sterile, pad size more than 48 square inches, with any size adhesive border, each dressing	0272	A6221
Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size 16 square inches or less, without adhesive border, each dressing	0272	A6222
Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 16 square inches, but less than or equal to 48 square inches, without adhesive border, each dressing	0272	A6223
Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 48 square inches, without adhesive border, each dressing	0272	A6224

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Gauze, impregnated, water or normal saline, sterile, pad size 16 square inches or less, without adhesive border, each dressing	0272	A6228
Gauze, impregnated, water or normal saline, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	0272	A6229
Gauze, impregnated, water or normal saline, sterile, pad size more than 48 square inches, without adhesive border, each dressing	0272	A6230
Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 square inches or less, each dressing	0272	A6231
Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 square inches, but less than or equal to 48 square inches, each dressing	0272	A6232
Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 square inches, each dressing	0272	A6233
Hydrocolloid dressing, wound cover, sterile, pad size 16 square inches or less, without adhesive border, each dressing	0272	A6234
Hydrocolloid dressing, wound cover, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	0272	A6235
Hydrocolloid dressing, wound cover, sterile, pad size more than 48 square inches, without adhesive border, each dressing	0272	A6236
Hydrocolloid dressing, wound cover, sterile, pad size 16 square inches or less, with any size adhesive border, each dressing	0272	A6237
Hydrocolloid dressing, wound cover, sterile, pad size more than 48 square inches, with any size adhesive border, each dressing	0272	A6239
Hydrocolloid dressing, wound filler, paste, sterile, per ounce	0272	A6240
Hydrocolloid dressing, wound filler, dry form, sterile, per gram	0272	A6241
Hydrogel dressing, wound cover, sterile, pad size 16 square inches or less, without adhesive border, each dressing	0272	A6242
Hydrogel dressing, wound cover, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	0272	A6243

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Hydrogel dressing, wound cover, sterile, pad size more than 48 square inches, without adhesive border, each dressing	0272	A6244
Hydrogel dressing, wound cover, sterile, pad size 16 square inches or less, with any size adhesive border, each dressing	0272	A6245
Hydrogel dressing, wound cover, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, with any size border, each dressing	0272	A6246
Hydrogel dressing, wound cover, sterile, pad size more than 48 square inches, with any size adhesive border, each dressing	0272	A6247
Hydrogel dressing, wound filler, gel, sterile, per fluid ounce	0272	A6248
Specialty absorptive dressing, wound cover, sterile, pad size 16 square inches or less, without adhesive border, each dressing	0272	A6251
Specialty absorptive dressing, wound cover, sterile, pad size more than 16 square inches but less than or equal to 48 square inches, without adhesive border, each dressing	0272	A6252
Specialty absorptive dressing, wound cover, sterile, pad size more than 48 square inches, without adhesive border, each dressing	0272	A6253
Specialty absorptive dressing, wound cover, sterile, pad size 16 square inches or less, with any size adhesive border, each dressing	0272	A6254
Specialty absorptive dressing, wound cover, sterile, pad size more than 16 square inches	0272	A6255
Specialty absorptive dressing, wound cover, sterile, pad size more than 48 square inches but less than or equal to 48 square inches, with any size adhesive border, each dressing	0272	A6256
Wound filler, gel/paste, sterile, per fluid ounce, not otherwise specified	0272	A6261
Wound filler, dry form, sterile, per gram, not otherwise specified	0272	A6262
Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yard	0272	A6266
Packing strips, non-impregnated, sterile, up to 2 inches in width, per linear yard	0272	A6407
Eye patch, occlusive, each	0272	A6412

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6441
Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than 3 inches, per yard	0272	A6442
Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6443
Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	0272	A6444
Conforming bandage, non-elastic, knitted/woven, sterile, width less than 3 inches, per yard	0272	A6445
Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6446
Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 5 inches, per yard	0272	A6447
Light compression bandage, elastic, knitted/woven, width less than 3 inches, per yard	0272	A6448
Light compression bandage, elastic, knitted/woven, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6449
Light compression bandage, elastic, knitted/woven, width greater than or equal to 5 inches, per yard	0272	A6450
Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6451
High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6452
Self-adherent bandage, elastic, non-knitted/non-woven, width less than 3 inches, per yard	0272	A6453
Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6454
Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to 5 inches, per yard	0272	A6455

continued on following page

Billable Non-Routine Home Health Services
The following services are to be billed using the applicable Revenue and HCPCS Codes

Description	Revenue Code	HCPCS Code
Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6441
Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to 3 inches and less than 5 inches, per yard	0272	A6456
Tubular dressing with or without elastic, any width, per linear yard	0272	A6457
Gradient compression wrap, non-elastic, below knee, 30-50 mm hg, each	0272	A6545
One way chest drain valve	0272	A7040
Water seal drainage container and tubing for use with implanted chest tube	0272	A7041
Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	0272	A7045
Tracheostoma valve, including diaphragm, each	0272	A7501
Replacement diaphragm/faceplate for tracheostoma valve, each	0272	A7502
Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each	0272	A7503
Filter for use in a tracheostoma heat and moisture exchange system, each	0272	A7504
Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each	0272	A7505
Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type each	0272	A7506
Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each	0272	A7521
Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each	0272	A7522
Tracheostomy shower protector, each	0272	A7523
Tracheostoma stent/stud/button, each	0272	A7524
Tracheostomy/laryngectomy tube plug/stop, each	0272	A7527
Heel or elbow protector, each	0272	E0191
Dry pressure pad for mattress, standard mattress length and width	0272	E0199

9.49.4

Pharmacist preventive services

Definition

- **Pharmacist preventive services** – Services that are listed on the pharmacist preventive services reimbursement schedule, that are covered services under the agreement and that are delivered by a participating provider located in designated retail and other sites as established by participating provider, at regional clinics established at Blue Cross NC's request (regional clinics) and at worksites of Blue Cross member groups (worksite clinics) at the request of Blue Cross NC. Preventive immunizations will be covered according to CDC guidelines.
- Provider must have a written protocol with a physician in order to administer any vaccine and must consult with the member's primary care provider before administering the pneumococcal or zoster vaccines.
- Provider must give the member the appropriate current vaccine information for review and answer any questions prior to administration of the vaccine.
- Covered services shall be delivered by qualified personnel as required under applicable state laws.
- Provider shall follow applicable guidelines issued by the North Carolina Department of Health and Human Services and any other applicable governing or regulating body pertaining to the provision of preventive services and disposal of waste. Upon receipt of written request, provider will forward a copy of its infection control guidelines to Blue Cross NC.

Member access

- Minimum availability shall be forty (40) hours per week with twenty-four (24) hour on-call coverage for urgent/emergent response. Provider will provide Blue Cross NC a complete schedule of designated site hours. Provider will notify Blue Cross NC in advance of any changes to the schedule.
- Provider agrees to make every reasonable effort to ensure access of members to covered services including, but not limited to, diversion of staff and resources.
- Provider agrees to guarantee the provision of appropriate vaccine, staffing, supplies and resources to provide vaccines by injection during scheduled site hours.
- Should vaccines become unavailable because of restrictions imposed by the federal, state or local government, as determined by the provider and Blue Cross NC, provider will not be required to provide immunizations pursuant to this agreement. Provider will have no liability to Blue Cross NC should the unavailability of vaccines prevent provider from performing under this agreement.

Billing

- Bill only those codes for services listed as billable pharmacist preventive services.
- Submit claims electronically on a CMS-1500 or successor claim form.
- Bill your reasonable charges.
- For each member who presents a valid and current member ID card to provider at the time of service, provider will bill Blue Cross NC for payment for such members' covered preventive services and will not bill or accept payment from such member or from any third party.

Supplies and services not separately billable

The following services are considered routine supplies and services for which payment is included in the reimbursement for pharmacist preventive services. These items are not separately billable:

- Educational materials.
- Supplies required for administering an injection, including but not limited to: Syringes, alcohol swabs, bandages, gauze and waste disposal equipment.

Billable Pharmacist Preventive Service Codes
The following services are to be billed using the applicable Service Code

Description	Service Code
Immunization Administration	90471
Immunization Administration	90472
Immunization Administration, single vaccine	90473
Immunization Administration, each additional single	90474
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, for intradermal use	90630
Hepatitis A vaccine, adult dosage	90632
Hepatitis A vaccine, pediatric/adolescent dosage	90633
Hepatitis A vaccine (HEPA), pediatric/adolescent dosage – 3 dose schedule, for intramuscular use	90634
Hepatitis A and Hepatitis B vaccine, adult dosage	90636
HPV vaccine	90649
Human papilomavirus vaccine, types 16, 18, bivalent (2VHPV), 3 dose schedule, for intramuscular use	90650
Human papilomavirus vaccine, types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9VHPV), 3 dose schedule, for intramuscular use	90651
Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	90653
Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	90654
Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, 0.25 ml dosage, for intramuscular use	90655
Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, 0.5 ml dosage, for intramuscular use	90656
Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 ml dosage, for intramuscular use	90657
Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 ml dosage, for intramuscular use	90658
Influenza virus vaccine, live, for intranasal use	90660
Influenza virus vaccine, trivalent (CCIIV3), derived from cell cultures, subunit, preservative- and antibiotic-free, 0.5 ml dosage, for intramuscular use	90661

continued on following page

Billable Pharmacist Preventive Service Codes
The following services are to be billed using the applicable Service Code

Description	Service Code
Influenza virus vaccine (IIV), split virus, preservative-free, enhanced immunogenicity via increased antigen content, for intramuscular use	90662
Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	90670
Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	90672
Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative- and antibiotic-free, for intramuscular use	90673
Influenza virus vaccine, quadrivalent (CCIIV4), derived from cell cultures, subunit, preservative- and antibiotic-free, 0.5 ml dosage, for intramuscular use	90674
Rotavirus vaccine	90680
Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, preservative- and antibiotic-free, for intramuscular use	90682
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.25 ml dosage, for intramuscular use	90685
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.5 ml dosage, for intramuscular use	90686
Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 ml dosage, for intramuscular use	90687
Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 ml dosage, for intramuscular use	90688
Diptheria and tetanus toxoids adsorbed (DT) when administered to individuals younger than 7 years, for intramuscular use	90702
Measles, Mumps and Rubella virus vaccine (MMR)	90707
Measles, Mumps, Rubella and Varicella vaccine (MMRV)	90710
Polio virus vaccine	90713
Tetanus and diphtheria toxoids adsorbed (TD), preservative-free, when administered to individuals 7 years or older, for intramuscular use	90714
Tdap	90715
Varicella virus vaccine	90716

continued on following page

Billable Pharmacist Preventive Service Codes The following services are to be billed using the applicable Service Code	
Description	**Service Code**
Pneumococcal polysaccharide vaccine, 23-valent	90732
Meningococcal polysaccharide vaccine subcutaneous	90733
Meningococcal conjugate vaccine intramuscular	90734
Zoster vaccine, live	90736
Hepatitis B vaccine (HEPB), adult dosage, 2 dose schedule, for intramuscular use	90739
Hepatitis B vaccine (HEPB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use	90740
Hepatitis B vaccine (HEPB), adolescent, 2 dose schedule, for intramuscular use	90743
Hepatitis B vaccine, pediatric/adolescent dosage	90744
Hepatitis B vaccine, adult dosage	90746
Hepatitis B vaccine, dialysis or immunosuppressed patient	90747
Administration of influenza virus vaccine	G0008
Administration of pneumococcal vaccine	G0009
Administration of Hepatitis B vaccine	G0010
Influenza vaccine, recombinant hemagglutinin antigens, for intramuscular use (flublok)	Q2033
Influenza virus vaccine, split virus, for intramuscular use (agriflu)	Q2034
Influenza virus vaccine, split virus	Q2035
Influenza virus vaccine, split virus	Q2036
Influenza virus vaccine, split virus	Q2037
Influenza virus vaccine, split virus	Q2038
Influenza virus vaccine, split virus	Q2039
Pneumococcal conjugate vaccine	S0195

9.49.5

Preventive services/mass immunization services

Definition

- **Preventive services/mass immunization services** – Services that are listed on the preventive services/mass immunization services reimbursement below, that are covered services under the agreement and that are delivered by a participating provider located in designated retail and other sites as established by the participating provider, at regional clinics established at Blue Cross NC's request (regional clinics) and at worksites of Blue Cross NC member groups (worksite clinics) at the request of Blue Cross NC. Preventive immunizations will be covered according to CDC guidelines.
- Provider must have a written protocol with a physician in order to administer any vaccine and must consult with the member's primary care provider before administering the pneumococcal or zoster vaccines.
- Provider must give the member the appropriate current vaccine information for review and answer any questions prior to administration of the vaccine.
- Covered services shall be delivered by qualified personnel, as required under applicable state laws.
- Provider shall follow applicable guidelines issued by the North Carolina Department of Health and Human Services and any other applicable governing or regulating body pertaining to the provision of preventive services and disposal of waste. Upon receipt of written request, provider will forward a copy of its infection control guidelines to Blue Cross NC.

Member access

- Provider will provide Blue Cross NC a complete schedule of designated site hours. Provider will notify Blue Cross NC in advance of any changes to the schedule.
- Provider agrees to make every reasonable effort to ensure access of members to covered services including, but not limited to, diversion of staff and resources.
- Provider agrees to guarantee the provision of appropriate vaccine, staffing, supplies and resources to provide vaccines by injection during scheduled site hours.
- Should vaccines become unavailable because of restrictions imposed by the federal, state or local government, as determined by the provider and Blue Cross NC, provider will not be required to provide immunizations pursuant to this agreement. Provider will have no liability to Blue Cross NC should the unavailability of vaccines prevent provider from performing under this agreement.

Billing

- Bill only those codes for services listed as billable preventive services/mass immunization services.
- Submit claims electronically on a CMS-1500 or successor claim form.
- Bill your reasonable charges.
- For each member who presents a valid and current member ID card to a provider at the time of service, the provider will bill Blue Cross NC for payment for such members' covered preventive services and will not bill or accept payment from such member or from any third party.

Supplies and services not separately billable

The following services are considered routine supplies and services for which payment is included in the reimbursement for pharmacist preventive services. These items are not separately billable:

- Educational materials.
- Supplies required for administering an injection, including but not limited to: Syringes, alcohol swabs, bandages, gauze and waste disposal equipment.

Billable Preventive Services/Mass Immunization Service Codes
The following services are to be billed using the applicable Service Code

Description	Service Code
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, for intradermal use	90630
Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	90653
Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	90654
Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, 0.25 ml dosage, for intramuscular use	90655
Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, 0.5 ml dosage, for intramuscular use	90656
Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 ml dosage, for intramuscular use	90657
Influenza virus vaccine, split virus	90658
Influenza virus vaccine, live, for intranasal use	90660
Influenza virus vaccine, trivalent (CCIIV3), derived from cell cultures, subunit, preservative- and antibiotic-free, 0.5 ml dosage, for intramuscular use	90661
Influenza virus vaccine (IIV), split virus, preservative-free, enhanced immunogenicity via increased antigen content, for intramuscular use	90662
Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	90670
Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	90672
Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative- and antibiotic-free, for intramuscular use	90673
Influenza virus vaccine, quadrivalent (CCIIV4), derived from cell cultures, subunit, preservative- and antibiotic-free, 0.5 ml dosage, for intramuscular use	90674
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.25 ml dosage, for intramuscular use	90685
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, 0.5 ml dosage, for intramuscular use	90686
Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 ml dosage, for intramuscular use	90687
Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 ml dosage, for intramuscular use	90688

continued on following page

Billable Preventive Services/Mass Immunization Service Codes
The following services are to be billed using the applicable Service Code

Description	Service Code
Pneumococcal polysaccharide vaccine, 23-valent	90732
Zoster vaccine, live	90736
Influenza vaccine, recombinant hemagglutinin antigens, for intramuscular use (flublok)	Q2033
Influenza virus vaccine, split virus, for intramuscular use (agriflu)	Q2034
Influenza virus vaccine, split virus	Q2035
Influenza virus vaccine, split virus	Q2036
Influenza virus vaccine, split virus	Q2037
Influenza virus vaccine, split virus	Q2038
Influenza virus vaccine, split virus	Q2039

9.50
Home health reimbursement

9.50.1
Eligible services

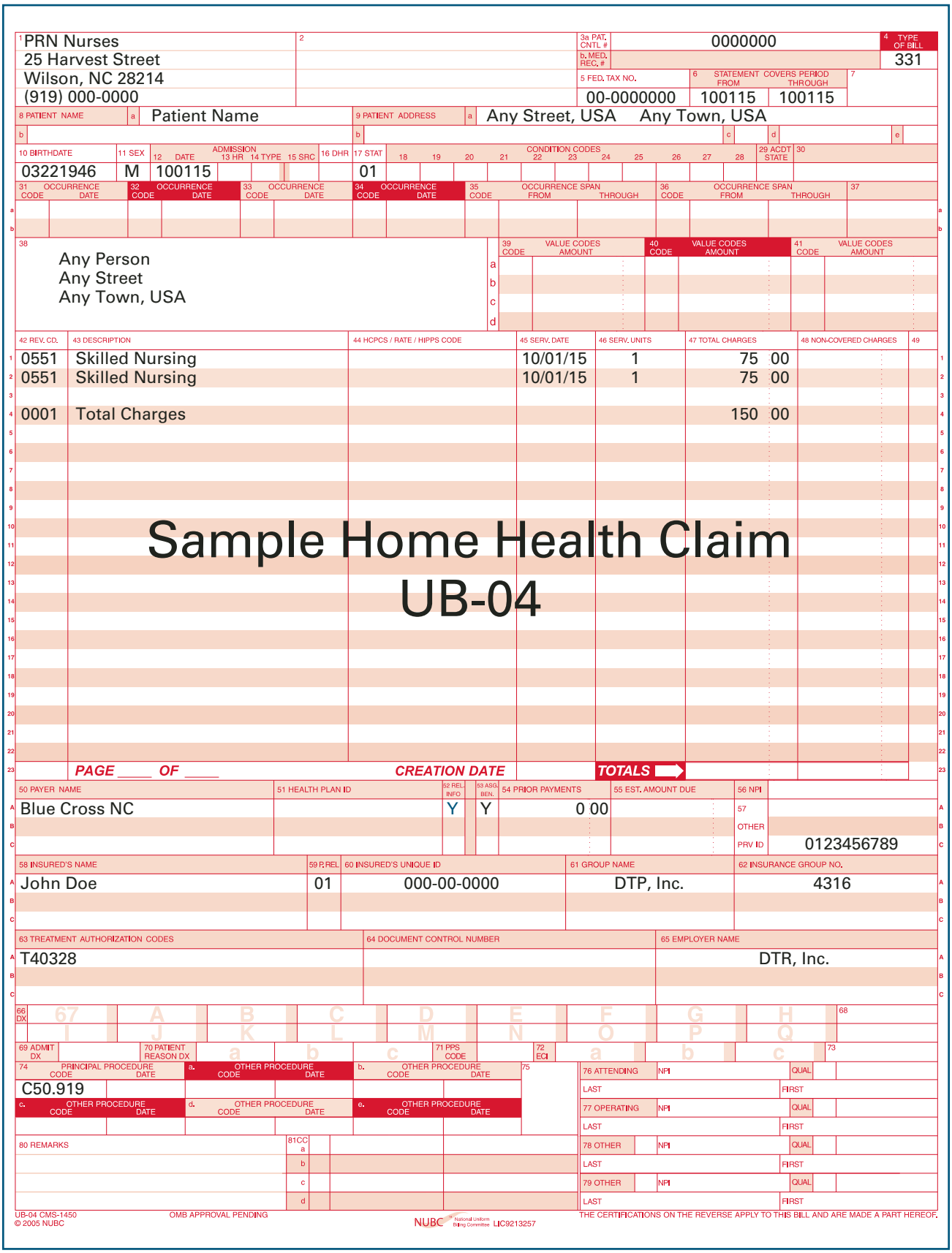
- Patients must be homebound to be eligible for coverage. A patient is considered homebound by Blue Cross NC if the patient:
  1. Has a condition or injury restricting his or her ability to leave home.
  2. Has a condition or injury for which leaving the home is medically contraindicated.
  3. Would 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.
- 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 forty-eight (48) hours for a normal vaginal delivery or ninety-six (96) hours for a cesarean section, you may bill a skilled nursing visit if rendered no later than seventy-two (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 FEP members at this time.

9.50.2
Ineligible services

- The following services may not be billed under home health and are not part of your home health contract with Blue Cross NC. 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 Blue Cross NC 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
  - Custodial (nonskilled services)
  - Home aides
- Visit our website at **BlueCrossNC.com** to view our corporate medical policy on home nursing services.



1 PRN Nurses
25 Harvest Street
Wilson, NC 28214
(919) 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 100115 THROUGH 100115

7

8 PATIENT NAME a Patient Name

9 PATIENT ADDRESS a Any Street, USA Any Town, USA

10 BIRTHDATE 03221946

11 SEX M

12 ADMISSION DATE 100115

13 HR 14 TYPE 15 SRC 16 DHR

17 STAT 01

18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28

29 ACDT STATE 30

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

38
Any Person
Any Street
Any Town, USA

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
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
0551	Skilled Nursing		10/01/15	1	75 00		
0551	Skilled Nursing		10/01/15	1	75 00		
0001	Total Charges				150 00		

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME: Blue Cross NC
51 HEALTH PLAN ID:
52 REL. INFO: Y
53 ASG. BEN.: Y
54 PRIOR PAYMENTS: 0 00
55 EST. AMOUNT DUE:
56 NPI:
57 OTHER PRV ID: 0123456789

58 INSURED'S NAME: John Doe
59 P. REL: 01
60 INSURED'S UNIQUE ID: 000-00-0000
61 GROUP NAME: DTP, Inc.
62 INSURANCE GROUP NO.: 4316

63 TREATMENT AUTHORIZATION CODES: T40328
64 DOCUMENT CONTROL NUMBER:
65 EMPLOYER NAME: DTR, Inc.

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: C50.919
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 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
© 2005 NUBC
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample Home Health Claim
UB-04

9.51
Private duty nursing (PDN)

All PDN services require prior review from Blue Cross NC in advance of services being provided. Please refer to **Chapter 7** in this e-Manual to learn more about prior review for Blue Cross NC members and see our most current prior review listing, available on the Blue Cross NC website at **BlueCrossNC.com/Providers/Prior-Authorization**.

9.51.1
Definition

PDN is defined as follows:

- Patient requires four (4) or more hours of continuous skilled nursing care per day in the home that cannot otherwise be met by the home health nursing service benefit.
- Patient must be homebound.
- Services must be rendered by an RN or an LPN.

9.51.2
Billing codes and unit definitions

Revenue Codes	Services	Units
0552	RN per hour (PDN)	Hour
0559	LPN per hour (PDN)	Hour

9.51.3
PDN billing

Bill on a UB-04 or successor claim form consistent with CMS implementation date.

- File claims after complete services have been provided.
- Bill your reasonable charges.
- All medical supplies provided in conjunction with PDN services are considered an integral part of the PDN reimbursement and cannot be billed separately (under HDME NPI or any other NPI).
- Skilled nursing visits may not be billed on the same days as private duty nursing visits.

9.52

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.
- Bill with appropriate revenue code and CPT and any approved HCPCS code on claim form.

The following services are not part of your skilled nursing facility contract with Blue Cross NC and must be billed by a provider contracted with Blue Cross NC to provide:

- Medical care rendered by a physician.
- Services rendered in a place or setting other than the skilled nursing facility while the member is an inpatient.
- Specialty pharmacy drugs must be filed by a contracted specialty pharmacy provider.

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.

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 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 four (4) or more hours of continuous skilled nursing care per day.
- All PDN services require certification for all Blue Cross NC plans.
- PDN services must be performed by individuals licensed in North Carolina as an RN or 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 Blue Cross NC lines of business.

Sample Private Duty Nursing Claim UB-04

Field	Value
1	Nursing Station 2053 Olive Boulevard Nashville, NC 27210
2	
3a PAT. CNTL #	
b. MED. REC. #	
4 TYPE OF BILL	331
5 FED. TAX NO.	00-0000000
6 STATEMENT COVERS PERIOD FROM	100115
6 STATEMENT COVERS PERIOD THROUGH	100115
7	
8 PATIENT NAME a	Patient Name
9 PATIENT ADDRESS a	Any Street, USA Any Town, USA
10 BIRTHDATE	09011925
11 SEX	M
ADMISSION 12 DATE	100115
13 HR	
14 TYPE	
15 SRC	
16 DHR	
17 STAT	01
CONDITION CODES 18–28	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	Any Person Any Street Any Town, USA
39–41 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	0552	Skilled Nursing		10/01/15	5	150 00		
2	0552	Skilled Nursing		10/01/15	4	150 00		
3								
4	0001	Total Charges				270 00		
5–22								
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
A	Blue Cross NC		Y	Y	0 00	
B	AETNA	123446	Y	Y	00 00	
C						

56 NPI: 012456789

57 OTHER PRV ID:

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Insured Name One	02	XXXW12345678	Ford Equipment	325
B	Insured Name Two	02	XXXW12345678		x431
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	76431		Ford Equipment
B			
C			

66 DX / 67 / 68: (blank)

69 ADMIT DX / 70 PATIENT REASON DX / 71 PPS CODE / 72 ECI / 73: (blank)

74 PRINCIPAL PROCEDURE CODE: L89.90

75 / 76 ATTENDING NPI / QUAL / LAST / FIRST; 77 OPERATING; 78 OTHER; 79 OTHER: (blank)

80 REMARKS: A5

81CC a–d: (blank)

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.

9.53
Private duty nursing/skilled nursing services

9.53.1
Eligible services

- Patients must be homebound to be eligible for coverage. A patient is homebound if the patient:
  - Has a condition or injury restricting his or her ability to leave home.
  - Has a condition or injury for which leaving the home is medically contraindicated.
  - Would require the physical assistance and significant supervision of another person in order to leave the home.
  - Transportation issues do not determine if a member is homebound.
- PDN patients must require four (4) or more hours of continuous skilled nursing care per day.
- All PDN services require certification for all Blue Cross NC plans.

9.53.2
Eligible health care providers

- PDN services must be performed by individuals licensed in North Carolina as an RN or an 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 Blue Cross NC lines of business.

9.54
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:
  - 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
  - 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 your current Blue Cross NC provider agreement for ambulance services.
- Submit claims to Blue Cross NC within one hundred and eighty (180) days of the date of service.
- Bill electronically on CMS-1500 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 (1) 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.
- Air or ground transportation provided for patient convenience.
- The non-emergency medical transport of a registered hospital inpatient to another location to obtain medically necessary specialized diagnostic or treatment services.

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.

Sample CMS-1500 Claim Form
Ambulance and Medical Transport

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

PATIENT AND INSURED INFORMATION

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
YPPW12345678	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	**4. INSURED'S NAME** (Last Name, First Name, Middle Initial)
Last Name, First Name	Last Name, First Name
3. PATIENT'S BIRTH DATE MM DD YY / SEX	
02 08 1919 M [ ] F [X]	
5. PATIENT'S ADDRESS (No., Street)	**7. INSURED'S ADDRESS** (No., Street)
550 Nobel Avenue	550 Nobel Avenue
6. PATIENT RELATIONSHIP TO INSURED	
Self [X] Spouse [ ] Child [ ] Other [ ]	
CITY / STATE	CITY / STATE
Charlotte / NC	Charlotte / NC
8. RESERVED FOR NUCC USE	
ZIP CODE / TELEPHONE (Include Area Code)	ZIP CODE / TELEPHONE (Include Area Code)
28220 / (704) 555-9099	28220 / (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 [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 02 08 1919 M [ ] F [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): First Bank
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield - NC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

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: 10/01/2015

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
10 01 2015	10 01 2015	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1B C4612 / 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
Lackey, James M.D.		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES	
PT Xport to Dialysis, Stretcher D/T PT HX: ESRD, Bilateral AKA, CHF		

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. N18.6 End Stage Renal Disease (ESRD)
B.
C. 150.1 Left Ventricular Failure
D.
E.
F. Complete Traumatic Amputation of Left Lower Leg
G.
H.
I. S88.912A
J.
K.
L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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 15 / 10 01 15	41	9	BLS NonEmerg Transport - BER A0428 RJ	1.2.3	175 00	1		NPI	0123456789
2 10 01 15 / 10 01 15	41	9	BLS Mileage - BERT A0428 RJ	1.2.3	153 00	17		NPI	
3 10 01 15 / 10 01 15	41	9	BLS Disp Supplies - BERT A0428 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. Rsvd for NUCC Use 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Signature of Claim Preparer SIGNED DATE	From: 111 Blue Road, Blue Town, NC 12345 To: 4 Blue Street, Blue City, NC 12356 a. 0123456789 b.	Ambulance Services, Inc. 123 Main Street Anytown, USA a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

9.55
Specialty pharmacy billing and reimbursement

Definition

The dispensing of physician prescribed, member specific pharmaceuticals intended to improve clinical outcomes. Specialty pharmacy includes utilization of information systems to perform safety checks, drug interaction screening and generic substitution (when appropriate).

Billing

- Bill on typed CMS-1500 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.
- Referring provider (name and NPI) is required for specialty pharmacy claims.
- File claims after complete services have been provided.
- Bill retail charges.

Participating specialty pharmacy providers

- **BlueCrossNC.com/Providers/pharmacy-program/specialty-pharmacy-network#search=network%20specialty%20Specialty%20network**

Specialty pharmacy drug list

- **BlueCrossNC.com/sites/default/files/document/attachment/services/public/pdfs/formulary/specialty-network/specialty-drug-list.pdf**

9.56

Home infusion therapy billing and reimbursement

Home infusion therapy services for HMO/PPO

Home infusion therapy is infusion services the member receives in the home. Home infusion is on the prior review list. Therefore, certain home infusion therapy services require prior review prior to services being rendered. When requesting authorization, the request needs to be specific and cover the following elements.

Definition

Home infusion therapy is:

- The administration of prescription drugs and solutions in the home via one (1) of the following routes: Intravenous, intraspinal, epidural or subcutaneous.
- Home infusion therapy must be supervised by an RN or an LPN.
- Only medications referenced in this exhibit are eligible for reimbursement under the home infusion therapy schedule and require administration by a health care provider such as a registered nurse or licensed practical nurse. Other drugs administered in the home by a provider during a home infusion therapy episode, but not related to the home infusion therapy, must be billed through the member's pharmacy benefit and may not be billed by the provider through this agreement.

General billing guidelines

Provider agrees:

- To bill Blue Cross NC for home infusion therapy services as defined in their reimbursement schedule, subject to the terms of the agreement and subject to all applicable Blue Cross NC programs, policies and procedures as set forth in Section 9.52 of the agreement, including but not limited to those policies and rules set forth in the provider e-Manual and Blue Cross NC billing, claims submission, reimbursement and medical policies.
- To bill Blue Cross NC provider's typical retainer charges for infusion services, nursing services and prescription drugs.
- Home infusion therapy related services such as durable medical equipment, medical supplies, solutions and diluents, flushes, administrative services, professional pharmacy services, care coordination and patient education are covered under a bundled per diem. This per diem rate includes all services not included in the pharmaceutical or nursing service component.
- Subject to Blue Cross NC policies and procedures, including but not limited to Blue Cross NC billing, claims processing and reimbursement policies, provider agrees to bill home infusion therapy requiring regular nursing services in three (3) components:
  - 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.
  - Nursing services provided by RN or LPN.
  - **Drug component:** Provider agrees to only bill for the quantity of drug actually administered, not unused mixed, compounded or opened quantities. Provider agrees to bill only for those drugs referenced in the fee schedule. Drugs not referenced in the fee schedule are not related to the home infusion therapy and must be billed through the member's pharmacy benefit by the pharmacy and may not be billed through the home infusion benefit.
- ***Per diem*** is the per day allowance for certain HCPCS codes. Per diems are recognized by the number of hours the member receives the infusion and not by the calendar day. Continuous infusions for a period longer than twenty-four (24) hours but less than forty-eight (48) hours are equal to one (1) per diem. If the continuous infusion is equal to or greater than forty-eight (48) hours, it is equal to two (2) per diems.
- Bill on the CMS-1500 claim form.
- Use your appropriate NPI.
- File claims after services have been provided.
- Home infusion therapy per diems and nursing visits are defined by the standard codes in this schedule.
- Home infusion therapy per diems and nursing visits must be documented in the home infusion clinical record, including the start date and end date of each visit in the member's home.
- 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.
- Medicare supplemental products (Medicare Crossover) – Use only billing codes as instructed by Medicare. Do not use Blue Cross NC home infusion codes for Medicare supplemental members.

The following services may not be billed under home infusion and are not part of provider's home infusion contract with Blue Cross NC

- Services and supplies that may not be billed under home infusion and are not part of provider's home infusion contract with Blue Cross NC are set out in the provider e-Manual and Blue Cross NC policies and procedures, and of which may be enacted and revised from time to time, including but not limited to Blue Cross NC billing, claims submission, reimbursement and medical policies. Such services include, but are not limited to:
  - 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, as determined by Blue Cross NC, to the home infusion (billed by HDME provider)
  - Drugs not referenced in the fee schedule (billed by pharmacy)
  - Drugs not related, as determined by Blue Cross NC, to the home infusion therapy (billed by pharmacy)
  - Any other service, drugs or equipment identified in the provider e-Manual or Blue Cross NC policies and procedures

9.56.1
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.

Sample CMS-1500 Claim Form

Home Infusion Therapy

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) / (Medicaid#) / (ID#/DoD#) / (Member ID#) / (ID#) / (ID#) / (ID#)	XXXW12345678
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Last Name, First Name	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) Last Name, First Name
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: City / STATE: NC	8. RESERVED FOR NUCC USE CITY: City / STATE: NC
ZIP CODE: 00000 / TELEPHONE (Include Area Code): (000) 000-0000	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. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) b. OTHER CLAIM ID (Designated by NUCC) Jerome Group
c. RESERVED FOR NUCC USE	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. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.
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: 10/01/2015	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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 01 2015 QUAL. 15. OTHER DATE QUAL. MM DD YY: 10 01 2015	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. 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NDC# 00074653301	20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. J18.9 B. C. D. E. F. G. H. I. J. K. L.	22. 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 15	10 01 15	12	9	J3370		1	AWP*	5		NPI	0123456789
2 10 01 15	10 01 15	12	9	S9497		1	43 00	5		NPI	
3 10 01 15	10 01 15	12	9	99601		1	61 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)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
56-7774321 [ ] [X]	654320198-1	[X] YES [ ] NO	$	$ 0 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Signature of Claim Preparer SIGNED DATE	PRN Services 4444 Olive Road Any Town, USA a. 0123456789 b.	PRN Services 4444 Olive Road Any Town, USA a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

9.57
Durable medical equipment billing and reimbursement

Definitions

- 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, is primarily and customarily used to serve a medical purpose and is appropriate for use in the home. Members may receive equipment through home delivery or mail-order.
- **Capped rentals:** Durable medical equipment that a member uses continuously over a relatively short period of time, where rental is more appropriate than purchase, as determined by Blue Cross NC. Therefore, capped rental items are reimbursed by Blue Cross NC as rentals rather than as purchases. Capped rental payment includes all related costs for the effective use of the equipment by the member including equipment, accessories, supplies, delivery, shipping and handling, labor, setup visits, patient education, maintenance, repairs and replacement parts of the DME item in question.
- 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 to 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: The HDME supplier must meet eligibility and/or credentialing requirements as defined by Blue Cross NC, in order to be eligible for reimbursement. HDME, when eligible for coverage, is considered as part of the member's HDME benefits provision.

Durable medical equipment billing requirements – general

- DME requires a prescription to rent or purchase, as applicable, before it is eligible for coverage.
- Bill claims with place of service 12.
- Certain items must be rented and may not be purchased (see "Capped rentals"). Certain other items must be rented prior to being converted to a purchase in accordance with Blue Cross NC medical policy.
- Bill electronically CMS-1500 claim form using the appropriate HCPCS code and billing unit.
- Bill maintenance and repair modifier codes first after the procedure code.
- Submit all claims for repairs with a complete description of services.
- Orthotic and prosthetic appliances, when billed bilaterally, require the use of the RT/LT modifier. Claim submissions with Modifier 50 will deny.
- Use E1399 or other miscellaneous HCPCS codes only if no suitable HCPCS billing code exists. Each claim with miscellaneous codes or custom items (i.e., foot orthotics, specialty wheelchairs) 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 (see **Chapter 21** for appropriate form).

- 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.
- Additional documentation cannot be transmitted with electronically submitted claims.

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. Items filed without the "**RR**" modifier and without the rental dates will be considered as purchases and will be reimbursed accordingly.
- Only bill for services already provided to a member.
- Bill each thirty (30) days of rental as one (1) unit.
- Indicate beginning and ending dates of a rental period.
- If an item is still being rented at the time of the claim, the claim must include the beginning date of the rental, and indicate the last day of the billing cycle as the ending date of service.
- 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) as provided by the prescribing physician.
  - 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.

- DME requires a prescription to rent or purchase, as applicable, before it is eligible for coverage.
- Coverage will begin on the day the device is delivered, set up and ready for use by the member at the location needed.
- Reimbursement for new or revised HCPCS codes will be reviewed and adjusted as pursuant to Blue Cross NC 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 Blue Cross NC and **Chapter 9** of this e-Manual for the pricing policy for procedure/service codes).
- The base reimbursement is inclusive of, and no additional reimbursement is payable for, fittings, shipping and handling, labor and subsequent adjustments to item.
- **Manufacturer's warranty:** Repairs and replacements should be addressed and paid through the manufacturer's warranty before submitting claims to Blue Cross NC. Provider is responsible for billing Blue Cross NC only after the manufacturer's warranty expires.
- DME may be purchased or rented at the discretion of Blue Cross NC.
- Additional detail can be found in Blue Cross NC's online Corporate Medical Policy for durable medical equipment at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes**.

Reimbursement – rentals

- Blue Cross NC will reimburse rentals up to the allowed amount for purchase.
- Rental rates are all-inclusive. Rental rates include all equipment, accessories, supplies, delivery, shipping and handling, labor, set-up, visits, education, maintenance, repairs and replacement part of DME.
- Rental rates are monthly. Ongoing rental claims will only be processed at the end of each month of service.
- DME rental rates and maintenance fees should be calculated for payment on a pro-rated basis, based on provider contracted rates, when a full thirty (30) days is not utilized by the member.
- When DME is rented, the benefits cannot exceed the total of the cost to purchase the DME or the contracted fee schedule.
- Reimbursement for capped rentals may be made up to, but not exceeding, the following time frames:
  - Pulse oximeters.....fifteen (15) months
  - Apnea monitors .....fifteen (15) months
  - Hospital beds.....fifteen (15) months
  - Mattress overlays .....fifteen (15) months
  - Oxygen devices .....thirty-six (36) months

Reimbursement – repairs and maintenance

Certain items are eligible for maintenance fees after the items are 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.
- Except for capped rentals, the conversion of a rental to a purchase may be selected by the member at any time prior to reaching the allowed amount for purchase of the item. If an item is converted from rental to purchase prior to the rental reaching its allowed amount, it is considered the property of the member and is not returned to the provider.
- Once the rental has reached the allowed amount for purchase, covered supplies and maintenance will be reimbursed according to the provider's contract.
- Equipment that is purchased without prior rental will be owned by the patient.

9.57.1
Maintenance, repairs and replacement of purchased DME

Maintenance, repair or replacement and supplies are **eligible for separate reimbursement under a contracted maintenance fee** with a DME supplier acceptable by the Plan.

- If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount in excess. The repair charge may include the use of "loaner" equipment when necessary.
- Replacement of a purchased item may occur when the item is irreparably damaged, or if replacement is required during repair and/or maintenance of a specific item. The cost will be negotiated on a rental versus purchase agreement. Replacement may be based on the maintenance contract as stated above.
- Replacement or repair of an item that has been misused or abused by the member or member's caregiver will be the responsibility of the member.

9.57.2
Maintenance, repairs and replacement of rental DME

- DME rental fees will cover the cost of maintenance, repairs, replacements, adjustments, supplies and accessories. Rental fees also include equipment delivery services and set-up, education and training for patient and family and nursing visits. These services are not eligible for separate reimbursement.
- Coverage will begin on the day the device is delivered to the member.
- Replacement of the rental equipment may occur when the rented item is irreparably damaged, or if replacement is required during repair and/or maintenance of a specific item.
- Replacement or repair of an item that has been misused or abused by the member or member's caregiver will be the responsibility of the member.

9.57.3
Coverage for DME add-ons or upgrades

Standard DME is one that will adequately meet the medical needs of the patient and is not designed or customized for a specific individual's use. Non-standard DME is any item that has certain convenience or luxury features. Electrical or mechanical features that enhance standard or basic equipment usually serve a convenience function. Providers should verify the specific coverage information regarding non-standard DME, add-ons or upgrades.

9.57.4
DME may be subject to medical necessity review

- DME requires a prescription to rent or purchase before it is eligible for coverage.
- Payment of eligible fees will begin on the day the device is delivered, set up and ready for use by our member at the location needed.
- DME rental rates and maintenance fees should be calculated for payment on a pro-rated basis, based on provider contracted rates, when a full thirty (30) days are not utilized by the member.

9.57.5
Rental versus purchase

DME rental versus purchase coverage is based on the item prescribed, the patient's prognosis, the time frame required for use and the total cost (rental vs. purchase) for the equipment.

When DME is purchased, the total benefits available cannot exceed the contracted fee schedule.

9.57.6
Guidelines for purchasing DME

DME may be purchased in any of the following situations:

- The equipment is classified as ***"Inexpensive DME,"*** which is defined as equipment with an allowed amount that does not exceed $200. Examples include, but are not limited to: Canes, walkers, crutches, arm slings, patient transfer belts, cervical collars, comfort rings, dextrometers, peak flow meters and commode chairs.
- The equipment is classified as ***"Other Routinely Purchased DME,"*** which is defined as equipment acquired by purchase at least 75% of the time. Equipment in this category may be rented or purchased, but the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount. Examples include, but are not limited to: Low pressure and positioning equalization pads, home blood-glucose monitors, braces for legs, arms, cast boots, cervical braces and Jobst stockings.

- More expensive DME not classified as ***"Routinely Purchased DME"*** (costing more than $200) may be purchased when all of the following criteria are met:
  a. Item is not a capped rental (see ***"Capped rental"*** in definition section) or indefinite rental.
  b. Long-term use is expected based on the patient's prognosis (rental is anticipated to exceed allowed amount of purchase) and maintenance of DME.
  c. A rental trial period (applied toward purchase price) has documented patient compliance, patient tolerance and clinical benefits.
- When DME is purchased, the total benefits available cannot exceed the contracted fee schedule.
- Blue Cross NC provides benefits for breast pumps for eligible, lactating mothers under a member's DME benefits. In order for members to receive 100% coverage for a breast pump, please ensure the following:
  a. Claims for breast pumps (E0602 for manual and E0603 for electric) must indicate Z39.1 as the primary diagnosis code.
  b. Breast pumps must be purchased from in-network DME providers. The member can use *Find a Doctor* online at **BlueCrossNC.com** to find another in-network DME provider.
  c. Members will not be reimbursed if they purchase a breast pump at a retail location.
  d. Standard member benefits do not provide coverage for hospital-grade breast pumps (E0604).
  e. Replacement breast pump supplies (A4281-A4286) are not separately reimbursable on the same date of service as the breast pump (E0602-E0603), as they are included in the initial purchase of the pump.
  f. Ongoing supplies, such as nursing bras or creams, are not covered.
  g. Standard member benefits provide coverage for only one (1) manual (E0602) or electric (E0603) breast pump purchase per delivery.
  h. Breast pump supplies (A4281-A4286) are limited to two (2) units per code, per year.

For more information, please see Reimbursement policies at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.57.7
Guidelines for renting DME

DME rental vs. purchase coverage is based on the item prescribed, the patient's prognosis, the time frame required for use and the total cost (rental vs. purchase) for the equipment.

When DME is rented, the benefits cannot exceed the total of the cost to purchase the DME or the contracted fee schedule.

Items that are considered to be a capped rental will be rented up to the allowed amount for purchase.

DME may be rented when:

- DME is not classified as ***"Routinely Purchased DME"*** (costing more than $200) or ***"Inexpensive DME"*** and anticipated medical need is for a limited time frame; or equipment requires high maintenance (i.e., specialized skills to service the item). Examples include but are not limited to the following: Apnea monitors, hospital beds, bili lights and bili blankets, CPM, traction, infusion pumps, intermittent positive pressure breathing (IPPB), nebulizers, CPAP, BiPAP, Diastolic Pulmonary Artery Blood Pressure (DPAP), lymphedema pumps, oxygen equipment (portable and stationary), ventilators and transcutaneous electrical nerve stimulation (TENS) units.
- DME rental fees will cover the cost of maintenance, repairs, replacements, supplies and accessories. Equipment delivery services and set-up, education and training for patient and family, and nursing visits are not eligible for separate reimbursement.
- Rental equipment which has reached a maximum reimbursement (rental paid up to purchase price) will continue to be owned by the DME provider with the understanding that the equipment will remain in the patient's custody until medical necessity is no longer met. The DME provider can no longer charge rental fees, but may charge separately for maintenance if such a contract has been signed. Once the member no longer needs the equipment, the DME provider will collect the equipment.
- Equipment that is purchased without prior rental will be owned by the patient.
- DME rental rates and maintenance fees should be calculated for payment on a pro-rated basis, based on provider contracted rates, when a full thirty (30) days are not utilized by the member.

Sample CMS-1500 Claim Form

HDME Rental

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#) [X]	FECA BLK LUNG (ID#)	OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): YPAW12345678

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Last Name, First Name	10 28 1963 M [X] F [ ]	Last Name, First Name
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
Any Street	Self [X] Spouse [ ] Child [ ] Other [ ]	Any Street
CITY: Any City / STATE: NC	8. RESERVED FOR NUCC USE	CITY: Any City / STATE: NC
ZIP CODE: 00000 / TELEPHONE (Include Area Code): (000) 000-0000		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 / SEX: 10 28 1963 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): HAAS Industries
c. RESERVED FOR NUCC USE	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. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

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: 10/01/2015

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
10 01 2015 QUAL.	QUAL. 10 01 2015	
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
Lackey, James M.D.	1234567890	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
NDC# 1098576822		

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. J44.9 B. C. D.
E. F. G. H.
I. J. K. L.

22. 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 15 10 01 15	12	L	E0601	RR	1	105 00		1	NPI	0123456789
2									NPI	
3 *Certificate of Medical Necessity Attached									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)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
56-1234567 [ ] [X]	123456789	[X] YES [ ] NO	$ 105 00	$ 0 00	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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Signature of Claim Preparer SIGNED DATE	Home Medical Supplier, Inc. 2945 Fern Drive Any Town, USA a. 0123456789 b.	Home Medical Supplier, Inc. 2945 Fern Drive Any Town, USA a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ANCILLARY PROVIDERS

Sample CMS-1500 Claim Form

HDME Purchase

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	X GROUP HEALTH PLAN (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	XXXW12345678
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Last Name, First Name
3. PATIENT'S BIRTH DATE / SEX	10 28 1963 M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Last Name, First Name
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 / STATE	Any City / NC
8. RESERVED FOR NUCC USE	
CITY / STATE	Any City / NC
ZIP CODE / TELEPHONE (Include Area Code)	00000 / (000) 000-0000
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Last Name, First Name
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	T0321
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES X NO
a. INSURED'S DATE OF BIRTH / SEX	05 20 1953 M X F
b. RESERVED FOR NUCC USE	
b. AUTO ACCIDENT? PLACE (State)	YES X NO
b. OTHER CLAIM ID (Designated by NUCC)	First Bank
c. RESERVED FOR NUCC USE	
c. OTHER ACCIDENT?	YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	Blue Cross Blue Shield - NC
d. INSURANCE PLAN NAME OR PROGRAM NAME	Unity Health Plan
10d. CLAIM CODES (Designated by NUCC)	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	X YES NO *If yes*, complete items 9, 9a, and 9d.

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 10/01/2015

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 ILLNESS, INJURY, or PREGNANCY (LMP)	10 01 2015 QUAL.
15. OTHER DATE	QUAL. 10 01 2015
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. / 17b. NPI	1234567890
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? / $ CHARGES	YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) / ICD Ind.	A. E11.9 Diabetes
22. 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 15		12		E0607 Blood Glucose Monitor			51 00	1		NPI	0123456789
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)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
56-9876543 X	987654321	X YES NO	$ 51 00	$ 0 00	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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Signature of Claim Preparer 10/01/2015 SIGNED DATE	Equipment Depot 62 North Main Street Any Town, USA a. 0123456789 b.	Equipment Depot 62 North Main Street Any Town, USA a. 0123456789 b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ANCILLARY PROVIDERS

9.58

Claim form detail for home infusion and durable medical equipment

The following patient and subscriber information is required on the CMS-1500 claim form:

Field Number	Description
1	Put [X] in group health plan or other box
1a	Subscriber's Blue Cross NC ID 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

continued on following page

- 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.

Field Number	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 ID number
18	Leave blank
19	• Enter 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 certification number: • Prior plan approval is required for all home infusion therapy services for HMO and POS • Specific HDME services require prior plan approval
24A	Leave blank
24B	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

continued on following page

Field Number	Description
24D	Blue Cross NC 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 Blue Cross NC 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
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/unit; 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 DME • 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: [X] Indicate whether this number is SSN or EIN
26	For provider's record keeping purposes
27	Accept assignment: [X] 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

continued on following page

Field Number	Description
32	Name and physical address of provider
33	Provider's name, billing address, telephone number Blue Cross NC home infusion therapy or durable medical equipment provider number

9.59
Hospice billing and claims submission

Definition

- **Hospice care services** – Services for the care of the terminally ill member with a life expectancy of six (6) 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 twenty-four (24) hours a day, seven (7) 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).

9.59.1
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 (6) 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.

9.59.2
Ineligible services

- Medical care rendered by a physician.
- Continuous home care greater than sixteen (16) hours per day.

Please refer to your contract with Blue Cross NC for specific details and instructions.

Visit our website at **BlueCrossNC.com** to view our corporate medical policy on hospice care.

9.60
Hospice reimbursement

9.60.1
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.

9.60.2
Billing

Provider agrees to:

- File claims electronically using the HIPAA 837 format or:
  - Bill on UB-04 claim form.
  - Bill only one (1) 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.
- Providers may bill for each day the member is under hospice care as identified in your contract and reimbursement schedule.

9.60.3
Billing codes and unit definitions

- **Levels of care** – There are four (4) levels of care provided by a licensed hospice program, and each level of care includes all services rendered to the member:

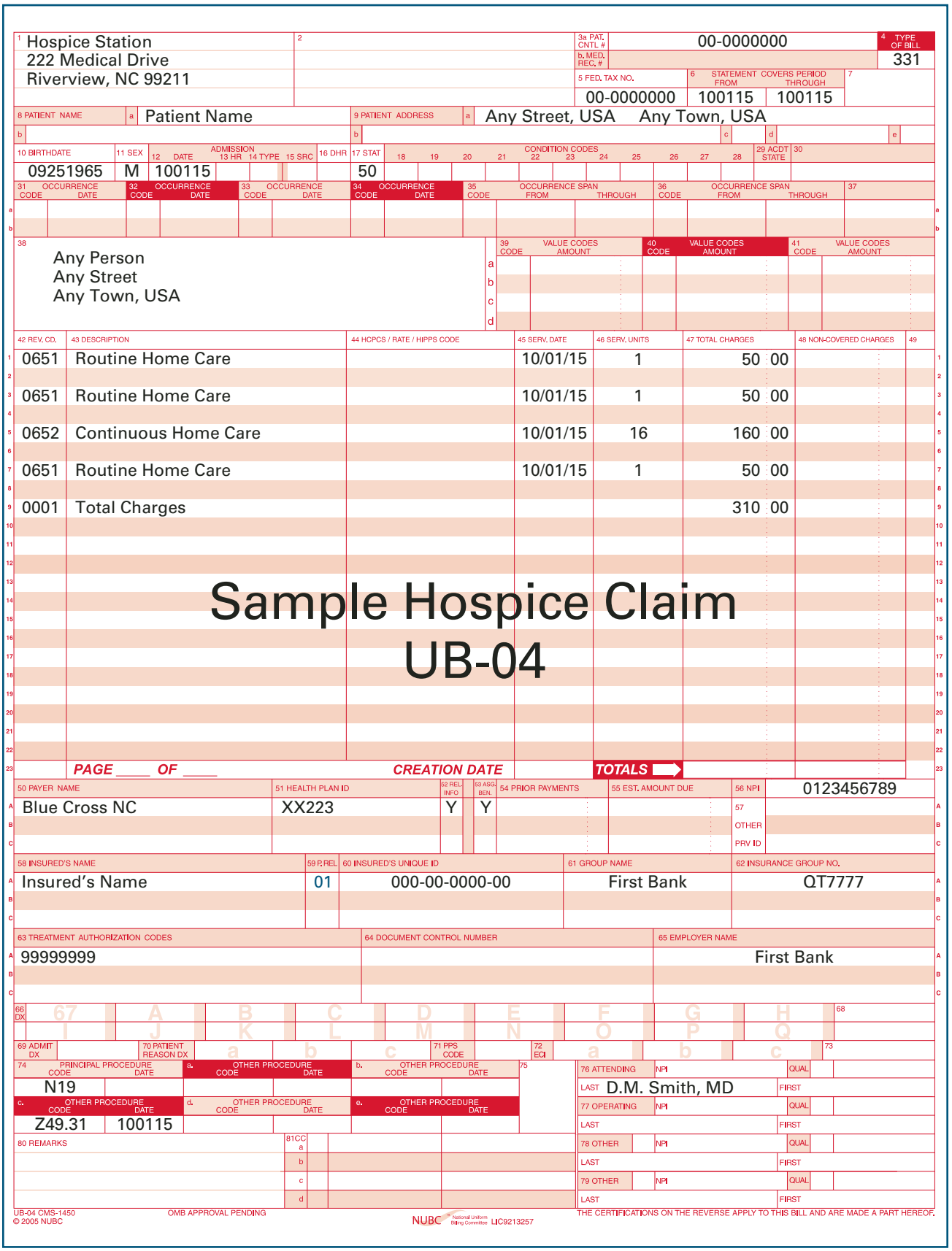
Revenue Codes	Services	Units
0651	Routine home care	Per diem
0652	Continuous home care	Per hour (beginning with the 9th hour)
0655	Inpatient respite care	Per diem
0656	General inpatient care	Per diem

- Routine home care is home care provided by the hospice program when fewer than eight (8) hours of care during a twenty-four (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 (8) hours of care during a twenty-four (24) hour period must be necessary to qualify for this level of care. Continuous home care begins with the ninth (9th) hour of care rendered within a twenty-four (24) hour period and is in addition to the routine home care (per diem) which was rendered during the initial eight (8) hours.
- Inpatient respite care is when the patient is admitted to a hospice unit for no greater than five (5) 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.

9.60.4
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
- Home health aides



1 Hospice Station
222 Medical Drive
Riverview, NC 99211

2

3a PAT. CNTL # 00-0000000
b. MED. REC. #

4 TYPE OF BILL 331

5 FED. TAX NO. 00-0000000

6 STATEMENT COVERS PERIOD FROM 100115 THROUGH 100115

7

8 PATIENT NAME a Patient Name

9 PATIENT ADDRESS a Any Street, USA Any Town, USA

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
09251965	M	100115					50			

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
Any Person
Any Street
Any Town, USA

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	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		10/01/15	1	50 00		1
2								2
3	0651	Routine Home Care		10/01/15	1	50 00		3
4								4
5	0652	Continuous Home Care		10/01/15	16	160 00		5
6								6
7	0651	Routine Home Care		10/01/15	1	50 00		7
8								8
9	0001	Total Charges				310 00		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 Hospice 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	Blue Cross NC	XX223	Y	Y			0123456789	A
B							57 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	Insured's Name	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 | 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
N19			
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	
Z49.31 100115			

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

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.

9.61
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 lithotriptor) • Ancillary services delivered in mobile lithotriptor unit (including kidneys, ureters, bladder (KUB) X-ray, anesthesia supplies and drugs, and medical surgical supplies) • Use of lithotriptor
Billing for Institutional Lithotripsy Services	Services would be billed via the UB-04 claim form using: • ICD-10 diagnosis codes N20.0, N20.1, N20.2, N20.9, N21.8, N21.9 and N22 • CPT-4 procedure code number 50590 • 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.
Billing for Professional Urology Services	All services of the urologist, notwithstanding location, including: • Routine operative and other services delivered on the date of the extracorporeal shock wave lithotripsy (EWSL) 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)
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 lithotriptor unit • Observation room
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.

continued on following page

Specific Services Included	
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
Institutional Lithotripsy Services	Hospital outpatient services, including: • Treatment room services (mobile lithotriptor) • Ancillary services delivered in mobile lithotriptor unit (including KUB, anesthesia supplies and drugs and medical surgical supplies) • Use of lithotriptor
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 standalone initial services, whether or not the retreatment 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 standalone services.

9.62
Dialysis services

Dialysis is the process of removing waste products and excess fluid from the body. Dialysis is necessary when the kidneys are not able to adequately filter the blood. There are two (2) types of dialysis: Hemodialysis and peritoneal dialysis.

9.62.1
Dialysis billing and reimbursement

Blue Cross NC 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.

Dialysis performed in the physician's office is subject to a copay (for members enrolled in copayment plans). Please refer to the most current version of your contract to review contractual obligations and responsibilities and detailed instructions for billing and claims submission.

Please verify member benefits for dialysis services and limits.

9.62.2
Definitions

Dialysis inclusive rate means that each procedure in the dialysis inclusive rate table is inclusive of all items as defined under Medicare's ESRD bundled PPS.

Dialysis inclusive rates include:

a. All routine supplies and services

b. All routine laboratory services

c. All routine pharmacy services as defined: **Non-ESRD Certified Dialysis Treatment** means hemodialysis treatment for acute kidney injuries (AKI).

9.62.3
Dialysis billing guidelines

- Bill on UB-04 or successor claim form consistent with CMS implementation date, using only those revenue codes indicated as **Billable Dialysis Facility Services**, along with corresponding HCPCS codes.
- Contemporaneously with the first claim for dialysis for a given member, provide us an electronic copy of the CMS 2728 to document the date of start of outpatient dialysis. You acknowledge and agree that we will not process claims without the CMS 2728 in our system. Within thirty (30) days of our request, provider will provide the CMS 2728 for a given member, or at the start date of outpatient dialysis for our use in coordination of Medicare benefits.
- You agree to not bill for routine laboratory, pharmaceutical and supplies as indicated under the applicable routine sections below.
- You may bill for non-routine (separately billable) laboratory and pharmacy services as indicated below.
- Claims must be billed by the unit type as follows:
  - **Per treatment** – Bill as a separate line item for each treatment on the claim
  - **Per day** – Bill by episode range, up to thirty-one (31) days, on the claim

9.62.4
Dialysis billing codes and unit definitions

Procedure Description	Revenue Code/HCPCS Code	Unit
Hemodialysis	0821 / 90963 0821 / 90964 0821 / 90965 0821 / 90966 0821 / 90967 0821 / 90999	Per treatment
Hemodialysis training	90989 90993	
Continuous Ambulatory Peritoneal Dialysis (CAPD)	0841 / 90963 0841 / 90964 0841 / 90965 0841 / 90966 0841 / 90967 0841 / 90999	Per day
CAPD training	90989 90993	
Continuous Cycle Peritoneal Dialysis (CCPD)	0851 / 90963 0851 / 90964 0851 / 90965 0851 / 90966 0851 / 90967 0851 / 90999	Per day
CCPD training	90989 90993	

Note: Non-ESRD Certified Dialysis Treatment, when approved, to be reimbursed in that same manner as ESRD.

9.62.5
Dialysis routine supplies and services

The following services are considered routine supplies and services for which payment is included in the dialysis inclusive rate. These items are not separately billable.

HCPCS	Description
A4215	Needle, sterile, any size, each
A4216	Sterile water, saline and/or dextrose, diluent/flush, 10 ml
A4217	Sterile water/saline, 500 ml
A4218	Sterile saline or water, metered dose dispenser, 10 ml
A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or phisohex solution, per pint
A4247	Betadine or iodine swabs/wipes, per box
A4248	Chlorhexidine containing antiseptic, 1 ml
A4450	Tape, non-waterproof, per 18 square inches
A4452	Tape, waterproof, per 18 square inches
A4657	Syringe, with or without needle, each
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope
A4663	Blood pressure cuff only
A4670	Automatic blood pressure monitor
A4927	Gloves, non-sterile, per 100
A4928	Surgical mask, per 20
A4929	Tourniquet for dialysis, each
A4930	Gloves, sterile, per pair
A4931	Oral thermometer, reusable, any type, each

continued on following page

HCPCS	Description
A6215	Foam dressing, wound filler, sterile, per gram
A6250	Skin sealants, protectants, moisturizers, ointments, any type, any size
A6260	Wound cleansers, sterile, any type, any size
A6402	Gauze, non-impregnated, sterile, pad size 16 square inches or less, without adhesive border, each dressing
E0210	Electric heat pad, standard
E1500	Centrifuge, for dialysis
E1510	Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system flowrate meter, power off, heater and temperature control with alarm, IV poles, pressure gauge, concentrate container
E1520	Heparin infusion pump for hemodialysis
E1530	Air bubble detector for hemodialysis, each, replacement
E1540	Pressure alarm for hemodialysis, each, replacement
E1550	Bath conductivity meter for hemodialysis, each
E1560	Blood leak detector for hemodialysis, each, replacement
E1570	Adjustable chair, for ESRD patients
E1575	Transducer protectors/fluid barriers, for hemodialysis, any size, per 10
E1580	Unipuncture control system for hemodialysis
E1590	Hemodialysis machine
E1592	Automatic intermittent peritoneal dialysis system
E1594	Cycler dialysis machine for peritoneal dialysis
E1600	Delivery and/or installation charges for hemodialysis equipment
E1610	Reverse osmosis water purification system, for hemodialysis
E1615	Deionizer water purification system, for hemodialysis

continued on following page

HCPCS	Description
E1620	Blood pump for hemodialysis, replacement
E1625	Water softening system, for hemodialysis
E1630	Reciprocating peritoneal dialysis system
E1632	Wearable artificial kidney, each
E1634	Peritoneal dialysis clamps, each
E1635	Compact (portable) travel hemodialyzer system
E1636	Sorbent cartridges, for hemodialysis, per 10
E1637	Hemostats, each
E1639	Scale, each
E1699	Dialysis equipment, not otherwise specified

9.62.6
Dialysis routine laboratory services

The following laboratory services are considered routine laboratory services for which payment is included in the dialysis inclusive rate. These items are not separately billable. This applies regardless of the frequency with which these services are performed. All laboratory services must be specifically ordered by a physician. Routine laboratory services must be rendered by you or your agent with written agreement not to bill Blue Cross NC and may not be sent out to an external laboratory which would bill us for services. If we are billed separately for such services in breach of this agreement, you shall be responsible to repay all payments for such services. All routine laboratory service codes must be filed with the applicable revenue code and accompanying HCPCS code to be eligible for payment.

HCPCS	Description
82040	Assay of serum albumin
82108	Assay of aluminum
82306	Vitamin D, 25 hydroxy
82310	Assay of calcium
82330	Assay of calcium, ionized
82374	Assay, blood carbon dioxide
82379	Assay of carnitine
82435	Assay of blood chloride
82565	Assay of creatinine
82570	Assay of urine creatinine
82575	Creatinine clearance test
82607	Vitamin B-12
82652	Vitamin D 1, 25-dihydroxy
82668	Assay of erythropoietin
82728	Assay of ferritin
82746	Blood folic acid serum

continued on following page

HCPCS	Description
83540	Assay of iron
83550	Iron binding test
83735	Assay of magnesium
83970	Assay of parathormone
84075	Assay alkaline phosphatase
84100	Assay of phosphorus
84132	Assay of serum potassium
84134	Assay of prealbumin
84155	Assay of protein, serum
84295	Assay of serum sodium
84466	Assay of transferrin
84520	Assay of urea nitrogen
84540	Assay of urine/urea-n
84545	Urea-n clearance test
85014	Hematocrit
85018	Hemoglobin
85025	Complete (CBC), automated (HgB, Hct, RBC, WBC, and Platelet count) and automated differential WBC count
85027	Complete (CBC), automated (HgB, Hct, RBC, WBC, and Platelet count)
85041	Automated RBC count
85044	Manual reticulocyte count
85045	Automated reticulocyte count
85046	Reticyte/HgB concentrate
85048	Automated leukocyte count

continued on following page

HCPCS	Description
86704	Hep B core antibody, total
86705	Hep B core antibody, IGM
86706	Hep B surface antibody
87040	Blood culture for bacteria
87070	Culture, bacteria, other
87071	Culture bacteria aerobic other
87073	Culture bacteria anaerobic
87075	Culture bacteria, except blood
87076	Culture anaerobe identify, each
87077	Culture aerobic identify
87081	Culture screen only
87340	Hepatitis B surface AG, EIA
G0306	CBC/Diff WBC without platelet
G0307	CBC without platelet

9.62.7
Dialysis non-routine laboratory services

All other laboratory services are considered non-routine and are eligible for billing by you. All laboratory services must be specifically ordered by a physician. All non-routine laboratory service codes must be filed with the applicable revenue code and accompanying HCPCS code to be eligible for payment. All non-routine laboratory service codes that are not ESRD-related must be filed with the AY modifier. Reimbursement for non-routine laboratory services will be as follows:

- Subject to Blue Cross NC's then-current standard laboratory services pricing as defined by us.

9.62.8
Dialysis routine pharmacy services

The following pharmacy services are considered routine pharmacy services for which payment is included in the dialysis inclusive rate. These items are not separately billable. This applies regardless of the frequency with which these services are performed. All pharmacy services must be specifically ordered by a physician. Routine pharmacy services must be rendered by you or your agent with written agreement not to bill us and may not be sent out to an external provider which would bill us for services. If we are billed separately for such services in breach of this agreement, you shall be responsible to repay all payments for such services. Any pharmaceutical or pharmaceutical category which is considered a clinical substitute for a pharmaceutical or pharmaceutical category listed below is considered a routine pharmacy service and not separately billable (e.g., new or existing brand drugs, generic drugs or substitute drug therapies). All routine pharmacy service codes that are not ESRD-related must be filed with the AY modifier.

Code	Description
J1642	Injection heparin sodium per 10 units
J1644	Injection heparin sodium per 1000 units
J1945	Lepiridun
J2993	Reteplase injection
J2997	Alteplase recombinant
J3364	Urokinase 5000 IU injection
J3365	Urokinase 250,000 IU injection
J0610	Calcium gluconate injection
J0630	Calcitonin salmon injection
J0635	Calcitriol

continued on following page

Code	Description
J0636	Injection calcitriol per 0.1 MCG
J0882	Darbepoetin
J0895	Deferoxamine mesylate injection
J1270	Injection, doxercalciferol
J1740	Ibandronate sodium
J1756	Iron sucrose injection
J2250	Injection midazolam hydrochloride
J2430	Pamidronate disodium/30 mg
J2501	Paricalcitol
J2916	NA ferric gluconate complex
J3360	Diazepam injection
J3420	Vitamin B12 injection
Q4081	EPO
J0878	Daptomycin
J3370	Vancomycin HCL injection
J1955	Injection levocarnitine per 1 gm

9.62.9
Dialysis non-routine pharmacy services

All other pharmacy services not listed above are considered non-routine and are separately billable for services or drugs prescribed for a member when not related to the ESRD bundle.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
Feel Better Health Care Department at 00000 Atlanta, GA 00000-0000 (000) 000-0000		0000000 b. MED. REC. #	331

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
00-0000000	100115	100115	

8 PATIENT NAME	9 PATIENT ADDRESS
a Patient Name	a Any Street, USA Any Town, USA

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
07111943	M	100115		3			01	71		

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 49	32 10		65100 00		
	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	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 Charges				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

Sample Dialysis Claim
UB-04 for PPO Members

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57
A Blue Cross NC	0059T		Y			0123456789	
B						OTHER PRV ID	
C							

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Insured's Name	01	XXXW12345678		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 76431		First Bank
B		
C		

66 DX	67	A	B	C	D	E	F	G	H	68
	585	Z23	D36.2	H42.9	T82.7xxA	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	

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	81CC		
Services Rendered in State of NC	a		
	b		
	c		
	d		

UB-04 CMS-1450
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NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

9.63

Hearing services

Hearing-related benefits for children and young adults under the age of twenty-two (22) are considered essential health benefits as mandated by the federal ACA.

Coverage

- The ACA-mandated pediatric and young adult hearing benefits provide coverage for one (1) hearing aid and affiliated supplies/services for each hearing-impaired ear every thirty-six (36) months for eligible members under the age of twenty-two (22).
- Hearing-related services, which include evaluation, fitting and adjustments of hearing aids, replacement of hearing aids and related supplies such as ear molds should be filed to Blue Cross NC by the servicing provider when the patient's medical benefits include the ACA-mandated pediatric and young adult hearing care services.
- Even though these services are considered essential benefits per the ACA, Blue Cross NC medical policy guidelines will still apply in determining if specific hearing-related devices are services are eligible for coverage.

Eligibility

- The ACA-mandated pediatric and young adult hearing benefits are available for eligible members under the age of twenty-two (22), if their plan includes the ACA's essential health benefits.
- Essential health benefits are included in Blue Cross NC commercial plans for individuals and small employer groups. Large employer groups (ASO accounts) are not required to cover all essential health benefits, although they may choose to purchase Blue Cross NC plans that include them.
- These benefits do apply to the State Health Plan.
- These benefits do not apply to the Federal Employee Program.
- Check the member's eligibility on **Blue *e*** to determine whether this benefit applies, as well as whether providers/members should submit claims to Blue Cross NC.
- Members who have plans that do not include hearing benefits, or who are ineligible for the benefit due to age, will continue to be responsible for payment of these services.

Billing and reimbursement

- File for the ACA-mandated pediatric and young adult hearing services if the patient is an eligible member and his or her plan includes the ACA's essential health benefits.
- When the fee is based on a percentage of the invoice amount, the invoice amount must be reasonable and the same as what would be charged to the general public.
- Health benefits and reimbursement will apply based on the provider's Blue Cross NC contract.

9.64

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 Z01.411, Z01.419 or Z01.42 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

9.65

New services to hospital's charge

Blue Cross NC 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 Blue Cross NC 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 Blue Cross NC.

As required by the Network Participation Agreement and Hospital Participation Agreement and the North Carolina State Health Plan Network Participation Agreement, modifications to the charge master must be submitted in writing thirty (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:

Pricing Team Business Application Expert
Provider Network
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, NC 27702-2291

If Blue Cross NC does not approve the proposed changes, the facility will be notified within thirty (30) days of our receipt of your letter requesting the new service.

9.66

UB-04 claims filing and billing coverage policies and procedures for Blue Cross NC

For a complete listing of our policies and procedures, refer to our website at **BlueCrossNC.com**.

9.66.1

Anesthesia supplies and services

- May be charged individually as used or included in a charge, based on time, in one (1) minute increments.
- A charge that is based on time must be computed from the induction of anesthesia (time of first drug given in operation room (OR) 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 a medical doctor or a qualified anesthetist under the direction of a medical doctor. The anesthesia care package consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia and post-anesthesia recovery care.

The following components are considered an integral part of the anesthesia service and additional reimbursement is not provided:

- Pre-anesthesia evaluation
- Post-operative visits
- Administration of anesthetic, fluids and/or blood administered by the 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 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, *Bundling Guidelines*.)
- Monitoring of IV sedation by an anesthesiologist for gastrointestinal endoscope, arteriograms, CT scans, MRIs, cardiac catherizations and PTCA is generally considered not medically necessary. Please review the medical policy for anesthesia services and separate evidence-based guideline, *Monitored Anesthesia Care (MAC)* at **BlueCrossNC.com**.

9.66.2
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.

9.66.3
Autopsy and morgue fee

- Autopsy and morgue fees are not covered under Blue Cross NC certificates.

9.66.4
Certified Registered Nurse Anesthetist

- 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).

9.66.5
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 twenty-four (24) hour basis. A nurse-patient ratio of one (1) nurse to two (2) patients per patient day must be maintained.
- A critical care unit is not a post-operative recovery room or a post-anesthesia room.

The charge for critical care unit (i.e., coronary care or intensive care unit) has two (2) components:

- The room charge includes all items listed under acute care.
- The nursing increment/equipment charge includes the use of special equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.) cardiac defibrillators, oxygen, supplies (e.g., electrodes, guidewires, telemetry pouches) and additional nursing personnel.

To ensure appropriate benefit payments, the critical care room charge should equal the corresponding routine room rate (i.e., either the routine semi-private or private rate). An accurate breakdown of these components ensures correct claims processing. Any claims received without a breakdown of these components may be returned for correction.

9.66.6
Diabetes education (inpatient)

- Admissions solely for the purpose of diabetic education are not covered under Blue Cross NC certificates.

9.66.7
Medical nutrition services

- Dietary evaluation and other nutritional assessment services (e.g., Optifast) are not covered under Blue Cross NC certificates.
- If included on the UB-04 claim form, use UB-04 Revenue Code 0940.

9.66.8
Durable medical equipment

- Our current certificates provide benefits for the rental of DME up to, but not exceeding, the total purchase price of the equipment.

9.65.9
EKG

- The charge for EKG services includes the use of a room, qualified technicians and supplies (e.g., electrodes, gel).

9.66.10
Handling/collection fee

- Generally, Blue Cross NC does not cover handling/collection fees as separate line ancillaries.

9.66.11
Hearing aid evaluation

- Blue Cross NC benefit plans include coverage for initial hearing evaluations for eligible individuals under the age of twenty-two (22). See **Section 9.62** of this e-Manual for further details regarding hearing aid coverage.
- If included on the UB-04 claim form, use Revenue Code 0940.

9.66.12
Partial hospitalization and intensive outpatient programs

Definition

Partial hospitalization and intensive outpatient care is outpatient care for psychiatric and/or chemical dependency, which must be furnished by or under the supervision of registered or licensed personnel and under the direction of a North Carolina licensed physician credentialed by Blue Cross NC. The member must require intensive psychiatric and/or chemical dependency services for the care to be considered a covered service for partial hospitalization and intensive outpatient services. The per diem rate(s) includes all facility, professional and other services rendered to the member at the site.

Intensive outpatient service

Intensive outpatient service is a treatment alternative to a hospital admission or partial hospitalization. An intensive outpatient service must provide a multi-modal and multi-disciplinary structured outpatient program. Intensive outpatient services are indicated for members, often in crisis, which require structured, multi-modal treatment (individual, group, family, multi-family as appropriate and psycho-education) to achieve alleviation of symptoms and improved level of functioning. The service will have a variable length of treatment (generally two [2] to three [3] hours per day, three [3] to five [5] times per week) and will have the ability to reduce each member's frequency of attendance as symptoms are alleviated and the member is able to resume more of their usual life obligations.

Partial hospitalization service

Partial hospitalization is a day or evening (non-residential) treatment alternative to a hospital admission. The service may be rendered in either a hospital or free-standing facility setting. Partial hospitalization service is designed to provide clinical diagnostic and treatment services at an inpatient program intensity level. The service is a multi-modal, inter-disciplinary alternative to a hospital admission for certain psychiatric or chemical dependency conditions. Partial hospitalization services include therapeutic milieu, nursing, psychiatric evaluation and medication management, individual, group and family therapy, psychological testing, vocational and rehabilitation recovery counseling, substance use evaluation and counseling and behavioral plans. Members receiving partial hospitalization are generally treated for up to seven (7) hours per day.

Billing guidelines

- Bill on a UB-04 or successor claim form consistent with CMS implementation date, using only those revenue codes indicated in the table below.
- The member must require intensive psychiatric and/or chemical dependency services for the care to be considered as a covered service for partial hospitalization and intensive outpatient services. The specific determination of covered services is made by Blue Cross NC or its designee in accordance with the member's benefit plan.
- Only one (1) unit of partial hospitalization (PHP) on a facility claim, or intensive outpatient hospitalization (IOP) on a facility or professional claim is allowed per date of service as these services are defined as per diem. PHP and IOP services are mutually exclusive (not eligible) on the same date of service.
- PHP and/or IOP is allowed on facility claims as a per diem and includes all facility, professional, ancillary, and other services rendered to the member at the site.

Description	Revenue Code	Unit
Intensive outpatient services – psychiatric	905	Per diem
Intensive outpatient services – chemical dependency	906	Per diem
Partial hospitalization – psychiatric	912	Per diem
Partial hospitalization – substance use disorder	913	Per diem

- Hospitals use Revenue Code 0944 to bill for drug rehabilitation and 0945 for alcohol rehabilitation.

Partial hospitalization and intensive outpatient services include but are not limited to the following components:

- Assessing the total needs of the member.
- Planning and managing of a member treatment plan involving services where specialized health care knowledge must be applied in order to attain the desired result.
- Observing and monitoring the member's response to care and treatment.
- Teaching, restoring and retraining the member.
- Provide services to the member that require specialized education and skills.

The following services are not part of this partial hospitalization and intensive outpatient services and must be billed by a provider contracted with Blue Cross NC:

- Services rendered in a place of service other than the site(s) noted in this agreement.

For more information, please see reimbursement policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**. For more information about Intensive Outpatient Services see the Physician's Office section.

9.66.13
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.

9.66.14
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.

9.66.15
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 Blue Cross NC for an obstetrics room in addition to the labor room when patient is still in the labor room at the time of patient census.

For more information, please see reimbursement policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.66.16
Leave of absence days

- Blue Cross NC 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 (0) charge in Form Locator 47.

9.66.17
Clinic billing

Blue Cross NC will no longer recognize revenue codes listed below when submitted by a contracted provider. Charges to Blue Cross NC for these services will be billable only on the professional CMS-1500 claim form from the physician. Blue Cross NC members should not be billed for denials related to this policy.

Code	Description
0510 - 0519	Clinic
0520 - 0529	Free-standing clinic
078X	Telemedicine
0900	General classification for behavioral health treatment
0902	Behavioral health milieu therapy
0903	Behavioral health play therapy
0904	Behavioral health activity therapy
0914	Behavioral health individual therapy
0915	Behavioral health group therapy
0916	Behavioral health family therapy
0940	General classification for other therapeutic services
0941	Recreational therapy
096X, 097X, 098X	Professional services

9.66.18

Residential mental health and substance use services

Definition

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 to achieve the medically desired result. The member must require continuous (daily) mental health and/or substance use services for the level of care to be considered covered. The per diem rate includes all services rendered to the member.

Billing guidelines

- Bill on a UB-04 or successor claim form consistent with CMS implementation date, using only those revenue codes indicated in the table below.
- The member must require continuous (daily) mental health and/or substance use services for the level of care to be covered.
- Provider should not file claims for services rendered unless a covered level of care has been authorized by Blue Cross NC or its designee.

Description	Revenue Code	Unit
Room and board – semi-private	129	Inpatient per diem
Partial hospitalization – psychiatric	912	Per diem
Partial hospitalization – substance use disorder	913	Per diem
Psychiatric/psychological services	949	Outpatient per diem

- Hospitals use revenue code 0944 to bill for drug rehabilitation and 0945 for alcohol rehabilitation.

Residential mental health and substance use services include but are not limited to the following components:

- Assessing the total needs of the member.
- Planning and managing of a member treatment plan involving services where specialized health care knowledge must be applied in order to attain the desired result.
- Observing and monitoring the member's response to care and treatment.
- Teaching, restoring and retraining the member.
- Providing services requiring specialized educational and skills.

The following services are not part of the residential mental health and substance use services and must be billed by a provider contracted with Blue Cross NC:

- Medical care rendered by a physician.
- Services rendered in a place or setting other than the residential mental health and substance use facility while the member is an inpatient.

9.66.18.1

Mental health/substance use stays

Blue Cross NC members discharged from an inpatient level of care should have and keep a follow-up appointment within seven (7) days of discharge, AND a follow-up appointment within thirty (30) days of discharge as part of after-care compliance and to prevent re-admissions. This visit must be with a mental health provider.

To ensure successful follow-up care after hospitalization:

- Discharge planning is expected to begin on the day of admission and should include the utilization review staff, discharge planner, the member's family, significant others, guardian or others as desired by the member.
- The admitting facility should make sure that members are provided follow-up appointments with a mental health provider within seven (7) days of discharge and within thirty (30) days of discharge from an acute inpatient setting. Remember that these follow-up visits must be with a mental health therapist and/or a psychiatrist.
- The admitting facility should make sure all members have actual verified appointments, as walk-in appointments do not meet this requirement. This includes members who are discharging over the weekend.
- Blue Cross NC can provide you with a list of mental health outpatient network providers.
- An after-care appointment with the member's primary care physician is in addition to the follow-up appointments with a mental health provider for members discharging from an inpatient level of care.
- Solely discharging to a group home, assisted living facility, Alcoholics Anonymous or Narcotics Anonymous is not considered an appropriate discharge plan.
- A member should not be discharged from a facility with instructions to set their own appointment. Engage the member by having them call the mental health provider while still an inpatient at your facility.
- Explain the benefits of after-care visits to the member, so they are aware of the importance of going to all outpatient follow-up appointments (within seven [7] days of discharge date, within thirty [30] days of discharge and beyond as necessary).
- Verify with the member that the after-care plan is a good fit for them (e.g., transportation is not problematic; time of the appointment will work, etc.).
- Involve and educate the member's family/support system to encourage the after-care plan.
- Explain to the member the importance of staying on their medication(s) and notifying you of any side effects.

These tips enable Blue Cross NC to comply with the NCQA requirements, but more importantly they help ensure that members receive the services they need when they need them.

9.66.19
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 9.60**.

9.66.20
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.
- 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.

For more information, please see medical policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.66.21
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.
- Fees for use of emergency room or observation holding area and other ancillary services provided are covered as a part of inpatient ancillaries.
- Occupational therapy services are limited to one (1) hour of treatment on a given day.

9.66.22
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. Blue Cross NC will allow reimbursement of up to fifteen (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.

For details on what is included in the operating room charge, please see reimbursement policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.66.23
Outpatient surgery

- All ancillaries and supplies associated with an outpatient surgical procedure should be billed on one (1) 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 pre-operative testing performed within seventy-two (72) hours of the surgical procedure, including date of surgery, should also be billed on the same claim with the ancillaries and supplies for outpatient surgery.
- Appropriate revenue codes must be placed in Form Locator 42 for each line item. CPT and HCPCS codes are assigned in Form Locator 44. CPT and HCPCS codes must be included in Form Locator 44 to describe specific procedures when and if appropriate codes are available. If multiple CPT or HCPCS codes are necessary to reflect multiple, distinct or independent services matching a single revenue code, claims should be coded to repeat that revenue code as necessary.

For more information, please see reimbursement policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.66.24
Behavioral health treatment – partial hospitalization

Partial hospitalization can be appropriate as a comprehensive, short-term, intensive, clinical treatment program when the level of treatment needed is a step below residential care but more concentrated than traditional outpatient care. Patients are generally referred to partial programs when they are experiencing acute psychiatric symptoms which are difficult to manage but that do not require twenty-four (24) hour care. Blue Cross NC provides coverage for psychiatric partial hospitalization. Since partial hospitalization is a treatment program, Blue Cross NC 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 three to five (3–5) hours, and a full day as being six (6) or more.

Therapies included in the program charge are:

- Activity therapy
- Adjunctive therapy
- Art therapy
- Family therapy
- Group therapy
- History and physical
- Individual therapy
- Music therapy
- Occupational therapy
- Psychiatric and psychological services
- Psychiatric social worker
- Psychotherapy

9.66.25
Personal supplies

- Personal supplies include items not ordered by the physician or that are not medically necessary.
- These items are not covered by Blue Cross NC health insurance. These items should be billed using UB-04 revenue code 0999.

For personal supply examples, please see reimbursement policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.66.26
Pharmacy

- Take-home drugs should not be filed.
- All pharmacy charges should be billed to Blue Cross NC using revenue code 0250.
- All drugs approved by the Food and Drug Administration are eligible for coverage with Blue Cross NC subject to the member's benefits and the Plan's Utilization Management programs.
- Pricing expensive drugs such as Tissue Plasminogen Activator (TPA) using the pharmacy formula would not be reasonable.
- A separate mark-up 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 rate, 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.).

9.66.27
Drug wastage

Blue Cross NC will provide payment for both the administered and discarded drugs or biologicals when certain criteria are met. Specifically, Blue Cross NC will reimburse discarded drugs or biologicals up to the dosage amount indicated on the vial or package label minus the administered dose(s) if:

- The units billed correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
- The drug or biological is supplied in a single-use vial or single-use package.
- The drug or biological is initially administered to the patient to appropriately address the patient's condition and any unused portion is discarded. A provider cannot bill Blue Cross NC for discarded drugs if none of the drug was initially administered to a patient (e.g., Blue Cross NC beneficiary misses an appointment).
- The amount wasted is recorded in the patient chart or a separate waste report log.
- The provider's written policy and practice is to manage single-use drugs and biologicals and bill all payors in the same manner.
- The amount billed to Blue Cross NC as discarded drug is not administered to another patient.

For more information, please see reimbursement policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

Modifier JW

Modifier JW is defined as *"drug or biological amount discarded/not administered to any patient."* Physicians, hospitals and other providers or suppliers may use Modifier JW to indicate drug wastage for non-inpatient administered drugs.

Blue Cross NC requests providers report the drug amount administered on one (1) line, and on a separate line report the amount of drug NOT administered (wasted) with Modifier JW appended to the associated HCPCS code.

It should be noted that Modifier JW is not used when the actual dose of the drug or biological administered is less than the billing unit defined in the HCPCS descriptor. For example, HCPSC J2175 descriptor states meperidine hydrochloride, per 100 mg. Therefore, one (1) billing unit is equal to 100 mg. If 97 mg of J2175 is administered and 3 mg of J2175 is wasted, Modifier JW should not be reported. This is because the amount administered, 97 mg, is less than the billing unit, which is 100 mg.

Billing reminders for drug wastage

The following table summarizes the do's and don't's regarding billing for drug wastage.

Do's	Don't's
Do bill Blue Cross NC for discarded drugs and biologicals up to the amount on the single-use vial or package label minus the administered dose(s) when appropriate.	Do not bill Blue Cross NC the extra amount the drug manufacturer provided to account for wastage in syringe hubs. Many manufacturers provide an extra drug in each vial to account for the wastage in the syringe hubs. This extra amount should not be billed to Blue Cross NC because it is not an expense to the provider and it exceeds the amount on the vial or package label.
Do use Modifier JW when single-use vials or single-use packages are appropriately discarded after administering dose(s). The use of Modifier JW is appropriate for services rendered in all non-inpatient places of service.	Do not bill Blue Cross NC for drug wastage if none of the drug was initially administered. Blue Cross NC will not reimburse for unused drugs or biologicals that result from a missed patient appointment.
	Do not bill Blue Cross NC for discarded drugs or biologicals for multi-use vials.

9.66.28
Physical therapy

- Physical therapy services should be billed using UB-04 revenue code 042X.
- 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 (1) hour of treatment and/or evaluation and may include up to four (4) 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.

9.66.29
Pre-operative/pre-admission services

- Include all pre-operative/pre-admission services performed at the hospital within seventy-two (72) hours of the admission (including date of admission) on the UB-04 claim form when used to report scheduled admissions/surgeries.

- Charges for pre-operative services/testing related to surgery should be included on the same bill as the surgery, whether or not the testing was provided on the date of surgery. For an inpatient claim, the "From Date" and "Admission Date" may be different, as the "Admission Date" will be the date the patient was admitted to the hospital, while the "From Date" reflects the date on which the pre-operative services were performed.
- Charges for pre-operative services/testing (i.e., radiology services, lab services) performed outside of the facility prior to a scheduled inpatient admission should be billed separately on a CMS-1500 claim form.

For more information, please see reimbursement policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

9.66.30
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 claim form.

9.66.31
Psychiatric inpatient 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)
  - Music therapy
  - Occupational therapy
  - Psychiatric social worker
  - Psychotherapy

9.66.32
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 Blue Cross NC 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 Blue Cross NC 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 prevalent semi-private room rate.

9.66.33
Rehabilitation room

- The rehabilitation room charge includes the cost of all items listed in acute care plus the psychiatric room therapy services.

9.66.34
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.
- The following should be included in the ER charge and should not be billed as separate items to Blue Cross NC or its members:
  - Administration of medications including IVs, IV therapy fees, drug administration fees, injection or infusion fees.
  - Thermometers, pulse oximeters, 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).

- You will be notified via HIPAA 835 ERA to submit the ER services with a bill type of 13J.

9.66.35
Room accommodation

- Bill the appropriate rate and corresponding UB-04 revenue code as shown on the Blue Cross NC Hospital Participation Agreement Statement of Accommodation (SOA). See an example of an SOA in **Chapter 21** (Form Number S133).

9.66.36
Room and board

- The following are included in daily hospital service acute care and should not be billed as separate items to Blue Cross NC 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, pulse oximeters, 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).

9.66.37
Special beds

- Special beds are covered as a separate charge when medically necessary.
- Incontinence management system beds are not covered as separate line ancillaries. These beds are covered only as part of the approved daily hospital services charge.
- Patient handling beds are covered as part of routine orthopedic care and are covered only in the daily accommodation allowance. Do not bill as a separate charge to Blue Cross NC or our members.
- High capacity beds for patients with weight accommodations 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 the UB-04 claim form with revenue code 0946 or 0947.

9.66.38
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.

9.66.39
Speech therapy

- Covered speech therapy services should be billed using UB-04 revenue code 044X.
- The itemization must be submitted on the claim.
- Speech therapy is covered when services are directed toward treatment of a specific disease, injury or congenital anomaly and are expected to result in a significant and measurable improvement in functional capabilities within a reasonable and defined period of time.
- 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.

9.66.40
Adaptive behavior treatment of autism spectrum disorder

Blue Cross NC offers benefits for adaptive behavior assessment and treatment (ABT) of autism spectrum disorder, in compliance with the Autism Health Insurance Coverage Act (NC Senate Bill 676). ABT is available for eligible members up to age nineteen (19) and includes annual benefit maximums. Eligibility for benefits includes criteria to help ensure the provision of ABT is appropriate for an individual member's health condition, and subsequently prior approval (i.e., prior authorization) of services is required.

ABT services will be considered for benefits coverage when provided in a provider's office, a member's home and an outpatient hospital setting. ABT services are not covered if provided in a school, an inpatient setting, emergency room or an urgent care facility.

Services must be ordered by a licensed physician or licensed psychologist, and treatment must be provided or supervised by the following licensed professionals: Clinical social worker, professional counselor, marriage and family therapist, occupational therapist, psychiatrist or developmental pediatrician, psychologist or speech and language pathologist.

9.66.41
Take-home drugs

- Covered take-home drugs should be billed using UB-04 revenue code 0253.
- Blue Cross NC health benefit plans do not provide inpatient hospital benefits for take-home items.

9.66.42
Take-home supplies

- Covered take-home supplies should be billed using UB-04 revenue code 0273.
- Blue Cross NC 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.

9.66.43
Transport services

- Transport services (e.g., nurse transport, attendant's fee and nursing support) are not covered under Blue Cross NC 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.

9.66.44
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 (1) payment. Facilities which have separate NPI numbers for inpatient care such a rehabilitation or psychiatric care may bill each episode of care with the appropriate NPI.

9.66.45
Transplant donor claims (facility services)

All claims reporting the medical services provided to a donor as part of a member's transplant procedure must be submitted on paper. Paper claim submissions allow us the ability to process a member's medical benefits for the payment of medical services provided to a donor. Paper claims reporting a donor's medical services are manually entered into our claims systems under the recipient member's name and date of birth, which allows us to document the services provided to a donor and enables the claim to pass through our membership validation and claim adjudication systems. To help facilitate this process, Blue Cross NC requires transplant donor claim cover sheets to be submitted with claims that report services provided to donors.

Transplant donor claim cover sheet

Transplant donor claim cover sheets can be created using your organization's standard stationary for correspondence and should contain the following information:

- Subject: Transplant donor claim
- The provider's name and NPI/provider ID
- The patient's name could be recipient or donor
- The recipient's ID number (including the prefix and suffix, e.g., YPPW1234567801)
- The recipient's date of birth
- The patient's date of service
- Provider contact information (Blue Cross NC will contact the individual listed if we have any questions about the received information)
- Address for mail-back (facility name, contact and address)

Transplant donor claim

The following information must be included on the UB-04 facility claim form:

- Write "Donor" in large letters on the claim form
- Patient (Box 8) = Donor's name
- Payor (Box 50) = Recipient's insured member
- Patient relationship (Box 59) = Code 39 (organ donor)
- The donor's diagnosis (Box 67) = V59.X (ICD-9)/Z52.X (ICD-10)

Submit the transplant donor claim to the dedicated Blue Cross NC transplant claim P.O. Box:

Blue Cross NC
Attention: Transplant Coordinator
P.O. Box 1972
Durham, NC 27702

Incomplete donor claims which are missing any of the above listed criteria will be mailed back to obtain the necessary information.

9.66.45.1

Blue Distinction Center for Transplants (BDCT) – recipient transplant claims

If your facility is designated as a BDCT, and the transplant recipient is a member of Blue Cross NC or is BlueCard-eligible with coverage from a Blue Cross and/or Blue Shield plan other than Blue Cross NC, the claim for services provided to the recipient should be filed to the address on the member's Blue Plan issued insurance card.

Transplant global packet filing

- All BDCT transplant global packet claims **must be submitted to the transplant patient's BCBS benefit plan via paper**.
- Assemble the global packet including the supplemental billing invoice.
- Ensure that the global transplant packet covers:
  - The recipient's name
  - The recipient's ID
  - The Donor Diagnosis Code (V59.X)
- Identify any transplant associated claim(s) submitted to BCBS benefit plan for processing.
- Collaborate with the patient's BCBS benefit plan claims operations representative to reconcile and recover the payment for any claim that has already payed but should have been included in the global packet.

Submit all parts of the BDCT global transplant packet, including Attachment H, to the patient's BCBS benefit plan transplant coordination organization. Incomplete donor claims which are missing any of the above listed criteria will be mailed back to obtain the necessary information.

9.66.45.2

Blue Cross NC global fee contract – recipient transplant claims non-Blue Distinction Center for Transplants

If your facility is not designated as a BDCT but does have a global fee contract with Blue Cross NC, all claims reporting the medical services provided to a recipient as part of a member's transplant procedure must be submitted on paper. Paper claim submissions allow us the ability to process a member's medical benefits for the payment of medical services provided to the recipient. Paper claims reporting a donor's medical services are manually entered into our claims systems under the recipient member name and date of birth, which allows us to document the services provided a member and enables the claim to pass through our membership validation and claim adjudication systems. To help facilitate this process, Blue Cross NC requires a transplant global claim cover sheet to be submitted with claims that report services provided to the recipients.

Transplant global claim cover sheet

Transplant claim cover sheets can be created using your organization's standard stationary for correspondence and should contain the following information:

- Subject: Transplant global claim
- The provider's name and NPI/provider ID
- The recipient's name
- The recipient's date of birth
- The Blue Cross NC patient's ID number (including the prefix and suffix, e.g., YPPW1234567801).
- The recipient's date of service
- Provider contact information (Blue Cross NC will contact the individual listed if we have any questions about the received information)

Transplant recipient claim (applicable for Blue Cross NC global fee contract – non-BDCT)

- Identify any transplant-associated claims that were submitted to BCBS for processing.
- Collaborate with the patient's BCBS benefit plan claims operations representative to reconcile and recover the payment for any claim that has already payed but should have been included in the global packet.
- All non-BDCT transplant global packet claims must be submitted to Blue Cross NC via paper.
- Assemble the global packet, including Attachment H, and the supplemental billing invoice.
- Ensure that the global transplant packet covers:
  - The recipient's name
  - The recipient's ID
  - The Donor Diagnosis Code (V59.X)

Mail the transplant global claim cover sheet followed by all information in the global packet to the dedicated Blue Cross NC transplant claim P.O. Box:

Blue Cross NC
Attention: Transplant Coordinator
P.O. Box 1972
Durham, NC 27702

Blue Cross NC will price the Blue Cross NC and BlueCard member's claims per existing Blue Cross NC/provider contract and/or hospital case rates for transplants.

Incomplete donor claims which are missing any of the above listed criteria will be mailed back to obtain the necessary information.

9.67
Fraud and abuse

Fraud and abuse may include, but are 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 Blue Cross NC's final HIPAA 835 ERA.

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, were indeed (1) medically necessary in your reasonable judgment (except with respect to cosmetic services), (2) actually performed by you to the member, (3) 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 Blue Cross NC Special Investigation Unit at **1-800-324-4963** if you suspect fraud and abuse.

9.68

Departmental revenue analysis general instructions

The coverage and billing policies and procedures have been updated to include Blue Cross NC 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 Blue Cross NC's insurance certificates, which have been filed with and approved by the North Carolina insurance department. Blue Cross NC 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 Blue Cross NC's policies and procedures. It is here to serve as a guide in developing charges for Blue Cross NC members. This document is not a substitute for your complete charge master. For more information regarding our policies and procedures, visit our website at **BlueCrossNC.com**.

The hospital must bill for covered hospital services rendered to Blue Cross NC 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 will be considered a hospital service requiring no additional charge to Blue Cross NC nor the patient unless the hospital specifically requests and receives approval from Blue Cross NC to use miscellaneous codes. When miscellaneous codes are used, actual cost information must be well documented in patient files to support the amount billed. Blue Cross NC 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 Blue Cross NC, in writing, at least thirty (30) days in advance of the effective date of the proposed change. Blue Cross NC and its participant-patients will not accept liability for charges which have not been agreed to by the hospital and Blue Cross NC 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 Blue Cross NC.

Benefits are excluded for procedures determined by Blue Cross NC 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
P.O. Box 4449
Cary, North Carolina 27519-4449

If you have questions, please call the North Carolina Hospital Association at **1-919-677-4224**.
All hospital services must be billed on the UB-04 claim form.

9.68.1
General coverage determinations

Clinic billing revenue code updates

The following revenue codes are not reimbursable when submitted on a UB-04 Form:

Code	Description
0510 - 0519	Clinic
0520 - 0529	Free-standing clinic
078X	Telemedicine
0900	General classification for behavioral health treatment
0902	Behavioral health milieu therapy
0903	Behavioral health play therapy
0904	Behavioral health activity therapy
0914	Behavioral health individual therapy
0915	Behavioral health group therapy
0916	Behavioral health family therapy
0940	General classification for other therapeutic services
0941	Recreational therapy
096X, 097X, 098X	Professional services

Positron emission tomography

For our complete medical policy, refer to our website at **BlueCrossNC.com**. When billing for covered services, please use UB-04 revenue code 0404.

Standby services and call-back services are covered only when actually received by the patient. Standby 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. Blue Cross NC 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 Blue Cross NC just because they are incurred outside normal working hours.

Observation beds are covered outpatient services when it is determined that the patient should be held for any observation stay exceeding twenty-four (24) hours (not to exceed forty-eight [48] hours), but it has not been determined that the patient should be admitted as an inpatient. For our complete medical policy, refer to our website at **BlueCrossNC.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.
- Blue Cross NC 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. The basic daily room rate includes general nursing care and food service, but does not include ancillary service.
- 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 Blue Cross NC 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 (this is defined as a patient who does not require a more intensive level of care that is rendered in the general medical or surgical unit), 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 Blue Cross NC nor the participant/patient.

9.68.2
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. Blue Cross NC 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 Blue Cross NC nor to its participant/patient. Examples of dietary supplements and/or tube feeding supplements are: Ensure, Forta, Isocal, Osmolite, Sustagen, 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 Blue Cross NC nor 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.

For more information, please see reimbursement policy at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies**.

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 – Special beds are covered as a separate charge when medically necessary:

a. Incontinence management system beds are not covered as separate line ancillaries. These beds are covered only as part of the approved daily hospital service charge.
b. Patient handling beds are covered as part of routine orthopedic care and are covered only in the daily accommodation allowance. Do not bill as a separate charge to Blue Cross NC nor our members.
c. High capacity beds for patients with weight recommendations 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 obstetrics room in addition to the labor room fee when the patient is still in the labor room at time of census.

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 – Blue Cross NC 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.

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 life-saving 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 twenty-four (24) hour basis.
e. A minimum nurse-patient ratio of one (1) nurse to two (2) 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 (2) 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 Blue Cross NC nor 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.

Standby services are not covered unless they are actually used.

Stereotactic radiosurgery – For our complete medical policy, refer to our website at **BlueCrossNC.com**.

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 standby 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.

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 Blue Cross NC certificates. This charge must not be billed as a separate line ancillary to Blue Cross NC.

- Stat charges
  Stat charges must not be billed just because they are incurred outside normal working hours. These charges are to be billed to Blue Cross NC 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 Blue Cross NC only when the procedure is ordered by the physician to be done immediately.

Handling/collection fee – Generally, Blue Cross NC does not cover handling/collection fees as separate line ancillaries.

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).

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.

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.

DME – Blue Cross NC 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 durable medical equipment should be billed using UB-04 revenue code 0291 so that claims may be processed promptly and accurately.

Pharmacy – Generally, all drugs approved by the Food and Drug Administration are eligible for coverage with Blue Cross NC, subject to the member's benefits and the Plan's Utilization Management programs.

Pricing expensive drugs such as TPA using the pharmacy formula would not be reasonable. A separate mark-up 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., IV admixture fee, dispensing fee, etc.) or to cover pharmacy overhead (e.g., pharmacy profile fee, drug assessment fee, dosage consultation, etc.).

Take-home drugs – Blue Cross NC 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 (1) hour of treatment and/or evaluation and may include up to four (4) 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 04X.

Activities in daily living and home programs – Activities in daily living and/or home programs instructions are not covered under the present Blue Cross NC 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 services are limited to one (1) hour of treatment and/or evaluation on a given day.

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 043X.

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 when services are directed toward treatment of a specific disease, injury or congenital anomaly and services are expected to result in a significant and measurable improvement in functional capabilities within a reasonable and defined period of time.

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 044X.

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 – Blue Cross NC 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.)

1. The outpatient cardiac rehabilitation program must be certified by the North Carolina Cardiac Rehabilitation plan.

Outpatient diabetes program

Blue Cross NC provides reimbursement for outpatient diabetes self-care services. Reimbursement will be made for the three (3) types of services listed below. One (1) total charge should be made for each program, not a per visit charge:

a. **Outpatient diabetic self-care program:** Three to six (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:** Twelve to sixteen (12–16) hours (with a minimum of four [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 two (2) hours, to be performed at six (6) months, twelve (12) months and annually thereafter.

Covered services should be billed using UB-04 revenue code 0942 or 0949.

(**Inpatient diabetes education** – Admissions solely for the purpose of diabetic teaching are not covered under our present certificates.)

Outpatient multiple cardiological procedures – When multiple diagnostic cardiovascular services are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 75%.

Outpatient multiple ophthalmological procedures – When multiple diagnostic ophthalmology services are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 80%.

Outpatient multiple radiological procedures – When multiple radiological procedures are performed during the same outpatient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 50%. The allowance for the professional component of the primary procedure is 100%. The allowance for the professional component of the second and each subsequent imaging procedure is 95%.

Dietary/nutrition services – Dietary evaluation and other nutritional assessment services (e.g., Optifast) are non-covered under our present Blue Cross NC 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 Blue Cross NC certificates.

Transport services – Transport services (e.g., nurse transport, attendant's fee and nursing support) are not covered under our present Blue Cross NC 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 obtain this form from their nearest Blue Cross NC service office.

Mobile services – Mobile cardiac catheterization and mobile lithotripsy services will be reimbursed through all-inclusive fees.

Lithotripsy – ESWL is a 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 three (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 1-1/2 cm or less to be successfully removed by a single ESWL treatment. Therefore, there will be no additional reimbursement for professional or hospital charge for subsequent treatments of stones that were originally 1-1/2 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 Blue Cross NC. Charges for this service should be billed to the patient.

9.69
Hospital agreements

- The NPA typically provides the basis for Blue Cross NC's hospital agreements.
- Changes to a hospital's approved charge master schedule or the addition of new services must be submitted to Blue Cross NC in writing at least thirty (30) days before the effective date of the proposed change.

9.70
Standard reimbursement methodologies

Inpatient Services	Outpatient Services
Per case rate by Medical Category or Medicare Diagnosis Related Groups (MS-DRG) code with additional per diem payments for outlier cases Per diem rate by Medical Category or MS-DRG code Payment based on MS-DRG Percentage of NPA-approved charges Lesser of Covered Charges or Contracted Amount applies to all methodologies	Case rate, per diem, or per unit rate for select procedures Percentage of NPA-approved charges Outpatient Prospective Payments Lesser of Covered Charges or Contracted Amount applies to all methodologies

9.71
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 Blue Cross NC on the same UB-04 form using revenue code 0490. The following requirements also apply to ASC claims:

- The principle procedure must 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 [7] secondary procedures may be considered in addition to the primary procedure.)
- Appropriate revenue codes must be placed in Form Locator 42 for each line item. CPT and HCPCS codes are assigned in Form Locator 44. CPT and HCPCS codes must be included in Form Locator 44 to describe specific procedures, when and if appropriate codes are available. If multiple CPT or HCPCS codes are necessary to reflect multiple, distinct or independent services matching a single revenue code, claims should be coded to repeat that revenue code as necessary.
- 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.

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 Blue Cross NC allowance for the procedure listed on the first line of the claim, and 50% of the Blue Cross NC allowance for the remaining eligible procedures. • Procedures performed in conjunction with the primary surgical procedure considered by Blue Cross NC 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: – the traditional/comprehensive major medical indemnity level or – retail charges

continued on following page

Health Benefit Plans	Reimbursement Methodology
PPO Products, continued	• For multiple surgical procedures, the provider is reimbursed 100% of the Blue Cross NC allowance for the procedure listed on the first line of the claim, and 50% of the Blue Cross NC allowance for the remaining eligible procedures. • Procedures performed in conjunction with the primary surgical procedure considered by Blue Cross NC 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: – the comprehensive major medical indemnity level or – retail charges • For multiple surgical procedures, the provider is reimbursed 100% of the Blue Cross NC allowance for the procedure listed on the first line of the claim, and 50% of the Blue Cross NC allowance for the remaining eligible procedures. • Procedures performed in conjunction with the primary surgical procedure considered by Blue Cross NC 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.

9.72
Billing

Payment of an 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 supplies, 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 the correct CPT code as indicated in the contract.

9.73
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.

9.74
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.

9.75
Integral procedures

Procedures considered integral occur in multiple surgery situations when one (1) 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.

9.76
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., CMM, HMO, POS, PPO).

9.77
Modifiers

For bilateral procedures, Blue Cross NC 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 one (1) unit in Form Locator 46 or a single line CPT code in Form Locator 44 with two (2) units reflected in Form Locator 46. RT and LT modifiers may be used when applicable.

9.78
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.

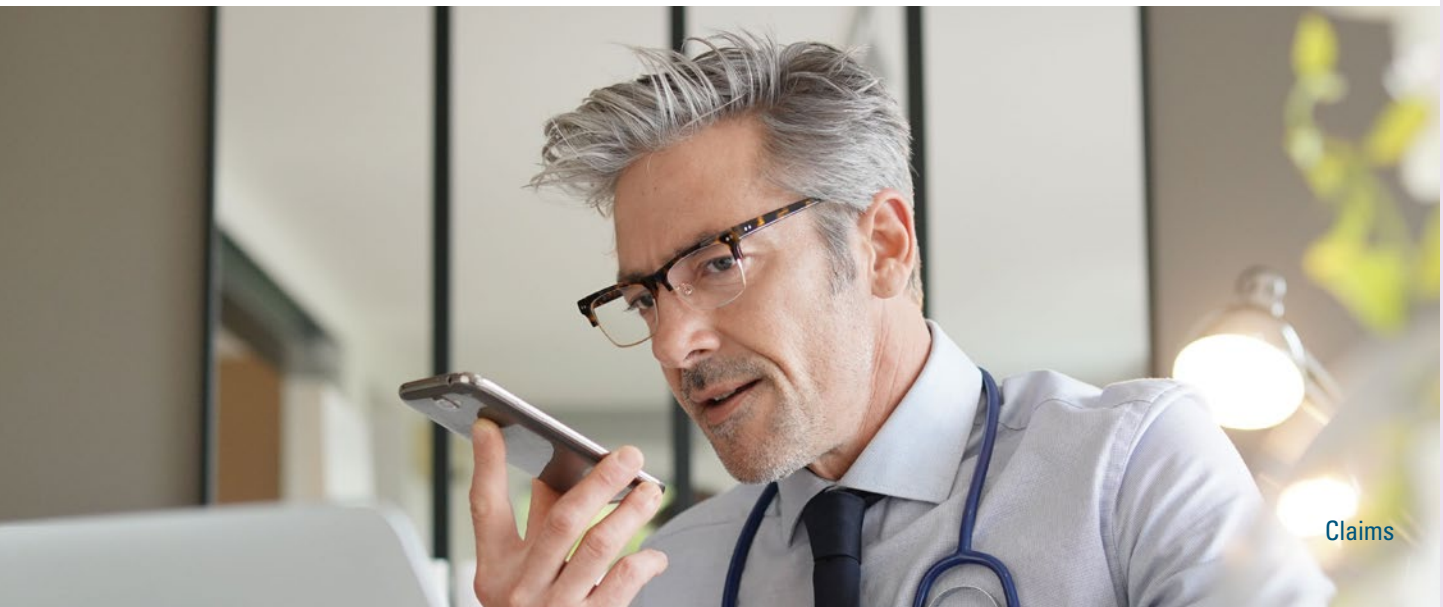
Participating providers agree to accept as full and final payment by Blue Cross NC for medically necessary covered services which are in compliance with Blue Cross NC Care Management programs for either of the following:

- 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

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.

If the ASC files a code which conflicts with coding submitted by the attending physician, one (1) of the following actions will be taken by Blue Cross NC:

- Mail the claim back
- Request operative notes



9.79
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 Blue Cross NC on the same UB-04. The following requirements also apply to ASC claims:

- All procedures must be placed in Form Locator 44. The primary procedure is determined by the highest allowed and not the first procedure billed.
- Secondary procedures should be listed in Form Locator 44. (There is no limit to the number of secondary procedures that can be billed.)
- Appropriate revenue codes must be placed in Form Locator 42 for each line item. CPT and HCPCS codes are assigned in Form Locator 44. CPT and HCPCS codes must be included in Form Locator 44 to describe specific procedures, when and if appropriate codes are available. If multiple CPT or HCPCS codes are necessary to reflect multiple, distinct or independent services matching a single revenue code, claims should be coded to repeat that revenue code as necessary.
- ASC providers can file any revenue code but the fee schedule will determine if the service is priced.
- ASC providers should file with the Bill Type 831.
- Surgical services are no longer placed in groupings; pricing is based on the fee schedule.
- ASC providers should file corrected claims with Bill Type 837 to indicate the replacement of a prior claim.

Health Benefit Plans	Reimbursement Methodology
Comprehensive Major Medical (includes the State of NC Teachers' and State Employees' Comprehensive Major Medical Plan)	• The negotiated fee schedule is based on CPT-4 codes that are paid on a fixed amount per procedure. • For multiple surgical procedures, select services are subject to multiple discount rules, where the surgical or other applicable procedure with the highest allowable is reimbursed at 100% of the Blue Cross NC allowance for the procedure and any other select surgical or applicable procedures are reimbursed at 50% of the allowed amount. • Procedures performed in conjunction with the primary surgical procedure considered by Blue Cross NC 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	• The negotiated fee schedule is based on CPT-4 codes that are paid on a fixed amount per procedure. • For multiple surgical procedures, select services are subject to multiple discount rules, where the surgical or other applicable procedure with the highest allowable is reimbursed at 100% of the Blue Cross NC allowance for the procedure and any other select surgical or applicable procedures are reimbursed at 50% of the allowed amount.

continued on following page

Health Benefit Plans	Reimbursement Methodology
PPO Products, continued	• Procedures performed in conjunction with the primary surgical procedure considered by Blue Cross NC 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	• The negotiated fee schedule is based on CPT-4 codes that are paid on a fixed amount per procedure. • For multiple surgical procedures, select services are subject to multiple discount rules, where the surgical or other applicable procedure with the highest allowable is reimbursed at 100% of the Blue Cross NC allowance for the procedure and any other select surgical or applicable procedures are reimbursed at 50% of the allowed amount. • Procedures performed in conjunction with the primary surgical procedure considered by Blue Cross NC 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.

9.80
Billing

- All payable codes will be priced. Excluded procedure codes will deny.
- Lesser of logic is applied at the line level and not the claim level.
- Implant HCPSC codes should not be billed by the ambulatory surgical center.

9.81
Primary procedures

The procedure with the highest allowable listed in Form Locator 44 will be designated as the primary procedure and will be processed at 100% of the allowable charge.

The eligible secondary procedures subject to multiple reduction will 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.

9.82
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.

9.83
Integral procedures

Procedures considered integral occur in multiple surgery situations when one (1) 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.

9.84
Modifiers

For bilateral procedures, Blue Cross NC 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 one (1) unit in Form Locator 46 or a single line CPT code in Form Locator 44 with two (2) units reflected in Form Locator 46. RT and LT modifiers may be used when applicable.

9.85
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 Blue Cross NC for medically necessary covered services which are in compliance with Blue Cross NC Care Management programs for either of the following:

- The allowed amount, minus deductible, coinsurance and/or copayment amounts; or the lesser of the provider's accepted charge minus deductible, coinsurance or copayment amounts.
- ASC claims are reimbursed according to the 2012 Blue Cross NC's ASC Fee Schedule that was established by utilizing the original (National Medicare Payment Rate) ASC Fee Schedule published by Medicare for 2012. Changes implemented by Medicare after the original file was published are not incorporated in these rates. For codes not priced by Medicare's ASC Fee Schedule, Medicare OPPS pricing was used to establish the base rate. If Medicare OPPS pricing wasn't available, then the base rate was determined by Blue Cross NC using clinically appropriate comparison data.
- All payable codes will be priced based on the provider's negotiated fee schedule.
- Codes are classified into the following health service categories and are reimbursed based on a negotiated fee schedule:
  - Surgery codes with implants
  - Surgery codes without implants
  - Ancillary
- Codes identified as *"Excluded Not Payable"* will not be eligible for reimbursement.
- ASC Fee Schedule is updated annually for new, revised and deleted codes.
- The eligibility for multiple reduction is updated annually.
- Anesthesia professional services in an ASC setting are billed separately by the anesthesia provider.

If the ASC files a code which conflicts with coding submitted by the attending physician, one (1) of the following actions will be taken by Blue Cross NC:

- Mail the claim back
- Request operative notes

10

Coordination of benefits

10.1
Coordination of benefits

Generally, COB is the method of combining payments when more than one (1) 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 Blue Cross NC 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.

Blue Cross NC'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 (2) or more sources.

Blue Cross NC 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, 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 Blue Cross NC'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 Blue Cross NC policy, when a provider submits a claim for a spouse or a dependent child of a Blue Cross NC subscriber who reports other coverage, but Blue Cross NC has not received or does not have in its records definitive information to correctly determine liability, Blue Cross NC will deny the claim and request additional information pertaining to the other coverage. Blue Cross NC will re-open the claim when the requested information is received within eighteen (18) months of the date of service (per the member's benefit booklet) or one (1) year from the date of denial, whichever is later.

10.2
Blue Cross NC as secondary carrier

For Blue Cross NC 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 Blue Cross NC with an EOB from the primary insurance carrier. Whether the primary insurance carrier paid or denied the claim, Blue Cross NC 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 Blue Cross NC to pay secondary liability with respect to any service or benefit, the member must follow our applicable rules and guidelines. That means the member must follow same authorization/approval procedures as if we were the only carrier. In all cases, the amount owed by Blue Cross NC as secondary liability will be no more than Blue Cross NC's allowed amount.

Procedural rules

If Blue Cross NC is secondary, the following rules apply:

- All prior review and certification policies and procedures must be followed according to the member's Blue Cross NC 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 EOP/NOP along with a paper claim form to Blue Cross NC. Please do not staple EOB to claim form.

Important note:

It is important that providers do not submit outdated coordination of benefits information on claims. Submitting inaccurate COB information can result in delays in payment or the inability for Blue Cross NC to process claims. In addition, this could result in duplicate primary payments from multiple carriers, which results in claims adjustments for the carriers, as well as potential bookkeeping issues for you, the provider.

Please make sure that any other coverage information is accurate on the first submission of the claim. Always make sure that any COB amounts paid by the primary carrier are indicated in the correct fields on the claim form.

Determining Blue Cross NC's and member's payment amount

- Blue Cross NC 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 Blue Cross NC payment to you will not exceed the amount necessary to bring the total payment including, but not limited to, all amounts paid by Blue Cross NC under other benefit plans, 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 Blue Cross NC.
- If Blue Cross NC receives a claim for which Blue Cross NC is secondary, the claim will be suspended pending Blue Cross NC'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. Blue Cross NC 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 toward the contractual allowance under your Blue Cross NC contract. The member's liability is always limited to the member's deductible, coinsurance and/or copayment under the Blue Cross NC policy. Additionally, Blue Cross NC and our member's combined liability is always further limited to the amount that remains unpaid toward the contractual allowance under your Blue Cross NC contract. The amounts payable by Blue Cross NC 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 Blue Cross NC's contractual allowance, the member should not have any liability.

10.3
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 copays, 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 Blue Cross NC allowed amount minus Blue Cross NC deductible, coinsurance and copay. If anything remains, it will be paid toward coordination. You, as a provider, should come out whole; greater financial liability is on the member.

10.4
Blue Cross NC as dual coverage

If a member has dual Blue Cross NC coverage (i.e., Blue Cross NC is both primary and secondary), the secondary Blue Cross NC coverage is typically responsible for covering any member copayments, coinsurance and deductibles, but not responsible for any disallowed amounts as a consequence of our contractual agreement.

When Blue Cross NC is both primary and secondary, you must submit two (2) separate claims. Submit the first claim to the primary Blue Cross NC plan using the member's complete identification number (prefix and subscriber number including suffix, if applicable). Upon receipt of the primary EOP/NOP, submit another claim to the secondary Blue Cross NC plan using the member's complete second identification number (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 payor's EOP/NOP with the secondary claim. If our records indicate the Blue Cross NC is secondary and the primary plan's (including Blue Cross NC) 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 Blue Cross NC.

10.5
BlueCard

All secondary BlueCard claims should be filed through BlueCard. Refer to **Chapter 5** for more COB information.

10.6
Workers' compensation

Blue Cross NC 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 workers' 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 workers' 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 Blue Cross NC, you may file with the secondary carrier.

10.7
Non-COB list

In most cases, Blue Cross NC 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:

- AARP
- AFLAC
- Auto Insurance
- Blue Cross NC will always be secondary when coordinating with the Canadian Health Ministry
- Carolina Alternatives
- Carolina Access
- CHAMPUS
- Cherokee Indian Hospital
- EDS Federal
- Medicaid
- Medicare supplemental plans
- NC Access
- NC Health Choice
- School insurance policies
- TRICARE
- Workers' compensation policies

10.8

Order of benefit determination – commercial

COB for subscriber or spouse

1. If one (1) of the two (2) 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 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).

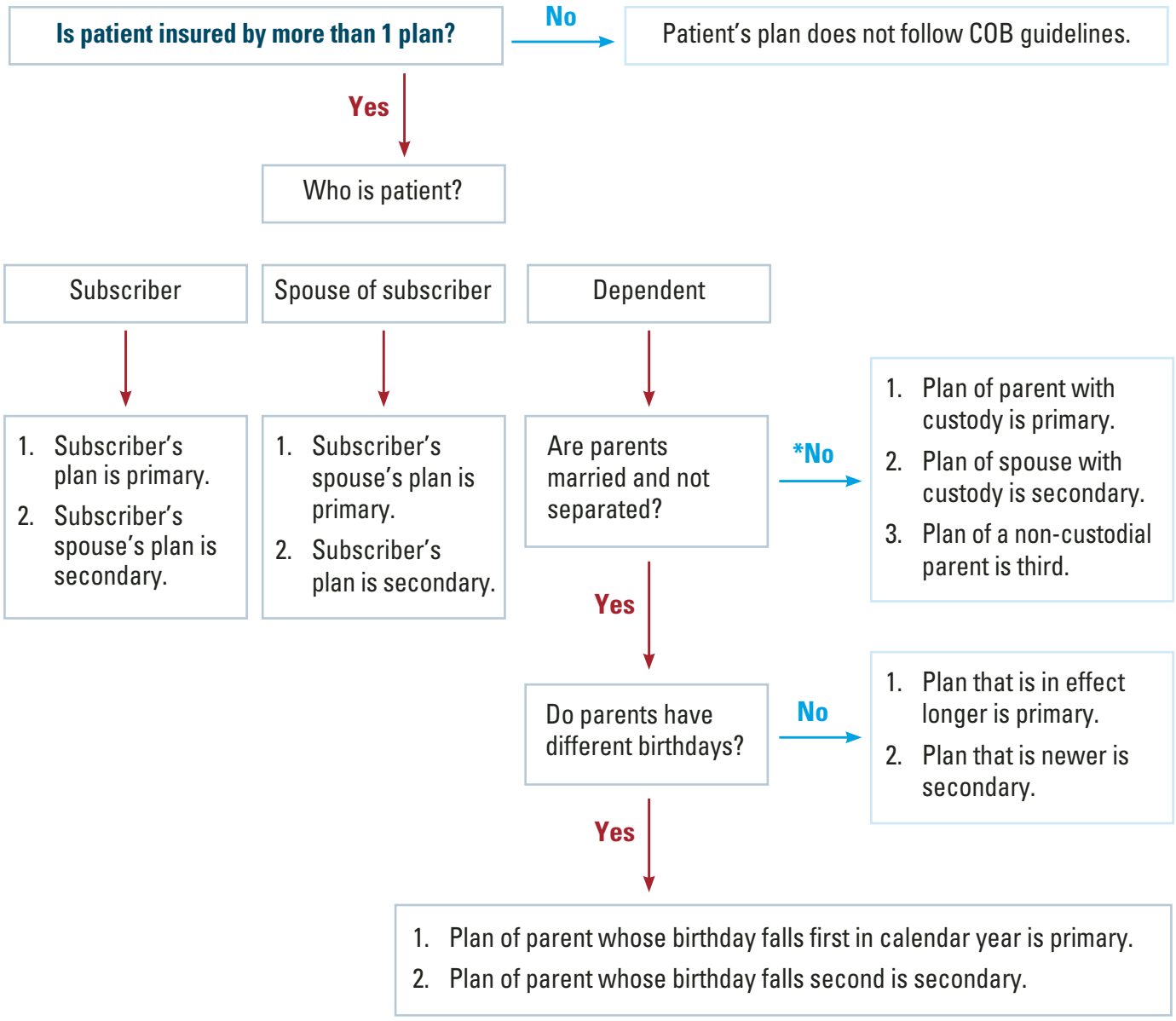
When custody is not indicated

When custody has not been indicated, Blue Cross NC 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



* These provisions apply in the absence of a specific court decree of which Blue Cross NC assigns responsibility for the health care expenses of the child to a particular parent.

10.9
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 Blue Cross NC for the following circumstances:

- Blue Cross NC is primary for individuals with ESRD during the first thirty (30)months of Medicare eligibility.
- For individuals sixty-five (65) and over who are covered by an actively working employee policy that employs twenty (20) or more employees, Blue Cross NC is primary if the individual or the individual's spouse (of any age) has current employment status.
- For disabled individuals under sixty-five (65) who are covered by an actively working employee policy that employs one hundred (100) or more employees, Blue Cross NC is primary if the individual or a member of the individual's family has current employment status.
- For individuals covered by an active employee policy, Medicare and a retiree policy, the active policy pays primary over Medicare and the retiree policy regardless of group size.
- For individual policies, once Medicare is effective, Medicare becomes primary.
- Blue Cross NC will always be secondary when coordinating with the Canadian Health Ministry.

Medicare Beneficiary is Over 65	Medicare Primary	Group Primary
Actively working and the employer has fewer 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 fewer 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	
Retired employee	X	
Has COBRA coverage	X	

continued on following page

Medicare Beneficiary is Under 65 and Disabled	Medicare Primary	Group Primary
Actively working and the employer has fewer 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 fewer than 100 employees		X
Has COBRA coverage	X	

ESRD Entitlement – Beneficiary is receiving dialysis 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 who starts a regular course of dialysis on July 15 would be entitled to Medicare on October 1.		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 payor following the age and disability rules above.	X	

continued on following page

ESRD Entitlement, continued – 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 payor following the age and disability rules above.	X	

Note: For multiple employer arrangements (including labor union plans), if any employer within the group has one hundred (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.

10.10
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.

10.11
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 $1,000.00
Commercial carrier paid.....$ 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 $1,000.00
Commercial carrier paid.....$ 800.00
Group allowance.....$1,000.00
Group liability .....$ 200.00

(Benefits will be applied)

Medicare primary

CMS-1500

If provider accepts Medicare's assignment

Charge amount $1,000.00
Medicare allowed .....$ 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 $1,000.00
Group allowed .....$ 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 plan's 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.)

10.12
Individual business COB examples

Medicare is always primary once member becomes effective with Medicare.

CMS-1500

If provider accepts Medicare's assignment

I. Charge amount.....$ 545.00
Medicare allowed.....$ 247.51
Medicare paid.....$ 198.01
Group liability.....$ 49.50

(Medicare allowed, less Medicare payment. Our payment may not equal 100% of Medicare's coinsurance and deductible).

II. Charge amount.....$2,546.00
Medicare allowed.....$ 0.00
Medicare paid.....$ 0.00
Blue Cross NC liability .....$?
(see scenarios 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 Blue Cross NC liability.

If provider does not accept Medicare's assignment

Charge amount $1,000.00
Medicare allowed .....$ 800.00
Medicare paid .....$ 640.00
Blue Cross NC 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)

10.13
State Health Plan COB examples

ASO/commercial carrier primary

CMS-1500

Charge amount $1,000.00
Commercial carrier paid.....$ 800.00
SHP liability .....$ 200.00
(The SHP's liability is still subject to deductibles and copayments)

Medicare primary

CMS-1500

If provider does not accept Medicare's assignment

Charge amount $1,000.00
Blue Cross NC contract allowed....$ 800.00
Medicare paid .....$ 640.00
State's liability "SHP" .....$ 160.00
Allowed - Medicare Payment = SHP Liability
(The SHP's liability is still subject to deductibles and copayments)

If provider accepts Medicare's assignment

Charge amount $1,000.00
Medicare allowed .....$ 800.00
Blue Cross NC contract allowed....$ 700.00
Medicare paid .....$ 640.00
State's liability "SHP" .....$ 60.00
Blue Cross NC coordinates based on the lesser of the allowed amounts
Allowed - Medicare Payment = SHP Liability
(The SHP's liability is still subject to deductibles and copayments)

UB-04

The provider's participation with Medicare does not affect our secondary liability.

The Plan's liability is coinsurance and/or deductible amounts. Our payment may not equal 100% of Medicare's coinsurance and deductible, as the SHP's liability is still subject to deductibles and copayments.

A1 = Inpatient deductible
A2 = Inpatient coinsurance
B1 = Outpatient deductible
B2 = Outpatient coinsurance

10.14

Federal Employee Program COB examples

ASO/commercial carrier primary

CMS-1500

Charge amount.....$1,000.00
Commercial carrier paid.....$ 800.00
FEP allowance.....$ 900.00
FEP's liability.....$ 200.00
(The FEP's liability is still subject to deductibles and coinsurance)

UB-04

Charge amount.....$1,000.00
Commercial carrier paid.....$ 800.00
FEP's 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.....$1,000.00
Medicare allowed.....$ 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.....$1,000.00
Medicare allowed.....$ 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 to 115% of the Medicare approved amount; called the limiting charge.

UB-04

Blue Cross NC primary carrier:

Charge amount.....$1,500.00
Blue Cross NC allowed amount....$1,000.00
Blue Cross NC paid amount.....$ 800.00
FEP's liability.....$ 200.00

10.15
COB rules

When a member is covered by more than one (1) insurance carrier, one (1) 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. Blue Cross NC prior review and certification requirements apply whether we are primary or secondary. Please refer to the order of benefits determination section for further information.

10.15.1
Medicare as primary/Blue Cross NC as secondary

Providers and facilities must request certification for all services requiring advanced approval by Blue Cross NC. This includes all services on the Blue Cross NC prior plan approval list, inpatient hospital admissions and admissions to non-Medicare certified skilled nursing facilities.

Unlike certification requests placed for other Blue Cross NC members, not all services authorized for Medicare primary members receive authorization numbers. Providers can expect:

- When a service, medication or supply requires prior authorization from Blue Cross NC and all eligibility criteria are met, Blue Cross NC will assign an authorization number for the authorized service(s).
- When certification is requested for an inpatient stay, which also includes a request for authorization-required services and/or procedures to be performed during the patient's stay of care and all eligibility criteria are met, Blue Cross NC will assign an authorization number.
- When certification is requested for an inpatient stay that does not include any additional services and/or procedures requiring prior authorization from Blue Cross NC, no authorization number will be assigned. Instead, Blue Cross NC makes a notation in our systems to record that certification was requested and allows Medicare to make the initial review of hospital necessity. If Medicare disallows the hospital admission, Blue Cross NC can then use the notation from our system if making an additional review.

10.16
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 (1) of the carriers does not have a 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.

- You should not collect or accept deductible, coinsurance payment or any other payments from a Medicare beneficiary prior to, or at the time of services being rendered, when Blue Cross NC is primary to Medicare. You must follow the Medicare Secondary Payor rules and bill Medicare as the secondary payor after Blue Cross NC has issued payment.

10.16.1
Blue Cross NC as primary

If Blue Cross NC 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 Blue Cross NC plan.
- You should not collect or accept deductible, coinsurance payment or any other payments from a Medicare beneficiary prior to, or at the time of services being rendered, when Blue Cross NC is primary to Medicare. You must follow the Medicare Secondary Payor rules and bill Medicare as the secondary payor after Blue Cross NC has issued payment.
- You should first file with Blue Cross NC.

10.17
HIPAA – 837 professional batch claims

When filing an 837 professional claim to Blue Cross NC as the secondary or tertiary payor, 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 payor amount paid. Do not include deductible, coinsurance, copayments or other adjustments in the payor paid amount field. (See table on the next pages.)
- File all other adjustments in the CAS segment with the appropriate reason code.
- 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	Blue Cross NC Business Rules
2320	SBR	Other subscriber information			
			SBR01	Claim filing indicator code	P = Primary
	CAS	Line adjustment			
			CAS01	Claim adjustment group code	CO = Contractual obligations CR = Correction and reversals OA = Other adjustments PI = Payor-initiated reductions PR = Patient responsibility
	AMT	COB payor paid amount			
			AMT01	Monetary amount	D = Payor amount paid
			AMT02	Monetary amount	Fill the actual amount paid by the other carrier. Do not include deductible, coinsurance, copayments or other adjustments in the payor paid amount field.
2330B	NM1	Other payor name			
			NM101	Entity type qualifier	PR = Payor

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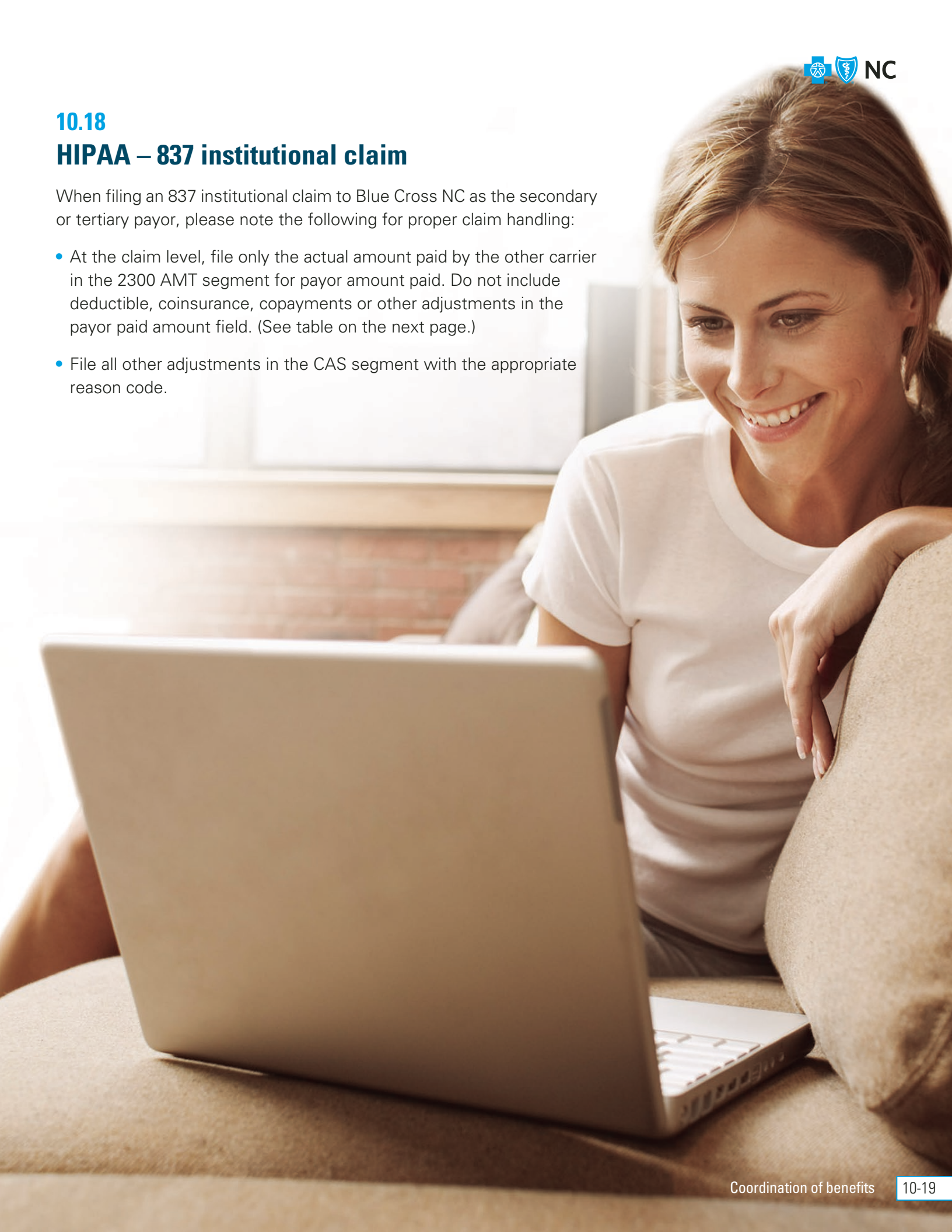
837 PROFESSIONAL CLAIM

Loop ID	Segment Type	Segment Designator	Element ID	Data Element	Blue Cross NC Business Rules
			NM103	Payor name	Use last name or organization name
	DTP	Claim adjudication			
			DTP01	Date/time qualifier	573 = Date claim paid
2430	SVD	Line adjudication information			
	CAS	Line adjustment			
			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			
			CAS01	Claim adjustment group code	CO = Contractual obligations CR = Correction and reversals OA = Other adjustments PI = Payor-initiated reductions PR = Patient responsibility
2430	DTP	Line adjudication information			
			DTP01	Date/time qualifier	573 = Date claim paid

10.18
HIPAA – 837 institutional claim

When filing an 837 institutional claim to Blue Cross NC as the secondary or tertiary payor, 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 payor amount paid. Do not include deductible, coinsurance, copayments or other adjustments in the payor paid amount field. (See table on the next page.)
- File all other adjustments in the CAS segment with the appropriate reason code.



837 INSTITUTIONAL CLAIM

Loop ID	Segment Type	Segment Designator	Element ID	Data Element	Blue Cross NC Business Rules
2320	SBR	Other subscriber information			
			SBR01	Claim filing indicator code	P = Primary
	CAS	Line adjustment			
			CAS01	Claim adjustment group code	CO = Contractual obligations CR = Correction and reversals OA = Other adjustments PI = Payor-initiated reductions PR = Patient responsibility
	AMT	Payor prior payment			
	AMT	COB total allowed amount			
2330B	NM1	Other payor name			
			NM101	Entity type qualifier	PR = Payor
			NM103	Payor name	Use last name or organization name
	DTP	Claim adjudication date			
			DTP01	Date/time qualifier	573 = Date claim paid

CMS-1500 health care claims filing

At this time, we are unable to process secondary Health Care Financing Administration (HCFA) claims via **Blue *e***. Please submit these claims on your 837 professional batch file.

UB-04 health care claims filing

To file a Blue Cross NC secondary claim via **Blue *e***, please follow the same guidelines as you would when filing a paper claim. Blue Cross NC payor information should show on line **A** for payor name "**FL50**," insured's name "**FL58**" and certificate number "**FL60**." The primary payor information should show on line **B** for the same information. Please remember to complete the prior payments field "**FL54**" for line **B**.

10.19
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 2-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.	
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 21 (diagnosis).	

continued on following page

Block	Field Name	Description	Comments
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 [X] 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 copayments 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.

10.20
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 institutional claim form. Please refer to the full claim form detail for a complete listing of the filing details.

Form Locator Number	Field Name	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 payor A A2 – Coinsurance payor A B1 – Deductible payor B B2 – Coinsurance payor B C1 – Deductible payor C C2 – Coinsurance payor C	
50a, b, c	**Insurance carrier name:** Line A – Primary payor Line B – Secondary payor Line C – Tertiary payor	
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 A – Primary payor B – Secondary payor C – Tertiary payor	
55a, b, c	Estimated amount due from each payor	Information in this section is only used by State Health Plan.
60a, b, c	Insured's unique identifier	

You will still need to fill out the entire claim. This section only emphasizes COB.

10.21
Filing Medicare crossover claims

The Medicare crossover program is a program that automatically files electronic claims for secondary payment. Under the Medicare crossover program, you need to submit only one (1) claim to the Medicare Part B carriers. The Medicare Part B carriers will process as the secondary payor.

The Medicare remittance advice will indicate whether a paper claim needs to be filed with Blue Cross NC. Providers are to wait thirty (30) calendar days from the Medicare remittance date before submitting the claim to Blue Cross NC. Medicare primary claims, including those with Medicare exhaust services that have crossed over and are received within thirty (30) calendar days of the Medicare remittance date, or with no Medicare remittance date, will be returned by Blue Cross NC.

If the claim was crossed over by Medicare, the Medicare payment advice/explanation of Medicare benefits (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 Blue Cross NC if the claim has a prefix.

If no prefix, file the claim to the address on the back of the card. Blue Cross NC or the member's Blue Cross Blue Shield 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.

BlueCard 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 Blue Cross NC Provider Data Management department at providerupdates@bcbsnc.com if there are any changes to your Medicare provider number or participation status. More information regarding Medicare and BlueCard COB can be found in **Chapter 5** and **Chapter 6**.

Please Note: There is a fifteen (15) day processing time for Medicare intermediaries before claims are crossed over to Blue Cross NC.

10.22
HIPAA – 835 ERA

We report payment and denial of claims to providers electronically through the 835 remittance transaction (see **Chapter 11** for additional information).

Please Note: Your contract overrides information on the HIPAA 835 ERA, especially where Blue Cross NC is the secondary payor.

10.23
Overpayments

10.23.1
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 21**).

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
- Provide the NPI the services were paid under
- 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.

10.23.2
Disbursement of overpayments

The following products licensed by Blue Cross NC 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

10.24
Prompt payment and COB

Prompt payment penalties apply beginning thirty (30) days after the receipt of all information required to process the claim. In the case of coordination of benefits, primary payor information or an EOB is a required piece of information for claim processing. Prompt payment penalties may apply thirty (30) days after the receipt of all required information including primary payor 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 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 the Provider Network.

10.24.1

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 payors need to pay claims

Although each plan and payor 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 payor prior to paying a claim as the secondary payor – 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 payors publish their requirements, and the information should be available in provider e-Manuals, online and by contacting provider representatives.

3. Determine primary and secondary payors

It is important for providers to determine primary and secondary payors so that claims can be sent to the primary payor 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 payors to determine the primary and secondary payor:

a. The payor covering the patient as a subscriber will be the primary payor.

b. If the patient is a dependent child, the payor whose subscriber has the earlier birthday in the calendar year will be the primary payor. This is known as the birthday rule.

4. Include primary payment amounts from primary payors 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 payor. In this case, the 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 payor. A paper claim submitted in this circumstance would be coded as a duplicate and rejected by the secondary payor.

Please Note:

There is a fifteen (15) day processing time for Medicare intermediaries before claims are crossed over to Blue Cross NC.

11

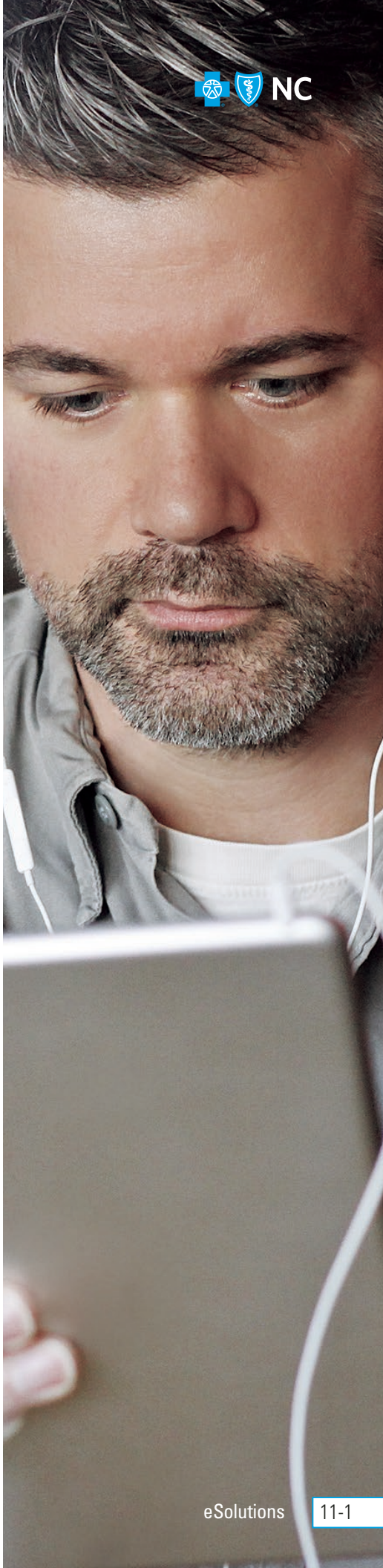
eSolutions

Electronic solutions, also known as eSolutions, enable the transmission of electronic files for the business processing of health care information. Blue Cross NC 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. eSolutions provides customer support for all of our trading partners that submit electronic transaction files.

eSolutions also offers the web-based product, **Blue *e***, for making interactive inquiries about eligibility and claim status, admission notifications and claims entry. Blue Cross NC has developed electronic solutions that allow contracted health care providers to access detailed claim management information from Blue Cross NC, 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 Blue Cross NC can obtain resources and required forms on the electronic solutions website at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**. All direct senders of batch files will need to sign and submit a Blue Cross NC Trading Partner Agreement and an Electronic Connectivity Request form. **Blue *e*** Interactive Network Agreements are also available at this website.

This chapter outlines the range of electronic solutions offered by Blue Cross NC.



11.1
Health Insurance Portability and Accountability Act (HIPAA)

The 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.

eSolutions has produced a companion guide to assist trading partners in understanding Blue Cross NC code and situation handling used in processing the ANSI ASC X12N transactions. This companion guide is available at **BlueCrossNC.com/providers/network-participation/hipaa**.

11.1.1
Blue Cross NC HIPAA companion guide

Blue Cross NC accepts the following HIPAA-compliant transactions:

Blue Cross NC Companion Guide Chapters
Introduction to the companion guide to Electronic Data Interchange (EDI) transactions (for all trading partners)
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** Claims Status Request and Response
278 Health Care Services Review and Response

You can download Blue Cross NC companion guide chapters that are essential to understanding issues applicable to all transmissions with Blue Cross NC.

11.1.2
Tools and forms

The following agreements, contracts, instructions and sample documents are also available online as PDF files for download:

- **Trading Partner Agreement (TPA)**

  This contract establishes the formal relationship between a direct sender of electronic files and Blue Cross NC. This agreement, along with the Electronic Connectivity Request form, needs to be completed by all trading partners and submitted to eSolutions before electronic transmissions are exchanged.

- **ECR form**

  Any health care provider wishing to transmit files electronically to Blue Cross NC, 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 Blue Cross NC electronic mailboxes. The Claims Audit Report is returned for 837 Transactions only.

- **999 Transaction sample**

  The 999 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**."

11.1.3
EDI Electronic Connectivity Request (ECR) form

ECR forms must be completed for any organization or provider that wants to submit or receive electronic transactions with Blue Cross NC.

The following ECR forms are available:

- Master ECR for 837 Claim, 27X Inquiry and 835 Remit
- The 835 Payment/Remittance Advice for Medicare crossover

Commonly asked questions about ECR forms

1. Who completes an EDI ECR form?

- Every health care provider wishing to exchange electronic information with Blue Cross NC, whether submitting information directly or via another party, must complete an ECR form. However, an ECR form must be accompanied by a Blue Cross NC 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 Blue Cross NC on your behalf.
- Providers who do not transmit transactions directly to Blue Cross NC may have their vendor/clearinghouse or billing service complete the detailed 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?

- Providers should complete the ECR form and specify the transaction sets that they wish to send to Blue Cross NC.

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. Blue Cross NC 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 5010A1 version is available.

4. What do I do with the completed ECR form(s)?

- Completed forms may be faxed to Blue Cross NC eSolutions at **919-765-7101**. Blue Cross NC eSolutions 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.

11.2
Electronic claims filing

Blue Cross NC 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 Blue Cross NC policies, Federal Employee Program 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 website at **BlueCrossNC.com/providers/network-participation/hipaa** for resources and the necessary forms. You must complete a TPA as well as an ECR form for the transaction.
- All Blue Cross NC trading partners are required to test their file submission formats with Blue Cross NC before submitting production files. The Blue Cross NC companion guide to EDI transactions is available at the Blue Cross NC website 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: Providers with electronic capability that submit paper claims will be asked to submit claims electronically to Blue Cross NC.

11.3
Tips for electronic claims filing

- Submit correct and complete member ID numbers, including any prefixes and numeric suffixes, (see **Chapter 3**) or the Blue Cross NC 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 eSolutions Customer Support at **1-888-333-8594**, or contact your provider service consultant for more information.
- Correct all electronic claim errors on your internal system and resubmit those claims electronically via the 837 transaction.
- A listing of all claims submitted via 837 is contained within the Claims Audit Report which is available in your mailbox. You may electronically access 837 rejected claims on **Blue *e*** via the 837 Claim Error Listing Transaction. Paper copies of the Claim Audit Report are not available.
- Professional corrected and voided 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/voided claim indicator in Loop **2300**, sub-element **CLM05-3** on the 837 Professional Claim Transaction or indicate corrected/voided claim by choosing the appropriate corrected/voided value in Box **22** (Resubmission Code) on the **Blue *e*** CMS-1500 Transaction. Enter Claim Frequency Type Code (Billing Code) **7** for a replacement/ correction, or **8** to void a prior claim, in the **2300** Loop in the in sub-element **CLM05-3**. Enter the original claim number in the **2300** Loop in the **REF*F8***. For **Blue *e***, the original reference claim number goes in Box **22** (Resubmission Code – Original Reference Number).
- 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**, sub-element **CLM05-3** on the 837 Institutional Claim Transaction, or indicate a 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**. For **Blue *e***, the original reference number goes in Field Locator **64** (Document Control Number).
- Blue Cross NC professional secondary claims can now be submitted electronically using the 837 Professional Claim Transaction. Include the COB payor paid amount in Loop **2320**; AMT segment, AMT01 qualifier = **D**; AMT02 = $ amount.
- Prior to electronically submitting claims for a newly registered group or individual NPI, contact the eSolutons Help Desk at **1-888-333-8594** to verify that the Connectivity Request form has been completed.

11.4
Blue e

Effective November 1, 2016, all providers participating in Blue Cross NC's commercial product networks must enroll in **Blue *e***. **Blue *e*** 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***, you can do the following from your desktop:

- Search for a member's ID number by name, including FEP members
- Access the Patient Care Summary (described in **Section 8.3.1**)
- 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 calendar year

Blue Cross NC encourages your participation in this interactive network for exchanging information and simplifying administrative tasks. Complete information on **Blue *e***. You may contact the eSolutions Help Desk at **1-888-333-8594** for more information regarding the **Blue *e*** interactive network.

11.5
Policy for Electronic Funds Transfer (EFT), ERA and Blue *e*

Effective November 1, 2016, all providers participating in Blue Cross NC's commercial product networks must be enrolled in Blue *e*.

All providers participating in Blue Cross NC's commercial product networks are required to enroll in and be able to accept EFT from Blue Cross NC. Additionally, all providers participating in Blue Cross NC's commercial product networks must enroll in **Blue *e***, and complete registration to receive ERA reports from Blue Cross NC.

All new provider applications requesting a contract to participate in Blue Cross NC's Provider Networks serving Blue Cross NC's commercial products include the requirement to enroll in EFT, **Blue *e*** and ERA, regardless of whether they are a new practice or an existing practice adding an additional contract.

Instructions for how to sign up for EFT can be accessed online through the *Forms and Documentation* section of the provider web portal at **BlueCrossNC.com**. Additionally, information about **Blue *e*** and how to register can be found under the *Manage Claims and Inquiries* section of the provider web portal at **BlueCrossNC.com**.

When a new practice opens or if new subsidiaries are acquired, payment information should be reviewed for each new location.

Blue Cross NC offers EFT and **Blue *e*** services free of charge. Providers should check with your financial institution and/or automated clearinghouse to see if any EFT processing fees may apply.

11.6
eSolutions contact information

Providers can contact the eSolutions Help Desk for questions or issues with **Blue *e*** or HIPAA transactions, missing electronic 837 Claims Audit/ Error Reports, questions regarding the content of your secure electronic mailbox or general eSolutions questions.

eSolutions Help Desk Contact Information

1-888-333-8594	**919-765-3514**	Fax **919-765-7101**

Contact information

General Questions about the EFT process:

Contact Blue Cross NC's Financial Processing Department at **919-765-2293**

Blue *e*

Questions about how to register for Blue *e* or how to set up an EFT account through Blue *e*:

Contact the eSolutions Help Desk at **1-888-333-8594**

12

Provider review

Hospitals

Ambulatory Surgical Centers

Skilled Nursing Facilities

12.1
Provider review

Upon request and at reasonable times, your contract grants Blue Cross NC 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 Blue Cross NC or our members. Blue Cross NC 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.

12.2
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. Blue Cross NC warrants that our members have given us the contractual right to obtain information about the services and/or supplies provided to them through their enrollment application, therefore no further authorization will be required from either Blue Cross NC 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 Blue Cross NC 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: Auditor, medical records department and patient account representatives. Blue Cross NC 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 thirty (30) days of completing the review.
- You may ask for a higher level of review within fifteen (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, Blue Cross NC will proceed with our normal adjustment process to recover the audit findings.
- Blue Cross NC members are not responsible for billing discrepancies and should not be subsequently billed.
- When new audit vendor contracts are secured by Blue Cross NC, a letter of introduction will be furnished to you.
- Please call the Blue Cross NC Special Investigation Unit at **1-800-324-4963** if you suspect a provider of fraudulent, abusive or otherwise improper billing practices.

12.3
Eligibility requirements for managed care products

- To be eligible for participation in Blue Cross NC 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 NCQA will require initial credentialing of any provider who seeks reinstatement in any of our networks after being out-of-network for more than thirty (30) days.

Please Note: This is a change from the previous time frame of ninety (90) days.

- Providers must be in good standing with all federal and state bodies at all times.
- Providers must be approved by an accredited body.
- An onsite quality assessment will be performed if the provider is not accredited by the proper bodies.

ELIGIBILITY REQUIREMENTS FOR MANAGED CARE NETWORKS

Requirements	Accredited Hospitals and Ambulatory Surgical Centers	Birthing Centers	Skilled Nursing Facilities	Home Health
1. Current North Carolina license	X	X	X	X
2. Current JCAHO, AAAHC or CARF certificate or letter of recommendation (for Birthing Centers, JCAHO or NACC certification)	X	X	X	X
3. Medicare/Medicaid certificate	X	X	X	X
4. Health coaching and intervention program				X
5. Documented policy and procedure for coverage arrangements (participating provider and hospital), in the event of an emergency situation			X	
6. 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	X	X Non-JCAHO Exemption Form Required	X	X
7. Skilled Nursing, Speech Therapy, Physical Therapy, Occupational Therapy, Medical Social Services and Home Health Aide Services must all be available services				X

13

Quality improvement program

13.1
Quality improvement

Blue Cross NC's quality improvement program is an important component of our HMO, POS, PPO and EPO products. The quality improvement program supports Blue Cross NC's ongoing commitment to quality health care.

Consistent with current professional knowledge, Blue Cross NC 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, Blue Cross NC 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 Blue Cross NC 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 Blue Cross NC by showing it to be the best HMO, POS, PPO and EPO 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 NCQA accreditation

1 Adapted from the Institute of Medicine's statement about quality of medical care.

At times it is necessary for Blue Cross NC to request medical records from you in order to perform quality improvement activities. Contracting providers are required to provide Blue Cross NC with medical records as requested without further payment or authorization from the member or Blue Cross NC. For more information on releasing medical records, see **Section 9.21**.

13.2
Medical policy

Our corporate medical policy consists of medical guidelines which 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. Benefits and eligibility are determined before medical 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: 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 **BlueCrossNC.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.

13.3
Members' rights and responsibilities

We have assembled a list of member's rights and responsibilities that apply directly to our Blue Cross NC members. This list is distributed to members annually and is available online at **BlueCrossNC.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 NC member, you have the right to:

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

As a Blue Cross NC member, you should:

- Present your Blue Cross NC ID card each time you receive a service.
- Read your Blue Cross NC benefit booklet and all other Blue Cross NC member materials.
- Call Blue Cross NC when you have a question or if the material given to you by Blue Cross NC is not clear.
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide Blue Cross NC 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 twenty-four (24) hours notice.
- Play an active part in your health care.
- Be polite to network doctors, their staff and Blue Cross NC staff.
- Tell your place of work and Blue Cross NC 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 possible.
- Protect your ID card from improper use.
- Comply with the rules outlined in your member benefits guide.

13.4
Practitioner rights

Each provider applying for credentialing and/or recredentialing with Blue Cross NC has the right to:

- Correct any errors
- Review information sent to support credentialing application
- Ask for information about credentialing and/or recredentialing application status
- Be informed of these rights

13.5
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 the Provider Network (see **Chapter 2**).

13.6
Network quality

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). Additional information regarding Blue Cross NC's Access to Care Standards can be found online at **BlueCrossNC.com/Providers/Network-Participation/Access-to-Care**.

The following components of our network quality program are discussed below:

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

13.6.1

Access to care standards (primary care physician)

Blue Cross NC and the Physician Advisory Group have established the following Access to Care Standards for primary care physicians.

Emergent (life-threatening) concerns should be referred directly to **911** or 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	within 48 hours
ADULT	within 48 hours
B. Symptomatic Non-Urgent – e.g., cold, no fever	
PEDIATRICS	within 30 calendar days
ADULT	within 30 calendar days
C. Follow-Up of Urgent Care	
PEDIATRICS	within 7 calendar days
ADULT	within 7 days
D. Chronic Care Follow-Up Care – e.g., blood pressure checks, diabetes checks	
PEDIATRICS	within 14 days
ADULT	within 14 calendar days

continued on following page

E. Complete Physical/Health Maintenance

PEDIATRICS	within 30 calendar days
ADULT	within 60 calendar days

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/Walk-Ins

(Called the 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 appointment; maximum wait time = 90 minutes.

Blue Cross NC discourages walk-ins, but reasonable efforts should be made to accommodate patients. Life-threatening emergencies must be handled immediately.

3. After Hours Call and Coverage (for home-based primary care providers, this standard is not applicable)

3A. Response Time Returning Call After-Hours (Minutes)

***URGENT**	20 minutes
OTHER	1 hour

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

continued on following page

3B. Coverage

Practice has a recorded telephone message instructing the patient to go to the ER for any life-threatening event or refers them to the physician on-call, to an answering service or nurse triage service.

4. Language

Interpreter services are available either in the practice, with a contracted interpreter phone line or through hospital interpreter services.

5. Office Hours

Indicates the posted hours during which appropriate personnel (i.e., MD, DO, FNP, PA) are 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	24 hours/day coverage
WEEKEND HOURS/WEEK	24 hours/day coverage

13.6.2
Access to care standards (specialists – including non-MD specialists)

The following Access to Care Standards for specialists have been established by the Blue Cross NC Physician Advisory Group. Non-MD specialists are Chiropractors (DC), Podiatry (DPM), Physical Therapy, Speech Therapy and Occupational Therapy.

1. Waiting Time for Appointment (Number of Days)

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

PEDIATRICS	within 48 hours
ADULT	within 48 hours

B. Regular

PEDIATRICS	within 2 weeks
ADULT	Sub-acute problem (of short duration): within 2 weeks Chronic problem (needs long time for consultation): within 4 weeks

2. Time in Waiting Room (Minutes)

A. Scheduled

After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time = 60 minutes.

B. Work-Ins/Walk-ins

(Called the 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 wait time = 90 minutes.

continued on following page

3. After Hours Call and Coverage

3A. Response Time Returning Call After-Hours (Minutes)

***URGENT**	20 minutes
OTHER	1 hour

3B. Coverage

DAYTIME HOURS/WEEKS	40 hours/week
NIGHT HOURS/WEEKEND	24 hour/day coverage

Practice has a recorded telephone message instructing the patient to go to the ER for any life-threatening event or refers them to the physician on-call or to an answering service.

4. Language

Interpreter services are available either in the practice, with a contracted interpreter phone line or through hospital interpreter services.

5. 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

13.6.3

Access to care standards (behavioral health)

The following Access to Care Standards for behavioral health have been established by the Blue Cross NC Provider Advisory Group.

Waiting Time for Appointment
Life-Threatening Emergency
Seen immediately or referred to the ER
Non-Life Threatening Emergency
Seen within 6 hours
Urgent Care
Seen within 48 hours
Initial Visit for Routine Care
Seen within 10 business days
Routine Office Visit
Seen within 30 business days

13.6.4
Facility standards

The following quality standards for the facilities of practices participating in our managed care programs have been adopted by Blue Cross NC and endorsed by the Physician Advisory Group for use in assessing the environment in which health care is provided to our members.

1. **PHYSICAL APPEARANCE –**

   General appearance of the facility provides an inviting, organized and professional demeanor.

   a. The grounds are well kept and patient parking is adequate with easy traffic flow.
   b. The office name or address is clearly visible from the street and office hours are posted.
   c. Internal waiting area(s) and treatment rooms are clean, well lit and smoke free.
   d. Exam and treatment rooms are clean and provide privacy for patients. (Conversations in the office/treatment area should be inaudible in the waiting area.)
   e. Halls, storage areas and stairwells are neat, uncluttered and a safe environment is maintained.
   f. There is an emergency lighting source.

2. **PHYSICAL ACCESSIBILITY –**

   Office allows ease of entry into the building with appropriate accessibility within the building.

   a. There are clearly marked handicapped parking space(s) and handicapped access to the facility or documented process for assisting handicapped patients into the building.
   b. Designated toilet and bathing facilities are easily accessible and equipped for the handicapped (i.e., grab bars).
   c. The room is large enough to accommodate a sixty inch (60") diameter wheelchair turn.
   d. Doors are sufficient width (twenty-eight inches [28"]) to accommodate EMS personnel and equipment.

***Exception:** Number 2(b), 2(c) and 2(d) above may be excluded from score (marked NA) if **1)** the building is rented; **2)** the owner refuses to upgrade the facility; and **3)** the practice provides written documentation of attempts to have the owner upgrade.

3. **ADEQUACY OF WAITING AND EXAM ROOM SPACE –**

   The organization allows for the appropriate size and seating for waiting rooms.

   a. The exam room is a minimum of ten foot by ten foot (10' x 10') or will accommodate four (4) people comfortably.
   b. There is a minimum of two (2) seating areas in the exam room to allow adequate seating for patients and family members.

4. ADEQUACY OF MEDICAL/TREATMENT RECORD KEEPING –

Record keeping is orderly, secure, confidential and well documented.

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

b. There is a procedure for monitoring expiration dates of all medications in the office (i.e., medication logs).

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

d. Dedicated emergency kit is available which must include sufficient equipment/supplies to support life until patient can be moved to an acute care facility (minimum equipment should include Ambu bag [adult, pediatric and infant, if applicable] and oxygen).

e. At least one (1) staff member is certified in CPR or basic life support.

f. Emergency procedures are in place and are reviewed with staff members at least annually. (Review must be documented.)

g. Emergency medications are available. (Emergency medications should include at a minimum aspirin [adults], glucose gel/tablets, epinephrine and Benadryl.)

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

i. A written infection control policy/program is maintained by the practice. (There is a periodic review and staff in-service on infection control.)

j. Sterilization procedures and equipment are available.

k. There is an adequate tracking method in place to retrieve medical records. Practice must be able to retrieve all records when requested for review. For ACA products, CMS requires retention of medical record information for a minimum of ten (10) years.

l. A quality improvement committee meeting is held at least every six (6) months and minutes are kept of the meeting (urgent care/convenience care only).

m. For non-physician clinics, clinical care protocols are available for review onsite reflecting physician oversight and approval that are updated at least annually (reviewer must see) (Retail clinic [RC]/ Convenience Care [CC] clinics only).

n. Medical home follow-up care referral lists are available and updated at least quarterly (reviewer must see) (RC/CC clinics only).

o. Written protocols are in place requiring medical records to be sent to the designated medical home provider for continuity of care purposes (reviewer must see) (RC/CC clinics only).

p. Electronic health record is utilized and is capable of transferring information to medical home provider (RC/CC clinics only).

13.6.5
Urgent care standards

The following standards for the facilities of convenience care/retail clinics participating in the Blue Cross NC Provider Network have been adopted by Blue Cross NC and endorsed by the Physician Advisory Group for use in assessing the environment in which health care is provided to our members.

1. The general appearance of the facility provides an organized and professional demeanor including, but not limited to, the following:
    a. The external grounds are well kept; patient parking is adequate with easy traffic flow.
    b. The office name or address is clearly visible from the street and office hours are posted.
    c. The internal waiting area(s) and treatment rooms are clean, well lit and smoke free with adequate seating for patients and family members.
    d. Exam and treatment rooms are clean, have adequate space and provide privacy for patients. (Conversations in the office/treatment area should be inaudible in the waiting area.)
    e. Halls, storage areas and stairwells are neat, uncluttered and a safe environment is maintained.
    f. Doors of sufficient width (twenty-eight [28] inches minimum) to accommodate EMS personnel and equipment.
2. There are clearly marked handicapped parking space(s) and handicapped access to the facility.
3. Designated toilet and bathing facilities are easily accessible and equipped for the physically challenged.
4. There is an emergency lighting source.
5. 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, third party payors, 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.
6. Biohazard and restricted 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.
7. Medications:
    a. Controlled substances are maintained in a locked container/cabinet. A record is maintained of use.
    b. There is a procedure for monitoring expiration dates of all medications in the office (i.e., medication log).
8. Dedicated emergency kit is available which must include sufficient equipment/supplies to support life until patient can be moved to an acute care facility (at minimum: Ambu bag for adult, pediatric and infant if applicable) and oxygen.

9. At least one (1) staff member certified in CPR or basic life support is on site at all times.
    a. Emergency procedures are in place and are reviewed with staff members annually. Review must be documented.
    b. Emergency supplies include, but are not limited to, emergency medications: aspirin (adults only), glucose tablets or gel, epinephrine and Benadryl.
    c. Emergency supplies are checked routinely for expiration dates. A separate log is maintained documenting the routine checks.
10. A written infection control policy/program is maintained by the practice. (There is periodic review and staff in-service on infection control.)
11. Sterilization procedures and equipment are in place and being followed.
12. The practice has an established quality improvement process which includes the quality improvement committee meeting at least every six (6) months.
13. The quality improvement committee monitors and documents care processes and outcomes appropriate for the practice.
14. There is an adequate tracking method in place to retrieve medical records. Practice must be able to retrieve all records when requested for review. For ACA products, CMS requires retention of medical record information for a minimum of ten (10) years.

***Exception:** Number **three (3)** above may be excluded from score if: **1)** The building is rented; **2)** the owner refuses to upgrade the facility; and **3)** the practice provides written documentation of attempts to have the owner upgrade. Must provide age of building if seeking exception to number **three (3)**.

13.6.6
Medical records standards for primary care, specialty and home-based care providers

Through our Physician Advisory Group and quality improvement committee, Blue Cross NC has established the following medical record standards.

Medical record standards and supporting documentation required:

- **All pages contain patient identification.**
  Each page in the medical record must contain the patient's name or ID number.

- **Each record contains biographical/personal data.**
  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.

- **The provider is identified on each entry.**
  Each entry in the medical record must contain author identification, including credentials (signature or initials).

- **All entries are dated.**
  Each entry in the medical record must include the date (month, day and year).

- **The record is legible.**
  The medical record must be legible to someone other than the writer.

- **There is a completed problem list.**
  The flow sheet includes age appropriate preventive health services. A blank problem list or flow sheet does not meet this standard.

- **Allergies and adverse reactions to medications are prominently displayed.**
  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.

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The record contains an appropriate past medical history.

Past medical history (for patients seen three [3] 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.

Documentation of smoking habits, alcohol use and substance use.

The medical record should reflect the use of or abstention from smoking (cigarettes, cigars, pipes and smokeless tobacco), alcohol (beer, wine, liquor) and substance use (prescription, over-the-counter and street drugs) for all patients ages 11 and above who have been seen three (3) or more times. It is best to include the amount, frequency and type in use notations.

The record includes a history and physical exam for presenting complaints.

The history and physical documents appropriate subjective and objective information for presenting complaints.

Each encounter includes a date for a return visit or other follow-up plan.

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).

Problems from previous visits are addressed.

Unresolved problems from previous office visits are addressed in subsequent visits.

Appropriate use of consultant services is documented.

Documentation in the record supports the appropriateness and necessity of consultant services for the presenting symptoms and/or diagnosis.

Continuity and coordination of care between primary and specialty physicians or agency documented.

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.).

continued on following page

Consultant summaries, lab and imaging study results reflect review by the primary care physician.

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.

Paper and/or electronic charts are maintained in an organized format.

There is a record keeping system in place that ensures all paper and/or electronic charts are maintained in an organized and uniform manner. All information related to the patient is filled in the appropriate place in the chart.

Review of chronic medications if appropriate for the presenting symptoms.

There is documentation in the record, either through the use of a medication sheet or in the progress notes.

School-based health only:
Follow-up care/medical home referral documented and records sent to medical home.

There is documentation in the medical record that each encounter has been sent to PCP and if a follow-up visit is necessary, a referral was made with the medical home PCP.

Document all conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or management.

Entries signed by provider.

Each entry in the medical record must contain author identification, including credentials (signature or initials).

Documentation of medical record format used in practice:

- Paper
- Electronic Health Record (EHR): EHR is a system that is electronic and has searchable data fields that allow reports to be run
- Name of EHR system and the version being used

13.6.7

Medical records standards for urgent care (i.e., convenience care, retail clinics) providers

Through our Physician Advisory Group and quality improvement committee, Blue Cross NC has established the following urgent care medical record standards:

Medical record standards and supporting documentation required:

- **History of current illness/injury.**
  The history documents appropriate subjective information for presenting complaints.

- **Physical status.**
  Documents appropriate objective information for presenting complaints.

- **Diagnostic data appropriate and in record.**
  Diagnostic studies are ordered as appropriate to presenting complaints.

- **Allergies prominently displayed.**
  Medication allergies and adverse reactions are PROMINENTLY noted in a CONSISTENT place in each medical record. Absence of allergies must also be noted. Use NKA (no known allergy) or NKDA (no known drug allergy) to signify this.

- **Patient name on each page.**
  Each page in the medical record must contain the patient's name or ID number.

- **Legible.**
  The medical record must be legible to someone other than the writer.

- **Care medically appropriate.**
  Medical record documentation verifies that the patient was not placed at inappropriate risk as a result of a diagnostic or therapeutic process.
  For convenience care clinics:
  * Consistent with approved onsite clinical protocols for nurse practitioner (NP) and physician assistant (PA) clinics.

continued on following page

Follow-up care and referrals.

** Follow-up care and medical home referral documented.

Medical records sent to medical home noted.

** Record indicates that medical records were sent to medical home.

Date of visit noted.

Each entry in the medical record must include the date (month, day and year).

Entries signed by provider.

Each entry in the medical record must contain author identification, including credentials (signature or initials).

Convenience care clinics:

* NP and PA clinics, protocols must be reviewed and approved by Blue Cross NC.

** Required for convenience care medical record request (MRR).

Note: While standards seven (7) and eight (8) are not required for urgent care facilities, it is the recommendation by Blue Cross NC that the urgent care practice have procedures in place to document the patient's medical home follow-up and referral.

13.7
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.

13.7.1
Nationally accepted guidelines

Blue Cross NC endorses the following nationally recognized clinical practice and preventive care guidelines:

- Asthma
- Cholesterol management
- Coronary Artery Disease
- Diabetes
- Heart failure
- Hypertension
- Overweight and obesity
- Tobacco counseling
- Additional guidelines for:
  - Attention Deficit Disorder (ADD)
  - Attention Deficit Hyperactivity Disorder (ADHD)
  - Depression
  - Imaging for low back pain
  - Inappropriate antibiotics use
  - Prenatal care

Please Note: Guidelines are subject to change and that the most current guidelines are published and made available to providers at the Blue Cross NC website: **BlueCrossNC.com/Providers/Network-Participation/Resources**. Providers are encouraged to visit the **BlueCrossNC.com** website regularly to receive the most current and up-to-date information available.

13.7.2
Preventive care guidelines

The Blue Cross NC preventive care guidelines are updated regularly and available to providers on the **BlueCrossNC.com** website for providers at **BlueCrossNC.com/Providers/Network-Participation/Resources**. 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.

13.8
Quality of care concern process

Definitions and application

Blue Cross NC 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. During the quality of care concern review process, medical records may be requested from the provider by that Plan for which providers are contractually obligated to provide to Blue Cross NC without any additional payment from the member nor Blue Cross NC.

13.8.1
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

13.8.2
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 Blue Cross NC medical director for a pattern of care review:

- Three (3) complaints within six (6) months
- Five (5) complaints within one (1) year
- Eight (8) complaints within two (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:

- Two (2) in six (6) months and additional complaints, regardless of disposition within six (6) months
- Three (3) in one (1) year and two (2) additional complaints, regardless of disposition within one (1) year
- Five (5) in seven (7) years and four (4) additional complaints, regardless of disposition within two (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 quality improvement (QI) coordinator to prepare for the credentialing committee review.

Follow-up by the Blue Cross NC 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 14** to review the process followed once an issue is referred to the credentialing committee.

Visit Blue Cross NC's website at **BlueCrossNC.com** for the latest information and updates regarding preventive care guidelines including vaccine schedules.

13.9
Preventive and behavioral health initiatives

13.9.1
Behavioral health initiatives

- **Follow-up after hospitalization or emergency department visit for mental illness:**

  This HEDIS measure looks at appropriate follow-up care after discharge from a hospital or emergency department with a mental health diagnosis. Blue Cross NC's behavior health vendor(s) implements initiatives associated with this measure with oversight provided by Blue Cross NC.

- **Follow-up after emergency department (ED) visit for alcohol or other drug use:**

  Blue Cross NC implements initiatives associated with this measure to ensure appropriate follow-up care post-ED visit.

13.9.2
Preventive care reminders

- **Childhood immunizations:**

  Reminder postcards are sent to families with children under two (2) years of age who are due for the CDC-recommended immunization, Pneumococcal Conjugate Vaccine (PCV). While the target population will be identified based on missing one (1) specific immunization, the goal is to increase overall use of all CDC-recommended vaccines in the target population.

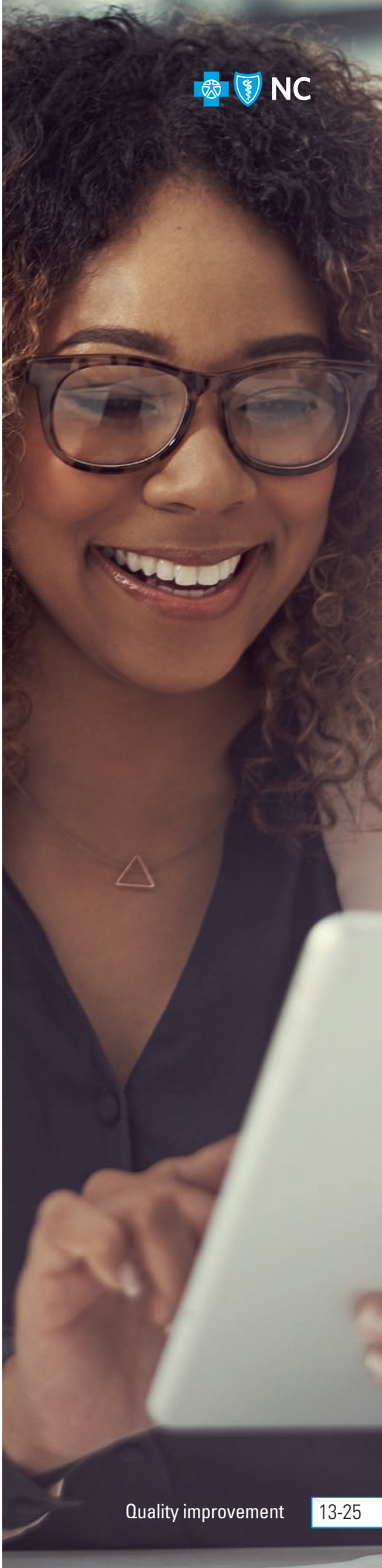
- Mothers of newborn may receive a congratulatory letter with an educational packet of Milestones Checklist from the CDC and a "Your Child's Health Records" booklet from American Academy of Pediatrics. The CDC materials are available at cdc.gov/ncbddd/actearly/pdf/checklists/Checklists-with-Tips_Reader_508.pdf.
- Members receive targeted reminder letters to encourage them to schedule an appointment for overdue health screenings including mammograms, colon cancer screenings, pap tests, cholesterol screening, diabetes screening and pneumococcal vaccine. The letter features a unique tear-off section that lists the specific health screenings that apply to them. The tear-off includes space for members to record the date of scheduled appointments as well as a checklist of preventive services on the back.

13.10
Quality-based programs

Blue Cross NC offers quality-based network programs designed to strengthen and improve the quality of our Provider Networks. Quality-based programs recognize providers who offer members outstanding quality care, and drive members to providers who embrace quality improvement. Information regarding Blue Cross NC quality-based programs is available online at **BlueCrossNC.com/Providers**.

13.10.1
Blue Distinction Centers

The Blue Distinction Centers program recognizes top-performing specialty doctors and health care facilities that meet strict national quality standards. Members can find facilities for a variety of procedures, such as cardiac care and spine surgery.



14

Provider data management and credentialing

14.1
Provider demographics

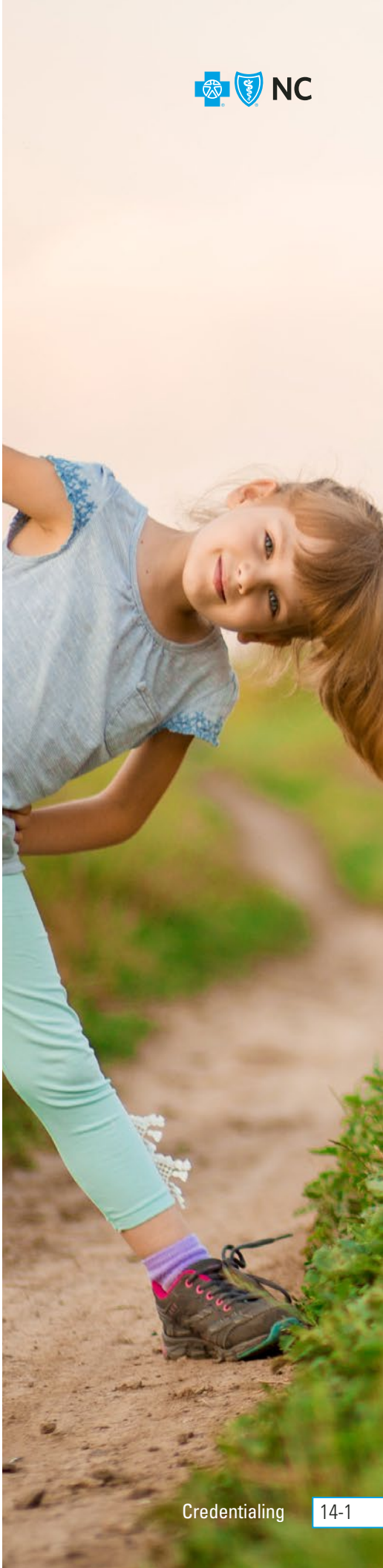
So that our members can quickly locate health care providers and schedule appointments, Blue Cross NC routinely updates the online provider directory with addresses, phone numbers, translation service(s) and current lists of all providers at a participating facility/practice. Our ability to successfully 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 Blue Cross NC website, **BlueCrossNC.com**, to validate your health care business's information.

If you find that your information needs to be updated, please let us know by contacting Blue Cross NC provider data management. Providers should complete the demographic change form available at **BlueCrossNC.com** or correct and attest to demographic accuracy through Quest Analytics Portal or by sending an updated spreadsheet to Quest (see form layout in the forms section) for compliance with the 2022 legislation. If you or your office personnel speak languages other than English, or if your practice/facility has access to translation services, let us know by emailing us at **credentialing@bcbsnc.com**.

Please Note: Having accurate mailing information on file for your practice ensures you receive claims payments and other important correspondence in a timely manner from Blue Cross NC.

You are required to maintain an email address that can be used by Blue Cross NC to contact you and to provide that email address to Blue Cross NC upon request.

The new legislative requirement (No Surprises Act) effective 1/1/22 requires all practitioners and providers to update demographic information every 90 days or the location information not attested will be suppressed from the online find a doctor tool.



14.2
Provider data management

For questions about submitting requests to provider data management department please review the provider page at **BlueCrossNC.com**. If you need resolution that requires you to speak to a customer contact agent, please contact the phone number listed on this page. Changes that can be submitted via the website may include:

- 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)
- NPI
- Telephone number, including daytime and twenty-four (24) hour numbers
- Hours of operation
- Covering physicians
- Language or translation service(s) offerings

Please notify us at least thirty (30) days in advance of planned changes to your practice, facility or entity. If you plan to acquire or merge your practice with another provider, all participating providers (i.e., professional providers, facilities and ancillary entities) are required to give a 60-day advance notice of this change prior to the effective date. An acquisition form must be completed and all supporting documentation submitted. Completing the acquisition form is the most efficient way to report an acquisition, merger or buyout between providers, facilities and entities. The acquisition form can be found at the following link: **BlueCrossNC.com/Providers/Network-Participation/Provider-Facility-Applications/Provider-Acquisition**.

Provider data management contact information:

Provider Contact Center

1-800-777-1643

Fax

919-765-4349

Email

ProviderUpdates @bcbsnc.com

Address

P.O. Box 2291 Durham, NC 27702-2291

14.3
Credentialing/recredentialing

The purpose of credentialing physicians and providers is to exercise reasonable care in the selection and retention of competent, participating providers. The initial credentialing process can take up to sixty (60) days for completion from the date a completed application is received by Blue Cross NC. Blue Cross NC deems an application to be complete when all applicable sections of the uniform application are completed accurately along with all required supporting documentation. Becoming an in-network Blue Cross NC provider or facility is a multi-step process that includes credentialing, completing a detailed Blue Cross NC Individual/Group Provider Enrollment form, submitting an application for electronic funds transfer (EFT), and more. Provider must first have their credentials verified. Some specialties may have additional requirements. The instructions for providers and facilities can be found at the following link: **BlueCrossNC.com/Providers/Network-Participation/Provider-Facility-Applications**. 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 two [2] or more malpractice settlements)

Initial credentialing requires non-facility practitioners to complete the CAQH universal application (register at CAQH.org) and upload all relevant and required documentation. You must complete and submit your application through CAQH – Proview. Once submitted Blue Cross NC will access your application file for verification and processing. To ensure that our quality standards are consistently maintained, providers are recredentialed at least every three (3) years.

Additional information required by the provider data management includes the following:

- CAQH provider ID**
- W-9 Form**

Any practitioner who seeks reinstatement in any of our networks after being out-of-network for more than thirty (30) days is required to undergo initial credentialing.

* For physicians who are not board certified, letters of reference will be required in support of the application.

** Samples of these forms may be found in **Chapter 21**.

14.3.1
Urgent care

Family practice, pediatrics and emergency medicine physicians may be credentialed as Blue Cross NC urgent care providers if they have met the following requirements:

- One (1) year of experience covering the full spectrum of care found in an urgent care setting
- Board certified in specialty
- CPR card required for PharmD's

14.3.2
Locum tenens

For purposes of a locum tenens provider, a practice must submit the Statement of Supervision form to provider data management prior to the effective start date of the locum tenens provider. The Statement of Supervision for the locum tenens provider will remain in effect for a maximum time period of ninety (90) days.

14.4
Council for Affordable Quality Healthcare (CAQH)

Blue Cross NC, working with the CAQH, is committed to streamlining the administrative process for physicians and other health care providers. Blue Cross NC has been an active participant in CAQH's efforts to help eliminate the need for physicians and other health care providers to fill out and submit multiple credentialing/recredentialing applications.

Blue Cross NC requires non-facility-based health care providers to register with CAQH and obtain a CAQH ID prior to enrolling in Blue Cross NC health plans. Blue Cross NC also requires that practitioners and allied health providers use CAQH for the common application.

To register with CAQH, please visit their website at **www.CAQH.org**.

14.5
Policy for practitioners pending credentialing

Blue Cross NC's current credentialing policy states that in order to receive the contracted reimbursement for covered services provided to a Blue Cross NC HMO, POS, PPO or EPO member, a practitioner must be credentialed and enrolled by Blue Cross NC.

Claims for covered services provided to Blue Cross NC HMO, POS, PPO or EPO members by a non-participating practitioner in a participating provider group will be denied. The Blue Cross NC member will be held harmless, including any copayments, coinsurance or deductibles.

14.5.1
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 the new provider is unable to submit the credentialing application in a timely manner, we have created a standard operating procedure which requires a Statement of Supervision form to be completed. This form will allow reimbursement for covered services provided by a non-participating provider who is in the process of joining a Blue Cross NC participating practice. The following must apply:

- A credentialing application must have been submitted to Blue Cross NC and a determination on such application is pending.
- The new provider must provide covered services to Blue Cross NC members under the direct supervision of a Blue Cross NC-similarly licensed and credentialed provider in the same practice who agrees to sign the medical record related to such treatment and files the claim under the Supervising provider's NPI.
- The Statement of Supervision form must be completed, signed and submitted to the provider data management department at **credentialing@bcbsnc.com** or by contacting Network Management at **800-777-1643**.

If you have any questions regarding the Statement of Supervision form, please call Network Management at **800-777-1643** for assistance.

14.6
Credentialing grievance procedure

There are times when Blue Cross NC must take immediate action to terminate a provider's contract in order to maintain the integrity of the HMO/POS/PPO/EPO 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
- Provider(s) name on CMS preclusion list

Upon receipt of notification of these actions, the provider will be notified of Blue Cross NC's intent to terminate them from the HMO/POS/PPO/EPO 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.

14.6.1

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/EPO 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 thirty (30) days from the date or the initial notification of termination.
- Our credentialing committee will review the additional information provided and make a recommendation to either uphold or reverse the original determination. The provider will be notified via certified mail of the decision and of their right to request a Level II appeal if the decision is unchanged.

14.6.2
Level II appeal (formal hearing)

A request for a Level II appeal must be made within thirty (30) days of the date of the certified letter from the results of the Level I appeal.

Practitioners requesting hearings within the specified time frame will be sent an acknowledgement letter within seven (7) business days giving notice as to the date, time and location of the hearing. The date of the hearing should not be less than thirty (30) days after the date of the notice.

A list of witnesses (if any) expected to testify on behalf of Blue Cross NC's credentialing committee should be given to the practitioner and similar information requested from the practitioner, i.e., notice of representation witness(es).

Blue Cross NC 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 Blue Cross NC may be represented by counsel or other person of their choice.
- **Court reporter:** Blue Cross NC may arrange for a court recorder to provide a record of the hearing. If Blue Cross NC 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 Blue Cross NC:** Blue Cross NC may present any information which is in the practitioner's Credentialing file that was used at the time of the initial determination when the practitioner was referred for decredentialing or used in the Level I appeal review. Only documentation that was used and considered during the initial Credentialing Committee determination or the Level 1 appeal can be introduced in the Level II appeal. Blue Cross NC shall have up to fifteen (15) minutes to present evidence.
- **Presentation of evidence by practitioner/provider:** Following Blue Cross NC's submission of its evidence, the practitioner may present their evidence. The practitioner's evidence is limited to what is contained in the information which is in the practitioner's Credentialing file that was used at the time of the initial determination when the practitioner was referred for decredentialing or used at the Level 1 appeal review. Only documentation that was used previously and considered during the initial Credentialing Committee determination or at Level I appeal can be introduced at Level II appeal. The practitioner shall have up to fifteen (15) minutes to present their evidence.
- **Questions for hearing panel:** Following submission of evidence by the parties, the Level II appeal hearing panel shall have up to thirty (30) minutes to present questions to the parties. The Level II appeal hearing panel may direct questions to either or both parties in any order at the discretion of the hearing panel. Any opportunity to present a closing or final statement by either party shall be at the discretion of the Level II hearing panel, and shall only be allowed if sufficient time remains in the thirty (30) minutes allowed for questions from the hearing panel.

- **Examination by the appeals committee:** Throughout the hearing, the appeals committee may question any witness who testifies.

The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear. In the hearing the practitioner has the right to representation by an attorney or other person of the practitioner's choice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated in preparation thereof, to call, examine and cross-examine witnesses, to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and to submit a written statement at the closing of the hearing.

Upon completion of the hearing, the practitioner involved has the right to receive a written recommendation of the arbitrator, officer or panel, including a statement of the basis for the recommendation, and to receive a written decision of the health care entity, including a statement of the basis for the decision.

The practitioner will be notified via certified letter within five (5) days from the date of the hearing of the final determination.

If a request for reconsideration or a formal hearing is not made by the practitioner within thirty (30) days of the receipt of the initial notification or thirty (30) days from the receipt of the notification of the Level I appeal decision, Blue Cross NC 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 the Provider Network operations department to proceed with termination from all managed care networks (HMO/POS/PPO/EPO). Communication will be sent from the Provider Network operations to the credentialing manager's administrative assistant to confirm the termination of the provider with copies sent to the managers of credentialing, the Provider Network, 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 Blue Cross NC managed care network.

If Blue Cross NC 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 Blue Cross NC to be placed in the subscriber file.

14.6.3
Provider rights and responsibilities

All practitioners applying for credentialing and recredentialing have the following rights:

- To review information submitted to support their credentialing application
- To correct erroneous information within forty-five (45) days from the notification
- To be informed, upon request, of the status of their credentialing or recredentialing application
- To be notified of these rights via website
- To be notified verbally or in writing of any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner

15

Quality and credentialing programs for ancillary providers

15.1
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 (4) hours as required
  - Home health and private duty nursing of less than or equal to twenty-four (24) hours
  - Twenty-four (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 (4) hours or less
- Delivery response time for non-custom equipment of twenty-four (24) hours or less

Hospice providers must meet the following service standards:

- Care must be available twenty-four (24) hours per day, seven (7) 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)

15.2
Dialysis facility provider standards

Dialysis facility providers must meet the following service standards:

- Patient must receive full amount of treatment as ordered by their physician
- Patient should have twenty-four (24) hour emergency telephone access to at least one (1) 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 (1) member of the dialysis team (preferable the social worker) must be available as Blue Cross NC's primary contact regarding patient's care management

15.3

Eligibility requirements for traditional/comprehensive major medical products

- To be eligible for participation in the Blue Cross NC traditional network, providers must meet the eligibility criteria listed below.
- All credentials must be maintained in good standing to remain a contracting provider.

ELIGIBILITY REQUIREMENTS FOR TRADITIONAL/ COMPREHENSIVE MAJOR MEDICAL PRODUCTS

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:			
HOME HEALTH AIDE	REQUIRED		
INFUSION NURSING		REQUIRED	
MEDICAL SOCIAL SERVICES	REQUIRED		
NURSING SERVICES	REQUIRED		OPTIONAL
OCCUPATIONAL THERAPY	REQUIRED		
PHYSICAL THERAPY	REQUIRED		
PRIVATE DUTY NURSING			REQUIRED
SPEECH THERAPY	REQUIRED		
2. Current pharmacy permit from NC Board of Pharmacy or contact with NC licensed pharmacy		REQUIRED	

continued on following page

Home Care Agency Eligibility for Traditional/Comprehensive Major Medical	Home Health Services	Home Infusion Therapy	Private Duty Nursing Services
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:	
INPATIENT HOSPICE	REQUIRED
NURSING SERVICES	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

continued on following page

Dialysis for Traditional/ Comprehensive Major Medical	Dialysis Services
1. Copy of 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 three (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	

continued on following page

HDME Credentials for Traditional/ Comprehensive Major Medical	Medical Equipment and Devices	Orthotics and Prosthetics
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 IN AGGREGATE	REQUIRED	REQUIRED
4. Completion of Ancillary Provider Application for Participation	REQUIRED	REQUIRED

15.4
Eligibility requirements for managed care products (credentialing)

- To be eligible for participation in Blue Cross NC PPO, POS, EPO 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 (3) 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.

ELIGIBILITY REQUIREMENTS FOR MANAGED CARE PRODUCTS (CREDENTIALING)

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 each location, and for the following services:			
HOME HEALTH AIDE	REQUIRED		
INFUSION NURSING		REQUIRED	
MEDICAL SOCIAL SERVICES	REQUIRED		
OCCUPATIONAL THERAPY	REQUIRED		
PHYSICAL THERAPY	REQUIRED		
PRIVATE DUTY NURSING			REQUIRED
SKILLED NURSING SERVICES	REQUIRED		OPTIONAL
SPEECH THERAPY	REQUIRED		
2. Current pharmacy permit from NC Board of Pharmacy		REQUIRED	

continued on following page

Home Care Agency Credentials for Managed Care Products	Home Health Services	Home Infusion Therapy	Private Duty Nursing Services
3. Current accreditation from at least one 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
$3 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. Current accreditation from at least one of the following agencies: • Also, The Compliance Team Inc.'s Exemplary Provider Award Program (ISO) • JCAHO • CHAP • NC 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
3. Current commercial liability insurance with the following minimum coverage:		
$1 MILLION PER OCCURRENCE	REQUIRED	REQUIRED

continued on following page

HDME Credentials for Managed Care Products	Medical Equipment and Devices	Orthotics and Prosthetics
4. Completion of Ancillary Provider Application for Participation	REQUIRED	REQUIRED
5. 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

continued on following page

Dialysis Credentials for Managed Care Products	Dialysis Services
1. Copy of 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 quality improvement (QI) or utilization management (UM) program • Copy of the UM, quality management (QM) and infection control policy copy of CLIA • Current copy of ESRD report • Copy of accreditation (if applicable)	REQUIRED

16

Appeal and grievance procedures

16.1
Disclaimer

The information contained in this chapter is current as of the date of publication of this e-Manual. For the most current information regarding the appeals process, call the Provider Blue Line at **1-800-214-4844** or visit our website at **BlueCrossNC.com**.

16.2
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, Blue Cross NC 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)
- Blue Cross NC decisions related to the availability, delivery or quality of health care
- Claims payment, handling or reimbursement
- The relationship between Blue Cross NC and the member

In order for you, the provider, to represent the member in a 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 21**. Requests for review should also include pertinent medical records not previously supplied to Blue Cross NC.

Member authorization must be received by Blue Cross NC 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 Blue Cross NC via mail or fax.

Submit documents:

Member Appeals

Blue Cross NC
Member Appeals
P.O. Box 30055
Durham, NC 27702-3055

Member Appeals Fax Number

919-765-4409

State Health Plan Member Appeals Fax Number

919-765-2322

16.3
Appeals and grievances for mental health and substance use services

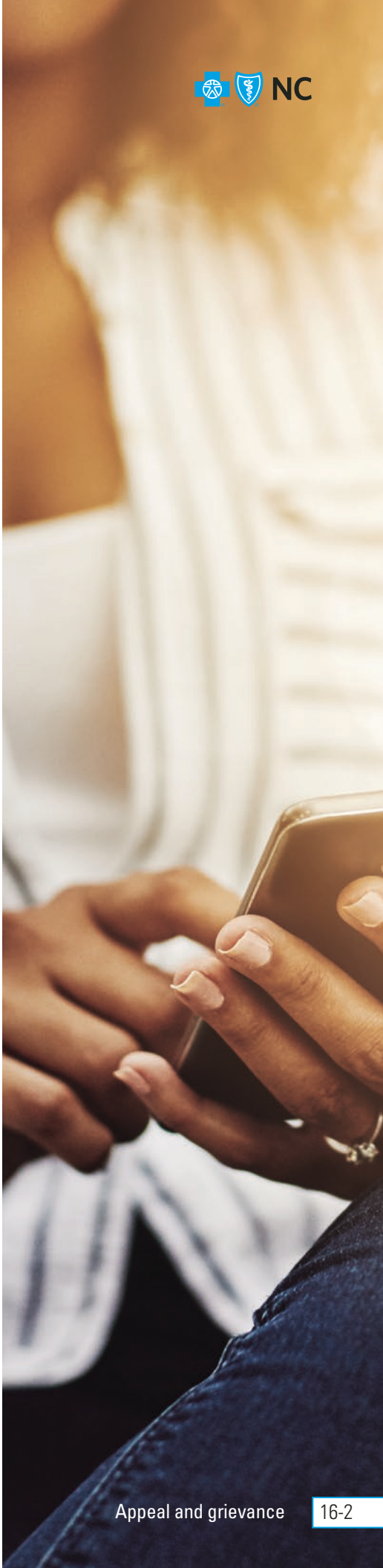
Appeals and grievances for mental health and substance use services are processed by Blue Cross NC.

16.4
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**. A decision will be made within seventy-two (72) hours of receiving all information, and a written decision from the Plan will be forwarded to you and the member within two (2) business days, but no later than three (3) days from the date all information necessary to review the appeal was received.

16.5
Member grievance policy

Occasionally, Blue Cross NC receives complaints from members about a provider or their staff regarding quality of care issues. In order to appropriately respond to our members, Blue Cross NC may ask you to review and provide a written response to such cases. You are required to cooperate with Blue Cross NC member grievance policies and must respond to Blue Cross NC direct inquiries within the time frame specified in each request. This will ensure the best service to our mutual customer.



16.6
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 7.**

Level I provider appeals consist of retrospective reviews and do not require a member signed authorization. A post-service Level I provider appeal of claims is performed based on your belief that a claim has been denied or adjudicated incorrectly. The provider appeal process is separate from Blue Cross NC's member rights and appeals process. Refer to **Section 16.2** 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 by submitting the Level I Provider Appeal form. You may 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 ninety (90) calendar days from the adjudication date to submit the Level I provider appeal or dispute.

To request a review, complete the Level I Provider Appeal form including objective medical documentation.

Always print a new form from the Forms and Documentation or Appeals section of our website each time you submit a Level I Provider Appeal form, in order to ensure that you are using the most current version. Please send the completed Level I Provider Appeal form to Blue Cross NC at the appropriate fax number:

Review of Coding or Bundling Denials	Review of a Medical Necessity Denial, Including No Pre-Authorization for an Inpatient Stay	Review of State Health Plan PPO Authorization Details
Fax to Blue Cross NC **919-287-8708**	Fax to Blue Cross NC **919-287-8709**	Fax to Blue Cross NC **919-765-2322**

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 appeal review. A provider appeal review is a formal review of a payment or denial of a claim. Provider appeal reviews are handled within forty-five (45) days from the date of receipt of all information. Supporting objective medical documentation should be submitted for provider appeal reviews. Providers may reduce administrative costs associated with records submissions by first verifying that the records document information is consistent with Blue Cross NC 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 or no pre-authorization for inpatient hospital admission.

- Level I provider appeal process for coding, bundling and fees applies to processed claims related to:
  - Integral part of primary service
  - Mutual exclusivity
  - 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 inpatient hospital admission

You can fax your inquiries to:

Provider Billing/Coding (Bundling and Fees)

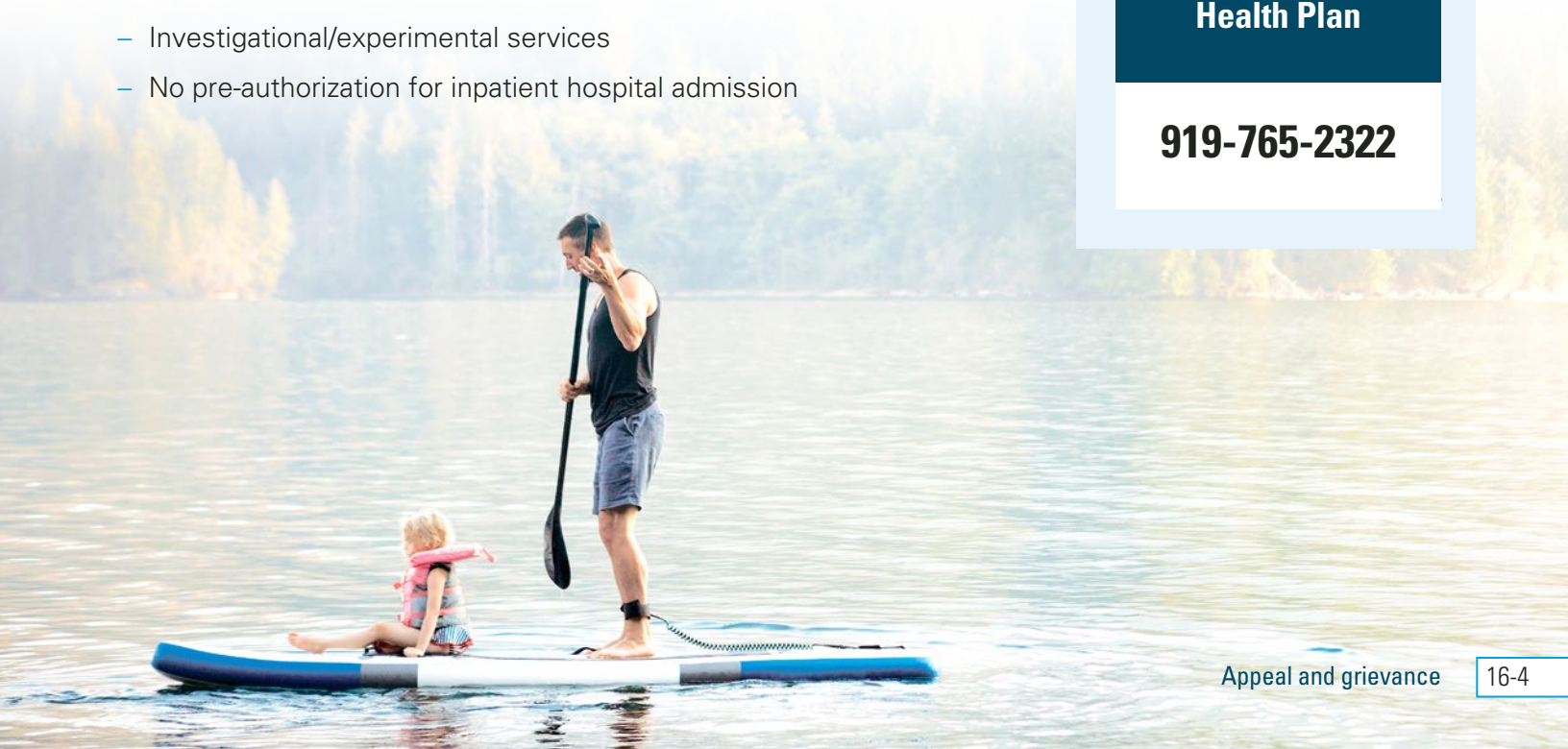
919-287-8708

Provider Medical Necessity

919-287-8709

State Health Plan

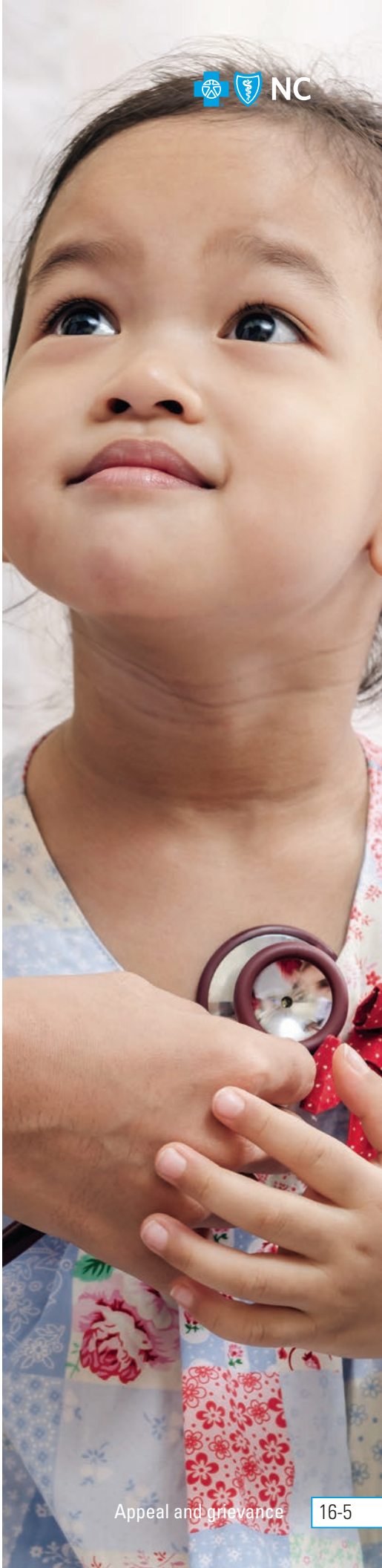
919-765-2322



16.7
Provider resources

The provider website contains a form for requesting provider appeal reviews regarding coding, bundling, fees, cosmetic, investigational, experimental or no pre-authorization for hospital admission. This form is located at **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**. Blue Cross NC provides resources that are readily available which may provide immediate resolution to questions for how a particular claim was considered. Your Blue Cross NC HIPAA 835 ERA provides information about 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 copayment, coinsurance, deductible amounts and status code explanations. Please refer to **Chapter 11** for additional information and services provided via **Blue *e***. 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 C3 pass through page via the **Blue *e*** connection. Please refer to **Chapter 9** for additional information on payment guidelines and C3. 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-10-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 Blue Cross NC website located in 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 Blue Cross NC website at **BlueCrossNC.com/Providers/Policies-Guidelines-Codes**.



17

Pharmacy and specialty networks

17.1
Pharmacy

This chapter does not apply to FEP, BlueCard or State Health Plan.

17.1.1
Formularies

Blue Cross NC currently maintains one open 4-tier formulary and one open 5-tier formulary.

There is also one closed five-tier formulary and one closed six-tier formulary. The formularies are developed through the efforts of the Blue Cross NC pharmacy and therapeutics committee, composed of North Carolina practicing physicians and pharmacists.

The formularies are intended to reflect current clinical practice in North Carolina and have various levels of member copayments, as defined below:

LEVELS OF MEMBER COPAYMENTS			
TIER	**4 TIER FORMULARY**	**5 TIER FORMULARIES**	**6 TIER FORMULARY**
1	Lowest-cost tier of prescription drugs, most are generic	Lowest-cost tier of prescription drugs, most are generic	Lowest-cost tier of prescription drugs, most are generic
2	Medium-cost prescription drugs, most are generic and some are brand-name prescription drugs	Medium-cost prescription drugs, most are generic and some are brand-name prescription drugs	Medium-cost prescription drugs, most are generic and some are brand-name prescription drugs
3	Higher-cost prescription drugs, most are brand-name prescription drugs and some are specialty drugs	High-cost prescription drugs, most are brand-name prescription drugs	High-cost prescription drugs, most are brand-name prescription drugs
4	Highest-cost prescription drugs, most are specialty drugs	Higher-cost prescription drugs, most are brand-name prescription drugs and some are specialty drugs	Higher-cost prescription drugs, most are brand-name prescription drugs and some are specialty drugs
5		Mostly specialty drugs	Mostly lower-cost specialty drugs
6			Mostly high-cost specialty drugs

You may receive calls from members or pharmacists as members seek ways to lower their copayments by having lower tier drugs prescribed. 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.

Three (3) and two (2) tier copayment structures (using different copayments or coinsurance for generic and brand drugs) may be maintained for some groups.

These formularies will continue to promote the use of the most clinically- and cost-effective pharmaceutical products. For your convenience, the most current list of drugs will be posted online at **BlueCrossNC.com**. Our formularies are 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.

17.1.2
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 applicable brand copayment or coinsurance, and also be responsible for paying the difference in cost between the brand-name and generic alternative drug.

We encourage you to prescribe lower cost, equally effective generic drugs where appropriate, and to promote their use by your patients.

17.1.3
Requesting a formulary

We are pleased to offer several ways to access the Blue Cross NC formulary.

Blue Cross NC printed formulary:

To request a printed formulary, please call the Provider Network.

Blue Cross NC online formulary:

Searchable online formulary is available on our website at **BlueCrossNC.com**.

17.1.4
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 formulary are online at **BlueCrossNC.com**.

17.1.5
Prior authorization requests in CoverMyMeds

For all pharmacy and medical benefit drug requests, the preferred method of submission is the CoverMyMeds (CMM) portal. Review requests can be sent electronically through the portal, and the status of requests can also be found at any point. The CMM portal can be accessed at **https://account.covermymeds.com/**.

- If a provider prefers to fax the request, it can be sent via fax.
- Peer to Peer (P2P) requests occur between the designated physician and a clinical review pharmacist. If a case has been denied, a provider may reach out at 1-800-672-7897, and follow the prompts for corporate pharmacy to initiate the P2P process. Option 3, authorization for medication, should be chosen at the prompt.
- Both Medical and Pharmacy benefit reviews are managed by the Clinical Pharmacy Review Team. Medical oncology reviews are handled outside the team by Carelon.
- Review timelines are 72 hours for non-urgent requests, and 24 hours for urgent requests. Providers have 24 hours to respond after provider outreach is made about a case.
- Providers may locate criteria and fax forms at **BlueCrossNC.com/Providers/Prior-Authorization/Prescription-Drugs**.

17.1.6
Certification

Blue Cross NC 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 website, **BlueCrossNC.com/Providers/Prior-Authorization/Prescription-Drugs** for commercial plans.

17.1.7
Quantity limitations

These programs apply to Blue Advantage, Blue Care, Blue Options, Blue Value and Blue Select members. Quantity limits may apply to coverage of certain drugs with the goal of optimizing patient outcomes. This program applies coverage limits to drugs that have the potential for abuse or misuse. If those patterns are different from what you intended, you will have the opportunity to intervene before the prescription is dispensed to the member.

Blue Cross NC will pay for quantities of limited drugs up to the allowed amount in a defined time period. If based on your clinical judgment, 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 Blue Cross NC, you may request certification for a greater quantity. Members may choose to pay cash for quantities that exceed Blue Cross NC'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 website, **BlueCrossNC.com/Providers/Prior-Authorization/Prescription-Drugs** for commercial plans.

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**.

17.1.8
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 thirty (30) day supply.

17.1.9
Extended supply prescriptions

Medicare supplement

Members may obtain up to a ninety (90) day supply of their medication from pharmacies participating in the extended supply network. Extended supply prescriptions must be written for a ninety (90) day supply rather than a thirty (30) day supply, regardless of the number of refills.

17.1.10
Drug utilization review

Blue Cross NC 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.

17.2
Behavioral health and substance use services

For members in HMO, PPO, CMM and EPO products, access to services for behavioral health and substance use is through the Blue Cross NC Provider Network.

17.2.1
Referrals/prior review/health coaching and intervention

Behavioral health and substance use services do not require a referral from the primary care physician, but certain services require prior review and certification be issued by the Plan for the following products:

- Blue Access
- Blue Advantage
- Blue Assurance
- Blue Care
- Blue Local
- Blue Options
- Blue Select
- Blue Value
- Classic Blue
- CMM Conversion

To arrange for behavioral health and substance use services:

- The member or physician must call Blue Cross NC at **1-800-672-7897** prior to arranging for services by the behavioral health provider.
- Eligibility and benefits for behavioral health and substance use services may also be verified via Provider Blue Line at **1-800-214-4844**.

17.3
Chiropractic services

Blue Cross NC subcontracts provider network services for chiropractic care to HNS for HMO and PPO products. All HNS participating chiropractors must submit claims to HNS for services provided to Blue Cross NC HMO and PPO members (including claims for BlueCard eligible PPO members). HNS forwards submitted claims to Blue Cross NC for processing. Payment is then routed back to HNS and HNS makes payments directly to HNS-participating chiropractic providers.

Claims for Blue Cross NC CMM plans as well as claims from non-HNS participating chiropractors should be filed directly to Blue Cross NC.

Providers are reminded to always verify a member's eligibility and chiropractic benefits prior to providing treatment. Benefits will vary by employer group and a member's coverage plan type. Additionally, chiropractic providers should verify their own participation status in advance of providing services, as intermediaries can be contracted with HNS on individual providers within a specific group practice.

HNS accepts claims through the *HNS Connected* electronic filing system, except for secondary claims and/or claims having an attachment. When filing claims electronically, claims must be identified as being for services provided to Blue Cross NC members by use of the abbreviated acronym "**BCBS**" placed in the address section at the top of the CMS-1500 claim form. Secondary claims and/or claims having an attachment should be mailed to:

HNS/BCBS
P.O. Box 2368
Cornelius, NC 28031

The abbreviated acronym "**BCBS**" should be included in Form Locator **11c** of the CMS-1500 claim form (HNS/BCBS is also an acceptable format).

For additional information about HNS, their policies and procedures for claims administration and Blue Cross NC chiropractic care guidelines through HNS, visit the HNS website located at **www.HealthNetworkSolutions.net**.

17.4
Reference laboratory services

Blue Cross NC subcontracts network services for reference laboratory to Avalon Healthcare Solutions. All Avalon participating providers must submit claims (excluding Medicare Advantage and Medicare Supplement) through Avalon for services provided to Blue Cross NC members (including claims for BlueCard eligible members). Medicare Advantage and Medicare Supplement claims should be submitted directly to Blue Cross NC.

Providers are reminded to verify member eligibility, benefits and required authorizations prior to providing treatment.

18

Brand regulations

How to use
our name and logos

Brand regulations are the legal rules that must be followed when using the BCBS brands and must be consistent with the terms of the BCBS license agreement (executed by all licensees). To download the Blue Cross NC corporate logo and corporate style guide, visit **BlueCrossNC.com/Policies-Best-Practices/Digital-Engagement-Vendor-Guidelines**. This is the only source for downloading the Blue Cross NC corporate logos.

18.1
How to use the Blue Cross NC name correctly

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. In cases where a long text document is involved, such as a newspaper article, use the full company's name the first time it is mentioned, followed by the acronym "**Blue Cross NC**" in parentheses. Use the acronym "**Blue Cross NC**" for any secondary mentions in the document.

Example: Blue Cross and Blue Shield of North Carolina (Blue Cross NC) has been in business for more than eighty (80) years. Blue Cross NC is also a leader in developing innovative health care products, services and information.

18.1.1
Logos

The Blue Cross NC logo is available in two formats, flush left and centered. Both are available in one (1) color (black, white) and two (2) color (cyan logos with either black or white type) versions. Do not alter any elements within the logos or the proportion of the logo.

The flush left logo is the preferred configuration. It works well in horizontal applications where it can be proportionately scaled to fit the desired area.

Cyan and black is the preferred color option. The cyan and white version is a preferred option if it's on a dark solid background. If limited to one (1) color, use the all-cyan, all-black or all-white version, depending on which works best in the design.

Clear space equal to the height and width of the Cross icon is required around all four (4) sides of the logo. To ensure legibility and recognition, the logo should never be smaller than these dimensions: .20" height for flush left and .40" height for centered.

Required legal copy

The legal copy line **®Marks of the Blue Cross and Blue Shield Association** should be used in conjunction with the logo. This statement must be included whenever the Blue Cross NC logo or name is used.

Note: For any piece with a definitive solicitation or call-to-action, the following legal copy must also appear:

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

Use the Blue Cross NC abbreviation if it has been used in the text or if there's insufficient space to use the full name.

18.1.2
Licensee disclosure

Licensee disclosure is also a Blue Cross Blue Shield Association (BCBSA) requirement. The following statement 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.

The type can be small (minimum six [6] point), as long as it remains legible and relatively independent of other copy or graphics.

18.1.3
Camera ready art

Blue Cross NC logos are available for download in GIF, TIFF and EPS formats. Visit **BlueCrossNC.com/Policies-Best-Practices/Digital-Engagement-Vendor-Guidelines**.

18.1.4
Approvals

All pieces that are being developed for dissemination to the public must be approved by Blue Cross NC's Brand Strategy and Marketing Communications Department and the Law and Regulatory Affairs Department.

Email **brand.review@bcbsnc.com** for coordination of creative approvals.

18.2
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)

19

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 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

19.1
Electronic transactions

The administrative simplification provisions mandate of HIPAA requires that all payors, providers and clearinghouses use specified standards when exchanging data electronically. Providers and payors 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 payors using the following standardized formats:

- Authorizations/referrals
- Claims
- Claims status
- Eligibility
- Remittance

Specific information about standard transactions to Blue Cross NC is discussed in **Chapter 11** and at the eSolutions website, **BlueCrossNC.com/Providers/Claims-Appeals-Inquiries**.

19.2
Code sets and identifiers

Providers should use the following standardized codes to submit claims to health plans:

- ICD-10 – CM
- CPT
- HCPCS
- CDT (formerly HCPCS dental codes, but now ADA codes, prefixed with "**D**")

These common code sets enable a standard process for electronic submission of claims by providers. Blue Cross NC 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.

Blue Cross NC 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.

Blue Cross NC only accepts active codes from national code set sources such as ICD-10, 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 the Provider Network if you have questions regarding this process.

19.3
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, Blue Cross NC 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. Blue Cross NC has implemented appropriate safeguards as required by the security rule and applicable North Carolina laws.

NPI

NPI is the ten (10) digit unique health identifier for health care providers as required by HIPAA. A health care provider is defined as any provider of medical or health services and any other person or organization that furnishes, bills or is paid for health care. NPI is required for the processing of all electronic transactions. The NPI replaces all legacy provider identifiers such as UPIN, Medicaid number, Medicare number, Blue Cross NC 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.

Please remember to update your address in the NPPES NPI registry, as many businesses rely on this information when sending communications to providers.

For more information about NPI, please access the Centers for Medicare and Medicaid Services at **www.CMS.gov** or call **1-410-786-3000**.

19.4
Privacy

The HIPAA privacy rule addresses the way in which a health plan, provider that transmits PHI electronically and health care clearinghouses 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 Blue Cross NC 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 e-Manual for a complete understanding of the ways in which Blue Cross NC may use and disclose its members' protected health information.

19.5
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**, or call **1-410-786-3000**
- Check with individual payors, clearinghouses, etc. for their individual plans, state of readiness and updates.

A list of clearinghouses that are capable of submitting transactions to Blue Cross NC is located on the eSolutions website at **BlueCrossNC.com/Providers/About-Blue-e**.

20

Privacy and confidentiality

At Blue Cross NC, we take seriously our duty to safeguard the privacy and security of our members protected health information, as we know you do. Blue Cross NC has developed corporate privacy policies and procedures that address 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, disclosing only the minimum necessary information that is legally appropriate. Our members have the right to expect that their PHI will be respected and protected by Blue Cross NC.
- 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 office who are charged with approving and reviewing Blue Cross NC's privacy policies and procedures. They are responsible for the oversight, implementation and monitoring of the policies.

20.1
Our fundamental principles for protecting protected health information

- 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 Blue Cross NC 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 website, **BlueCrossNC.com**, for the most current version.

20.1.1
Sample Notice of Privacy Practices form

Notice of Privacy Practices

of Blue Cross and Blue Shield of North Carolina

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

We are 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 is effective as of July 1, 2013** and will remain in place until we replace it.

We reserve the right to change this notice and our privacy practices at any time, provided such changes are permitted by applicable law. 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 at the time of the change or as required by applicable law.

You may request a copy of this notice by calling the customer service number on the back of your identification card. You may also obtain a copy from our website, **BlueCrossNC.com**. For more information or questions about our privacy practices, please contact the Privacy Official by writing to PO Box 2291, Durham, NC 27702-2291.

How We Use and Disclose Your Protected Health Information

We may use and disclose your PHI as permitted by federal and state privacy laws and regulations, including the federal health care privacy regulations known as "HIPAA." If an applicable state privacy law is more protective of your health information or is more stringent than HIPAA, we will follow the state law. For example, some state laws have stricter requirements about disclosing information about certain conditions or treatment for certain conditions such as HIV, AIDS, mental health, substance abuse / chemical dependency, genetic testing or reproductive rights.

If you cease to be a member, we will no longer disclose your PHI, except as permitted or required by law.

Visit us at **BlueCrossNC.com**

BlueCross BlueShield of North Carolina

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 under your policy. For example, we may use or disclose your PHI to pay claims from your health care providers for treating you, issue statements to explain such payments, determine and coordinate eligibility for benefits, make medical necessity determinations for treatment that you received or plan to receive, obtain premiums and other purposes related to payment.

Health Care Operations. We may use and disclose your PHI to support various business functions and activities that enable us to provide services to you. These functions may include but are not limited to: Quality assessment and improvement activities; reviewing the competence or qualifications of the health care providers in our network; and legal, auditing and general administrative services. For example, we may use or disclose your PHI to: (i) inform you about programs to help you manage a health condition; (ii) provide Customer Service or; (iii) investigate potential or actual fraud and abuse. 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. We talk about this more below under "**Business Associates**," which is the name HIPAA gives to certain third parties working for us.

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 disclosure permitted by your authorization that has already occurred, but will apply to those in the future. 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. 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 and certain aspects of their health care operations activities as permitted by HIPAA.

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, as permitted by law. 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. We will not use genetic information for underwriting purposes.

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.

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 HIPAA. 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 or 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. We will not use or disclose your PHI for marketing communications unless you authorize us to do so, except as permitted by law. Furthermore, we will not sell your PHI without authorization, except as permitted by law.

Employer or Organization Sponsoring a Group Health Plan. We may disclose your PHI to the employer, educational institution or other organization that sponsors your health plan. 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, or (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, 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 or Plan Sponsor**, such as information about your eligibility for insurance coverage; (v) **Your Health Care Providers** who currently treat you or have treated you in the past, such as information about your health status; or (vi) **Insurance Support Organizations** that collect information about your past medical transactions.

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 are trained on these policies when they are hired and thereafter receive annual refresher training. Employees that violate our privacy policies are subject to disciplinary action. We have developed a variety of other safeguards for protecting your information including: (i) using only aggregate or non-identifiable information when feasible; (ii) requiring 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) implementing access control procedures such as pass codes to access computer systems; and (iv) using physical security measures in our facilities to restrict access to personal information, including employee badges and escorting guests while in our facilities.

Your Rights

The following is a list of your rights with respect to your PHI.

Right to Access and Inspect Your PHI. You may ask to see or get a copy of certain 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, or in certain circumstances, this may include an electronic copy. 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 Amend Your PHI. You may ask us to correct, amend or delete your PHI. Your request must be in writing. We are not required to agree to make the change. For example, we will not generally change our information 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 providing 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 amendment request, 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 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 may ask to receive a list of certain disclosures of your PHI that we or our business associates made for purposes other than treatment, payment or health care operations. You are entitled to this accounting of disclosures for the six years prior to the date of your request. The list we provide will contain the date 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. We will not charge a fee for providing the list unless you make more than one request in a 12-month period, in which case we may charge 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 may 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.

Breach Notification. While we follow our safeguards to protect your PHI, in the event of a breach of your unsecured health information, we will notify you about the breach as required by law or where we otherwise deem appropriate.

Right to File a Privacy Complaint. You may complain to us if you believe that we have violated your privacy rights by contacting the 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. We will not take any action against you or in any way retaliate against you for filing a complaint with the Secretary or with us.

Right to Obtain a Copy of this Privacy Notice. You may request a copy of this notice at any time by calling the number on the back of your identification card or you may view or download this notice from our website. Even if you agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

20.2
Privacy regarding services or items paid out-of-pocket

If a member pays the total cost of medical services and requests that a provider keep the information confidential, the provider must abide by the member's wishes and should not submit a claim to Blue Cross NC for the specific services paid by the member. Under current regulations, providers may collect the cost of a service or supply provided to a member from that member, if the member requests non-disclosure of his or her protected health information to Blue Cross NC. The member should be advised, in advance of services being provided, the amount of their financial responsibility, if electing to request a claim to be withheld from submission to Blue Cross NC. Providers may collect from the member an amount up to their standard charge amount for that particular service or supply. Unless otherwise permitted by law or regulation, the amount charged to the member for a service or supply may not exceed the Blue Cross NC allowed amount for that particular service or supply.

Additionally, providers are not permitted to **(i)** submit claims related to, or **(ii)** bill, charge, seek compensation or remuneration or reimbursement or collection from us for services or supplies that you have provided to a member for which that member paid out-of-pocket.

21

Forms

Provider forms are available by visiting our provider portal at **BlueCrossNC.com/Providers**.

Important Note: Drug-specific fax forms are available on Blue Cross NC's *Prior Review* page at **BlueCrossNC.com**. Generic fax forms are only acceptable to submit to Blue Cross NC if it's indicated as the correct fax form to use for requesting prior review of a specific drug.

V510

Blue Cross and Blue Shield of North Carolina
Group Provider Enrollment Application
(Please print or type)

Please Check One:
Non Participating Enrollment Request ☐
OR
Participation Contract Request ☐

Group Name: _____ Specialty: _____

Tax ID (IRS #): _____ *Medicare Number: _____ Appointment Phone #: _____

National Provider Identifier (NPI): _____ Taxonomy Code/Description: _____

Actual office location: _____ Date group established: _____
Street, Suite, Apt., etc.

_____
City State Zip County

Billing Address
(if different from above): _____
Street, Suite, Apt., etc.

_____
City State Zip

Do you have additional locations within this group?
☐ **Yes** ☐ **No**
If **yes**, please complete Section 2.

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: _____

Does your location have high-tech imaging equipment (PET, MRI, CT, Nuclear Medicine or Echocardiography)?
☐ **Yes** ☐ **No**

Has group ever had a Blue Cross NC provider number before? ☐ Yes ☐ No

If checked Yes, then list number: _____

Does group currently file electronically with Blue Cross and Blue Shield of North Carolina? ☐ Yes ☐ No

Please complete for each individual provider in the group (attach additional pages as necessary):

Name	Blue Cross NC Prov #	License Number	Year Licensed	Specialty	NPI

*Medicare Number is required for Blue Medicare℠

In order to insure compliance with IRS 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 Provider Network field office.

Signature of Authorized Representative (from Provider Group): _____

Date: _____ Contact phone #: _____

FIELD OFFICE USE ONLY: Date Mailed: _____ Systems Checked: Power MHS_____ Legacy_____
Verification with Attached Paperwork: _____ Initials: _____

Sample of the Group Provider Enrollment Application (Page 1)

Additional Office Locations

Office location: _____
Street, Suite, Apt., etc.

_____
City State ZIP County

Appointment phone number: _____

Office location: _____
Street, Suite, Apt., etc.

_____
City State ZIP County

Appointment phone number: _____

Office location: _____
Street, Suite, Apt., etc.

_____
City State ZIP County

Appointment phone number: _____

Office location: _____
Street, Suite, Apt., etc.

_____
City State ZIP County

Appointment phone number: _____

Office location: _____
Street, Suite, Apt., etc.

_____
City State ZIP County

Appointment phone number: _____

Office location: _____
Street, Suite, Apt., etc.

_____
City State ZIP County

Appointment phone number: _____

Provider / Doctor Claim Inquiry

INSTRUCTIONS	
IMPORTANT: *This form will not be accepted for review of* ***NC provider appeals*** ▪ Use this form to request review of a previously adjudicated claim ▪ Submit only ***one form per member*** ▪ New or corrected claims should be submitted directly to the plan electronically or by mail if you are not an electronic biller. Faxed claims are not accepted ▪ Inquiries received without the required information below or completed in its entirety will not be reviewed or processed ▪ Out of state provider appeals, see home plan policies ***Indicates a required field**	**FOR PROVIDER USE ONLY** To help expedite your review, please complete this form in its entirety: **PLEASE MAIL ALL INQUIRIES TO:** BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA P.O. BOX 2291 DURHAM, NC 27702 **Please Fax to:** 1-866-987-4167

PROVIDER INFORMATION		CLINICAL INFORMATION
*PROVIDER NAME		*CLAIM NUMBER
*PROVIDER MAILING ADDRESS		*TOTAL CHARGE
*CITY/STATE	*ZIP CODE	*TO-DATE OF SERVICE
*INDIVIDUAL NPI NUMBER	*GROUP NPI NUMBER	*FROM-DATE OF SERVICE

MEMBER INFORMATION	
*MEMBER NAME	*MEMBER DATE OF BIRTH
*SUBSCRIBER ID WITH ALPHA PREFIX	MEMBER ACCOUNT NUMBER

*TYPE OF REVIEW

(You must check one of the following)

Please note: In an effort to support compliance with the Paperwork Reduction Act (44 U.S.C. 3501 et seq.) we are requesting the minimal records. However, if the requested information does not support reimbursement for the claim, please send any additional information necessary to support the claim as originally submitted.

The reason for this inquiry is:

☐ **Claim(s) Inquiry**

- ☐ Original claim denied for timely filing (proof of timely filing attached)
- ☐ Original claim denied or closed for "coordination of benefits"
- ☐ Original claim denied for no authorization but valid authorization on file
- ☐ Claim denied as duplicate to a previously finalized claim
- ☐ Original claim denied no coverage
- ☐ Newborn added to policy, original claim denied
- ☐ Incorrect member name/ID billed on previously submitted claim
- ☐ Incorrect copay/coinsurance applied benefit quoted was not received
- ☐ Overpayment/underpayment due to another payer (COB)
- ☐ Contractual allowance dispute (fee schedule documentation required)

☐ **Special Investigations** (submit a copy of the inquiry form, the claim and all supporting medical records must be attached)

☐ **Medical Records** - Reconsideration of a ***previously adjudicated*** claim related to:

* Only use for **out of state** member submissions

- ☐ medical necessity
- ☐ potentially cosmetic, experimental or investigational services

☐ **Medical Records** - Upfront submission of ***supporting medical records in advance*** of claim(s) being processed

- ☐ proactive medical records

G102, 4/23

***Indicates a required field**

Level One Provider Appeal

Level One Provider Appeal Form

NOT to be used for Federal Employee Program (FEP)

Note: This form is intended for use only when requesting a review of a post service claim denied for one of the following three reasons: (1) coding/bundling denials, (2) services not considered medically necessary or (3) inpatient administrative denials. Level One Provider Appeals should be accompanied by any supporting documentation. Please complete the form in its entirety.

Note: If you are acting on the member's behalf and have a signed Blue Cross and Blue Shield of North Carolina (Blue Cross NC) appeal authorization from the member, or you are appealing a pre-authorization denial and the services have yet to be rendered, DO NOT USE THIS FORM. Please follow the member appeal process for appeal requests on behalf of the member as outlined at **www.BlueCrossNC.com/Providers/Medical-Policies-and-Coverage/Member-Appeal-Representation-Authorization-Form#Search=Member Appeal Members.** The Blue Cross NC authorization form should be submitted with a written appeal request or with the member appeal form if appealing on behalf of member.

Today's Date	**Member's ID Number**	**Member's Group Number (optional)**
Member's First Name	**Member's Last Name**	**Member's Date of Birth**
Provider Name		**Provider Number/NPI**
Provider Group Name (if applicable)	**Office Contact**	**Contact Mailing Address**
Contact Phone Number	**Contact Fax Number**	**Contact Email Address (optional)**

To help Blue Cross NC review and respond to your request, please provide the following information below. (This information may be found on prior correspondence you received from Blue Cross NC.) You may use this form to appeal multiple dates of service for the same member.

Claim Number(s)	**Reference/Authorization Number(s) (if applicable)**	**Date(s) of Service(s)**
CPT/HCPCS Code of Service Being Disputed		
Explanation of Your Request (please use additional pages if necessary)		

For Provider Appeals, please fax your request with all supporting documentation and medical records to:

Billing/Coding Denials – **919-287-8708**
Medical Necessity/Administrative Denials – **919-287-8709**

If documentation needs to be sent to Blue Cross NC by mail, please send to:

Provider Appeal Department
P.O. Box 2291, Durham, NC 27702-2291

Certification/Prior Review Request

Blue Cross NC Certification/Prior Review Request Form

Please complete every field on this form to prevent delays in processing. You will receive a response from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) 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	BLUE CROSS NC ID NUMBER	DATE OF BIRTH
		____/____/____
SEX: ☐ FEMALE ☐ MALE	**Is this a reconsideration?** ☐ YES ☐ NO	
MEDICAL RECORDS INCLUDED: ☐ Op Notes ☐ H&P ☐ Complete Records ☐ Consultation ☐ Photos ☐ D/C Summary ☐ Labs/X-rays/Diagnostics ☐ Progress Notes		
TYPE OF PLAN: ☐ HMO ☐ PPO ☐ POS ☐ CMM		

PART II

PRIMARY CARE PHYSICIAN	**PROVIDER #**
ATTENDING PHYSICIAN	**PROVIDER #**
PRIMARY DIAGNOSIS	**ICD-10 CODE**
SECONDARY DIAGNOSIS	**ICD-10 CODE**
TREATMENT SETTING AND 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 Blue Cross NC Care Management department at 1-800-672-7897.

BLUE CROSS NC USE ONLY:	REVIEWER
	BLUE CROSS NC CERTIFICATION #

Sample of the Certification/Prior Review Request

Certificate of Medical Necessity

Blue Cross NC 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 ☐ D. Ambulation impaired _____

B. Room confined ☐ To what degree? _____

C. Chair confined ☐ 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 of the Certificate of Medical Necessity

Professional Mailback (Paper Claims)

BlueCross BlueShield of North Carolina
An independent licensee of the Blue Cross and Blue Shield Association

PAPER Mailback
PO Box 35 • Durham, North Carolina 27702-0035
1-800-214-4844

Professional Claim Mailback	
	Subscriber ID:
	Patient Name:
Provider Name:	Date(s) of Service:
Provider Address:	Provider ID:
City: State: Zip:	Claim/DCN #:

Make the necessary changes and resubmit 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.

P001		The member ID in Field 1a is not valid for this patient: ☐ Verify member ID number and health insurance carrier. ☐ Send a Copy of the ID card. ☐ The three character alpha/numeric prefix is missing, invalid, or not valid for the date of serivce. ☐ The two-digit dependent suffix at the end of the Member ID is missing or not valid. ☐ The Member ID is not valid for the dates of service on the claim. ☐ Re-file the claim with the complete Member ID number as shown on the ID card to the appropriate insurance carrier.
P002		Verify the patient information and provide the missing data: ☐ Patient Name (Field 2) ☐ Birthdate/Sex (Field 3) ☐ Patient Relationship (Field 6)
P003		☐ The provider number is missing or invalid for this date of service. ☐ Group ☐ Individual ☐ The NPI is not valid. Please confirm all NPI information at claim and line level and resubmit with correct NPI. ☐ Group ☐ Individual ☐ The NPI has not been registered with Blue Cross NC. Please contact your Blue Cross NC Network Management Field Office. ☐ Group ☐ Individual ☐ NPI discrepancy. Claim cannot be processed until resolved. Please contact your Blue Cross NC Network Management Field Office. ☐ Group ☐ Individual ☐ The attached CMS1500 has been filed with an NPI/PPN that is for Institutional claims. Please file using the Professional NPI/PPN.
P004		Provide Field 14 Date of Current Illness, Injury or Pregnancy.
P005		The accident diagnosis requires the Other Date in Field 15.
P006		The Referring Provider in Field 17 is not a valid NC provider. Please refile claim with the local plan per BCBS Ancillary rules.
P007		Provide Field 18 Hospitalization From and To Dates.
P008		Diagnosis code in Field 21 is missing or invalid. Provide complete and specific diagnosis code for each service rendered. ☐ If services are rendered on or after 10/1/15, please submit with ICD-10 diagnosis code in Field 21. ☐ If services are rendered prior to 10/1/15, please submit with ICD-9 diagnosis code in Field 21. ☐ Diagnosis is out of sequence in Field 21.
P009		Provide specific dates in Field 24A for each service rendered.
P010		Provide 2 digit place of service code in Field 24B.
P011		Provide a valid procedure code in Field 24D for each service line.
P012		Procedure code or diagnosis code is inconsistent with patient's: ☐ Age ☐ Sex ☐ Diagnosis
P013		CPT 99070/E1399 is a generic supply code. Provide valid HCPCS code or description of service/supply in Field 24D.
P014		Provide Drug Name, quantity and IDC number for code _____ in Field 24D.
P015		File Physician Assistant charge with the appropriate modifier for surgical assistance with the surgeon's claims.

G305, 8/17

Institutional Mailback (Paper Claims)

BlueCross BlueShield of North Carolina
An independent licensee of the Blue Cross and Blue Shield Association

PAPER Mailback
PO Box 35 • Durham, North Carolina 27702-0035
1-800-214-4844

Institutional Claim Mailback	
	Subscriber ID:
	Patient Name:
Provider Name:	Date(s) of Service:
Provider Address:	Patient ID:
City: State: Zip:	Provider ID:
	Claim/DCN #:

Make the necessary changes and resubmit 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.

I001		Type of Bill in Field 4 is missing, invalid or illegible.
I002		Federal Tax ID in Field 5 is missing, invalid or illegible.
I003		If Outpatient claim type, and Field 6 Statement From and Through Dates span fiscal/calendar years, claim must be split.
I004		Verify the patient information and provide the missing data for: ☐ Patient Name (Field 8) ☐ Birthdate (Field 10) ☐ Sex (Field 11)
I005		Admission Date in Field 12 is missing, invalid or illegible.
I006		Admission Hour in Field 13 is missing, invalid or illegible.
I007		Admission Type in Field 14 is missing, invalid or illegible.
I008		Source Code in Field 15 is missing, invalid or illegible.
I009		Discharge Hour in Field 16 is missing, invalid or illegible.
I010		The Patient Status Code in Field 17 is missing, invalid for the bill type or illegible.
I012		Condition Code in Field _____ is invalid for the bill type.
I013		Occurrence Code or Date in Field _____ is missing.
I014		Ambulance claims (POS 41 or 42) require Field 39-41 to have a value code of A0 and the 5-digit zip code of the drop off location.
I015		Occurrence Code 55 with a valid Occurrence Code Date (date of death) is required when the Patient Status Code in Field 17 is 20, 40, 41 or 42.
I016		Value Code or the Value Code Date in Field _____ is missing.
I017		Revenue Code in Field 42 (line _____) is missing, invalid or illegible.
I018		An inpatient claim must contain one accommodation Revenue Code.
I019		A HCPCS code (Field 44) is required for lines _____ .
I020		If Outpatient claim and Field 6 Statement Covers Period (From and Through) dates span, Field 45 is required.
I021		The CPT Code(s) on line(s) _____ requires an NDC number. Please include the N4 qualifier, NDC code, unit of measurement qualifier, number of units, and the description when resubmitting the claim.
I022		Unit in Field 46 is missing on line(s) _____ .
I023		Charge in Field 47 is missing on line(s) _____ .
I024		Error in total charge. Please re-compute.

G304, 9/17

G303 – Dental Mailback

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

Dental Paper Mailback
PO Box 35
Durham, North Carolina 27702-0035

Dental Claim Mailback	
	Subscriber ID:
	Patient Name:
Provider Name:	Date(s) of Service:
Provider Address:	**Total Charges:**
City: State: Zip:	Provider ID:
	Claim / DCN #:

We are returning the attached claim(s) for the additional information checked below. Please furnish this information and return both the claim(s) and the form to us.

M400		Recheck the BCBSNC Dental Subscriber ID. The number reported does not agree with our records. Please send a copy of your card.
M401		Give your dentist's IRS number. ☐ Individual ☐ Group
M402		Give the date(s) of service(s).
M403		Submit a separate itemization for each family member.
M404		Give the American Dental Association (ADA) code, if available.
M405		Give the appropriate ICD-9-CM *(prior to 10/1/2015)* or ICD-10-CM *(on or after 10/1/2015)* diagnosis code, as applicable.
M406		List tooth surfaces for each amalgam or composite.
M407		List tooth surfaces for inlay.
M408		Indicate date crown or bridge was seated. File after seat date. Seat date should be the date of service.
M409		Indicate date partial or denture was delivered. File after delivery date. Delivery date should be the date of service.
M410		Indicate the date and nature of accident.
M411		Indicate for which month the orthodontic payment is intended and verify monthly contract charges for orthodontic services.
M412		Send fee schedule each time an orthodontic claim is filed. Indicate date and charges for initial exam, records, initial payment and monthly visits including number of months in active treatment.
M413		Indicate type of crown or bridge. (Example: Porcelain with gold base; Gold; Plastic).
M414		Indicate type of periodontal surgery. Give code.
M415		Indicate type of repair on bridge or crown.
M416		Indicate type of extractions. Give code. If surgical extraction, clarify if partially bony, completely bony or soft tissue impacted. Give code.
M417		Indicate type of partial. Give code.
M418		Indicate type of repair on partial or denture.
M419		Indicate size of lesion.
M420		Specify type of x-rays.
M421		Specify number of bitewings or periapicals taken.
M422		Itemize charges for periapicals or bitewings.
M423		List tooth numbers for amalgams or composites.
M424		List tooth numbers extracted.
M425		List tooth numbers on which crown or bridge placed.
M426		List tooth numbers on which endodontics performed.
M427		List tooth numbers for sealants. Itemize charges for each tooth.

G303, 3/17

G303 – Dental Mailback (continued)

M428		Itemize charges for fluoride prophylaxis.
M429		Code(s) _____ are invalid. Submit with current ADA code(s).
M430		Give description for: _____.
M431		Please submit a separate charge for each ADA code.
M432		For accidental injury dental claims, a medical diagnosis is required. Please provide a medical diagnosis for the medical procedure. Please submit a separate charge for each ADA code.
M433		List number of quadrant for periodontal services.
M434		Indicate who should receive payment – Dentist or Subscriber?
M435		Verify total charges.
M436		Give correct CPT procedure code.
M437		File claim with the plan that holds the member's policy.
M438		Please file the claim to the dental address on the back of your dental card.
M439		Code _____ does not match tooth number. Submit with correct code.
M440		Pre-treatment estimates are no longer accepted by Blue Cross and Blue Shield of North Carolina. Please contact Customer Service for benefits verification.
M441		Other: _____

Name:	Department:	Date:

G303, 3/17

G292

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

PAPER Mailback
PO Box 30025 • Durham, North Carolina 27702-3025
1-800-422-4658

Professional and Institutional Mailback

	Patient Name:
Provider Name:	Date(s) of Service:
Provider Address:	Patient Account Number:
City: State: Zip:	**Claim #:** **Total Charges:**

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 is not valid. Please confirm all NPI information and resubmit with correct NPI. 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 The following CMS1500/UB04 has been filed with an NPI/PPN that is for Institutional/Professional claims. Please refile using a Professional/Institutional NPI/PPN.
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 code 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 charge 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.
M022		Provide name of supervising M.D. or PhD.
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 Form CMS1500 or the equivalent. Resubmit using Form 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.

G292, 10/15

G292 (continued)

M027		File all prescription drug claims to Medco Health Solutions, Inc.: PO Box 14711, Lexington, KY 40512-4711.
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		☐ If services rendered on or after 10/1/15, please submit with ICD-10 diagnosis code. ☐ If services rendered prior to 10/1/15, please submit with ICD-9 diagnosis code.
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 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:

Provider Refund Return

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

This form serves as a remittance advice to assist in properly adjusting your account/claim with either Blue Cross NC or the NC State Health Plan. Please use one form per claim, complete the form in its entirety and include with your payment. This will help us properly identify and credit the funds appropriately and will prevent us from returning your payment. Make checks payable to Blue Cross NC or the State Health Plan, depending on which company paid the claim.

Billing Provider Name:

Billing National Provider Identifier:

Billing Provider Tax ID Number:

Claim Number:

Subscriber ID Number:
(include prefix)

Date of Service(s):

Subscriber Name:

Patient Name:

Check(s) or EFT(s) Number:

Check(s) or EFT(s) Date:

Amount of Refund:

Please check reason(s) for the refund:

- ☐ Duplicate Payment (submit both EOPs)
- ☐ Workers' Compensation (give injury/sickness onset date or submit Dept. of Labor Letter)
- ☐ Medicare primary/Medicare adjusted payment (submit Medicare EOB)
- ☐ Other insurance primary/Other insurance adjusted payment (submit other insurance EOB)
- ☐ Corrected claim (submit copy of corrected claim & add reason in Comments field)
- ☐ Not our patient
- ☐ Other (add details in the comments below)

Comments:

Please include all relevant supporting documentation with this form.

Contact Person:

Contact Phone Number:

Contact Email:

Return to:
Financial Processing Services
Blue Cross NC
P.O. Box 30048
Durham, NC 27702-3048

Sample of the Provider Refund Return

G293

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 Blue Cross NC 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 Blue Cross NC 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 Blue Cross NC vouchers)
   - ☐ b. Workers' 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 and Blue Shield of North Carolina
Attention: Cashiers Department
P.O. 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 Blue Cross NC, please attach a copy of the information described above, as well as a copy of the Blue Cross NC 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, Blue Cross NC requests that you submit one check per claim. Organizing this information in this manner will allow Blue Cross NC to effectively 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.

Thank you in advance for providing the necessary information and attaching it to the check to be sent to Blue Cross NC.

G293, 10/08

ECR270 (270/271 = Eligibility Inquiry; 276/277 = Claim Status Inquiry; 278 = Authorization)

Blue Cross and Blue Shield of North Carolina
Electronic Remittance Advice (ERA) Authorization Agreement

Please complete the following form and fax the form to Electronic Solutions at 919-765-7101.

Provider Information	
Provider Name	
Doing Business As Name (DBA)	
Provider Address	
Street	
City	
State/Province	
ZIP Code/Postal Code	

Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	
National Provider Identifier (NPI)	

Provider Contact Information	
Provider Contact Name	
Title	
Telephone Number	
Telephone Number Extension	
Email Address	
Fax Number	

Electronic Remittance Advice Information	
National Provider Identifier (NPI)	
Method of Retrieval	
Direct	☐
Clearinghouse	☐

Electronic Remittance Advice Clearinghouse Information	
Clearinghouse Name	
Clearinghouse Contact Name	
Telephone Number	
Email Address	

Electronic Remittance Advice Vendor Information	
Vendor Name	
Vendor Contact Name	
Telephone Number	
Email Address	

Submission Information	
Reason For Submission	
New Enrollment	☐
Change Enrollment	☐
Cancel Enrollment	☐
Authorized Signature	
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	
Submission Date	
Requested ERA Effective Date	

ECR835 (835 = Remittance Advice)

BCBS INTER-PLAN BATCH ELECTRONIC CONNECTIVITY REQUEST
Medicare Crossover 835 – Payment/Remittance Advice

This form should be completed by providers supplying Medicare services to members who hold additional insurance coverage with a Blue Cross and Blue Shield (BCBS) plan other than Blue Cross and Blue Shield of North Carolina (Blue Cross NC). Blue Cross NC electronically forwards 835 remittances for Medicare crossover claims received from other BCBS plans to North Carolina providers who hold a Blue Cross NC Provider ID. Providers submitting this form must also be receiving standard 835 Remittances not associated with Medicare.

Please complete the following information and fax this page to eSolutions at 919-765-7101.

Provider Name:	
Provider's NPI:*	Provider's Federal Tax ID:*
***Important Notice:** If there are multiple NPIs associated with the Federal Tax ID, please complete this form using the Blue Cross NC designated outbound payment NPI.	

Contact Name:	Title:
Mailing Address:	
City, State, ZIP:	
Phone Number:	Fax Number:
Email Address:	

Are you changing vendor/clearinghouse or billing service for your Medicare Crossover remittances?
_____ Yes _____ No **If yes,** effective date of change ____/___/___

Type of Receiver (select one): ____ Provider ____ Clearinghouse ____ Billing Service	
ISA07 Receiver ID Qualifier **:	ISA08 Receiver ID **:
** As a business practice, Blue Cross NC defines the Receiver ID Qualifier to be "30" and the Receiver ID to be the "Federal Tax ID."	

X12 Version:
Mode of Connectivity:
Secure FTP (via Internet)

X

AUTHORIZED SIGNATURE OF STAKEHOLDER **DATE OF AUTHORIZATION**

PRINT NAME / TITLE OF AUTHORIZED SIGNER

ECR837 (837 = Claim/Encounter)

Blue Cross NC eSolutions – Electronic Connectivity Request

for Clearinghouses/Billing Services (direct submitting only)

Please complete the following and fax the form to Electronic Solutions at **919-765-7101** .
A Trading Partner Agreement is required for new submitters.

Type of Direct Sender: ☐ Clearinghouse ☐ Billing Service

Status: ☐ New Trading Partner ☐ Existing Trading Partner

COMPANY NAME			IDENTIFIER (FEDERAL TAX ID)
CONTACT NAME		TITLE	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS (REQUIRED)	

	Connectivity Methods					
	Batch			Real Time		Effective Date
Electronic Transactions	HTTPS	FTP	SOAP	SOAP/WSDL	SOAP/MIME	
Eligibility Inquiry 270/271						
Claims Inquiry 276/277						
Authorization & Referral 278						
Electronic Remit 835*						
Institutional Claims 837I						
Professional Claims 837P						
Benefit Enrollment 834						

* Par providers only

Date: _____ Print Name: _____

Title: _____

Authorized Signature: _____

Submit

Visit us at **BlueCrossNC.com**

BlueCross BlueShield of North Carolina

Sample of the eSolutions Batch Connectivity Request

Member Appeal Representation Authorization

BlueCross BlueShield of North Carolina

BlueCrossNC.com

PO Box 30055, Durham, NC 27702-3055

Date

Name
Address
City, State, Zip Code

Patient Name:
Member ID:
Date of Birth:
Date(s) of Service:
Provider:
Regarding:

I have given my permission for (**please enter representative's name**) to represent me, and act on my behalf regarding the above referenced denial of service(s).

I authorize Blue Cross and Blue Shield of North Carolina (Blue Cross NC) to release any of my protected health information (PHI), including information that may be related to substance use disorders, 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 Blue Cross NC at the address above. I understand that revoking this authorization will not affect action that Blue Cross NC has taken prior to receiving my notice of revocation.

I further understand that Blue Cross NC 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 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.

Please note: By completing and submitting this form, you are granting authority to a third party (such as a provider or other representative) to file an appeal on your behalf. This form is not intended to be your actual appeal request. Please ensure that your appeal request is submitted by your third-party representative if it has not already been submitted to us.

Thank you,

_____ _____

Member Signature Date

22

Glossary of terms

A

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. 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.

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 Blue Cross NC) 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.

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.

Allowable charge/amount

The maximum amount to be reimbursed to a provider as negotiated.

Allowed amount

The charge that Blue Cross NC determines is reasonable for covered services provided to a member. This may be established in accordance with an agreement between the provider and Blue Cross NC. In the case of providers that have not entered into an agreement with Blue Cross NC, Blue Cross NC's methodology is determined based on several factors including Blue Cross NC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the provider may be combined into one (1) procedure for reimbursement purposes.

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 (6) 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.

B

bcbs.com

The Blue Cross Blue Shield Association's website, which contains useful information for providers.

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.

Benefit period

The period of time, usually twelve (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 Blue Cross NC. A charge shall be considered incurred on the date the service or date supply was provided to a member.

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.).

Billed charge

The amount a physician, institution, pharmacy, supplier 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; or **(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).

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 not required, to select a primary care physician or provider.

Blue Cross and Blue Shield of North Carolina

A non-profit hospital, medical and dental service corporation organized and operated under Chapters 55A and 58 of the North Carolina General Statutes. Blue Cross NC is an independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross NC

Blue Cross and Blue Shield of North Carolina. Blue Cross NC may also be referred to as "we" or "us."

Blue Options PPO

A 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.

Blue Value

A lower-cost POS product which offers a smaller, more streamlined Provider Network while providing an affordable choice for our most cost-conscious employer groups and members.

Blue365

A program exclusive to members of participating Blue Cross and Blue Shield companies offering health and wellness deals.

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.

BlueCard® Access® 1-800-810-BLUE

A toll free 800 number for you and members to use to locate health care providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or health care facility in another location.

BlueCard doctor and hospital finder website – provider.bcbs.com

A website you can use to locate health care providers in another Blue Plan's area: **provider.bcbs.com**. This is useful when you need to refer the patient to a physician or health care facility in another location. If you find that any information about you, as a provider, is incorrect on the website, please contact Blue Cross NC.

BlueCard Eligibility 1-800-676-BLUE

A toll free 800 number for you to verify membership and coverage information, and obtain pre-certification on patients from other Blue Plans.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO member

Carries an ID card with this identifier on it: Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard® Worldwide

A program that allows Blue members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from health care providers worldwide. The program also allows members of foreign Blue Cross and/or Blue Shield Plans to access domestic (United States) Blue Provider Networks.

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.

C

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.

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 Blue Cross NC 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 their 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 (1) claim.

Classic Blue

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

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

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.

Comprehensive Major Medical (CMM)

An indemnity policy characterized by a deductible amount, a coinsurance feature and maximum benefits.

Concurrent review

Care management 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.

Consumer Directed Health Care/Health plans (CDHC/CDHP)

Consumer Directed Health Care is a broad umbrella term that refers to a movement in the health care industry to empower members, reduce employer costs and change consumer health care purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate health care decision through the use of member support tools, provider and network information and financial incentives.

Control plan

A plan that has responsibility for administering a national account normally headquartered in the Plan's service area.

Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two (2) 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.

Copayment

A specified charge that a member incurs for a specified service at the time the service is rendered.

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 composed 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 them 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 Blue Cross NC without regard to the provider prescribing or providing the services.

D

Deductible

A flat amount the member incurs before the insurer will make any benefit payments.

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 to 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 (2) 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 Blue Cross NC 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.

E

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, behavioral health, substance use, 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.

F

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 Blue Cross NC.

FEP

The Federal Employee Program.

Formulary

The list of outpatient prescription drugs and insulin that are available to members.

G

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 e-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 administrator

A representative of the group designated to assist with member enrollment and provide information to subscribers and members concerning the health benefit plan.

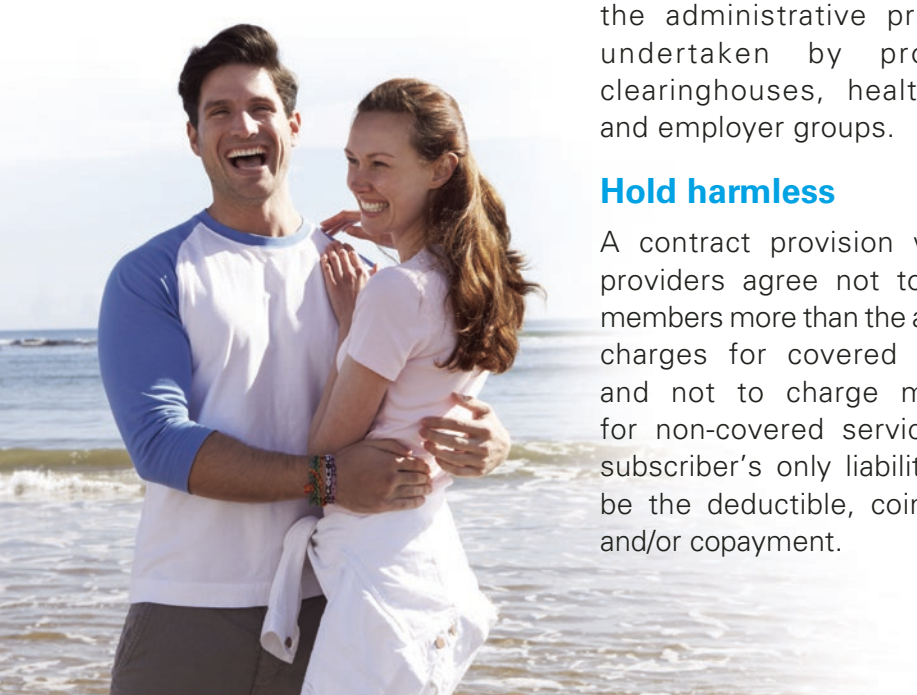
Group contract

The agreement between Blue Cross NC 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.

H

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 pre-payment 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.

Healthy Outcomes

A fully integrated health management solution featuring wellness, case management and condition care programs. Healthy Outcomes includes resources to help members improve and maintain their health.

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.

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 Blue Cross NC.

Home Plan

The Blue Cross and/or Blue Shield plan that carries the member's contract when the member receives services out-of-area.

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.

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 Blue Cross NC.

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 who are designated hospital-based by Blue Cross NC 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). Blue Cross NC serves as the Host Plan in the BlueCard program.

I

Identification card (ID card)

The card issued to our members upon approval of the request for enrollment application and change form.

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 Blue Cross NC.

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 coinsurance. See Classic Blue.

Infertility

The inability of a heterosexual couple to conceive a child after twelve (12) months of unprotected male/female intercourse.

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.

M

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-10-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 Advantage (MA)

Medicare Advantage is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "Traditional Medicare." MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including HMO, PPO, POS and PFFS plans.

Medicare crossover

The crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

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 Blue Cross NC.

Medicare supplemental (Medigap)

Pays for expenses not covered by Medicare.

Member

A subscriber or dependent whose enrollment application and change form has been accepted and for whom premium is paid or in a grace period.

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 (1) level of charges for rooms in the same category.

N

National account

An employer group with employee and/or retiree locations in more than one (1) Blue Plan's service area.

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 (5) 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 Blue Cross NC.

Non-participating provider

A provider that has not been designated as a Blue Care provider by Blue Cross NC.

O

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 Blue Cross NC.

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 Blue Cross NC.

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.
- 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 cases

Services that are outside of the stated length of stay parameters or charge thresholds.

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.

Outpatient

Pertaining to services received from a hospital or non-hospital facility by a member while not an inpatient.

Outpatient surgery

Surgery performed in a setting that does not require an inpatient admission. Sometimes called ambulatory surgery.

P

Partial hospitalization

A program that provides less than twenty-four (24) hour care (usually during the day) for behavioral 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 Blue Cross NC.

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

Refers to any Blue Plan.

Plan profile

A tool that allows a plan to capture prefix information. It defines the relationship between BCBS plans for the accounts Blue Cross NC serves.

Point of Service (POS)

A health insurance product that offers a limited network of providers from which members can select. Members have incentive to use in-network providers to receive richer benefits, but may choose to use out-of-network providers at a higher out-of-pocket cost.

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 health benefit plan offered by an insurer in which covered services are available from health care providers who are under contract with the insurer. Enrollees are given incentives through differentials in deductibles, coinsurance or copayments to obtain covered health care services.

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.

Primary care provider

A participating provider from one (1) of the following specialties: Family practice/general practice, internal medicine, obstetrics and/or gynecology, physician's assistant, certified nurse practitioner or pediatrics.

Primary payor

When a member is covered by more than one (1) insurance carrier, the primary payor 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 Blue Cross NC 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 and reviews comply with Blue Cross NC corporate medical policy and MCG evidence-based medical necessity guidelines.

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.

R

Readmission

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 Blue Cross NC.

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 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.

S

Secondary payor

When a member is covered by more than one (1) insurance carrier, the secondary payor is the carrier responsible for providing benefits after the primary payor 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 Blue Cross NC 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 (1) 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 Blue Cross NC.

T

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.

U

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.

V

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.

W

We

Blue Cross NC 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.

BlueCross BlueShield of North Carolina