



THE Blue BOOK

Provider eManual

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**BlueCross BlueShield
of North Carolina**

for Physicians, Ancillary Providers, Hospitals and Facilities

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Chapter 1

The **Blue** BookSM
Provider eManual

Introduction



Visit us at bcbsnc.com



1.1 About this e-manual

We are pleased to provide you with a completely revised and comprehensive **Blue BookSM** Provider eManual, for providers participating in the Blue Cross and Blue Shield of North Carolina (BCBSNC) 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 BCBSNC insurance products, healthcare management & operations policies and procedures, and the health care claims billing guidelines of Blue Cross and Blue Shield of North Carolina (BCBSNC).

Web site resource

Please note that BCBSNC will periodically update this e-manual. The most current version of The **Blue BookSM** will be available in the providers section of the BCBSNC Web site at <http://www.bcbsnc.com/providers/>.

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

BCBSNC health care benefit plans overview

Health care benefit plans can typically be categorized into three basic plan types: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Comprehensive Major Medical (CMM). Contracting providers with questions about in which plan(s) they participate, should refer to their individual health care businesses, Network Participation Agreement (NPA) with BCBSNC or contact their local Network Management field representative for assistance. Local field office contact information can be found in chapter two of this e-manual. Except where otherwise indicated, this e-manual refers to all of the following BCBSNC HMO, PPO and CMM product offerings, including but not inclusive to the products indicated in the following chart:

BCBSNC HMO product

- Blue Care[®] (Health Maintenance Organization [HMO] plan)

BCBSNC PPO products

- Blue OptionsSM (Preferred Provider Organization [PPO] plan)
 - ‡ Blue Options (PPO plan with deductible and coinsurance plan)
 - ‡ Blue Options (PPO plan with in-network benefits only)
- Blue Options 1-2-3SM (PPO plan with three benefit levels)
- Blue Options HSASM (high-deductible PPO plan paired with a health savings account)
- Blue Options HRASM (high-deductible PPO plan paired with a health reimbursement account)
- Blue Options FCSM (PPO plan with fixed contributions)
- Blue Advantage[®] (PPO plan purchased by individuals)
- State Health Plan (PPO plan for State Health Plan membership)

BCBSNC CMM products

- Classic Blue[®] (Comprehensive Major Medical [CMM] plan)
 - ‡ Blue AssuranceSM (CMM plan for individuals)
 - ‡ AccessSM (CMM)
 - ‡ Short Term Health Care (CMM)



Please note the following:

- Information relative to the Federal Employee Program (FEP) PPO plan can be found in chapter four of this e-manual.
- Information relative to the inter-plan programs (including BlueCard®) can be found in chapter five of this e-manual.
- Information relative to Medicare and Medicare Supplement programs (non-Medicare Advantage plans) can be found in chapter six 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 BCBSNC can be found in chapter two
- Health benefit plans and sample identification cards can be found in chapter three
- Healthcare management & operations can be found in chapter eight

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

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

1.2 Provider e-manual online

The **Blue Book**SM is maintained on the BCBSNC Web site for providers at <http://www.bcbsnc.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**SM connectivity. Whether accessing the provider e-manual from the providers section or from **Blue e**SM, the process to view is the same.

Just click on The **Blue Book**SM hyperlink and select the option to open, it's that easy. If you want to save a copy of the 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**SM from our Web site, or if you're already a **Blue e**SM user and need assistance with The **Blue Book**SM viewing, please contact your local Network Management field office (field office contact information is available on pages 9-13 of chapter two in this e-manual).

Additionally, if you cannot access the Web site or **Blue e**SM, please contact your local Network Management field office to receive a copy of the e-manual in another format.

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 BCBSNC Web site at <http://www.bcbsnc.com/providers/>, or by using **Blue e**SM.

1.3 Additional references

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

- Your health care business's provider Network Provider Agreement (NPA) with BCBSNC
- Our Web site [bcbsnc.com](http://www.bcbsnc.com)
- BCBSNC Provider Blue LineSM at **1-800-214-4844**
- The Blue LinkSM online provider newsletters, also located on our Web site [bcbsnc.com](http://www.bcbsnc.com)



- Your Network Management service team as listed in chapter two, Quick contact information
- BCBSNC medical policies and guidelines, evidence based guidelines, payment guidelines for providers, and our diagnostic imaging management policies that can be accessed on our Web site at ***<http://www.bcbsnc.com/services/medical-policy/>***.

1.4 Feedback

We value your feedback. Please direct comments regarding this e-manual to your regional Network Management representative.

Quick contact information

BCBSNC

Magellan Behavioral Health

Value Options

Health Network Solutions

(formerly Chiropractic Network
of the Carolinas)

American Imaging
Management





(To find contact information for the Federal Employee Program (FEP), please refer to the corresponding plan specific section that's contained within this e-manual [see chapter four for FEP]).

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.

2.1 Helpful telephone numbers

2.1.1 Provider Blue LineSM 1-800-214-4844

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

- Eligibility
- Benefits
- Claims

In a hurry?

Providers with **Blue eSM** 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 eSM**, visit BCBSNC electronic solutions on the Web at: <http://www.bcbsnc.com/providers/edi> or refer to chapter eleven of this e-manual.

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

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

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

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

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

About the Provider Blue LineSM automated system

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

Help us to help you!

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

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



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

The Provider Blue LineSM automated services are available:

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

The Provider Blue LineSM representatives are available:

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

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

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

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

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

To find out more about BlueCard[®] and the inter-plan program, please refer to chapter five of this e-manual.

2.3 Healthcare Management & Operations 1-800-672-7897

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

- Certification requests (except for mental health/substance abuse)
 - ‡ Certification requests for members enrolled in the State Health Plan **1-800-672-7897**
- Prior review requests (except for mental health/substance abuse)
 - ‡ Prior review requests for members enrolled in the State Health Plan
- Discharge planning (when calling include extension **51910** to be connected with discharge services)
 - ‡ Discharge planning requests for members enrolled in the State Health Plan **1-800-672-7897** at extension **53065** (except for mental health/substance abuse)
- Pharmacy quantity limitations (when calling include extension **51689**)
- Transplants
- Medical director reviews (when calling include extension **57078**)
- Request a reconsideration of an initial medical necessity denial
- Physician hotline (when calling include extension **51019**)

To learn more about healthcare management & operations services, processes and policies, please refer to chapter seven of this e-manual. Additionally, the BCBSNC Healthcare Management & Operations department makes available fax capability for providers arranging member services and supplying BCBSNC requested documentation.



Healthcare management & operations is available 24 hours (to learn more, please see chapter seven of this e-manual):

Support	Day	Hours
Representative	Monday - Friday	8 a.m. - 5 p.m.
Voice messaging system	Monday - Friday	Other than regular business hours

2.4 Mental health substance abuse services

Magellan Behavioral Health **1-800-359-2422**

Value Options **1-800-367-6143**

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

Activity	HMO/POS	PPO	CMM
Utilization management programs	Magellan Behavioral Health	Magellan Behavioral Health Exception(s): BCBSNC for members enrolled in Blue Advantage® *Value Options for members enrolled in the State Health Plan	Magellan Behavioral Health Exception(s): BCBSNC for members enrolled in Access® or Blue Assurance®
Quality management	Magellan Behavioral Health	BCBSNC Exception(s): *Value Options for members enrolled in the State Health Plan	BCBSNC
Claims processing	Magellan Behavioral Health	BCBSNC	BCBSNC
Provider contracting and network management	Magellan Behavioral Health	BCBSNC	BCBSNC
Customer service	Magellan Behavioral Health	BCBSNC	BCBSNC
Eligibility and benefit verification	Magellan Behavioral Health	Magellan Behavioral Health or BCBSNC Exception(s): *Value Options for members enrolled in the State Health Plan	Magellan Behavioral Health or BCBSNC

Continued on the following page.



Activity	HMO/POS	PPO	CMM
First level appeals	Magellan Behavioral Health	<p>Utilization first level appeals: Magellan Behavioral Health</p> <p>Claims first level appeals: BCBSNC</p> <p>Exception(s): *Utilization first level appeals for members enrolled in the State Health Plan are reviewed by Value Options</p>	<p>Utilization first level appeals: Magellan Behavioral Health</p> <p>Claims first level appeals: BCBSNC</p>

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

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

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

The below chart displays the intermediary, delegated activities for Health Network Solutions, Inc. (HNS), formerly Chiropractic Network of the Carolinas (CNC) (to learn more about these delegated activities, please refer to the specialty networks information located in chapter seventeen of this e-manual):

Activity	HMO/POS	PPO	CMM
Utilization management programs	BCBSNC	BCBSNC	BCBSNC
Quality management	BCBSNC	BCBSNC	BCBSNC
Claims processing	*BCBSNC	*BCBSNC	*BCBSNC
Provider contracting and Network Management	Health Network Solutions, Inc. (HNS)	Health Network Solutions, Inc. (HNS)	BCBSNC
Customer service	BCBSNC	BCBSNC	BCBSNC
Eligibility and benefit verification	BCBSNC	BCBSNC	BCBSNC
First level appeals	BCBSNC	BCBSNC	BCBSNC

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

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



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

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

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

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

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

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

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

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

2.7 Mailing addresses

For fastest claims processing, file electronically!

Visit BCBSNC electronic solutions on the Web at: <http://www.bcbsnc.com/providers/edi/>



Health care claims	Address
Health care claims – BCBSNC Exception(s): The State Health Plan	Blue Cross and Blue Shield of North Carolina PO Box 35 Durham, NC 27702
Health care claims – The State Health Plan	Blue Cross and Blue Shield of North Carolina PO Box 30087 Durham, NC 27702



Mental health and substance abuse services claims	Address
Mental health and substance abuse services claims – BCBSNC Exception(s): BCBSNC HMO The State Health Plan	Blue Cross and Blue Shield of North Carolina PO Box 35 Durham, NC 27702
Mental health and substance abuse services claims – BCBSNC HMO	Magellan Behavioral Health NC Unit PO Box 1659 Maryland Heights, MO 63043
Mental health and substance abuse services claims – The State Health Plan	Blue Cross and Blue Shield of North Carolina PO Box 30087 Durham, NC 27702

Chiropractic services	Address
Chiropractic service claims BCBSNC HMO BCBSNC PPO Exception(s): CMM	HNS/BCBS PO Box 2368 Cornelius, NC 28031

Level I member appeals	Address
Level I member appeals including a member signed Appeal Authorization Form – BCBSNC Exception(s): BCBSNC HMO mental health and substance abuse services The State Health Plan mental health and substance abuse services	Blue Cross and Blue Shield of North Carolina Member Rights and Appeals PO Box 30055 Durham, NC 27702-3055
Level I member appeals for BCBSNC HMO mental health and substance abuse services	Magellan Behavioral Health NC Unit Attention: Appeals Coordinator PO Box 1619 Alpharetta, GA 30009

Continued on the following page.



Level I provider appeals	Address
Level I provider appeals – Exceptions: BCBSNC HMO mental health and substance abuse services The State Health Plan mental health and substance abuse services	Blue Cross and Blue Shield of North Carolina Provider Appeals PO Box 2291 Durham, NC 27702-2291 (please use the level I provider appeal form located in chapter twenty-two of this e-manual)

Overpayments	Address
Overpayments – BCBSNC Exception(s): BCBSNC HMO mental health and dental	Blue Cross and Blue Shield of North Carolina Financial Processing Services PO Box 30048 Durham, NC 27702-3048 (please use form G252 located in chapter twenty-two of this e-manual)

2.8 Written claim inquiries

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

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

1. Provider claim inquiry form
2. Provider resolution form

Both forms are available to be copied from chapter twenty-two of this e-manual or can be printed from the BCBSNC Web site <http://www.bcbsnc.com/providers/>.

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

- A refund or overpayment, a request about a denial for service(s) not included in a member’s health benefit plan, or a claim believed to be processed incorrectly but not due to bundling and/or unbundling, please use the provider claim inquiry form.

- A specific service code(s) and how it bundled or unbundled and/or how charges pertaining to a corresponding code(s) were considered, please use the provider resolution form.
- ‡ When using the provider resolution form, supporting medical documentation should be submitted. Providers may reduce administrative cost associated with records submissions by first verifying that the records document information consistent with BCBSNC medical policy, pricing and adjudication policy, and Claim Check Clinical (C-3) edit rationale.

Provider claim inquiry form	BCBSNC Provider Inquiry Customer Service Department PO Box 2291 Durham, NC 27702-2291
Provider resolution form	BCBSNC Provider Inquiry Attention: Provider Resolution PO Box 2291 Durham, NC 27702-2291
Find out what Blue eSM can offer you: http://www.bcbsnc.com/providers/	



2.9 Provider demographics – contacting you

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

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

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

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

2.10 Online availability

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

Provider resources

- Most current **Blue Book**SM Provider eManual
- BlueLinkSM newsletters
- Provider information
- Most current prior authorization listing
- Medical policies and guidelines
- Evidence based guidelines
- Payment guidelines for providers
- Diagnostic imaging management policies
- Medical policy
- News releases
- Online provider directory
- Office-administered specialty drug network
- Product information
- Health and wellness programs
- Online services
- Access to care standards
- Pharmacy formulary information
- and much more. . .

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

Continued on the following page.



Electronic resources	
<ul style="list-style-type: none"> • Blue eSM • RealMed • Electronic solutions important news • HIPAA information • Electronic solutions • Electronic solutions vendor list 	<p>http://www.bcbsnc.com/providers/edi/</p>

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

2.11 Electronic solutions customer support 1-888-333-8594

Electronic claim filing issues, Blue eSM and RealMed
<p>1-888-333-8594 Option 1</p> <p>1-919-765-3514</p> <p>1-919-765-7101 Fax</p>

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

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

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

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

County	Region	Telephone	Fax
Alexander	West	704-561-2756	704-676-0501
Anson	West	704-561-2756	704-676-0501
Avery	West	704-561-2756	704-676-0501
Buncombe	West	704-561-2756	704-676-0501

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Quick contact information



County	Region	Telephone	Fax
Burke	West	704-561-2756	704-676-0501
Cabarrus	West	704-561-2756	704-676-0501
Catawba	West	704-561-2756	704-676-0501
Cherokee	West	704-561-2756	704-676-0501
Clay	West	704-561-2756	704-676-0501
Cleveland	West	704-561-2756	704-676-0501
Gaston	West	704-561-2756	704-676-0501
Graham	West	704-561-2756	704-676-0501
Haywood	West	704-561-2756	704-676-0501
Henderson	West	704-561-2756	704-676-0501
Jackson	West	704-561-2756	704-676-0501
Lincoln	West	704-561-2756	704-676-0501
Macon	West	704-561-2756	704-676-0501
Madison	West	704-561-2756	704-676-0501
McDowell	West	704-561-2756	704-676-0501
Mecklenburg	West	704-561-2756	704-676-0501
Mitchell	West	704-561-2756	704-676-0501
Polk	West	704-561-2756	704-676-0501
Rowan	West	704-561-2756	704-676-0501
Rutherford	West	704-561-2756	704-676-0501
Stanly	West	704-561-2756	704-676-0501
Swain	West	704-561-2756	704-676-0501
Transylvania	West	704-561-2756	704-676-0501
Union	West	704-561-2756	704-676-0501

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County	Region	Telephone	Fax
Watauga	West	704-561-2756	704-676-0501
Yancey	West	704-561-2756	704-676-0501
Alleghany	Triad	704-561-2751	704-676-0501
Ashe	Triad	704-561-2751	704-676-0501
Caldwell	Triad	704-561-2751	704-676-0501
Davidson	Triad	704-561-2751	704-676-0501
Davie	Triad	704-561-2751	704-676-0501
Forsyth	Triad	704-561-2751	704-676-0501
Hoke	Triad	704-561-2751	704-676-0501
Iredell	Triad	704-561-2751	704-676-0501
Montgomery	Triad	704-561-2751	704-676-0501
Moore	Triad	704-561-2751	704-676-0501
Randolph	Triad	704-561-2751	704-676-0501
Richmond	Triad	704-561-2751	704-676-0501
Rockingham	Triad	704-561-2751	704-676-0501
Scotland	Triad	704-561-2751	704-676-0501
Stokes	Triad	704-561-2751	704-676-0501
Surry	Triad	704-561-2751	704-676-0501
Wilkes	Triad	704-561-2751	704-676-0501
Yadkin	Triad	704-561-2751	704-676-0501
Alamance	Raleigh	919-765-4635	919-765-2564
Caswell	Raleigh	919-765-4635	919-765-2564
Chatham	Raleigh	919-765-4635	919-765-2564
Durham	Raleigh	919-765-4635	919-765-2564

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County	Region	Telephone	Fax
Franklin	Raleigh	919-765-4635	919-765-2564
Granville	Raleigh	919-765-4635	919-765-2564
Guilford	Raleigh	919-765-4635	919-765-2564
Harnett	Raleigh	919-765-4635	919-765-2564
Johnston	Raleigh	919-765-4635	919-765-2564
Lee	Raleigh	919-765-4635	919-765-2564
Orange	Raleigh	919-765-4635	919-765-2564
Person	Raleigh	919-765-4635	919-765-2564
Vance	Raleigh	919-765-4635	919-765-2564
Wake	Raleigh	919-765-4635	919-765-2564
Warren	Raleigh	919-765-4635	919-765-2564
Beaufort	East	919-765-2584	919-765-2564
Bertie	East	919-765-2584	919-765-2564
Bladen	East	919-765-2584	919-765-2564
Brunswick	East	919-765-2584	919-765-2564
Camden	East	919-765-2584	919-765-2564
Carteret	East	919-765-2584	919-765-2564
Chowan	East	919-765-2584	919-765-2564
Columbus	East	919-765-2584	919-765-2564
Craven	East	919-765-2584	919-765-2564
Cumberland	East	919-765-2584	919-765-2564
Currituck	East	919-765-2584	919-765-2564
Dare	East	919-765-2584	919-765-2564
Duplin	East	919-765-2584	919-765-2564

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County	Region	Telephone	Fax
Edgecombe	East	919-765-2584	919-765-2564
Gates	East	919-765-2584	919-765-2564
Greene	East	919-765-2584	919-765-2564
Halifax	East	919-765-2584	919-765-2564
Hertford	East	919-765-2584	919-765-2564
Hyde	East	919-765-2584	919-765-2564
Jones	East	919-765-2584	919-765-2564
Lenoir	East	919-765-2584	919-765-2564
Martin	East	919-765-2584	919-765-2564
Nash	East	919-765-2584	919-765-2564
New Hanover	East	919-765-2584	919-765-2564
Northampton	East	919-765-2584	919-765-2564
Onslow	East	919-765-2584	919-765-2564
Pamlico	East	919-765-2584	919-765-2564
Pasquotank	East	919-765-2584	919-765-2564
Pender	East	919-765-2584	919-765-2564
Perquimans	East	919-765-2584	919-765-2564
Pitt	East	919-765-2584	919-765-2564
Robeson	East	919-765-2584	919-765-2564
Sampson	East	919-765-2584	919-765-2564
Tyrrell	East	919-765-2584	919-765-2564
Washington	East	919-765-2584	919-765-2564
Wayne	East	919-765-2584	919-765-2564
Wilson	East	919-765-2584	919-765-2564



2.12 BCBSNC Network Management – local offices

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

Please contact your local Network Management field office for contract issues, fee information and educational needs. BCBSNC Network Management field offices are located across the state and are assigned territories; each of the Network Management field offices supports its provider community by specific geographical region.

Network Management contact information:

Phone/Fax/Email	Address
1-800-777-1643 919-765-4349 (fax) NMSpecialist@bcbsnc.com	P.O. Box 2291 Durham, NC 27702-2291

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

2.13 Changes to your office and/or billing information

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

- Name and address of where checks should be sent
- Name changes, mergers or consolidations
- Group affiliation
- Physical address
- Federal tax identification number (W-9 form required)
- National Provider Identifier (NPI)
- Telephone number, including daytime and twenty-four hour numbers
- Hours of operation
- Covering physicians

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

2.14 Hearing aid coverage

Effective January 1, 2011, hearing aid coverage will be available for members under the age of 22 by state mandate.

- Coverage is provided to members under the age of 22 for one hearing aid for each hearing-impaired ear up to \$2,500 per ear every 36 months.
- Coverage includes hearing aid evaluation, fittings and adjustments, or supplies such as ear molds. Coverage includes a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered individual.
- Member liability will apply to deductible and coinsurance* before coverage kicks in applicable hearing aid benefits are applied.

Healthcare

Benefit plans and
member identification cards





3.1 Health care benefit plan types and provider participation

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

3.2 Health care benefit plans overview

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

HMO product

- Blue Care[®]
(Health Maintenance Organization [HMO] plan)

PPO products

- Blue OptionsSM
(Preferred Provider Organization [PPO] plan)
- ‡ Blue OptionsSM
(PPO plan with deductible and coinsurance only)
- ‡ Blue OptionsSM
(PPO plan with in-network benefits only)
- Blue Options 1-2-3SM
(PPO plan with three benefit levels)
- Blue Options HSASM
(high-deductible PPO plan paired with a health savings account)
- Blue Options HRASM
(high-deductible PPO plan paired with a health reimbursement account)
- Blue Options FCSM
(PPO plan with fixed contributions)
- Blue Advantage[®]
(PPO plan purchased by individuals)
- State Health Plan
(PPO plan for State Health Plan membership)

CMM products

- Classic Blue[®]
(comprehensive major medical CMM plan)
- Blue AssuranceSM
(CMM plan for individuals)

Information relevant to each of these products, including sample member identification cards can be found within this section. Additional information about BCBSNC offered health care plans is available on our Web site for members, located at bcbsnc.com/content/shopping/. Health care providers should always (except for 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, BCBSNC offers to members Blue ExtrasSM value-added programs, which provide discounts and information on a wide variety of health related services at no additional cost to members. BCBSNC also offers AccessSM and Short Term Health Care through its CMM network of providers, as well as, Medicare related and Medicare Supplement programs. COBRA and ancillary products including life, dental and disability insurance. Because BCBSNC continually reviews its products for members, new products may be developed and introduced or existing products 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 BCBSNC. To find out more about Blue ExtrasSM and other BCBSNC product offerings, please view information available on our Web site at bcbsnc.com or contact your regional Network Management representative for assistance.

3.3 Determining eligibility

Blue eSM is the fastest and easiest way to obtain a member's eligibility and benefits information. With **Blue eSM** access providers can verify a member's eligibility, 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 in real-time, a member's information, from the provider's own computer screen. If your organization does not yet have access to **Blue eSM**, find out more by visiting the BCBSNC electronic solutions page on the Web at <http://www.bcbsnc.com/providers/edi/> or refer to chapter eleven of this e-manual.



Blue eSM and the Provider Blue LineSM are the most accurate and up-to-date sources for verifying member's eligibility. If you have not yet signed up for the convenience of **Blue eSM**, you can still verify member's benefits and eligibility by calling the Provider Blue LineSM 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, etc. 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 BCBSNC 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 alpha prefix and member suffix, without any special characters such as hyphens, spaces or dashes.

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

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

Front of card

		BlueOptions123	
Subscriber Name: BLUEOPTIONS123MEMBER01		Group No:	064196
Subscriber ID: YPPW14844803		Rx Bin/Group:	610014/PAID BNCDRUG
		Date Issued:	01/01/10
Members: SPOUSE 02		In-Network Member Responsibility:	
		Primary:	\$15
		Specialist:	30%
		Urgent Care/ER:	30%
		Deductible:	\$1,500
		Prescription Drug:	\$10/\$40/\$55/25%

Back of card

		BCBSNC.COM	
		Customer Service:	1-877-275-9787
		Nurse Support Line:	1-877-477-2424
		Mental Health:	1-800-359-2422
		Locate Non-NC Provider:	1-800-810-2583
		Provider Service:	1-800-214-4844
		Prior Review/Certification:	1-800-672-7897
		Pharmacist Help Desk:	1-800-922-1557
Claims are subject to review. For nonparticipating or non-NC providers , members are responsible for ensuring that prior review/certification is obtained. Participating NC providers are responsible for obtaining prior review/certification.			
BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association, provides administrative services only and does not assume any financial risk for claims.			
		Providers should send claims to their local BlueCross BlueShield Plan.	
		Medical: BCBSNC PO Box 35, Durham, NC 27702-0035	
		Pharmacy Benefits Administrator	

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. BCBSNC member ID numbers typically have an alpha prefix in the first three positions, followed by a “W” and eight randomly assigned numbers, which are followed by two additional numbers that are displayed to the left of the subscriber’s or dependent’s name on the member’s ID card (e.g., YPPW1234567801).

To help identify members with BCBSNC coverage, look for a “W” in the fourth position (e.g., YPPW12345678). However, exceptions do exist, such as identification numbers for FEP members, which have a single alpha prefix beginning with “R” (e.g., R1234567801). Member IDs for other Blue Plans will typically include an alpha prefix in the first three positions and can contain any combination of numbers and letters up to 17 characters.

Alpha prefixes identify the Blue Cross and/or Blue Shield (BCBS) health care plan to which a member belongs. Alpha prefixes should always be included when filing claims (if the member’s ID includes an alpha prefix). The alpha prefix is necessary to accurately verify eligibility and benefits, and route claims to the appropriate BC and/or BS plan.

Following is a list of the most commonly recognized alpha prefixes for BCBSNC members. Please note that this list is not all inclusive and does not include many of the customized employer group alpha prefixes.

Alpha prefix	Plan	
YPHW	Blue Care [®]	HMO
YPPW	Blue Options SM	PPO
YPPW	Blue Options 1-2-3 SM	PPO
YPDW	Blue Options HSA SM	PPO
YPDW	Blue Options HRA SM	PPO
YPDW	Blue Options FC SM	PPO

Alpha prefix	Plan	
YPPW	Blue Advantage [®]	PPO
YPYW	State Health Plan	PPO
YPMW	Classic Blue [®]	CMM
YPMW	Blue Assurance [®]	CMM

Member identification numbers for federal employees always begin with the letter “R.”

3.3.3 Verification of coverage form

BCBSNC makes every effort to provide ID cards prior to a member’s effective date. If however, a newly enrolled member having coverage benefits changes, which require a new card to be issued, becomes effective before receiving their new BCBSNC member identification card, members are asked to download and print a temporary verification of coverage form. The temporary verification of coverage form is available from the “My Member Services” page on our Web site at bcbsnc.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, BCBSNC will reimburse you according to your contract. You must reimburse the member the total amount previously collected, less any copayment, coinsurance and/or deductible due from the member.

3.4 Pre-existing conditions

Some members may have a waiting period for coverage of care due to pre-existing conditions. Verification of a member’s pre-existing conditions and/or coverage clarifications can be obtained using **Blue eSM** or by calling the Provider Blue LineSM at **1-800-214-4844**.



3.5 Blue Care® an HMO product

Blue Care® is an open access Health Maintenance Organization (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.

Sample Blue Care® membership ID card:

Front of card

		BlueCare®	
<hr/>			
Subscriber Name:		Group No:	064313
HMO MEMBER	01	Rx Bin/Group:	610014/PAID BNCDRUG
Subscriber ID:		Date Issued:	01/01/10
YPHW14844798			
<hr/>			
Member Responsibility:			
		Primary	\$20
		Specialist	\$30
		Urgent Care	\$30
		ER	\$150
		Prescription Drug:	\$10/75%
<hr/>			

Back of card

		BCBSNC.COM	
<hr/>		Customer Service:	1-877-258-3334
Claims are subject to review. Participating NC providers are responsible for obtaining prior review/certification.		Nurse Support Line:	1-877-477-2424
Insured by BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association.		Mental Health:	1-800-359-2422
		Locate Non-NC Provider:	1-800-810-2583
		Provider Service:	1-800-214-4844
		Prior Review/Certification:	1-800-672-7897
		Pharmacist Help Desk:	1-800-922-1557
<hr/>			
		Providers should send claims to their local BlueCross BlueShield Plan.	
		Medical: BCBSNC PO Box 35, Durham, NC 27702-0035	
<hr/>			
		Pharmacy Benefits Administrator	

An individual's possession of a BCBSNC 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.

The full member ID begins with YPHW and is a total of 14 characters, which includes 8 subscriber numbers followed by two additional numbers that are displayed to the left of the subscriber's or dependent's name.

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 BCBSNC 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 BCBSNC 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 BCBSNC in advance of service, are not covered under Blue Care®.
 - ‡ In specific situations, BCBSNC 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® (see section 7.5.1.5, Certification list).
- 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.



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

Blue Care® - typical coverage for services provided in an office

Service category	Member liability
<p>Office visits</p> <ul style="list-style-type: none"> • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care 	<ul style="list-style-type: none"> • Primary care or specialist copayment (listed on ID card) • OB/GYNs always collect the primary copayment
<p>Preventive care</p> <ul style="list-style-type: none"> • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears (with office visit) • Immunizations (with office visit) • Screening mammograms (with office visit) • Prostate Specific Antigen (PSA) tests (with office visit) • Colorectal screening 	<ul style="list-style-type: none"> • Primary care or specialist copayment (listed on ID card) • OB/GYNs always collect the primary copayment
<p>Maternity</p> <ul style="list-style-type: none"> • Prenatal • Post-delivery 	<ul style="list-style-type: none"> • Copayment for determination of pregnancy visit only
<p>Short-term rehabilitative therapy</p> <ul style="list-style-type: none"> • Occupational therapy/physical therapy (including chiropractic services) • Speech therapy 	<ul style="list-style-type: none"> • Applicable copayment (listed on ID card) • On most Blue Care® plans, short-term rehabilitative therapies are limited to a maximum of 30 visits total per benefit period per therapy combination (i.e., occupational and physical therapies are combined)

Continued on the following page.



Blue Care® - typical coverage for services provided in an office	
Service category	Member liability
<p>Other therapies</p> <ul style="list-style-type: none"> • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy 	<p>Office location:</p> <ul style="list-style-type: none"> • No copayment - covered services are typically paid at 100% unless billed with an office visit <p>Other locations:</p> <ul style="list-style-type: none"> • Deductible and coinsurance
Urgent care	Urgent care copayment (listed on ID card)
Prescription drugs	<ul style="list-style-type: none"> • On most Blue Care® plans, prescription drugs are covered under a four-tier copayment design • Copayments are listed on the ID card • Standard drug plans include a brand penalty. This penalty typically does not apply when the brand is determined to be necessary by the provider and Dispense as Written (DAW) is included on the prescription.

Blue Care® - typical coverage for services provided in a facility depends on the network status of the facility	
Service category	Member liability
Emergency room services	Emergency care copayment (listed on ID card)
<p>Ambulatory surgery centers</p> <p>Facility must be contracting with BCBSNC as an ambulatory surgery center</p>	Deductible and coinsurance typically apply
Outpatient services	<ul style="list-style-type: none"> • Subject to deductible and coinsurance Professional services subject to deductible and coinsurance • On most Blue Care® plans, facility charges for outpatient services are subject to deductible and coinsurance • All labs and mammograms performed alone paid at 100%. All other diagnostic services, subject to deductible and coinsurance

Continued on the following page.



Blue Care® - typical coverage for services provided in a facility depends on the network status of the facility	
Service category	Member liability
Inpatient services	<ul style="list-style-type: none"> Professional services subject to deductible and coinsurance On most Blue Care® plans, facility charges for inpatient services are subject to deductible and coinsurance New options for inpatient hospital copayment of \$250 or \$500 per admission
Skilled nursing facilities	<ul style="list-style-type: none"> On most Blue Care® plans, all charges for services at a skilled nursing facility are subject to deductible and coinsurance Limited to 60 days per benefit period
Inpatient and outpatient services for mental health and substance abuse (outpatient services do not include office visits, typically limited to 30 days)	Coordinated through Magellan Behavioral Health

Blue Care® - typical coverage for services provided by an ancillary provider		
Service category	In-network member liability	Out-of-network member liability
Home health care	Deductible and coinsurance	Not covered
Hospice care	Deductible and coinsurance	Not covered
Private duty nursing (certification required)	Deductible and coinsurance	Not covered
Home infusion therapy	Deductible and coinsurance	Not covered
Durable medical equipment	Deductible and coinsurance	Not covered
Short-term therapy*	Deductible and coinsurance	Not covered
Dialysis**	Deductible and coinsurance	Not covered

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

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

Covered short-term therapies include:

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



3.6 Blue OptionsSM plans, State Health Plan and Blue Advantage[®] PPO products

BCBSNC PPO (Preferred Provider Organization) products offer coverage for members when receiving care from in-network/participating providers, hospitals and clinics. Most PPO plans also provide benefits for both in- and out-of-network services (however, not all plans and not for all 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. BCBSNC PPO products include plans with; copayments-only for certain services, copayments partnered with coinsurance and deductibles, only coinsurance and deductibles (non-copayment plans). BCBSNC PPO plans give members the freedom to go directly to participating Primary Care Providers (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.

Blue OptionsSM plans, State Health Plan and Blue Advantage[®] PPO (Preferred Provider Organization) products offer flexible and convenient copayment and/or coinsurance and deductible options for BCBSNC members.

PPO plans	Copayments apply (depending on services provided)	Deductible and coinsurance apply (depending on services provided)	Out-of-network benefits available*	Individual plans available	Employer group plans available
Blue OptionsSM	■	■	■	■	■
Blue Options SM deductible and coinsurance only		■	■		■
Blue Options SM in-network only	■	■			■
Blue Options 1-2-3SM	■	■	■		■
Blue Options HSASM		■	■	■	■
Blue Options HRASM		■	■		■
Blue Options FCSM	■	■	■	■	
Blue Advantage[®]	■	■	■	■	
State Health Plan	■	■	■	State Health Plan for Teachers and State Employees only	

■ = Yes

*Plans that include out-of-network availability may have restrictions for certain services, service locations and/or provider specialty type. Always verify a member's individual benefit limitations in advance of providing or arranging services.



Sample PPO membership ID cards

Sample Blue OptionsSM membership ID card

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

Front of card

		BlueOptions	
Subscriber Name: PPO MEMBER			
Subscriber ID: YPPW14844818	01	Group No: 064300 Rx Bin/Group: 610014/PAID BNCDRUG Date Issued: 01/01/10	
<hr/> Members: JESSICA			
	02	In-Network Member Responsibility: Primary \$20 Specialist \$40 Urgent Care \$40* ER \$150* Prescription Drug: \$5/\$15/\$30/25% *Same for out-of-network	
Dental			

Back of card

		BCBSNC.COM BCBSNC-DENTAL.COM	
Claims are subject to review. For nonparticipating or non-NC providers , members are responsible for ensuring that prior review/certification is obtained. Participating NC providers are responsible for obtaining prior review/certification.		Customer Service: 1-877-258-3334 Dental: 1-800-305-6638 Nurse Support Line: 1-877-477-2424 Mental Health: 1-800-359-2422 Locate Non-NC Provider: 1-800-810-2583 Provider Service: 1-800-214-4844 Prior Review/Certification: 1-800-672-7897 Pharmacist Help Desk: 1-800-922-1557	
Insured by BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association.		Providers should send claims to their local BlueCross BlueShield Plan. Medical: BCBSNC PO Box 35, Durham, NC 27702-0035 Dental: BCBSNC PO Box 2100, Winston-Salem, NC 27102 or emdeon #61473.	
		Pharmacy Benefits Administrator	

The full subscriber ID begins with four alpha characters and is a total of 10 digits, which includes the two digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a BCBSNC 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.

Sample Blue Options 1-2-3SM membership ID card

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

Front of card

		BlueOptions123	
Subscriber Name: BLUEOPTIONS123MEMBER01			
Subscriber ID: YPPW14844803		Group No: 064196 Rx Bin/Group: 610014/PAID BNCDRUG Date Issued: 01/01/10	
<hr/> Members: SPOUSE			
	02	In-Network Member Responsibility: Primary \$15 Specialist 30% Urgent Care/ER 30% Deductible \$1,500 Prescription Drug: \$10/\$40/\$55/25%	

Back of card

		BCBSNC.COM	
Claims are subject to review. For nonparticipating or non-NC providers , members are responsible for ensuring that prior review/certification is obtained. Participating NC providers are responsible for obtaining prior review/certification.		Customer Service: 1-877-275-9787 Nurse Support Line: 1-877-477-2424 Mental Health: 1-800-359-2422 Locate Non-NC Provider: 1-800-810-2583 Provider Service: 1-800-214-4844 Prior Review/Certification: 1-800-672-7897 Pharmacist Help Desk: 1-800-922-1557	
BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association, provides administrative services only and does not assume any financial risk for claims.		Providers should send claims to their local BlueCross BlueShield Plan. Medical: BCBSNC PO Box 35, Durham, NC 27702-0035	
		Pharmacy Benefits Administrator	



Sample PPO membership ID cards (continued)

Sample Blue Options HSASM membership ID card

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

Front of card

		BlueOptionsHSA	
<hr/>			
Subscriber Name:		Group No:	064181
HSA MEMBER	01	Rx Bin/Group:	610014/PAID BNCDRUG
Subscriber ID:		Date Issued:	01/01/10
YPDW14844815			
<hr/>			
In-Network Member Responsibility:			
		Coinsurance	40%
		Deductible	\$3,000
		Prescription Drug	40% after ded
<hr/>			
Dental			

Sample Blue Options HRASM membership ID card

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

Front of card

		BlueOptionsHRA	
<hr/>			
Subscriber Name:		Group No:	064187
HRA MEMBER	01	Rx Bin/Group:	610014/PAID BNCDRUG
Subscriber ID:		Date Issued:	01/01/10
YPDW14844816			
<hr/>			
Members:		In-Network Member Responsibility:	
SPOUSE	02	Coinsurance	40%
CHILD	03	Deductible	\$3,000
		Prescription Drug	40% after ded
<hr/>			

Back of card

		BCBSNC.COM BCBSNC-DENTAL.COM	
<hr/>			
Customer Service:		1-877-275-3334	
Dental:		1-800-305-6638	
Nurse Support Line:		1-877-477-2424	
Mental Health:		1-800-359-2422	
Locate Non-NC Provider:		1-800-810-2583	
Provider Service:		1-800-214-4844	
Prior Review/Certification:		1-800-672-7897	
Pharmacist Help Desk:		1-800-922-1557	
<hr/>			
Insured by BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association.		Providers should send claims to their local BlueCross BlueShield Plan.	
		Medical: BCBSNC PO Box 35, Durham, NC 27702-0035	
		Dental: BCBSNC PO Box 2100, Winston-Salem, NC 27102 or emdeon #61473	
<hr/>			
		Pharmacy Benefits Administrator	

Back of card

		BCBSNC.COM	
<hr/>			
Customer Service:		1-877-258-3334	
Nurse Support Line:		1-877-477-2424	
Mental Health:		1-800-359-2422	
Locate Non-NC Provider:		1-800-810-2583	
Provider Service:		1-800-214-4844	
Prior Review/Certification:		1-800-672-7897	
Pharmacist Help Desk:		1-800-922-1557	
<hr/>			
Insured by BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association.		Providers should send claims to their local BlueCross BlueShield Plan.	
		Medical: BCBSNC PO Box 35, Durham, NC 27702-0035	
<hr/>			
		Pharmacy Benefits Administrator	

The full subscriber ID begins with four alpha characters and is a total of 10 digits, which includes the two digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a BCBSNC 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.



Sample PPO membership ID cards (continued)

Sample Blue Advantage® membership ID card

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

Front of card

		BlueAdvantage
Subscriber Name: First and Last Name Subscriber ID: YPPW13800186	01	Group No: IADV01 Account No: 300563072 Rx Bin/Group: 610014/PAID BNCDRUG Date Issued: 09/29/08
		In-Network Member Responsibility: Primary \$25 Specialist \$50 Urgent Care \$50* ER \$150* Rx Deductible \$200 Prescription Drug \$10/\$35/\$50/25% *Same for out-of-network

Back of card

	BCBSNC.COM Customer Service: 1-888-206-4697 Nurse Support Line: 1-877-477-2424 Locate Non-NC Provider: 1-800-810-2583 Provider Service: 1-800-214-4844 Prior Review/Certification: 1-800-672-7897 Pharmacist Help Desk: 1-800-922-1557
Claims are subject to review. For nonparticipating or non-NC providers, members are responsible for ensuring that prior review/certification is obtained. Participating NC providers are responsible for obtaining prior review/certification. Insured by BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association.	Providers should send claims to their local BlueCross BlueShield Plan. Medical: BCBSNC PO Box 35, Durham, NC 27702-0035
	Pharmacy Benefits Administrator

The full subscriber ID begins with four alpha characters and is a total of 10 digits, which includes the two digits that are displayed to the left of the subscriber's or dependent's name.

An individual's possession of a BCBSNC 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.

Sample State Health Plan membership ID card

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

Front of card

		BlueCross. BlueShield.	
Subscriber Name: PPO Member Subscriber ID: YPYW15345304	01	PPO – Standard Group No: S16031 Rx Bin/Group: 610014/NC SHPHC Date Issued: 07/01/10	In-Network Member Responsibility: Primary \$25 Specialist \$60 PT/OT/ST/Chiro \$45 MH, SA \$45 Urgent Care \$75* ER \$200 + 20% *Same for out-of-network

Back of card

	BCBSNC.COM www.shpnc.org Customer Service: 1-888-234-2416 Locate Non-NC Provider: 1-800-810-2583 Provider Service: 1-800-214-4844 Prior Review/Certification: 1-800-672-7897 NC HealthSmart Coaches*: 1-800-817-7044 ValueOptions Mental Health*: 1-800-367-6143 Medco Customer Service*: 1-800-336-5933 Medco Pharmacy Help Desk*: 1-800-922-1557 *Not a BlueCross BlueShield Product
Claims may be subject to review. For nonparticipating or non-NC providers or outpatient mental health, members are responsible for ensuring that prior certification is obtained. Participating NC providers are responsible for obtaining certification. BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association, provides administrative services only and does not assume any financial risk for claims. For prescription drug claims, see web site above for address.	Providers should send claims to their local BlueCross BlueShield Plan. Medical: Blue Cross and Blue Shield of North Carolina PO Box 30087, Durham, NC 27702-0035
	Pharmacy Benefits Administrator



3.6.1 Health benefit summary

BCBSNC offers PPO products for individual subscribers and for employer groups. Employer groups with more than 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. BCBSNC PPO products also offer Consumer-Driven Health Plans (CDHP), where members pay deductible and coinsurance amounts but have no copays.

Benefits are available for covered services received from BCBSNC 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 BCBSNC (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 BCBSNC 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 BCBSNC in advance of service, will not be covered if the PPO plan does not include out-of-network benefits.

‡ In specific situations, BCBSNC 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 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 (see section 7.5.1.5, Certification list).
- 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.



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

Blue OptionsSM – typical coverage for services provided in an office

Service category	In-network member liability	Out-of-network member liability
<p>Office visits</p> <ul style="list-style-type: none"> • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care 	<ul style="list-style-type: none"> • Primary care or specialist copayment as listed on the member's ID card (for members enrolled in copayment plans) • OB/GYNs always collect primary care copayment • Applicable deductible and/or coinsurance (for members enrolled in non-copayment plans) 	<ul style="list-style-type: none"> • Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
<p>Preventive care</p> <ul style="list-style-type: none"> • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears (with office visit) • Immunizations (with office visit) • Screening mammograms (with office visit) • Prostate Specific Antigen (PSA) tests (with office visit) • Colorectal screening 	<ul style="list-style-type: none"> • Primary care or specialist copayment as listed on the member's ID card (for members enrolled in copayment plans) • OB/GYNs always collect primary care copayment • Applicable deductible and/or coinsurance (for members enrolled in non-copayment plans) 	<ul style="list-style-type: none"> • On most PPO plans the only preventive care services covered out-of-network are mammograms, pap smears, and PSA test. They are subject to out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits).
<p>Maternity</p> <ul style="list-style-type: none"> • Prenatal • Post-delivery 	<ul style="list-style-type: none"> • Copayment for determination of pregnancy visit, followed by deductible and coinsurance for subsequent visits (for members enrolled in copayment plans) • Applicable deductible and/or coinsurance (for members enrolled in non-copayment plans) 	<ul style="list-style-type: none"> • Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits) • Applicable deductible and/or coinsurance (for members enrolled in non-copayment plans)

Continued on the following page.



Blue Options SM – typical coverage for services provided in an office		
Service category	In-network member liability	Out-of-network member liability
<p>Short-term rehabilitative therapy</p> <ul style="list-style-type: none"> Occupational/physical therapy (including chiropractic services) Speech therapy 	<ul style="list-style-type: none"> Primary care or specialist copayment (for members enrolled in copayment plans) Applicable deductible and/or coinsurance (for members enrolled in non-copayment plans) On most PPO plans short-term rehabilitative therapies are limited to a combined in- and out-of-network maximum of 30 visits per benefit period, per therapy combination (i.e., occupational and physical therapies are combined). 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits) On most PPO plans, short-term rehabilitative therapies are limited to a combined in- and out-of-network maximum of 30 visits per benefit period, per therapy combination (i.e., occupational and physical therapies are combined).
<p>Other therapies</p> <ul style="list-style-type: none"> Chemotherapy Dialysis treatment Radiation therapy Respiratory therapy 	<p>Office location:</p> <ul style="list-style-type: none"> No copayment for covered services, these are typically paid at 100% unless billed with an office visit E/M service (for members enrolled in copayment plans). Applicable deductible and/or coinsurance (for members enrolled in non-copayment plans) <p>Other locations:</p> <ul style="list-style-type: none"> Deductible and coinsurance (including members enrolled in copayment plans) 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
<p>Urgent care</p>	<ul style="list-style-type: none"> Urgent care copayment as listed on the member’s ID card (for members enrolled in copayment plans) Applicable deductible and/or coinsurance (for members enrolled in non-copayment plans) 	<ul style="list-style-type: none"> Urgent care copayment as listed on the member’s ID card (for members enrolled in copayment plans that also offer out-of-network benefits) Applicable out-of-network deductible and/or coinsurance (for members enrolled in non-copayment plans that also offer out-of-network benefits)

Continued on the following page.



Blue Options SM – typical coverage for services provided in an office		
Service category	In-network member liability	Out-of-network member liability
Prescription drugs	<ul style="list-style-type: none"> On most PPO plans prescription drugs are covered under a four-tier copayment design. Standard drug plans include a brand name penalty. This penalty typically does not apply when the brand is determined to be necessary by the provider and Dispense as Written (DAW) is included on the prescription. 	<ul style="list-style-type: none"> Members may be charged by the pharmacy

Blue Options SM – typical coverage for services provided in a facility depends on the network status of the facility		
Service category	In-network member liability	Out-of-network member liability
Emergency room services	<ul style="list-style-type: none"> Emergency care copayment as listed on the member's ID card (for members enrolled in copayment plans) Applicable deductible and/or coinsurance (for members enrolled in non-copayment plans) 	<ul style="list-style-type: none"> Emergency care copayment as listed on the member's ID card (for members enrolled in copayment plans that also offer out-of-network benefits) Applicable out-of-network deductible and/or coinsurance (for members enrolled in non-copayment plans that also offer out-of-network benefits)
Ambulatory surgery centers Facility must be contracting with BCBSNC as an ambulatory surgery center	<ul style="list-style-type: none"> In-network deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
Outpatient services	<ul style="list-style-type: none"> On most PPO plans professional and facility charges for outpatient services are subject to deductible and coinsurance Certain diagnostic services are not paid solely based on place of service. Mammograms and simple lab work are typically paid at 100% at outpatient hospital centers when not performed with other services at the same time. All other diagnostics are typically subject to deductible and coinsurance. 	<ul style="list-style-type: none"> Emergency care copayment as listed on the member's ID card (for members enrolled in copayment plans that also offer out-of-network benefits) Applicable out-of-network deductible and/or coinsurance (for members enrolled in non-copayment plans that also offer out-of-network benefits)

Continued on the following page.



Blue OptionsSM – typical coverage for services provided in a facility depends on the network status of the facility

Service category	In-network member liability	Out-of-network member liability
Inpatient services	<ul style="list-style-type: none"> On most PPO plans professional and facility charges for inpatient services are typically subject to deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
Skilled nursing facilities	<ul style="list-style-type: none"> On most PPO plans all charges for services at a skilled nursing facility are typically subject to deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
	<ul style="list-style-type: none"> This benefit is typically limited to 60 days per benefit period (combined in- and out-of-network) 	
Inpatient and outpatient services for mental health and substance abuse	<ul style="list-style-type: none"> Coordinated through Magellan Behavioral Health 	<ul style="list-style-type: none"> On most PPO copay plans out-of-network inpatient and outpatient mental health and substance abuse services are subject to coinsurance without copayment or deductible Out-of-network coinsurance and/or deductible (for members enrolled in non-copayment plans offering out-of-network benefits)

Continued on the following page.



Blue Options SM – typical coverage for services provided by an ancillary provider		
Service category	In-network member liability	Out-of-network member liability
Home health care	<ul style="list-style-type: none"> Deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
Hospice care	<ul style="list-style-type: none"> Deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
Private duty nursing (certification required)	<ul style="list-style-type: none"> Deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
Home infusion therapy	<ul style="list-style-type: none"> Deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
Durable medical equipment	<ul style="list-style-type: none"> Deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
Home short-term therapy*	<ul style="list-style-type: none"> Deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)
Dialysis**	<ul style="list-style-type: none"> Deductible and coinsurance 	<ul style="list-style-type: none"> Out-of-network deductible and coinsurance (for members enrolled in plans offering out-of-network benefits)

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

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

Covered short-term therapies include:

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



3.6.2 The State Health Plan for teachers and state employees

The State Health Plan offers teachers, state employees and state retirees of North Carolina the option to choose from two preferred provider organization PPO health plans:

- **PPO Basic Plan** offers State Health Plan members higher copays, coinsurance and deductibles in exchange for reduced premiums. State Health Plan members can save on health care premiums when selecting the PPO Basic Plan as the coverage choice for the needs of a healthy family.
- **PPO Standard Plan** provides a higher coverage level than the coverage level of the Basic plan. The PPO Standard Plan is typically elected for employee-only coverage or for families who experience more frequent health care needs.

The State Health Plan is administered as part of the BCBSNC Blue OptionsSM PPO product. 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 differ, based on the option selected by the employee.

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

Providers familiar with the PPO plans for State Health Plan members may recall that three PPO plan options were formerly available. The PPO Plus plan, part of the original three plan options, was withdrawn from offering as of July 1, 2009. State Health Plan members enrolling in a plan are now given a choice between two plans that offer members the most cost savings.

Providers can recognize a State Health Plan member by simply reading the member's ID card or by review of the member's alpha prefix. State Health Plan PPO members have an alpha prefix of YPYW.

Sample ID card

Front of card

Subscriber Name: PPO Member Subscriber ID: YPYW15345304	01	PPO – Standard Group No: S16031 Rx Bin/Group: 610014/NCSHPHC Date Issued: 07/01/10	
		In-Network Member Responsibility:	
		Primary \$25 Specialist \$60 PT/OT/ST/Chiro \$45 MH, SA \$45 Urgent Care \$75* ER \$200 + 20% *Same for out-of-network	
BlueOptions	Bluee		

Back of card

		BCBSNC.COM www.shpnc.org Customer Service: 1-888-234-2416 Locate Non-NC Provider: 1-800-810-2583 Provider Service: 1-800-214-4844 Prior Review/Certification: 1-800-672-7897 NC HealthSmart Coaches:* 1-800-817-7044 ValueOptions Mental Health:* 1-800-367-6143 Medco Customer Service:* 1-800-336-5933 Medco Pharmacy Help Desk:* 1-800-922-1557 *Not a BlueCross BlueShield Product
Claims may be subject to review. For nonparticipating or non-NC providers or outpatient mental health, members are responsible for ensuring that prior certification is obtained. Participating NC providers are responsible for obtaining certification.		
BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association, provides administrative services only and does not assume any financial risk for claims.		Providers should send claims to their local BlueCross BlueShield Plan. Medical: Blue Cross and Blue Shield of North Carolina PO Box 30087, Durham, NC 27702-0035
For prescription drug claims, see web site above for address.		Pharmacy Benefits Administrator

The full member ID begins with YPYW and is a total of 14 characters, which includes 8 subscriber numbers followed by two additional numbers that are displayed to the left of the subscriber's or dependent's name.

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

Summary of benefits offered as an example of typical benefit options available as of July 1, 2009, and should not be considered as a guarantee of benefits, eligibility or plan coverage. Always verify a member's actual eligibility and benefits prior to providing services.



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

The State Health Plan - typical coverage for services provided in an office

Service category	In-network member liability	Out-of-network member liability
<p>Office visits</p> <ul style="list-style-type: none"> • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care <p>Note: Office visits for the evaluation and treatment of obesity are limited to four visits per benefit period.</p>	<p>Basic Plan</p> <ul style="list-style-type: none"> • Primary care or specialist copayment as listed on the member's ID card • OB/GYNs always collect primary care copayment 	<p>Basic Plan</p> <ul style="list-style-type: none"> • Plan pays 50% after deductible
	<p>Standard Plan</p> <ul style="list-style-type: none"> • Primary care or specialist copayment as listed on the member's ID card • OB/GYNs always collect primary care copayment 	<p>Standard Plan</p> <ul style="list-style-type: none"> • Plan pays 60% after deductible
<p>Preventive care</p> <ul style="list-style-type: none"> • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears (with office visit) • Immunizations (with office visit) • Screening mammograms (with office visit) • Prostate Specific Antigen (PSA) tests (with office visit) • Colorectal screening 	<p>Basic Plan</p> <ul style="list-style-type: none"> • Primary care or specialist copayment as listed on the member's ID card • OB/GYNs always collect primary care copayment 	<p>Basic Plan</p> <ul style="list-style-type: none"> • Benefits not available
	<p>Standard Plan</p> <ul style="list-style-type: none"> • Primary care or specialist copayment as listed on the member's ID card • OB/GYNs always collect primary care copayment 	<p>Standard Plan</p> <ul style="list-style-type: none"> • Benefits not available
<p>Maternity</p> <ul style="list-style-type: none"> • Prenatal • Post-delivery 	<p>Basic Plan</p> <ul style="list-style-type: none"> • Copayment for the determination of pregnancy visit, followed by deductible 	<p>Basic Plan</p> <ul style="list-style-type: none"> • Plan pays 50% after deductible

Continued on the following page.



The State Health Plan – typical coverage for services provided in an office		
Service category	In-network member liability	Out-of-network member liability
	<p>Standard Plan</p> <ul style="list-style-type: none"> Copayment for the determination of pregnancy visit, followed by deductible 	<p>Standard Plan</p> <ul style="list-style-type: none"> Plan pays 60% after deductible
Nutritional counseling	<p>Basic Plan</p> <ul style="list-style-type: none"> Diabetes care (first 6 visits) - Plan pays 100% Diabetes care (after 6th visit) - Plan pays 70% after deductible All other conditions (combined in- and out-of-network maximum of four visits per benefit period). Copayment listed on the member's ID card. 	<p>Basic Plan</p> <ul style="list-style-type: none"> Diabetes care (first 6 visits) - Plan pays 50% after deductible Diabetes care (after 6th visit) - Plan pays 50% after deductible All other conditions (combined in- and out-of-network maximum of four visits per benefit period). Plan pays 50% after deductible.
	<p>Standard Plan</p> <ul style="list-style-type: none"> Diabetes care (first 6 visits) - Plan pays 100% Diabetes care (after 6th visit) - Plan pays 80% after deductible All other conditions (combined in- and out-of-network maximum of four visits per benefit period). Copayment listed on the member's ID card. 	<p>Standard Plan</p> <ul style="list-style-type: none"> Diabetes care (first 6 visits) - Plan pays 60% after deductible Diabetes care (after 6th visit) - Plan pays 60% after deductible All other conditions (combined in- and out-of-network maximum of four visits per benefit period). Plan pays 60% after deductible.
<p>Short-term rehabilitative therapy</p> <ul style="list-style-type: none"> Occupational/physical therapy Speech therapy 	<p>Basic Plan</p> <ul style="list-style-type: none"> Copayment as listed on the member's ID card 	<p>Basic Plan</p> <ul style="list-style-type: none"> Plan pays 50% after deductible
	<p>Standard Plan</p> <ul style="list-style-type: none"> Copayment as listed on the member's ID card 	<p>Standard Plan</p> <ul style="list-style-type: none"> Plan pays 60% after deductible

Continued on the following page.



The State Health Plan – typical coverage for services provided in an office		
Service category	In-network member liability	Out-of-network member liability
<p>Chiropractic services</p> <p>Combined in- and out-of-network maximum of 30 visits per benefit period</p>	<p>Basic Plan</p> <ul style="list-style-type: none"> Copayment as listed on the member’s ID card 	<p>Basic Plan</p> <ul style="list-style-type: none"> Plan pays 50% after deductible
	<p>Standard Plan</p> <ul style="list-style-type: none"> Copayment as listed on the member’s ID card 	<p>Standard Plan</p> <ul style="list-style-type: none"> Plan pays 60% after deductible
<p>Other therapies</p> <ul style="list-style-type: none"> Chemotherapy Dialysis treatment Radiation therapy Respiratory therapy 	<p>Basic Plan</p> <ul style="list-style-type: none"> Plan pays 100% 	<p>Basic Plan</p> <ul style="list-style-type: none"> Plan pays 50% after deductible
	<p>Standard Plan</p> <ul style="list-style-type: none"> Plan pays 100% 	<p>Basic Plan</p> <ul style="list-style-type: none"> Plan pays 50% after deductible
<p>Urgent care</p>	<p>Basic Plan</p> <ul style="list-style-type: none"> Urgent care copayment as listed on the member’s ID card 	<p>Basic Plan</p> <ul style="list-style-type: none"> Urgent care copayment as listed on the member’s ID card
	<p>Standard Plan</p> <ul style="list-style-type: none"> Urgent care copayment as listed on the member’s ID card 	<p>Basic Plan</p> <ul style="list-style-type: none"> Urgent care copayment as listed on the member’s ID card
<p>Mental health and substance abuse</p> <ul style="list-style-type: none"> First 26 combined mental health and chemical dependency visits each benefit period do not require prior review by Value Options (the mental health case manager). The first 26 visits can include 6 preventive visits per benefit period. For visits 27 and beyond its necessary to obtain prior approval from Value Options. 1-800-367-6143. Note: Medication checks do not require prior approval. 	<p>Basic Plan</p> <ul style="list-style-type: none"> MH/SA copayment 	<p>Basic Plan</p> <ul style="list-style-type: none"> Plan pays 50% after deductible
	<p>Standard Plan</p> <ul style="list-style-type: none"> MH/SA copayment 	<p>Basic Plan</p> <ul style="list-style-type: none"> Plan pays 60% after deductible

Continued on the following page.



The State Health Plan – typical coverage for services provided in an office

Service category	In-network member liability	Out-of-network member liability
<p>Prescription drugs</p> <p>For brand name drugs with an available generic, members are required to pay the generic copayment, plus the difference between the Plan’s cost of the brand name drug and the Plan’s cost of the generic drug.</p>	<p>Basic Plan</p> <ul style="list-style-type: none"> • Prescription drugs for generic, preferred brand (without generic available) and non-preferred: <ul style="list-style-type: none"> ‡ One copayment applies for up to a 30-day supply ‡ Two copayments apply for supplies for 31-60 days ‡ Three copayments apply for supplies up to 61-90 days ‡ Specialty medications: 25% coinsurance up to \$100 for each 30-day supply <p>Standard Plan</p> <ul style="list-style-type: none"> • Prescription drugs for generic, preferred brand (without generic available) and non-preferred: <ul style="list-style-type: none"> ‡ One copayment applies for up to a 30-day supply ‡ Two copayments apply for supplies for 31-60 days ‡ Three copayments apply for supplies up to 61-90 days ‡ Specialty medications: 25% coinsurance up to \$100 for each 30-day supply 	<p>Basic Plan</p> <ul style="list-style-type: none"> • Members may be charged by the pharmacy <p>Standard Plan</p> <ul style="list-style-type: none"> • Members may be charged by the pharmacy



The State Health Plan – typical coverage for services provided in a facility depends on the network status of the facility

Service category	In-network member liability	Out-of-network member liability
Emergency room services	Basic Plan <ul style="list-style-type: none"> Emergency care copayment as listed on the member's ID card, followed by deductible and coinsurance 	Basic Plan <ul style="list-style-type: none"> Emergency care copayment as listed on the member's ID card, followed by deductible and coinsurance
	Standard Plan <ul style="list-style-type: none"> Emergency care copayment as listed on the member's ID card, followed by deductible and coinsurance 	Standard Plan <ul style="list-style-type: none"> Emergency care copayment as listed on the member's ID card, followed by deductible and coinsurance
Ambulatory surgery centers Facility must be contracting with BCBSNC as an ambulatory surgery center	Basic Plan <ul style="list-style-type: none"> Plan pays 70% after deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 50% after deductible
	Standard Plan <ul style="list-style-type: none"> Plan pays 80% after deductible 	Standard Plan <ul style="list-style-type: none"> Plan pays 60% after deductible
Outpatient services <ul style="list-style-type: none"> Certain diagnostic services are not paid solely based on place of service. Mammograms and simple lab work are typically paid at 100% at outpatient hospital centers when not performed with other services at the same time. All other diagnostics are typically subject to the member's deductible. 	Basic Plan <ul style="list-style-type: none"> Plan pays 70% after deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 50% after deductible
	Standard Plan <ul style="list-style-type: none"> Plan pays 80% after deductible 	Standard Plan <ul style="list-style-type: none"> Plan pays 60% after deductible
Inpatient medical physician services	Basic Plan <ul style="list-style-type: none"> Plan pays 70% after deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 50% after deductible
	Standard Plan <ul style="list-style-type: none"> Plan pays 80% after deductible 	Standard Plan <ul style="list-style-type: none"> Plan pays 60% after deductible

Continued on the following page.



The State Health Plan – typical coverage for services provided in a facility depends on the network status of the facility

Service category	In-network member liability	Out-of-network member liability
Inpatient medical hospital based services*	Basic Plan <ul style="list-style-type: none"> Inpatient hospital copayment, followed by deductible 	Basic Plan <ul style="list-style-type: none"> Inpatient hospital copayment, followed by deductible
	Standard Plan <ul style="list-style-type: none"> Inpatient hospital copayment, followed by deductible 	Standard Plan <ul style="list-style-type: none"> Inpatient hospital copayment, followed by deductible
Skilled nursing facilities <ul style="list-style-type: none"> This benefit is limited to 100 days per benefit period (combined in- and out-of-network) 	Basic Plan <ul style="list-style-type: none"> Plan pays 70% after deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 50% after deductible
	Standard Plan <ul style="list-style-type: none"> Plan pays 80% after deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 60% after deductible
Outpatient services for mental health and substance abuse <ul style="list-style-type: none"> Requires certification and prior review by Value Options 1-800-367-6143. 	Basic Plan <ul style="list-style-type: none"> Plan pays 70% after deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 50% after deductible
	Standard Plan <ul style="list-style-type: none"> Plan pays 80% after deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 60% after deductible
Inpatient services for mental health and substance abuse <ul style="list-style-type: none"> Requires certification and prior review by Value Options 1-800-367-6143. 	Basic Plan <ul style="list-style-type: none"> Plan pays 70% after copayment and deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 50% after copayment and deductible
	Standard Plan <ul style="list-style-type: none"> Plan pays 80% after copayment and deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 60% after copayment and deductible



The State Health Plan – typical coverage for services provided by an ancillary provider		
Service category	In-network member liability	Out-of-network member liability
Home health care	Basic Plan • Plan pays 70% after deductible	Basic Plan • Plan pays 50% after deductible
	Standard Plan • Plan pays 80% after deductible	Standard Plan • Plan pays 60% after deductible
Hospice care	Basic Plan • Plan pays 70% after deductible	Basic Plan • Plan pays 50% after deductible
	Standard Plan • Plan pays 80% after deductible	Standard Plan • Plan pays 60% after deductible
Private duty nursing (certification required) There is a four hour per day limit for private duty nursing care for non-ventilated patients and a 12 hour per day limit for ventilated patients.	Basic Plan • Plan pays 70% after deductible	Basic Plan • Plan pays 50% after deductible
	Standard Plan • Plan pays 80% after deductible	Standard Plan • Plan pays 60% after deductible
Home infusion therapy	Basic Plan • Plan pays 70% after deductible	Basic Plan • Plan pays 50% after deductible
	Standard Plan • Plan pays 80% after deductible	Standard Plan • Plan pays 60% after deductible
Durable medical equipment Orthotic devices for the correction of positional plagiocephaly limited to a lifetime maximum of \$600.	Basic Plan • Plan pays 70% after deductible	Basic Plan • Plan pays 50% after deductible
	Standard Plan • Plan pays 80% after deductible	Standard Plan • Plan pays 60% after deductible
Home short-term therapy**	Basic Plan • Plan pays 70% after deductible	Basic Plan • Plan pays 50% after deductible
	Standard Plan • Plan pays 80% after deductible	Standard Plan • Plan pays 60% after deductible

Continued on the following page.



The State Health Plan – typical coverage for services provided by an ancillary provider		
Service category	In-network member liability	Out-of-network member liability
Dialysis**	Basic Plan <ul style="list-style-type: none"> Plan pays 70% after copayment and deductible 	Basic Plan <ul style="list-style-type: none"> Plan pays 50% after deductible
	Standard Plan <ul style="list-style-type: none"> Plan pays 80% after copayment and deductible 	Standard Plan <ul style="list-style-type: none"> Plan pays 60% after deductible

* Effective July 1, 2010, bariatric surgeries that are not performed at Blue Distinction Centers (BDC) will not be covered for member's benefits and prior approval will not be a guarantee to non-BDC facilities, even if a facility is in network for other services.

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

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

Covered short-term therapies include:

- Physical (PT), occupational (OT), and speech therapies.

3.7 Classic Blue®, an indemnity CMM product

Classic Blue® is an indemnity Comprehensive Major Medical (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 the participating Primary Care Provider (PCP) or specialist, without a referral. Classic Blue® also provides an extensive wellness program to help keep our members healthy. The Classic Blue® product offering includes benefits for Blue Assurance®, CMM Conversion, AccessSM and Short Term Health Care.

Sample Classic Blue® membership ID card

Front of card

**BlueCross.
BlueShield.**

ClassicBlue

Subscriber Name:		Group No:	064182
CLASSIC MEMBER NAME	01	Rx Bin/Group:	610014/PAID BNCDRUG
Subscriber ID:		Date Issued:	02/01/10
YPMW14842049			

Member Responsibility:

Coinsurance	20%
Deductible	\$500
Prescription Drug:	\$10/\$20/\$35/25%

Back of card

**BlueCross.
BlueShield.**

BCBSNC.COM	1-877-258-3334
Customer Service:	1-800-359-2422
Mental Health:	1-800-810-2583
Locate Non-NC Provider:	1-800-214-4844
Provider Service:	1-800-672-7897
Prior Review/Certification:	1-800-922-1557
Pharmacist Help Desk:	

Claims are subject to review. For nonparticipating or non-NC providers, members are responsible for ensuring that prior review/certification is obtained. Participating NC providers are responsible for obtaining prior review/certification.

Insured by BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association.

Providers should send claims to their local BlueCross BlueShield Plan.

Medical: BCBSNC PO Box 35, Durham, NC 27702-0035

Pharmacy Benefits Administrator

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



An individual's possession of a BCBSNC 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.

3.7.1 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/participating 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 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 BCBSNC CMM participating and non-participating providers.

- 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 certain services (see section 7.5.1.5, Certification list).
- Deductible and/or coinsurance amounts typically apply.

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

Classic Blue® - typical coverage for services provided in an office

Service category	Member liability
<p>Office visits</p> <ul style="list-style-type: none"> • Medical services • Office surgery • Second surgical opinion • Consultation • Complications of pregnancy • Chiropractic care 	<ul style="list-style-type: none"> • Deductible and/or coinsurance
<p>Preventive care</p> <ul style="list-style-type: none"> • Routine physical examinations • Well-baby care • Well-child care • Gynecological examinations • Pap smears • Immunizations • Screening mammograms • Prostate Specific Antigen (PSA) tests • Colorectal screening 	<ul style="list-style-type: none"> • Deductible and/or coinsurance

Continued on the following page.



Classic Blue® - typical coverage for services provided in an office	
Service category	Member liability
Maternity <ul style="list-style-type: none"> • Prenatal • Post-delivery 	<ul style="list-style-type: none"> • Deductible and/or coinsurance
Short-term rehabilitative therapy <ul style="list-style-type: none"> • Occupational therapy/physical therapy (including chiropractic services) • Speech therapy 	<ul style="list-style-type: none"> • Deductible and/or coinsurance • On most Classic Blue® plans, short-term rehabilitative therapies are limited to a maximum of 30 visits per benefit period per therapy combination (i.e., occupational and physical therapies are combined)
Other therapies <ul style="list-style-type: none"> • Chemotherapy • Dialysis treatment • Radiation therapy • Respiratory therapy 	<ul style="list-style-type: none"> • Deductible and/or coinsurance
Urgent care	<ul style="list-style-type: none"> • Deductible and/or coinsurance
Prescription drugs	<ul style="list-style-type: none"> • On most Classic Blue® plans, prescription drugs are covered under a four-tier copayment design. • Standard drug plans include a brand penalty. This penalty will not apply when the brand is determined to be necessary by the provider and Dispense as Written (DAW) is included on the prescription.
Mental health and substance abuse	<ul style="list-style-type: none"> • Deductible and MH/SA coinsurance

Classic Blue® - typical coverage for services provided in a facility	
Service category	Member liability
Emergency room services	<ul style="list-style-type: none"> • Deductible and/or coinsurance
Ambulatory surgery centers Facility must be contracting with BCBSNC as an ambulatory surgery center	<ul style="list-style-type: none"> • Deductible and MH/SA coinsurance

Continued on the following page.



Classic Blue® - typical coverage for services provided in a facility	
Service category	Member liability
Outpatient services	<ul style="list-style-type: none"> Professional and facility charges for outpatient services are subject to deductible and/or coinsurance Certain diagnostic services are not paid solely based on place of service
Inpatient services	<ul style="list-style-type: none"> Professional and facility charges for inpatient services are typically subject to deductible and/or coinsurance
Skilled nursing facilities	<ul style="list-style-type: none"> All charges for services at a skilled nursing facility are typically subject to deductible and/or coinsurance This benefit is typically limited to 60 days per benefit period (combined in- and out-of-network)
Inpatient and outpatient services for mental health and substance abuse	<ul style="list-style-type: none"> Professional and facility charges for mental health and substance abuse services are subject to deductible and/or coinsurance Inpatient mental health and substance abuse days are subject to a day limit, usually 30-days per benefit period

Classic Blue® - typical coverage for services provided by an ancillary provider	
Service category	Member liability
Home health care	<ul style="list-style-type: none"> Deductible and coinsurance
Hospice care	<ul style="list-style-type: none"> Deductible and coinsurance
Private duty nursing (certification required)	<ul style="list-style-type: none"> Deductible and coinsurance
Home infusion therapy	<ul style="list-style-type: none"> Deductible and coinsurance
Durable medical equipment	<ul style="list-style-type: none"> Deductible and coinsurance
Home short-term therapy*	<ul style="list-style-type: none"> Deductible and coinsurance
Dialysis**	<ul style="list-style-type: none"> Deductible and coinsurance

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

** Dialysis performed in the physician's office is subject to a copay (for members enrolled in copayment plans).

Covered short-term therapies include:

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

Federal employee program

Blue Cross and Blue Shield
service benefit plan





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

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

4.1 Identification cards

Front of card – Standard option

		Government-Wide Service Benefit Plan		
Federal Employee Program				
Member Name: I M Sample		www.fepblue.org		
Member ID: R30048850				
Enrollment Code	105	RxGrp	65006500	
Effective Date	01/01/2006	RxBIN	61415	
		RxPCN	ABC1234567	

Front of card – Basic option

		Government-Wide Service Benefit Plan		
Federal Employee Program				
Member Name: I M Sample		www.fepblue.org		
Member ID: R30048852				
Enrollment Code	112	RxGrp	65006500	
Effective Date	01/01/2006	RxBIN	610415	
		RxPCN	ABC1234567	

Enrollment codes are:

- **104** – Standard option - self only
- **105** – Standard option - self and family
- **111** – Basic option - self only
- **112** – Basic option - self and family

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

4.2 BCBSNC Federal Employee Program contact information

BCBSNC FEP Customer Service 1-800-222-4739

- Benefits (for all services including mental health/ substance abuse)
- Claims
- Eligibility

FEP Precertification and Prior Approval 1-800-672-7897

- Certification (except outpatient mental health and substance abuse)
 - ‡ Precertification for inpatient admission
 - ‡ Prior review
- Home hospice care
- Organ and tissue transplants
 - ‡ Clinical trials for certain organ and tissue transplants **1-800-225-2268**



Additional important numbers	
FEP health management (case management)	1-888-234-2415
FEP Healthy Endeavors (disease management)	1-888-392-3506
Magellan: mental health/substance abuse visit approvals	1-800-288-3976
Retail pharmacy information	1-800-624-5060 1-877-727-3784 (prior approval)
Mail service pharmacy information	1-800-262-7890
Blue health connection information	1-888-258-3432
Mailing addresses	
Claims processing	Blue Cross and Blue Shield of North Carolina PO Box 35 Durham, NC 27702
Claims review/provider inquiry/correspondence	Blue Cross and Blue Shield of North Carolina Customer Service PO Box 2291 Durham, NC 27702-2291

For fastest claims processing, file electronically!

Visit BCBSNC electronic solutions on the Web at: <http://www.bcbsnc.com/providers/edi/>

Visit us on the Web at fepblue.org



4.3 Certification for the Federal Employee Program

4.3.1 Inpatient precertification for the Federal Employee Program

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

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

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

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

4.3.2 Flexible benefits option

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

4.3.3.1 Home hospice care

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

4.3.3.2 Organ and tissue transplants

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

- Heart
- Heart-lung
- Liver
- Pancreas
- Simultaneous liver-kidney
- Simultaneous pancreas-kidney
- Single or double (bilateral) lung
- Lobar transplant (living donor lung)
- Blood or marrow stem cell transplants
- Related transplant services

4.3.3.3 Clinical trials for certain organ and tissue transplants

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

- Myeloablative Allogenic blood or marrow stem cell transplants for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL); multiple myeloma; Amyloidosis;
- Nonmyeloablative allogenic blood or marrow stem cell transplants for acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia; advanced forms of myelodysplastic syndromes; advanced Hodgkin's lymphoma; chronic lymphocytic leukemia; chronic myelogenous leukemia; early state (indolent or non-advanced) small cell lymphocytic lymphoma; multiple myeloma; myeloproliferative disorders; renal cell carcinoma;

advanced non-Hodgkin's lymphoma; breast cancer; colon cancer; non-small cell lung cancer; ovarian cancer; prostate cancer; sarcoma

- Autologous blood or marrow stem cell transplants for: breast cancer; chronic lymphocytic leukemia; early stage (indolent or non-advanced) small cell lymphocytic lymphoma; epithelial ovarian cancer; chronic myelogenous leukemia
- Autologous blood or stem cell transplants for the following autoimmune diseases; multiple sclerosis; systemic lupus erythematosus; systemic sclerosis

4.3.3.4 Partial hospitalization or intensive outpatient treatment for mental health/substance abuse

The member or someone acting on their behalf must contact BCBSNC at **1-800-222-4739** to verify benefits prior to obtaining services for intensive outpatient treatment or partial hospitalization. The provider must obtain prior authorization through Magellan at **1-800-288-3976** prior to the first visit. **Basic Option members must use in-network providers.**

4.3.3.5 Outpatient mental health and substance abuse treatment – Standard Option

The member or someone acting on their behalf must contact BCBSNC at **1-800-222-4739** to verify benefits for outpatient visits. **In- and out-of-network** provider must contact Magellan at **1-800-288-3976** prior to the first outpatient visit. When Magellan approves the plan of care, the provider will be given authorization for additional visits. The number of visits will depend on the treatment plan. If the provider fails to contact Magellan, the Plan will not provide benefits for services. If the member changes providers, Magellan must be contacted for approval of visits.

4.3.3.6 Outpatient mental health and substance abuse treatment – Basic Option

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



4.3.3.7 Prescription drugs and supplies

Prior approval is needed for certain drugs and supplies. The retail pharmacy program will request the medical evidence necessary to make a coverage determination. The provider can call **1-877-727-3784** for prior approval.

4.3.3.8 Outpatient surgical services

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

The surgical services listed below require prior approval when they are to be performed on an outpatient basis.

- Outpatient surgery for morbid obesity;
- Outpatient surgical correction of congenital anomalies; and
- Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

4.3.3.9 Outpatient Intensity-Modulated Radiation Therapy (IMRT)

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

4.3.3.10 Morbid obesity surgery

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

FEP 2011 Definition of Morbid Obesity:

A condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with co-morbidities who has failed conservative treatment; eligible members must be age 18 or over.

Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the following pre-surgical requirements.

The following requirements apply to gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity:

- Diagnosis of morbid obesity for a period of 2 years prior to surgery.

- Participation in a medically supervised weight loss program, including nutritional counseling, for at least 3 months prior to the date of surgery.
- Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating, and exercise.
- Evidence that attempts at weight loss in the 1 year period prior to surgery have been ineffective.
- Psychological assessment of the member's ability to understand and adhere to the pre- and post-operative program, performed by a psychiatrist, clinical psychologist, psychiatric social worker, or psychiatric nurse.
- Patient has not smoked in the 6 months prior to surgery.
- Patient has not been treated for substance abuse for 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 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 patient's provider(s) that all pre-surgical requirements have been met.

4.4 Review of disputed claims / reconsideration review / Office of Personnel Management (OPM) appeal

4.4.1 Disputed claims

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



4.4.2 Reconsideration review

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

4.4.3 OPM appeal

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

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

4.5 Federal Employee Program covered professional providers

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

4.5.1 Physician

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

4.5.2 Physician assistant

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

4.5.3 Independent laboratory

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

4.5.4 Clinical psychologist

A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or 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 R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.

4.5.7 Clinical social worker

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

4.5.8 Physical, speech and occupational therapist

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

4.5.9 Nursing school administered clinic

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



4.5.10 Audiologist

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

4.5.11 Dietitian

A professional who, if the state requires it, is licensed, certified or registered as a dietician 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 abuse professional

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

4.6 Health benefit highlights – Standard and Basic Options

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

Standard Option	Basic Option
<ul style="list-style-type: none"> • Standard Option as a calendar year deductible It is as follows: ‡ \$300.00 per person ‡ \$600.00 per family (aggregate) • Benefits are available to out-of-state members seeking treatment. Claims should be filed with the state rendering the service. • Benefits are available for services received from PPO Select network physicians or providers called preferred provider in member materials. • Benefits from non-preferred physicians and providers are paid at a lower level. Members are responsible for any deductible and coinsurance amounts as well as the difference between the providers charge and BCBS’s payment. 	<ul style="list-style-type: none"> • Under Basic Option, members must use preferred providers for all medical care. Benefits are only available for care provided by non-preferred providers in certain situations, such as: <ol style="list-style-type: none"> (1) Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport; (2) Professional care provided at preferred facilities by non-preferred radiologists, anesthesiologists (CRNAs), pathologists, emergency room physicians, and assistant surgeons; (3) Laboratory and pathology services, x-rays and diagnostic tests billed by non-preferred laboratories, radiologists, and outpatient facilities; (4) Services of assistant surgeons; (5) Special provider access situations (contact your local plan for more information); or (6) Care received outside the United States and Puerto Rico

Continued on the following page.



Standard Option	Basic Option
<ul style="list-style-type: none"> If a member has Standard Option and Medicare Part A and Part B as the primary payer, the calendar year deductible, coinsurance amounts, copayment amounts for inpatient and outpatient hospital care, physician care, medical supplies and other covered services are waived. 	<ul style="list-style-type: none"> When services of non-preferred providers are covered in a special exception, benefits will be provided based on the Plan’s allowance. The member is responsible for the applicable copayment, and may also be responsible for any difference between the Plan’s allowance and the billed amount. For Basic Option, the term primary care provider includes family practitioners, general practitioners, medical internists, pediatricians and obstetricians/gynecologists. The Federal Employee Program encourages physicians to prescribe a brand-name drug from the formulary list when there is no generic equivalent available. The drug cost for non-formulary drugs will be higher. A formulary listing can be viewed on our Web site at fepblue.org or request a copy by calling 1-800-624-5060. Benefits are nationwide and are available to out-of-state members seeking treatment. Claims should be filed with the state rendering the service. Benefits are available for services received from PPO Select network physicians or providers called preferred provider in member materials. If a member has Basic Option and Medicare Part A and Part B as the primary payer, the inpatient and outpatient hospital copayments, preferred physician copayments, copayments of other preferred health care professionals are waived.

Federal Employee Program – Blue Cross and Blue Shield service benefit plan
Standard Option and Basic Option typical coverage for services

Service category	In-network member liability Standard Option	In-network member liability Basic Option
<p>Office visits</p> <ul style="list-style-type: none"> Home and office visits Second surgical opinions Outpatient consultation Pharmacotherapy for prescription drug coverage 	<ul style="list-style-type: none"> \$20 copayment per office visit for primary care provider; \$30 copayment per office visit for specialists 	<ul style="list-style-type: none"> \$25 copayment per office visit for primary care provider; \$35 copayment per office visit for specialists

Continued on the following page.



Federal Employee Program – Blue Cross and Blue Shield service benefit plan
Standard Option and Basic Option typical coverage for services

Service category	In-network member liability Standard Option	In-network member liability Standard Option
<p>Preventive care screenings</p> <ul style="list-style-type: none"> • History and physical examination • Chest x-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) when performed by a preferred provider or any independent laboratory • Screening and behavioral change interventions for tobacco use and alcohol/ substance abuse • Individual counseling on prevention and reducing health risks • Note: preventive care benefits are not available for group counseling • Administration and Interpretation of a Health Risk Assessment (HRA) questionnaire 	<p>New for 2010: copay credit for annual physical</p> <ul style="list-style-type: none"> • \$20 copayment per office visit for primary care provider; • \$30 copayment per office visit for specialists • No out-of-pocket expenses for covered preventive screenings 	<p>New for 2010: copay credit for annual physical</p> <ul style="list-style-type: none"> • \$25 copayment per office visit for primary care provider; • \$35 copayment per office visit for specialists • No out-of-pocket expenses for covered preventive screenings <p>Note: 30% for drugs and supplies</p>
<p>Preventive cancer screenings and diagnostic tests</p> <ul style="list-style-type: none"> • Colorectal cancer tests, including: <ul style="list-style-type: none"> ‡ Fecal occult blood test ‡ Colonoscopy ‡ Sigmoidoscopy ‡ Double contrast barium enema 	<ul style="list-style-type: none"> • \$20 copayment per office visit for primary care provider; • \$30 copayment per office visit for specialists • No out-of-pocket expenses for covered preventive screenings 	<ul style="list-style-type: none"> • \$25 copayment per office visit for primary care provider; • \$35 copayment per office visit for specialists • No out-of-pocket expenses for covered preventive screenings • Note: 30% for drugs and supplies

Continued on the following page.



Federal Employee Program – Blue Cross and Blue Shield service benefit plan Standard Option and Basic Option typical coverage for services		
Service category	In-network member liability Standard Option	In-network member liability Standard Option
<ul style="list-style-type: none"> • Prostate cancer test – Prostate Specific Antigen (PSA) test • Breast cancer tests (routine or non-routine mammograms) • Ultrasound for aortic abdominal aneurysm 		
<p>Preventive care children</p> <ul style="list-style-type: none"> • All healthy newborn visits including routine screening (inpatient or outpatient) • Routine physical examinations 	<ul style="list-style-type: none"> • No expenses for covered services 	<ul style="list-style-type: none"> • No expenses for covered services
<ul style="list-style-type: none"> • Human Papillomavirus (HPV) vaccines • Rotavirus vaccines • Routine hearing tests • Laboratory tests • Immunizations • Meningococcal vaccine • Related office visits 	<p>Note: when billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility</p>	<p>Note: when billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility</p>
<p>Routine immunizations without regard to age, limited to:</p> <ul style="list-style-type: none"> • Hepatitis immunizations (types A & B) for patients with increased risk or family history • Influenza and pneumococcal vaccines, annually • Tetanus – diphtheria (TD) booster – once every 10 years • Herpes Zoster (shingles) vaccines • Human Papillomavirus (HPV) vaccines 	<ul style="list-style-type: none"> • \$20 copayment per office visit for primary care provider; • \$30 copayment per office visit for specialists • No out-of-pocket expenses for covered preventive screenings 	<ul style="list-style-type: none"> • \$25 copayment per office visit for primary care provider; • \$35 copayment per office visit for specialists • No out-of-pocket expenses for covered preventive screenings • Note: 30% for drugs and supplies

Continued on the following page.



Federal Employee Program – Blue Cross and Blue Shield service benefit plan Standard Option and Basic Option typical coverage for services		
Service category	In-network member liability Standard Option	In-network member liability Standard Option
<p>Accidental injury / emergency care</p> <ul style="list-style-type: none"> • Accidental injury care, physician and facility care • Related ambulance services 	<ul style="list-style-type: none"> • No expenses for covered services <p>Note: These benefit levels apply for care rendered with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply.</p>	<ul style="list-style-type: none"> • \$75 copayment for emergency room care; • \$30 copayment for urgent care
<ul style="list-style-type: none"> • Medical emergency care – physician and facility 	<ul style="list-style-type: none"> • \$300 calendar year deductible • 15% coinsurance 	<ul style="list-style-type: none"> • Same as accidental
<p>Professional care</p> <ul style="list-style-type: none"> • Inpatient care (surgical and medical) • Outpatient surgery and related diagnostic tests such as x-rays, laboratory tests and machine diagnostic tests 	<ul style="list-style-type: none"> • \$300 calendar year deductible • 15% coinsurance 	<ul style="list-style-type: none"> • No expenses for covered services
<p>Maternity care</p> <ul style="list-style-type: none"> • Inpatient hospital care – precertification is not required unless stay is in excess of 48/96 hours for a vaginal/cesarean delivery 	<ul style="list-style-type: none"> • No deductible or coinsurance 	<ul style="list-style-type: none"> • The member pays nothing for the delivery • \$150 per admission copay • No out-of-pocket expenses for outpatient covered services
<ul style="list-style-type: none"> • Physician care including delivery and pre- and post-natal care 	<ul style="list-style-type: none"> • No deductible or coinsurance 	<ul style="list-style-type: none"> • No expenses for pre- or post-natal care and delivery
<ul style="list-style-type: none"> • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) 	<ul style="list-style-type: none"> • No deductible or coinsurance 	<ul style="list-style-type: none"> • No expenses for pre- or post-natal care and delivery

Continued on the following page.



Federal Employee Program – Blue Cross and Blue Shield service benefit plan
Standard Option and Basic Option typical coverage for services

Service category	In-network member liability Standard Option	In-network member liability Standard Option
<p>Hospital / facility care</p> <ul style="list-style-type: none"> Hospital inpatient (precertification required) 	<ul style="list-style-type: none"> Unlimited days \$200 per admission copayment 	<ul style="list-style-type: none"> Unlimited days \$150 per day up to \$750 per admission
<p>Professional inpatient treatment therapies</p> <p>(chemotherapy, radiation therapy, renal dialysis, pharmacotherapy)</p>	<ul style="list-style-type: none"> \$300 calendar year deductible 15% coinsurance 	<ul style="list-style-type: none"> No expenses for covered services
<p>Outpatient surgery</p> <p>(facility)</p>	<ul style="list-style-type: none"> 15% coinsurance No deductible 	<ul style="list-style-type: none"> \$75 per day per facility
<p>Outpatient professional medical services</p> <p>(including medical, emergency care and diagnostic tests)</p>	<ul style="list-style-type: none"> \$20 copayment per office visit for primary care provider; \$30 copayment per office visit for specialists \$300 calendar year – deductible – 15% coinsurance 	<ul style="list-style-type: none"> \$25 copayment per office visit for primary care provider \$35 copayment per office visit for specialists \$75 per day per facility
<p>Extended care benefits / nursing care facility benefits</p> <ul style="list-style-type: none"> Limited to the following benefits for Medicare Part A copayments: <ul style="list-style-type: none"> ‡ When Medicare Part A is the primary payer and has made payment, limited secondary benefits are provided ‡ The plan pays the applicable Medicare Part A copayments incurred in full during the first through the 30th day of confinement for each benefit period in a qualified nursing facility** 	<ul style="list-style-type: none"> No out-of-pocket expenses for covered services <p>Note: The member pays all charges not paid by Medicare after the 30th day</p>	<ul style="list-style-type: none"> All charges

Continued on the following page.



Federal Employee Program – Blue Cross and Blue Shield service benefit plan Standard Option and Basic Option typical coverage for services		
Service category	In-network member liability Standard Option	In-network member liability Standard Option
<p>‡ If Medicare pays the first 20 days in full, plan benefits will begin on the 21st day and will end on the 30th day</p> <p>Note: If the patient does not have Medicare Part A, no benefits are provided for skilled nursing facility care</p>		
<p>Prescriptions</p> <ul style="list-style-type: none"> Retail pharmacy (up to a 90-day supply) 	<ul style="list-style-type: none"> 30% coinsurance – brand name 20% coinsurance – generic 	<ul style="list-style-type: none"> Up to an initial 34-day supply \$10 copay for generic drugs \$30 copay for formulary brand name drugs 50% coinsurance of \$35 minimum for non-formulary brand name drugs
<ul style="list-style-type: none"> Mail-service pharmacy (up to a 90-day supply) 	<ul style="list-style-type: none"> No copayment – generic (first 4 fills) \$10 copayment – generic (additional fills) \$65 copayment – brand name (first 30 fills) \$50 copayment – brand name (additional fills) 	<ul style="list-style-type: none"> No benefit available
<p>Hospice care</p> <ul style="list-style-type: none"> Outpatient – prior review required 	<ul style="list-style-type: none"> No expenses for covered services 	<ul style="list-style-type: none"> No expenses for covered services
<ul style="list-style-type: none"> Inpatient – certification required 	<ul style="list-style-type: none"> \$200 per admission copayment 	<ul style="list-style-type: none"> \$150 per day up to \$750 per admission
<p>Home nursing services</p> <ul style="list-style-type: none"> Two hours per day, up to 25 visits per calendar year When ordered by a physician and services rendered by an RN or LPN 	<ul style="list-style-type: none"> \$300 calendar year deductible 15% prior review 	<ul style="list-style-type: none"> \$25 copayment per office visit for primary care provider \$35 copayment per office visit for specialists \$75 per day per facility

Continued on the following page.



Federal Employee Program – Blue Cross and Blue Shield service benefit plan Standard Option and Basic Option typical coverage for services		
Service category	In-network member liability Standard Option	In-network member liability Standard Option
Ambulance	<ul style="list-style-type: none"> \$100 copayment per day for ground ambulance transport services <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>	<ul style="list-style-type: none"> \$100 copayment per day for ground ambulance transport services <p>Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of \$150 per day.</p>
Durable medical equipment and medical supplies	<ul style="list-style-type: none"> \$300 calendar year deductible 15% prior review 	<ul style="list-style-type: none"> 30% plan allowance
Chiropractic care <ul style="list-style-type: none"> Spinal manipulations Initial office visit Initial set of x-rays 	<ul style="list-style-type: none"> \$20 copayment No deductible Up to 12 spinal manipulations per calendar year 	<ul style="list-style-type: none"> \$25 copayment per office visit Up to 20 spinal manipulations per calendar year
Nutritional counseling	<ul style="list-style-type: none"> \$300 calendar year deductible 15% prior review <p>Note: Nutritional counseling 6 visits limit (for other than anorexia and bulimia)</p>	<ul style="list-style-type: none"> \$25 copayment per office visit for primary care provider \$35 copayment per office visit for specialists \$75 per day per facility <p>Note: Nutritional counseling 6 visits limit (for other than anorexia and bulimia)</p>
Physical therapy	<ul style="list-style-type: none"> \$20 copayment per office visit for primary care provider \$30 copayment per office visit for specialists <p>Note: Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three</p>	<ul style="list-style-type: none"> \$35 copayment per office visit for specialists \$75 per day per facility <p>Note: Benefits are limited to 50 visits per person, calendar year for physical, occupational, or speech therapy, or a combination of all three</p>

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



4.7 Preventive care screenings

What are the programs?

Beginning 1/1/2010, the BlueCross and BlueShield service benefit plan will reward members when they complete either the adult Blue Health assessment or a child's BMI assessment. The intent of these programs is to encourage wellness and prevention and aim to remove barriers to care.

The member reward will be enhanced benefits:

- If an adult member completes the Blue Health assessment, our Health Risk Assessment, the copayment for his/her subsequent annual physical examination or an individual preventive counseling visit will be waived. The member will receive a certificate that entitles them to a preventive visit at no charge and the member will be directed to present the certificate to the physician at time of care. The member must complete the Blue Health assessment and present a certificate of completion in order for the provider to waive the copayment for the visit. (Following this article is a copy of the certificate for your reference.)
- The second incentive targets children who complete a BMI assessment. Once the BMI assessment is complete, the member will receive a certificate to present at the time of care. The copayments for up to four (4) nutritional counseling visits will be waived. This incentive is limited to children ages five through seventeen, whose Body Mass Index (BMI) falls in the 85th percentile or higher, according to standards established by the Centers for Disease Control and Prevention (CDC). Only those children who meet these requirements will be presented with a certificate. The member must complete the child BMI assessment and present a certificate of completion in order for the provider to waive the copayment for the visit. (Following this article is a copy of the certificate for your reference.)

The certificates for both programs will include the member's name, contract ID number, effective date and expiration date.

How does it affect my office?

The directions for providers can be found on the certificates; we are also providing them here for your convenience:

1. If a service benefit plan member presents a certificate, please do **not** collect the copayment amount from the member at the time of visit. The

reimbursement from the local BlueCross BlueShield Plan for these visits will include the payment of the copayment.

2. If a member presents a certificate and an office visit copayment is collected in error for these types of visits, providers will be required to refund this amount to the member upon receiving payment from the local BlueCross BlueShield Plan.
3. To ensure correct reimbursement the claims must be filed with the appropriate evaluation/management procedure code and diagnosis to reflect that the visit was primarily a routine/annual examination for adults or the appropriate medical nutrition therapy/nutritional counseling codes and diagnosis to reflect the visit was primarily a nutritional counseling visit for children.
4. Providers may retain the certificate for their records; it is not required to be submitted with the claim.
5. The child certificate encompasses four visits, so providers are asked to sign and date the certificate when presented by the member in order for the member to track usage of visits.
6. For questions about the certificate or the process, please contact the local BlueCross BlueShield Plan.

Members will be told they do not have to pay copayments for these visits, so we want to ensure our members do not get charged copayment amounts for these visits. Please follow these important directions and do not charge a copayment when a member brings in a certificate. Reimbursement for this visit will be 100% of the plan allowance, including payment of the copayment amount.

What action do you need to take?

1. Please ensure that the entire office staff is aware of these programs and the process, especially those that normally collect member copayments and arrange appointments. If the patient is a service benefit plan member, you may want to ask if they have a certificate to waive the copayment amount.
2. Beginning on 1/1/2010, follow the directions on the certificate that are listed above when a certificate is presented by a service benefit plan member to ensure a positive member experience with your office and the patient's health coverage.

We hope that these programs will encourage wellness and prevention. We appreciate your support of these programs that encourage good health practices for our service benefit plan members.



About the BlueCross and BlueShield service benefit plan

The local BlueCross and BlueShield plans underwrite and administer the BlueCross and BlueShield service benefit plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) program. Sixty percent 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 for 2010 and these new programs should be directed to the plan’s provider contacts.

Exhibit A: Sample annual physical examination certificate

XXXXXXXXXX

Wellness Certificate for:

Sample A. Sample

MEMBER NAME

XXXXXXXXXXXXXXXXXX

CONTRACT ID#

This certificate entitles the above member to:

One (1) Free Annual Physical Examination or Individual Preventive Counseling Office Visit at a BlueCross BlueShield Plan Preferred Provider. Valid from XX/XX/XXXX to XX/XX/XXXX.

Provider Information & Instructions

- Do NOT charge co-payment at time of visit. Reimbursement for this visit will include the payment of co-payment.
- If you collect an office visit co-payment in error for this visit, you will be required to refund this amount to the member within 30 days of our payment of the claim.

- In order for the member to receive this benefit, the claim (electronic or paper) for the annual physical must contain the appropriate evaluation/management code and the appropriate diagnosis to reflect the visit was primarily a routine/annual examination.
- You may retain this certificate for your records, but it does not need to be submitted with claim.

- If you have a question about this certificate or the process please call the Local BlueCross BlueShield Plan.

BlueCross.
BlueShield.

Federal Employee Program

BLUE HEALTH
ASSESSMENT



Exhibit B: Sample nutritional counseling certificate

My Blue Wellness Certificate

XXXXXXXXXX

Sample A. Sample XXXXXXXXXXXXXXXXXX
MEMBER NAME CONTRACT ID#

This certificate entitles the above Service Benefit Plan member to:

Four (4) Nutritional Counseling Visits with no member cost-share at a BlueCross BlueShield Plan Preferred Provider upon presentation of this certificate. Valid from XX/XX/XXXX to XX/XX/XXXX.

<input type="checkbox"/> Visit #1 Acknowledgement:	PROVIDER SIGNATURE	DATE
<input type="checkbox"/> Visit #2 Acknowledgement:	PROVIDER SIGNATURE	DATE
<input type="checkbox"/> Visit #3 Acknowledgement:	PROVIDER SIGNATURE	DATE
<input type="checkbox"/> Visit #4 Acknowledgement:	PROVIDER SIGNATURE	DATE

Provider Information & Instructions

- Please sign and date the certificate when presented by the member in order for the member to track usage of visits.
- Do NOT collect co-payment amount from member at time of visit. Your reimbursement for these visits will include the payment of co-payment.
- If you collect an office visit co-payment in error for any of these visits, you will be

required to refund this amount to the member within 30 days of receiving payment from the BlueCross BlueShield Plan.

- To ensure correct reimbursement this claim must be filed with the appropriate medical nutrition therapy/nutritional counseling codes and diagnosis to reflect the visit was primarily a nutritional counseling visit.
- You may retain this certificate for your records after the fourth visit; it is not required to be submitted with the claim.

- If you have a question about this certificate or the process, please contact the local BlueCross BlueShield Plan.

**BlueCross
BlueShield**
Federal Employee Program

Healthy Kids Healthy Families
A Blue Cross & Blue Shield Service Benefit Plan Program



4.8 Home health services

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

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

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 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate)
- Ostomy and catheter supplies
- Oxygen, regardless of the provider
- 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 22, limited to \$1,000 per ear per calendar year
- Hearing aids for adults age 22 and over, limited to \$1,000 per ear per 36-month period

- 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 \$1,000 per ear per calendar year
- Surgically implanted penile prostheses to treat erectile dysfunction
- Wigs for hair loss due to chemotherapy for the treatment of cancer

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 \$1,000 per calendar year
- Other items that we determine to be DME, such as compression stockings



4.12 Claims billing tips

4.12.1 Venipuncture

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

4.12.2 Preventive care children

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

4.12.3 Immunizations

Claims for immunizations should be filed as follows:

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

4.12.4 Timely filing requirements (FEP)

Providers participating with BCBSNC are required to file FEP claims by December 31st of the calendar year, following the year in which the services were rendered or the date of discharge.

4.12.5 Do not file the same claim multiple times

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

4.12.6 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 8 digits). This is a critical piece of information for the claim to be processed correctly. An extra quality step to recheck the member number before filing the claim could avoid many claim mailbacks and double work for both you and the FEP department. Other common reasons for mailbacks are:

- Invalid or missing provider number
- Missing primary payer’s Explanation of Benefits (EOB)
- Missing dates and/or diagnosis code

4.13 Care coordination processes

4.13.1 Medical review

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



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

4.14 Blue Health Connection – 24-hour nurse telephone service

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

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 **feblue.org**.

4.16 Other important numbers and addresses

Affinity programs

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

FEP Web site address

- **feblue.org**

Address for claims

- PO Box 35, Durham, NC 27702

The BlueCard[®] program





5.1 BlueCard® overview

BlueCard® is a national program that enables members of one 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 866,000 members of other Blue Plans are currently residing in the BCBSNC 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 BCBSNC. BCBSNC is your single point of contact for BlueCard® claims payment, problem resolution and adjustments. The BlueCard® inter-plan programs department at BCBSNC is available to assist you with all your out-of-state Blue Plan member claims and claims questions by calling **1-800-487-5522**.

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 eSM** 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 eSM**, visit BCBSNC electronic solutions on the Web at <http://www.bcbsnc.com/providers/edi/>, or refer to chapter eleven 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 BCBSNC unless otherwise noted on the back of the member's identification card.

5.1.1 BlueCard® applicable services

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

- Prescription drugs
- Stand-alone dental
- Federal Employee Program (FEP)
(Members who are part of the FEP will have the letter "R" in front of their member ID number. Please follow the BCBSNC and Federal Employee Program billing guidelines contained within this e-manual).

Claims for BlueCard® excluded products and services should be filed to the address that's 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 Comprehensive Major Medical (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 services from a physician or hospital outside their Blue Plan's service area.
- 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: Health Maintenance Organizations [HMO], Preferred Provider Organizations [PPO], Point-Of-Service [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.

The main identifier for out-of-area Blue Plan members is the alpha prefix. The members' ID cards will typically also display a:

- PPO in a suitcase logo for eligible PPO members (BlueCard® PPO members are uniquely identified by their BC and/or BS 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 [Private Fee For Service] and MSA [Medical Savings Account] 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 an alpha prefix as part of the member's ID.)
- Blank suitcase logo (CMM and HMO members will typically have an empty suitcase logo displayed on their cards, which signifies the coverage type, is non-PPO.)

All BlueCard® eligible members have an alpha 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 BC and/or BS PPO, HMO, Medicare Advantage, and CMM members are BlueCard® eligible. Only a member who has an identification number that begins with a minimum of three 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 an alpha 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 an alpha 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 an alpha prefix in the first three 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 comprise a member's ID and can be up to 17 character positions in total. This means that you may see cards with ID numbers between six and 14 (numeric/alpha) characters in length, in addition to the alpha prefix (3-letter alpha prefix + 6-14 additional characters = 9-17 characters in total, depending on the ID given to a specific member).

Examples of member ID numbers:

ABC1234567
 {
 alpha prefix

ABC1234H567
 {
 alpha prefix

ABC12345678901234
 {
 alpha prefix

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 alpha prefix. Additionally, always include the alpha prefix because it is necessary for identifying Plans and electronic routing of specific HIPAA transactions to the appropriate Blue Plans.

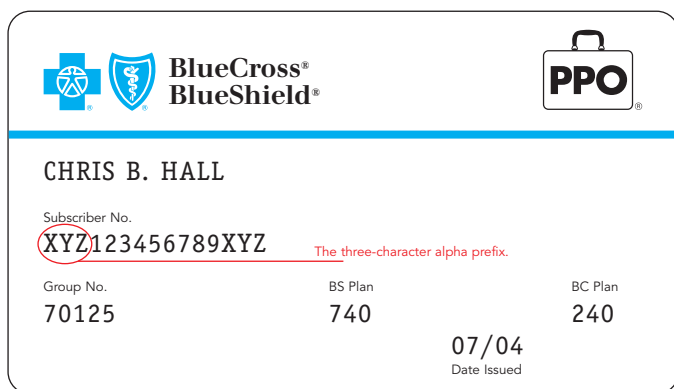
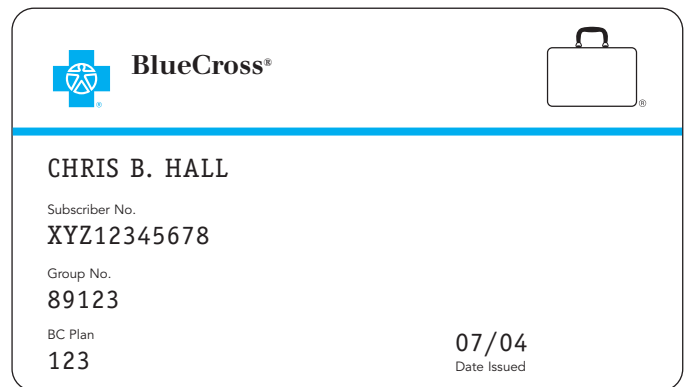
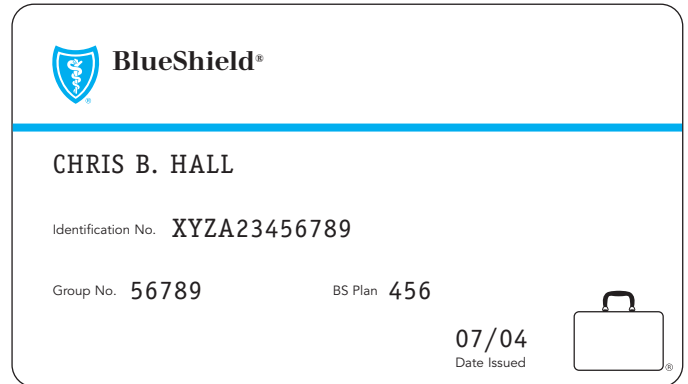


5.2.2 Alpha prefix

The three-character alpha prefix at the beginning of the member’s identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue 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 alpha 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 Sample ID cards

Blue Plan members who are enrolled in a benefit plan and eligible as part of the BlueCard® program will have an alpha prefix included as part on 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 an alpha prefix in the first three 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.



The “suitcase” logo may appear anywhere on the front of the card.

5.2.4 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-character alpha prefixes. Please treat these members the same as domestic Blue Plan members and submit claims for services to BCBSNC.

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.



5.3 Coverage and eligibility verification

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

To verify coverage and BlueCard® eligibility for members from other Blue Plans submit an electronic inquiry (HIPAA 270 transaction) using **Blue eSM** 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 am and midnight, central time, Monday through Saturday (english and spanish speaking phone operators are available to assist you). When calling BlueCard® eligibility line, you will be asked for the alpha 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 BCBSNC. 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 that the BlueCard® eligibility line is for eligibility, benefits and pre-certification/referral authorization inquiries only. It should not be used for claim status.

5.4 Prior review and certification

Out-of-area BlueCard® eligible members are responsible for obtaining pre-admission certification or authorization from their home plan. Providers are encouraged to assist BlueCard® members with obtaining pre-admission certification or authorization (if not assisting, you should remind patients that they are responsible for obtaining pre-certification/preauthorization for their services from their Blue Plan). When the length of an inpatient hospital stay extends past a previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

Providers have access to view the out-of-area Blue Plan's medical policy and general pre-certification/pre-authorization information directly from the member's Home Plan via the BCBSNC Provider Portal Web site at: http://www.bcbsnc.com/content/providers/medpol_ppa_router.htm.

Providers have the option to contact the member's home plan on the member's behalf to obtain an authorization. When assisting a member to obtain an authorization or a certification, call BlueCard® Eligibility at **1-800-676-BLUE (2583)** and ask to be connected to the member's home plan's

utilization review area, or providers with **Blue eSM** access can simply submit an electronic HIPAA 278 transaction.

Please note that the member's Blue Plan may contact you directly related to clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

5.4.1 Mental health and substance abuse services

Mental health and substance abuse 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 BCBSNC radiology management program administered through American Imaging Management (AIM). However, it's important to always verify a member's eligibility and prior authorization requirements, as a member may be enrolled in a benefit coverage plan that 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 eSM** 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

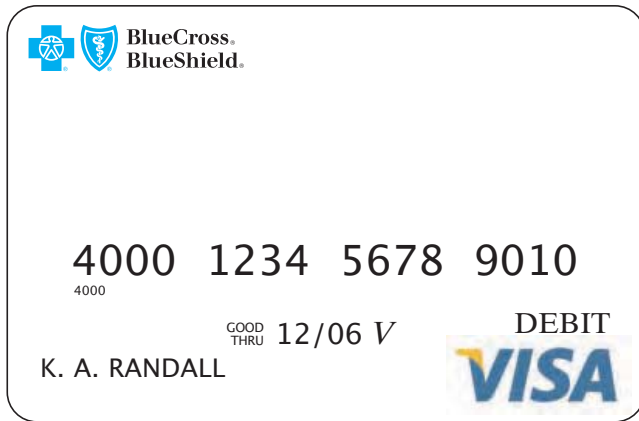
BlueCard® eligible members from another Blue Plan's service area who have CDHC plans often carry health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). Some cards are "stand-alone" 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

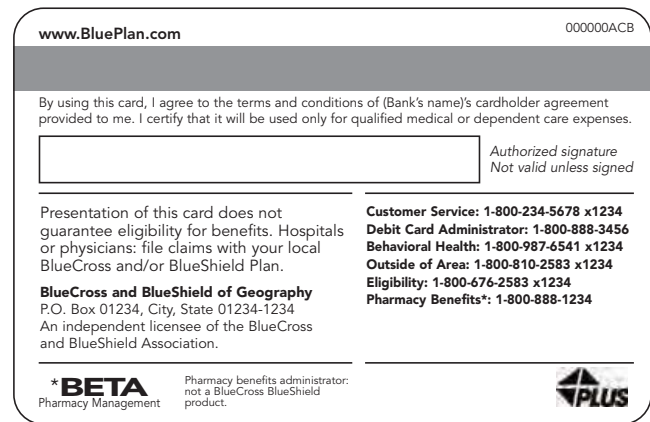
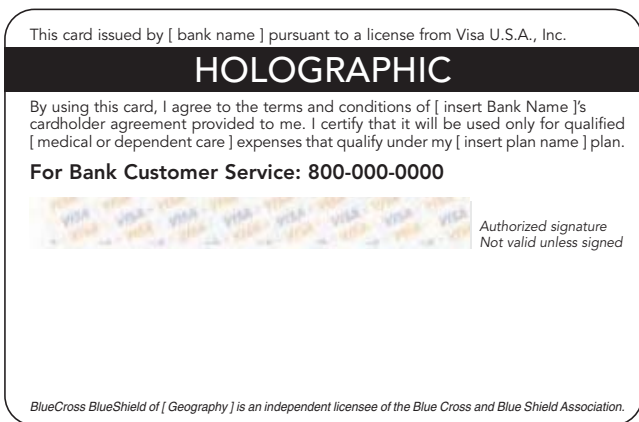
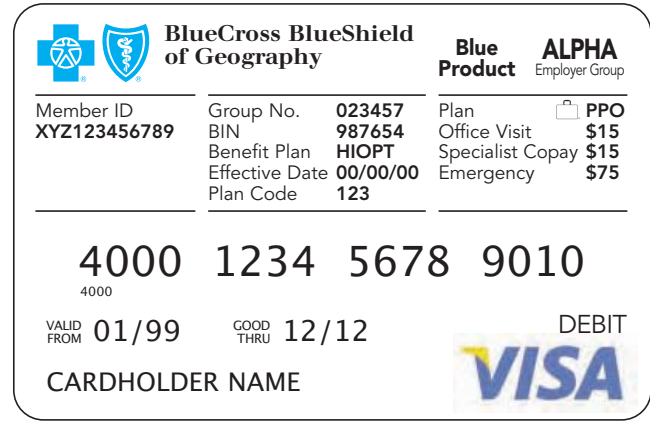
Debit cards will have the nationally recognized Blue logos, along with the logo from a major debit card such as MasterCard® or VISA®.



Sample of stand-alone health care debit card



Sample of combined health care debit card and member ID card



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

Combined 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.

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 eSM** 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 alpha prefix) and avoid unnecessary claims payment delays.
- If the member presents a debit card (stand-alone 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 eSM**.
 - ‡ 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 BCBSNC for processing

All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to BCBSNC for proper benefit processing. Additionally, 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 traditional Medicare. Many Blue Plans offer Medicare Advantage products (within their service areas) for Medicare beneficiaries; product options include; Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-Of-Service (POS) and Medical Savings Account (MSA) products. Additionally, out-of-state Blue Plans offer Private Fee-For-Service (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:

MEDICARE | PPO
ADVANTAGE

MEDICARE | PFFS
ADVANTAGE

MEDICARE | HMO
ADVANTAGE

MEDICARE | POS
ADVANTAGE

MEDICARE | MSA
ADVANTAGE

 **MEDICARE | PPO**
ADVANTAGE

The Blue Cross and Blue Shield Association, BCBSNC provides 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. Terms and conditions for non-BCBSNC BlueCard® PFFS members can be accessed online at <http://www.bcbsnc.com/content/providers/edi/pffs.htm>.

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 that 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 alpha 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 BCBSNC Web site at <http://www.bcbsnc.com/content/providers/edi/pffs.htm>.
3. Submit claims to BCBSNC. Do not bill Medicare directly for any services rendered to a Blue Plan Medicare Advantage member. Applicable payment will come to you from BCBSNC. 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. BCBSNC 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.

BCBSNC 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 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 BCBSNC Web site located at <http://www.bcbsnc.com/content/providers/edi/pffs.htm>).
- 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 PPOSM Medicare Advantage products

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

5.6.4 Medicare Advantage claims appeals

Providers who participate in the BCBSNC PPO plans but not with the Blue Medicare PPOSM plan may submit a "non-network provider claim appeal" in the event that they disagree with an out-of-state Blue Plan member's processed claim, for one of the following reasons:



- Medical policy/medical necessity (e.g., cosmetic and investigational)
- Benefit determinations made by the member's Blue Plan

The "non-network provider claim appeal" should be submitted to the following address:

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

Blue Medicare PPOSM providers participating

In the event that a provider contracted to provide services to Medicare Advantage members enrolled in the Blue Medicare PPOSM 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 of the following reasons:

- Payor allowance/pricing
- Incorrect payment/coding rules applied
- Benefit determinations made by the member's Blue Plan

in writing within 90 days of claim adjudication and should be mailed to:

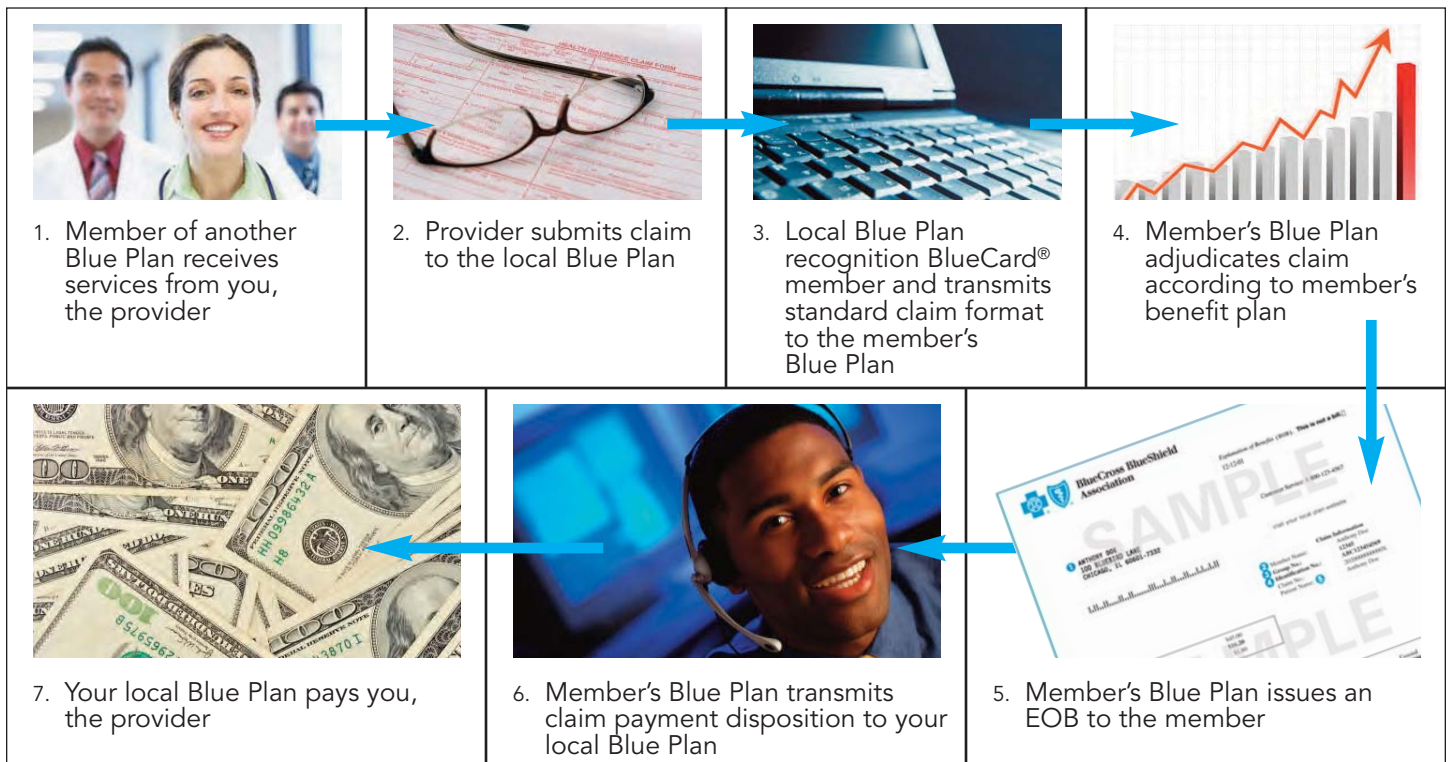
Blue Medicare PPOSM
Attention: IPP Provider Appeals
PO Box 17509
Winston-Salem, NC 27116-7509

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

5.7 Claims submission

Submit claims for services provided to BlueCard® members to BCBSNC using your normal claims billing processes. BCBSNC 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 BCBSNC for payment to (you) the provider.

Below is an example of how claims flow through BlueCard®





You should always submit claims to BCBSNC.

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, BCBSNC 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 alpha prefix) and avoid unnecessary claims payment delays.
 - ‡ Incorrect or missing alpha prefixes and incorrect member identification numbers delay claims processing. Claims will be returned or denied if subscriber information is incorrect or invalid.
- Check eligibility and benefits electronically using **Blue eSM** 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 BCBSNC member liability collection policy located in chapter nine 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 eSM** or by contacting BCBSNC at **1-800-487-5522**.

5.7.1 Other Party Liability (OPL)

In cases where there is more than one payor and a Blue Plan is the primary payor, submit Other Party Liability (OPL) information with the Blue claim. Upon receipt, BCBSNC 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 BCBSNC.

5.7.2 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 BCBSNC.

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.

5.7.3 Coding

Follow all BCBSNC claim submission instructions, except for the BlueCard® specific instructions noted within this chapter (chapter five). Code claims, use appropriate forms, and complete claim forms and/or electronic entry detail, as you would for correctly filed BCBSNC claim submissions. Just like other claims filed to BCBSNC, 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.



5.7.4 Timely filing

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

Note: Providers contracted with BCBSNC are allowed 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, BCBSNC participating providers are encouraged to file claims for BlueCard® patients without delay.

5.7.5 Chiropractic services for Blue members

If you're a chiropractic provider participating with both BCBSNC and Health Network Solutions, Inc. (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 BCBSNC.

File chiropractic claims to:

- Health Network Solutions, Inc. (HNS) for BlueCard® PPO and HMO members
- BCBSNC 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.

5.7.6 Exceptions to BlueCard® claims submission

Occasionally, exceptions may arise in which BCBSNC 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 an alpha prefix

5.7.7 Accounts exempt from the BlueCard® program

Sometimes Blue Plan members will have identification numbers that include alpha 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, BCBSNC 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 BCBSNC through your normal claims filing processes.

Submit claims with alpha prefixes exempt from BlueCard®, directly to BCBSNC, 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-character alpha prefix at the beginning. If you don't include this information, BCBSNC may return the claim to you and this will delay claims 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 eSM**.

5.8 Reimbursement

Reimbursement to BCBSNC participating providers for BlueCard® eligible services, for claims that are submitted to, and processed by BCBSNC for BlueCard® eligible members from another Blue Plan's service area, are considered based upon the provider's BCBSNC 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, 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-BCBSNC BlueCard® PFFS members can be accessed online at: <http://www.bcbsnc.com/content/providers/edi/pffs.htm>.

Additional information about reimbursement is available in chapter nine of this e-manual, located in your businesses participation agreement with BCBSNC, and from your regional Network Management representative.

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

5.9 Claim status inquiry

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

- Using **Blue eSM** to send a HIPAA transaction 276 (claim status inquiry) to BCBSNC
- Phone by calling BCBSNC 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. BCBSNC's standard time for claims processing is 5.5 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 Plan's to complete BlueCard® processing is 30 days, as follows:

- BCBSNC receives and routes BlueCard® claims to the appropriate Blue Plan within **10** days
- Blue Plan in another state makes member benefit decisions and processes claims within **15** days
- BCBSNC receives processing information back from other Blue Plans and pays claims within **5** days
- **10 + 15 + 5 = 30**

If you have not received your payment or a response regarding your payment, please call BCBSNC for BlueCard® customer service at **1-800-487-5522** or review status on **Blue eSM**. 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, BCBSNC will contact you for the additional detail.

5.9.1 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 BCBSNC.

BCBSNC 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 Health Insurance Portability and Accountability Act of 1996 (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 Protected Health Information (PHI) before we can answer questions over the phone. BCBSNC 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.



5.10 Claim adjustments

File a corrected BlueCard® claim to BCBSNC whenever a claim adjustment is necessary. Follow BCBSNC standard requirements for filing a corrected claim; filing just as you would for a BCBSNC member. Once we receive a corrected claim, BCBSNC 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 when it's returned to BCBSNC. 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 nine of this e-manual or contact your regional Network Management representative.

5.11 Appeals

Appeals for all BlueCard® claims are handled through BCBSNC. 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 nine of this e-manual or contact your regional Network Management representative.

5.12 Coordination of Benefits (COB) claims

Coordination of Benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two 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 health plan, and:

- BCBSNC or any other Blue Plan is the primary payor, submit the other carrier's name and address with the member's claim to BCBSNC. 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.

5.12.1 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 Coordination of Benefits questionnaire from the BCBSNC Web site at: <http://www.bcbsnc.com/assets/common/pdfs/BCBSNCCOBquestion.pdf>.

The Coordination of Benefits (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 Web sites, 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 their Blue Plan, 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.

Please note that the coordination of benefits questionnaire is only for the BlueCard® member's completion and it is not for use by BCBSNC members when visiting in-state, North Carolina providers.

5.12.2 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-character alpha 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 both the Medicare contractor and BCBSNC at the same time, instead wait until the claim has processed and Medicare has provided you with an explanation of payment 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” 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 BCBSNC if the member’s ID includes an alpha prefix. If no alpha prefix is included, file the claim to the address on the back of the member’s Blue Plan ID card. BCBSNC or the member’s BC and/or BS 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.

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

BCBSNC along with all BlueCard® plans maintain HIPAA compliant software 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 allowed amount should be filed using the AMT segment in the 2320 loop with a “B6” qualifier and the corresponding \$ amount.
- Medicare paid amount should be filed using an AMT segment in the 2320 loop with a “C4” qualifier and the corresponding \$ amount.
- The contractual adjustment should be filed using the CAS segment in the 2320 loop using a claim adjustment group code of “PR”, claim adjustment reason code “45” and the corresponding claim adjustment \$ amount.

- The claim level deductible amounts should be filed using the CAS segment in the 2320 loop using a claim adjustment group code of “PR”, claim adjustment reason code “2” 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 BCBSNC electronic solutions by calling **1-888-333-8594**.

5.13 Medical records

Do not send medical records unless BCBSNC requests the records from you using a medical request letter. When medical records are requested by BCBSNC, send the records, including the medical request letter received from BCBSNC, to BCBSNC. Upon receipt of the medical records, BCBSNC will forward the records to the member’s home plan. Blue Plans are able to send and receive medical records electronically among 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 BCBSNC 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 BCBSNC 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 BCBSNC.
- Include the letter that you received from BCBSNC, which requested medical records be submitted, when sending the needed medical records to BCBSNC. Please place the BCBSNC 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 BCBSNC.

- Submit the information to BCBSNC as soon as possible to avoid delay.
- Only send the information specifically requested. Complete medical records are not always necessary.
- Do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

5.13.1 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 BCBSNC; 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 BCBSNC.

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

5.13.2 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.

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

When BCBSNC receives non-requested refunds for Blue Plan members, both BCBSNC 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. BCBSNC 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 BCBSNC, please use the following checklist to help ensure that all necessary information is provided:

- Provide the Explanation of Payment (EOP) documentation for all insurance carriers associated with the claim. Ensure that the EOP documentation details the following items:
 - Provide the following support documentation (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
- Specific reason for the refund
 - Provide the following support documentation (if available)
 - a. Duplicate payment (requires both BCBSNC vouchers)
 - b. Worker's compensation (provide the date of the 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 BCBSNC, please attach a copy of the information described above, as well as a copy of the BCBSNC check voucher.



- Provide the following support documentation (if available)
 - a. Original claim number or a copy of the original claim
 - b. Original explanation of benefits

By going through this checklist and verifying that all needed information and documentation is being included your refund check, we (BCBSNC) will be better able to represent you when advising another Blue Plan for both the reason and how to apply your refund. To assist in this process we have developed the inter-plan programs par/host plan form, which contains this same checklist of information we will need to process your request. This form can be copied for use from page 15 in the Forms chapter of this e-manual.

Unfortunately, if we cannot accurately trace your returned payment to its appropriate claim, BCBSNC must return the payment to the provider. Submitting all necessary information will help ensure that you're returned payment is processed appropriately.

Medicare supplemental products







BCBSNC offers Blue Medicare supplement plans to help cover health care costs that Medicare does not cover alone, such as deductibles and coinsurance amounts. BCBSNC Blue Medicare supplement products allow members to receive services from any Medicare-participating doctor, hospital or clinic. Blue Medicare supplemental 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 65 years or older, certain people with disabilities, and people with permanent kidney failure treated with dialysis or a transplant. Medicare has three parts; Part A, which is hospital insurance; Part B, which is medical insurance; 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 10 standard plans; Plan A through Plan J, and two high deductible plans called Plan H Prime and Plan J Prime. BCBSNC offers plans A through Plan F and Plan H through Plan J (BCBSNC does not offer Plan G).

Please note: BCBSNC Blue Medicare supplemental plans discussed within this chapter are not the same product as the Blue Medicare HMOSM and Blue Medicare PPOSM products. Blue Medicare HMOSM and Blue Medicare PPOSM plans are Medicare replacement products vs. Medicare supplemental products: Blue Medicare Supplemental and Blue Medicare Rx. Additional information about the Blue Medicare HMOSM and Blue Medicare PPOSM products is available in The **Blue Book**SM Provider Manual - Blue Medicare HMO and Blue Medicare PPO Supplemental Guide, which is located on our Web site at: www.bcbsnc.com/content/providers/blue-medicare-providers/resources-and-forms/index.htm.

Sample Blue Medicare supplement membership ID card

Front of card

 BlueCross. BlueShield.		Medicare Supplemental Insurance	
Subscriber Number: YPZW12345678		Group No: 123400 Date Issued: 06/01/10	
Members: 01, Name of Member		Prescription Drug: Covered BC Plan: 000, BS Plan: 000	
			

Back of card

Toll-free Customer Service:
Medical: Benefits & Claims **1-800-672-6584**

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

bcbsnc.com:
 – online Provider Directory
 – e-Member customer service
 Blue ValuesSM, discount programs and more

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

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

Insured by Blue Cross and Blue Shield of North Carolina

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

An individual's possession of a BCBSNC 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

Original Medicare is a fee-for-service plan managed by the federal government. In general, Medicare recipients can go to any doctor or supplier that accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility. Benefits for services are covered based on the coverage type (i.e., Medicare Part A, Medicare Part B, Medicare Part D) and the coverage for which an individual is enrolled. Basic benefits cover Part A and Part B coinsurance and the first 3 pints of blood each year. Medicare Part D covers prescription drugs and certain vaccine serums.

Services and coverage parts		
Medicare Part A	Medicare Part B	Medicare Part D
<p>Processes claims for:</p> <ul style="list-style-type: none"> • Inpatient hospital • Skilled nursing facilities • Home health care • Hospice <p>In North Carolina, the Intermediary is Palmetto GBA. Provider contact center: 1-877-567-9249.</p>	<p>Processes claims for:</p> <ul style="list-style-type: none"> • Physician charges • Medical and surgical services, including anesthesia • Treatment of mental illness • Diagnostic test and procedures that are part of treatment (radiology and pathology services [inpatient and outpatient]) • Ambulance services • Ambulatory surgical centers • X-rays • Services of ancillary personnel • Drugs and biologicals that cannot be self-administered • Certain medical supplies • Physical/occupational/speech pathology therapy and services <p>In North Carolina, the carrier is CIGNA Government Services. Provider customer service: 1-866-655-7996.</p>	<p>Processes claims for:</p> <ul style="list-style-type: none"> • 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)

Medicare recipients will typically pay a portion of the costs not covered by Medicare, i.e., deductibles and coinsurance amounts. Medicare supplemental 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 10 standard supplemental plans (plans A through J) with which individuals with Medicare coverage may supplement their benefits. BCBSNC offers nine of the standardized plans: A, B, C, D, E, F, H, I and J. Benefits in these plans vary in both benefit levels and cost. With reference to hospital benefits in particular, BCBSNC Medicare supplement plans are designed to fill in the gaps and pay the cost-sharing amounts not covered by Medicare. Additionally, covered individuals may choose to be treated in any facility approved by Medicare.



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 60 days at 100% of all covered services except for the Medicare Part A inpatient hospital deductible of \$1,100.
- Member has coverage for days 61 to the 90th day and pays a daily coinsurance amount of \$275.00.
- Member has coverage for days 91 to the 150th day and pays a daily coinsurance amount of \$550.00.

For hospital services after the 90 basic days available each benefit period, your patients are eligible for lifetime-reserve days equaling 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.

6.1.1.4 Part A deductible and coinsurance amounts

Inpatient hospital		
Deductible	Per benefit period in 2010	\$1,100.00
Coinsurance	Days 1-60 in year 2010	\$0.00
Daily coinsurance	Days 61-90 in year 2010	\$275.00
Daily coinsurance	Days 91-150 in year 2010	\$550.00
Lifetime reserve days	Days 91-150 in year 2010	60 days at \$550.00 daily coinsurance amount
Skilled nursing facility	Days 1-20 in year 2010	\$0.00
Skilled nursing facility	Days 21-100 in year 2010	\$137.50 daily coinsurance amount

6.1.1.2 Post hospital skilled nursing facility

Basic benefits available each benefit period:

- Member has coverage for the first 20 days at 100% of all covered services.
- Member has coverage for days 21 to the 100th day and pays a daily coinsurance amount of \$137.50.
- Coverage is not available for days beyond the maximum 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 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 60 consecutive days.

If a patient is readmitted as a hospital inpatient after the 60 days, a new benefit period begins and the hospital and skilled nursing facility benefits are renewed. Beginning a new benefit period also requires the patient to pay another Part A inpatient hospital deductible. There is no limit to the number of Medicare benefit periods that a patient can have for hospital and skilled nursing facility care.



6.1.2 Medicare Part B benefits

Medicare Part B helps cover medical services that Part A does not cover. Part B benefits typically include coverage for; professional services, outpatient hospital care, physical and occupational therapists, and home health care. Members are responsible for the first \$155.00 Medicare Part D deductible amount plus 20% of the balance of any approved amounts (Medicare pays 80% less the member’s \$155.00 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 swabs 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 HCFA-1500 under the member’s medical benefits can be submitted using eDispense (for additional details about eDispense see chapter nine, section 9.32.2 of this e-manual or contact your regional Network Management representative).

6.1.4 Supplemental plans

Supplemental plans are offered as eight standard plans; Plan A through Plan J, and two high deductible plans called Plan H Prime and J Prime. BCBSNC offers plan A through Plan F and Plan H through Plan J (BCBSNC does not offer Plan G). Supplemental plans help pay the member’s deductible and coinsurance amounts not covered by original Medicare.

Supplemental plan pays									
Medicare Part A medical expenses	Plan A pays	Plan B pays	Plan C pays	Plan D pays	Plan E pays	Plan F pays	Plan H pays	Plan I pays	Plan J pays
Hospitalization first 60 days	- 0 -	\$1,100	\$1,100	\$1,100	\$1,100	\$1,100	\$1,100	\$1,100	\$1,100
Hospitalization first 61-91 days	\$275.00 a day	\$275.00 a day	\$275.00 a day	\$275.00 a day	\$275.00 a day	\$275.00 a day	\$275.00 a day	\$275.00 a day	\$275.00 a day
Hospitalization first 91-150 days	\$550.00 a day	\$550.00 a day	\$550.00 a day	\$550.00 a day	\$550.00 a day	\$550.00 a day	\$550.00 a day	\$550.00 a day	\$550.00 a day
Hospitalization beyond 150 days	100% of approved amount up to 365 days lifetime maximum	100% of approved amount up to 365 days lifetime maximum	100% of approved amount up to 365 days lifetime maximum	100% of approved amount up to 365 days lifetime maximum	100% of approved amount up to 365 days lifetime maximum	100% of approved amount up to 365 days lifetime maximum	100% of approved amount up to 365 days lifetime maximum	100% of approved amount up to 365 days lifetime maximum	100% of approved amount up to 365 days lifetime maximum

Continued on the following page.



Supplemental plan pays									
Medicare Part A medical expenses	Plan A pays	Plan B pays	Plan C pays	Plan D pays	Plan E pays	Plan F pays	Plan H pays	Plan I pays	Plan J pays
Post hospital skilled nursing facility care for the first 20 days	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -
Post hospital skilled nursing facility care day 21 through day 100	- 0 -	- 0 -	\$137.50 a day	\$137.50 a day	\$137.50 a day	\$137.50 a day	\$137.50 a day	\$137.50 a day	\$137.50 a day
Post hospital skilled nursing facility care beyond 100th day	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -
Medicare Part A medical expenses	Plan A pays	Plan B pays	Plan C pays	Plan D pays	Plan E pays	Plan F pays	Plan H pays	Plan I pays	Plan J pays
First \$155.00 of Medicare approved amounts	- 0 -	- 0 -	\$155.00 of the member's Part B deductible	- 0 -	- 0 -	\$155.00 of the member's Part B deductible	- 0 -	- 0 -	- 0 -
Remainder of Medicare approved amounts (after deductible)	20% of Medicare's approved amount	20% of Medicare's approved amount	20% of Medicare's approved amount	20% of Medicare's approved amount	20% of Medicare's approved amount	20% of Medicare's approved amount	20% of Medicare's approved amount	20% of Medicare's approved amount	20% of Medicare's approved amount

Continued on the following page.



Supplemental plan pays									
Medicare Part A medical expenses	Plan A pays	Plan B pays	Plan C pays	Plan D pays	Plan E pays	Plan F pays	Plan H pays	Plan I pays	Plan J pays
Part B excess charges (amounts above those approved by Medicare)	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -	100%	- 0 -	100%	100%
Home health recovery care when approved by Medicare	- 0 -	- 0 -	- 0 -	Up to \$40.00 per visit, limited to seven visits per week, \$1,600.00 calendar year maximum	- 0 -	- 0 -	- 0 -	Up to \$40.00 per visit, limited to seven visits per week, \$1,600.00 calendar year maximum	Up to \$40.00 per visit, limited to seven visits per week, \$1,600.00 calendar year maximum
Preventative medical care	- 0 -	- 0 -	- 0 -	- 0 -	\$120.00 per calendar year	- 0 -	- 0 -	- 0 -	\$120.00 per calendar year

Note: Deductibles/coinsurance amounts as stated in these charts are for calendar year 2010.

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



6.1.5 Blue Medicare Rx

BCBSNC offers two 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.

Plan feature	Standard	Enhanced
Drug list (formulary)	Includes nearly 100% of the drugs covered by Medicare Part D	Includes nearly 100% of the drugs covered by Medicare Part D
Tier 1 generic copayment	\$6	\$6
Tier 2 preferred brand copayment	\$41	\$35
Tier 3 non-preferred brand copayment	\$81	\$75
Tier 4 specialty	33% coinsurance	
Phase 1: annual deductible	Member pays \$0.00	
Phase 2: initial coverage	Member pays the copayment or coinsurance for their drugs, and BCBSNC pays the remainder until total drug costs reach \$2,830.	
Phase 3: coverage gap	Member pays 100% of drug costs until yearly out-of-pocket drug costs equal \$4,550.	Member pays; \$0 for preferred mail order generics, a \$6 copayment for all other generics and 100% for all other tier drugs.
Phase 4: catastrophic coverage	Member pays 5% after reaching \$4,550 in out-of-pocket costs (the member pays the greater of: \$2.50 for generic, \$6.30 for brand name or 5% of the total drug cost).	

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 Center of Medicare and Medicaid Services (CMS) require that providers identify and report situations where Medicare should be the secondary payor. Three categories of coverage that Medicare may be secondary to are listed as follows:

Employer group health plans:

- Working-aged
- Disability
- End-Stage Renal Disease (ESRD)

Accident/injury related insurance:

- No-fault
- Liability
- Worker’s compensation

Other government sponsored health plans

- Veterans Administration (VA)
- Black lung



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

Healthcare management & operations





7.1 Overview

In an effort to work with physicians and members to facilitate the most medically appropriate, cost effective quality care, the Healthcare management & operations department has designed comprehensive processes to administer BCBSNC benefit plans.

As your partner in managing care, BCBSNC is committed to focusing on our customers. We will attempt to simplify processes, assist when needed, and empower our customers with the knowledge they need.

The Healthcare management & operations department administers the following processes:

- Prospective review
- Prior review
- Admission certification
- Discharge planning
- Case management
- Continuity of care

Contracted providers are responsible for complying with medical management policies and procedures, which utilize nationally accepted healthcare management guidelines. You are responsible for contacting BCBSNC to obtain all necessary certifications when a BCBSNC member seeks care from you.

Medical decisions are based on Milliman Care Guidelines™ and BCBSNC medical policy. You may request a copy of a specific criteria set or medical policy by calling the Healthcare Management & Operations Department at **1-800-672-7897**. Medical policy is also available on the BCBSNC Web site at **bcbsnc.com**.

For information pertaining to health coaching and intervention for the Federal Employee Program (FEP), see chapter four.

For information pertaining to health coaching and intervention for inter-plan programs, see chapter five, The BlueCard® program.

7.2 Contacting health coaching and intervention

The Healthcare Management & Operations department is available as follows:

- Monday through Friday, 8 a.m. - 5 p.m. by calling **1-800-672-7897**.
- You may also access the contacting health coaching and intervention functions via the Provider Blue LineSM at **1-800-214-4844**.
- Healthcare management & operations may also be accessed via the **Blue eSM** electronic network. See chapter eleven, Electronic solutions for more detailed information.

Contact information for discharge services can be found in section 8.7 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 BlueSM (the 24-hour health information line) may provide guidance in an emergency or urgent situation. Health Line BlueSM can be accessed at **1-877-477-2424**. Members are not required to obtain certification prior to an emergency room visit. Primary care physicians are not required to submit a referral to BCBSNC when they have referred a member to the emergency room. The primary care physician should coordinate continuing care that results from the emergency room or urgent care center and the member should contact their primary care physician as soon as possible after any emergent service. The primary care physician should obtain certification for any inpatient admission following an emergency service, but no later than two (2) business days following notification by the member (see section 7.5.1.5, Certification list).



7.3.1 Observation

BCBSNC no longer requires notification for hospital observation for HMO, POS and PPO plans. BCBSNC encourages (but does not require) notification for hospital observation when the HMO, POS or PPO patient will have discharge needs.

Notification to BCBSNC will facilitate the coordination and authorization of discharge (i.e., home health, home IV therapy, and DME services that require prior review for HMO, POS and PPO).

7.4 If appropriate participating physician is not available

It is the policy of BCBSNC to provide members reasonable access to a network physician. If a specific service is not reasonably accessible within the network, the physician or member must contact BCBSNC to certify coverage for a non-participating provider before services are provided (see section 7.5.1.5, Certification list). Reasonable access is defined by BCBSNC’s access to care standards, which are available at **bcbsnc.com** or by contacting customer service.

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

- No benefits are available to HMO members for care from non-participating providers except in emergencies or with certification from BCBSNC. If an HMO member elects to receive non-emergency care from a non-participating provider without certification, the member is responsible for all charges incurred.
- POS and PPO members have the option of seeking care from participating or non-participating providers. If a POS or PPO member sees a non-participating provider, the care will be reimbursed at the lower benefit level, with the member having liability for a higher out-of-pocket expense.
- Non-participating providers may in certain instances provide care to members with special ongoing conditions who are in a continuity of care situation (see section 7.7 of this chapter for more information about continuity of care).

If you have a question about whether a provider participates in our HMO, POS or PPO networks, visit our Web site at **bcbsnc.com** or call the Provider Blue LineSM at **1-800-214-4844** to speak to a representative.

To request certification for a referral to a non-participating provider, call Health Coaching and Intervention at **1-800-672-7897**.

7.5 Certification and prior review

7.5.1 Certification

Certification is the determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy our requirements for medically necessary services and supplies, appropriateness, health care setting, level of care and effectiveness.

Type of certification	Applies to
Prior review approval	<ul style="list-style-type: none"> • HMO • POS • PPO • CMM (some large groups require prior review, verify member’s benefit plan)
Admission certification	<ul style="list-style-type: none"> • All products

The purpose of obtaining certification is to:

- Determine whether proposed care is a covered benefit and the setting is appropriate.
- Promptly advise the provider of the benefits available for selected services and/or procedures.

As part of the BCBSNC prospective review process, certification is required prior to delivery of certain outpatient services such as home health, home infusion therapy, private duty nursing and durable medical equipment. A list of services requiring certification has been included in this section for your convenience. This list is reviewed quarterly at that time. Please check at Web site **bcbsnc.com** for the current up-to-date list. This list is current as of the date of publication of this e-manual. For questions regarding this list, call the Provider Blue LineSM at **1-800-214-4844**.

It is the physician’s/provider’s responsibility to request certification from BCBSNC. Failure to obtain certification for services will result in reduction or denial of payment for the charges both institutional and professional.



7.5.1.1 How to request certification

All certification requests for services, with the exception of mental health and substance abuse services, should be made directly to BCBSNC.

To request certification:

- Fax a completed BCBSNC certification request form to BCBSNC at one of the following fax numbers:

Department	Fax number
Healthcare Management & Operations – commercial lines of business	1-800-571-7942
Discharge services	1-800-228-0838
State Health Plan PPO	1-866-225-5258
Federal Employee Program	1-919-765-2081
Pharmacy quantity limitations	1-800-795-9403
Pharmacy restricted access drugs	1-888-348-7332

or

- Call Healthcare Management & Operations at **1-800-672-7897**

or

- Mail a completed BCBSNC certification request form to:
Blue Cross and Blue Shield of North Carolina
Attention: Healthcare Management & Operations
PO Box 2291
Durham, NC 27702-2291

Inpatient admissions:

- Hospitals and facilities may notify BCBSNC via the admission notification application on **Blue eSM**. If your organization does not have access to **Blue eSM**, please refer to chapter eleven, Electronic solutions or visit our Web site at **bcbsnc.com/providers/edi**.
- To request certification for mental health and/or substance abuse services for HMO, POS, PPO and CMM members, contact Magellan Behavioral Health at **1-800-359-2422**.
- To request certification for mental health and/or substance abuse services for State Health Plan PPO members or NC Health Choice members. Contact Value Options at **1-800-367-6143**.

Provide the following information when submitting a request:

- Practice name and BCBSNC provider number
- Contact name, phone number, and fax number
- Patient’s name, BCBSNC member ID number, and date of birth
- Attending physician’s name, BCBSNC provider number, and phone number
- Treatment setting - i.e., physician’s/provider’s office, home, inpatient, outpatient
- Facility name and number (if applicable)
- Expected dates of service
- Description of diagnosis and diagnosis codes
- Description of procedure and applicable codes
- Clinical information, including history and physical, treatment plan, and discharge needs
- If the service requested is part of a clinical trial, you will be asked to provide a copy of the signed informed consent and the clinical protocols.

You will be contacted if additional clinical information is required and will be notified of decisions within two (2) business days of our receipt of all necessary information.

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 fax or phone the request to the following:

Fax: **1-800-571-7942**
 Phone: **1-800-672-7897**

As part of the implementation of the Health Care Reform guidelines, BCBSNC will respond to all urgent authorization requests within 24-hours of receipt of the authorization request and supporting clinical documentation - including on weekends and holidays. Providers should only be submitting urgent authorization requests on cases that meet the criteria of urgent as outlined below.

As part of the new 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 best efforts to notify you within two (2) business days of our receipt, of all necessary information, of our decisions regarding prior review and/or certification or non-certification of services, as set forth in our healthcare management & operations programs.

Certification is required for appropriate claims payment but does not guarantee claim payment. BCBSNC will honor a certification to cover medical services or supplies under a health benefit plan, except in the following instances:

- The member is not eligible for the services under his/her health benefit plan due to termination of coverage or non-payment of premiums
- The member's benefits are exhausted
- The certification was based on false or misleading information provided about a member's condition

A request for service that, based on the clinical information provided, does not meet the Milliman Care Guidelines™ and/or the corporate medical policy, is referred to the regional medical director. If benefit coverage for services is denied by the medical director, you will receive a letter from the medical director outlining the reason for the denial and information on the appeal process. BCBSNC will issue written notification of the decision within two business days of our receipt of all necessary information. If you feel a non-certification is in error, you may request a courtesy review (see chapter sixteen, Appeal and grievance procedures). If appropriate certification is not obtained, the claim will be denied or benefits will be reduced based on the product, and you cannot bill the member for charges denied or reduced due to failure to receive certification. Retrospective certification requests may be considered in 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 BCBSNC to be avoidable or not medically necessary will not be eligible for reimbursement to hospital.
- The hospital may not bill charges for those days to the member.

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

- No benefits are available to HMO members for care from non-participating providers except in emergencies or with certification from BCBSNC. If an HMO member elects to receive non-emergency care from a non-participating provider without certification, the member is responsible for all charges incurred.
- POS members have the option of seeking care from participating or non-participating providers. If a POS member self-refers to a non-participating provider, the care will be reimbursed at the lower benefit level, with the member having liability for a higher out-of-pocket expense.
- In specific situations, BCBSNC may approve coverage for services received from non-participating physicians or providers. This includes situations where continuity of care or network adequacy issues dictate the use of a non-participating physician or provider (see section 7.12.3, Continuity of care in this e-manual).
- Services received from a non-participating physician or provider that are not urgent or emergent, and are not approved by BCBSNC in advance will not be paid at the in-network benefit level.
- If you have a question about participation in our HMO networks, visit our Web site at **bcbsnc.com** or call the Provider Blue LineSM at **1-800-214-4844** to speak to a representative.
- To request certification for a non-participating provider, call Healthcare Management & Operations at **1-800-672-7897**.

7.5.1.5 Certification list

This list applies to BCBSNC commercial (non-Medicare Advantage) products only and excludes the Federal Employee Program and NC Health Choice.

Every quarter the prior review list is updated with new service codes, and/or service codes that are no longer effective. If changes are made to the prior review list, our Web site at **bcbsnc.com** will be updated by the 10th day of January, April, July and October. To access the prior review list, select the providers section and choose the prior authorization category. You can also contact Healthcare Management & Operations at **1-800-672-7897** for a list of services requiring prior approval. In addition, our internet-based application, **Blue eSM** will contain a notification whenever changes are made to the review list. **Blue eSM** is available to you free-of-charge for verification of membership eligibility, claims submission and inquiry.



BCBSNC requires certification for certain services, procedures, inpatient admissions and pharmaceuticals. If the process of obtaining certification changes, BCBSNC will notify you in accordance with your contract. The list of services, procedures and drugs requiring certifications is available on the Web or by contacting Health Care Coaching and Intervention at **1-800-672-7897**. For an up-to-date listing of the medications that may require certification or have quantity limitations please refer to our Web site, **bcbsnc.com**. If the member’s physician certifies in writing to health care coaching and intervention that the member has previously used an alternative drug(s) that was detrimental to the member’s health, was ineffective in treating the same condition, and is likely to be ineffective or detrimental in treating the same condition again, drugs will be approved through the prior review process. A “Yes” indicates the following services, procedures, inpatient admissions and pharmaceuticals require certification, including prior review and admission certification. N/A is noted if certification is not required or is not applicable. Providers should verify benefits prior to providing services listed as N/A. PPO products have out-of-network benefits. Members should refer to their member guide for their responsibilities when seeking services from out-of-network providers.

Services/procedures/admissions	HMO	POS	PPO	CMM
Inpatient admissions <ul style="list-style-type: none"> Scheduled (elective) admissions must be approved prior to admission (including inpatient hospital, inpatient hospice, and skilled nursing facility admissions). For emergency admissions, BCBSNC should be notified by the next business day or no later than the second business day after the admission. For maternity admissions, certification is required for days beyond the first 48 hours after vaginal delivery or the first 96 hours after c-section. Acute inpatient admission for rehabilitation. 	Yes	Yes	Yes	Yes
Surgery and/or outpatient procedures, such as: <ul style="list-style-type: none"> Morbid obesity surgery UPPP, surgical management of obstructive sleep apnea Orthotripsy Vertebroplasty and Kyphoplasty Percutaneous treatment of HNP 	Yes ²	Yes	Yes	N/A
Procedures potentially cosmetic, such as: <ul style="list-style-type: none"> Abdominoplasty Blepharoplasty Breast surgeries including insertion and removal of silicone breast implants (not resulting from mammoplasty), reduction mammoplasty, and gynecomastia Orthognathic surgery Reconstructive surgery, including but not limited to rhytidectomy, dermabrasion, and scar revision Rhinoplasty Therapy of superficial veins, such as varicose veins, telangiectasias 	Yes ²	Yes	Yes	N/A

Continued on the following page.



Services/procedures/admissions	HMO	POS	PPO	CMM
Mental health and substance abuse treatment <ul style="list-style-type: none"> • Routine office visit • Outpatient mental health and substance abuse treatment, including partial day and intensive outpatient services • Inpatient treatment for mental health and substance abuse 	Yes ² Yes ² Yes ²	Yes Yes Yes	N/A Yes ¹ Yes ¹	N/A Yes ¹ Yes ¹
Ambulance non-emergent air services	Yes	Yes	Yes	N/A
DME-rental or purchase of durable medical equipment	Yes, ^{2,4} but you must call	Yes, but you must call	Yes, but you must call	N/A
Private duty nursing	Yes ²	Yes	Yes	Yes
Skilled nursing facility admissions	Yes ²	Yes	Yes	Yes
Transplants	Yes ²	Yes	Yes	Yes
Certain pharmaceuticals as indicated on our Web site, bcbsnc.com or by calling Health Coaching and Intervention at 1-800-672-7897	Yes ^{2,3}	Yes	Yes	N/A
BCBSNC may authorize out-of-network/non-participating services at the in-network benefit level if a service is not available in-network or if there is a continuity of care issue	Yes ²	Yes	Yes	N/A
Certain non-emergency, outpatient, high-tech diagnostic imaging services, as defined by our diagnostic imaging management program. Please see chapter seven for additional detail or visit our Web site at https://www.bcbsnc.com/services/medical-policy/dim-policies.cfm#DIM				

- 1 Applies to Blue OptionsSM and Classic BlueSM only (excludes Blue Advantage[®], AccessSM, CMM Conversion and Blue AssuranceSM)
- 2 Some large groups have special benefits. Please see member benefit booklet for some large groups. Please also reference benefit exclusions under, "What is not covered."
- 3 RJ Reynolds has carved out pharmacy and mental health/substance abuse benefits. For inpatient mental health/substance abuse inpatient authorization contact BCBSNC at **1-800-672-7897**. Non-participating mental health/substance abuse may be referred only by Winston-Salem Health Care (WSHC) psychiatric department.
- 4 A referral is required for Blue HMOSM members to go outside of WSHC to the Blue Care[®] network. Home ST/OT/PT does not require prior review.



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 certification or non-certification of benefits.

7.5.3 Guidelines for obtaining durable medical equipment and home health services

applies to HMO, PPO, 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 **bcbsnc.com** for most current DME service code list under prior review.
- ‡ Only HDME suppliers that meet BCBSNC eligibility and/or credentialing requirements can request prior review for HDME equipment.
- All equipment services require a physician’s order/prescription, or a certificate of medical necessity form (see chapter twenty-two, Forms).

7.5.3.2 Home health services

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

- Prior review/authorization is required for skilled nursing visits, medical social services and home infusion. Use the HCFA-285 (Home Health Certification and Plan of Care) and the HCFA-487 (addendum to plan of treatment/medical update) forms to communicate your orders to the health coaching and intervention department (out-of-network).
- All home care services must be prescribed by a physician.
- The member must be homebound for home health services with the exception of home health infusion services. Refer to the medical policy on definition of home health homebound. Medical policies may be viewed on the Web site at **bcbsnc.com**.

See chapter four, Federal Employee Program for requirements for FEP members.

7.5.4 Certification list for ancillary services

BCBSNC requires certification for certain services and procedures. The following chart indicates when certification is required.

Services/procedures/admissions	HMO	POS	PPO	CMM
Home health	Certification for RN/LPN only ²	Certification for RN/LPN only ²	Certification ¹	Not applicable
Home infusion therapy	Certification ²	Certification ²	Certification	Not applicable
Private duty nursing	Certification ²	Certification ²	Certification	Certification
Home durable medical equipment	Refer to specific DME service code list at bcbsnc.com under prior review	Refer to specific DME service code list at bcbsnc.com under prior review	Refer to specific DME service code list at bcbsnc.com under prior review	Not applicable

Continued on the following page.



Services/procedures/admissions	HMO	POS	PPO	CMM
Hospice – inpatient	Certification ²	Certification	Certification	Certification
Hospice – outpatient	Not applicable ²	Not applicable	Not applicable	Not applicable
Dialysis	Not applicable ²	Not applicable	Not applicable	Not applicable

- 1 Applies to Blue OptionsSM, State Health Plan, and Classic Blue[®] only
- 2 Some CMM plans require prior review for home health, home infusion, and home durable medical equipment. Verify member benefits.

- Certification can be requested by any participating physician or ancillary provider if the services have been ordered by the member’s physician.
- Utilization program requirements must be requested and received prior to rendering services.
- POS members do not require certification for out-of-network services, unless it is an inpatient admission.
- A participating physician must request certification to refer to a non-participating provider.

7.5.5 Hospital observation

(Applicable for all BCBSNC products and lines of business)

Observation services are defined as the use of a bed and periodic monitoring by hospital nursing or other staff. These services are considered reasonable and necessary to evaluate a patient’s condition to assess the need for an inpatient admission.

Conditions that are usually appropriate for observation status include:

- Abdominal pain (r/o appendicitis, renal colic, PID, UTI, gastritis, spastic colon)
- Allergic reactions, immunization side effects
- Back pain
- Chest pain (including rule out myocardial infarction)
- Hypoglycemia
- Irritable bowel disease, mild diverticulitis, etc.
- Leg pain/swelling (r/o DVT, phlebitis, cellulitis)
- Nausea/vomiting/diarrhea/gastroenteritis/dehydration
- Syncope
- Transient Ischemic Attacks (TIA)

In order to be successful in assuring medically appropriate, quality care, we rely on your cooperation. Timely, appropriate reviews require prompt notification of inpatient admissions, the submission of complete medical information, access to patient charts, and specification of discharge needs.

During the course of an admission, BCBSNC should be notified of a change in clinical status or an anticipated change in clinical status so that we can review the original certification.

Medical director’s responsibility

- The medical director will review all clinical information provided by the concurrent reviewer and document his or her determination. The continued stay may be approved based on the information provided, or the attending physician may be contacted for additional information.
- If the medical director concludes that there may be a medically appropriate alternative to continued hospital stay, coverage for continuing inpatient stay will be denied. The healthcare management & operations coordinator will notify the requesting provider of the denial via telephone or fax within applicable regulatory timeframes.
- Written notice of the denial, including the appeals process, will be sent to the physician or provider, the facility, and the member within applicable regulatory timeframes.
- For information on appeals, refer to chapter sixteen, Appeal and grievance procedures.



7.6 Peer to peer review

BCBSNC medical directors are available to discuss clinical problems and benefit issues with network providers particularly where there are issues that complicate the management of the patient's condition.

- A peer to peer review is a clinical discussion between a requesting physician and a BCBSNC medical director.
- If you have questions about a certification request, you may request to speak directly to a medical director by calling **1-800-672-7897, x51019**.
- A peer to peer review may also be requested by a BCBSNC medical director in order to obtain more clinical information from an attending physician before making a final determination.
- The purpose of the peer to peer discussion is to give the requesting physicians an opportunity to discuss the clinical details of a requested service.

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, Skilled Nursing Facility (SNF), inpatient hospice facility, outpatient services or home. Staff work frequently with the nurses in both the concurrent review and the case management departments, collaborating to maximize the member's benefits.

The discharge services staff is available to assist with discharge arrangements for BCBSNC members.

Services include:

- DME - specific DME code listed at **bcbsnc.com** under prior review and/or prior plan approval
- Home health, including IV therapy
- Skilled Nursing Facility (SNF) placement
- Rehabilitative admissions

Requests for discharge services may be made to discharge services 24 hours a day, seven days a week by:

- Faxing a request to **1-800-228-0838** and including the provider's phone and fax numbers

or

- Calling the voice mailbox at **1-800-672-7897, x51019** and leaving a message

All requests/messages should contain the following information:

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

7.8 Transfer to long term acute care facilities

Requests for transfer to a Long-Term Acute Care (LTAC) hospital are not authorized if the necessary care can be provided in the acute care hospital where the patient is currently admitted. Additionally, because most North Carolina LTACs are not contracting providers with our health plans, some members (e.g., HMO) may not have a benefit for the LTAC. Other members in PPO plans may incur a significant financial obligation for care in these facilities that they would not if they received their care in-plan.

When healthcare management & operations receives a request for a transfer from an acute care hospital to a LTAC hospital we ask for the following information:

- 1) What is the clinical reason for the transfer?
- 2) Are these services available at the current acute care hospital?
- 3) Does the patient/family know they may face significant financial responsibility if they choose to transfer to a LTAC hospital due to limited contracts for this type of facility (e.g., the member may be responsible for up to 100% of charges)?

While most of the requests for transfer to a LTAC will not meet the plan's definition of medically necessary services, any non-certification of services on this basis must be made by a medical director. Physicians may avail themselves of a peer-to-peer consultation that is offered during the BCBSNC review process. A discussion between physicians may help clarify the situation and reach the best decision for the patient. A BCBSNC medical director is available during regular business hours and can be reached at **1-800-672-7987, x51019**.

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

To refer a member to case management, call **1-800-672-7897**.



7.9 Diagnostic imaging management program

BCBSNC implemented a diagnostic imaging management program in February 2007. American Imaging Management, Inc., (AIM) administers the program for BCBSNC for the management of outpatient, high-tech diagnostic imaging services.

For dates of service on or after February 15, 2007, prior review is required for the non-emergency, outpatient, diagnostic imaging services listed below – when they are performed in a physician’s office, the outpatient department of a hospital, or a freestanding imaging center:

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

Ordering physicians must contact AIM via Web or phone to obtain a certification prior to scheduling an imaging exam for these outpatient diagnostic non-emergency services.

For dates of service on or after January 15, 2012, prior approval is required for the following services:

- Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)
- Stress Echocardiography (SE)

Servicing providers (hospitals and freestanding imaging centers) should confirm that certification was issued prior to scheduling the exam. Issuance of certification is not a guarantee of payment; claims will be processed in accordance with the terms of a subscriber’s health benefit plan. Only ordering physicians can request prior review. Hospitals and freestanding imaging centers that perform the imaging services cannot obtain the certification.

Ordering physicians can obtain and confirm certification by contacting AIM in one of the following ways:

1. By logging on to provider portal through **Blue eSM**: seven days a week, 4 a.m. to 1 a.m., eastern time.
2. By calling AIM: **1-866-455-8414** (toll free), Monday through Friday, 8 a.m. to 5 p.m. eastern time.

Imaging service providers can also contact AIM, either through the provider portal or by phone, to ensure that a certification has been issued or to confirm that the certification information is correct. Imaging service

providers can also call AIM to change the date of service on the certification, change the location of the service or request add-on procedures.

Neither AIM nor BCBSNC will issue retro-certification. However, if the requested scan is of an urgent nature, the ordering physician can request the certification within 48 hours of the procedure.

If you are not currently registered to use **Blue eSM**, you will need to register online at <https://www.bcbsnc.com/providers/edi/bluee.cfm>. BCBSNC provides **Blue eSM** 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 **bcbsnc.com** Web site at <https://www.bcbsnc.com/pdfs/DIM-PPA-List.pdf>. This list is subject to change once per quarter. Changes will be posted to the BCBSNC Web site **bcbsnc.com** by the 10th day of January, April, July, and October. Diagnostic imaging management policies and medical policies are also available, located on the Web at <https://www.bcbsnc.com/services/medical-policy/dim-policies.cfm#DIM>.

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

7.9.2 Diagnostic imaging Physician Recognition Program (PRP)

The goal of the Diagnostic Imaging Management Program (PRP) is to simplify the authorization process for physicians who demonstrate appropriate utilization and the highest level of compliance with clinical practice guidelines. Physicians who qualify for the PRP will be subject to notification only (no medical necessity review) for the time period in which they qualify.

Physicians must have a regular ordering pattern with sufficient volume to demonstrate understanding of newer technologies and clinical practice guidelines. Physicians are evaluated against established PRP criteria every six months; those physicians who qualify for PRP status are evaluated against maintenance criteria once per calendar year. For specific criteria, physicians should contact their Network Management representative.



7.9.3 Diagnostic imaging employer group participation

Most BCBSNC employer groups are participating in the diagnostic imaging management program. However, not all employer groups are participating, so BCBSNC offers a Web-based employer group number search, available at <https://providers.bcbsnc.com/providers/imaging.faces> and on **Blue eSM**. The employer group number search, allows providers to quickly determine whether an authorization is needed. BCBSNC will update this system as new employer groups enter the program, so it is important that you confirm participation in advance of providing services.

7.10 Health coaching/ case management

Health coaching and case management is a voluntary program. Health coaches and case managers are all licensed health care professionals who assist members with coordination of quality health care services to meet specific health care needs. Health coaching and case management goals include the coordination of care and enhancement of the member's quality of life. Case management proactively assists members and their families who are at risk of developing medical complications, or for whom a life altering incident has caused a need for rehabilitation or other health care support. Each member is individually screened for placement into the case management program.

7.10.1 About health coaches

A BCBSNC health coach is a health care professional whose role is to work with a member to set goals and develop a self care health plan that focuses on the individuals health care needs and treatment options. Health coaches will remain in contact with members via telephone to ensure follow through with their self-care goal plan, to identify and remove obstacles to care, and to provide education and guidance. They will utilize personalized mailings, identify local support services, educate and encourage members to use their BCBSNC benefits, incorporate and direct members to online decision support tools and initiate members into other MHP modules when appropriate.

When a patient is identified as a candidate for case management, a process begins which includes problem identification, intervention planning, monitoring, evaluation, and outcomes measurement. Throughout the case management process, the case manager considers all treatment alternatives and presents these alternatives to the member to ensure that the needs and goals of the member are incorporated into the treatment plan. This individualized plan is then reviewed with the physician and the member. Care is coordinated among multiple disciplines including the physician and provider in the implementation of this specific treatment plan. Case management by BCBSNC continues until the member's condition is stabilized, the need for care ends, or the member is no longer enrolled with BCBSNC.

Participants in the process may include but are not limited to:

- Physicians
- Physical therapists
- Pharmacists
- Social workers
- Home health agencies
- Available community resources
- DME providers

7.10.2 Referrals to case management

Members can be referred from the following sources:

- BCBSNC staff
- Health Line BlueSM nurse (24 hour health information line)
- Hospital discharge planner or case manager

Members can be referred from the following sources:

- BCBSNC staff
- Health Line BlueSM nurse (24 hour health information line)
- Hospital discharge planner or case manager
- Primary care physician

7.10.3 Transplant management program

Our transplant program includes preauthorization, a transplant network, and a case management component.

- Requires preauthorization for all lines of business.
- HMO and POS members must use participating providers in the BCBSNC transplant network.



- PPO and CMM members can maximize their benefits by using the BCBSNC transplant network, but may also access care outside the transplant network. If care is received at an in-network facility, benefits will be applied at an in network level. If care is received at a non-participating facility, the lower out-of-network benefits will apply.

Case management for members requiring transplants includes addressing pre- and post-transplant needs. Special attention is given to assisting the member and provider with selection of the best transplant facility, coordinating travel and lodging, and resolving any organ/tissue procurement issues.

To refer a member to transplant management, contact our Healthcare Management & Operations Department at **1-800-672-7897**.

7.11 Mental health and substance abuse management programs

BCBSNC delegates mental health and substance management and administration (including certification, concurrent review, discharge planning and case management) to Magellan Behavioral Health and Value Options. Depending on the member’s plan type and/or employer group, mental health and substance management and administration may be handled by Magellan Behavioral Health, Value Options, or BCBSNC. The back of the member’s identification card includes contact information when Magellan Behavioral Health or Value Options is providing the delegated services and is to be contacted.

Sample back view of a member identification card

Toll-free Customer Service:

Medical: Benefits & Claims1-877-258-3334
Dental: Dental Blue®1-800-305-6638
Mental Health / Substance Abuse1-800-359-2422

Magellan Behavioral Health: Certification for all mental health & substance abuse services, except office visits.
 To find a participating provider outside of NC:
BlueCard®1-800-810-BLUE (2583)
Health Line Blue™1-877-477-2424
 24-hour health information line staffed by nurses

bcbsnc.com: Provider Directory, Healthcare Management & Operations, My Member Services to review claim status, update contact information, request ID card, etc. Blue Extras™: discount programs, exercise incentives, and more

Toll-free Customer Service:

Medical: Benefits & Claims1-888-234-2416
Pharmacy Customer Service:.....1-800-336-5933
Pharmacy Services Help Desk:.....1-800-922-1557
Mental Health Case Manager1-800-367-6143
Value Options: Certification for all mental health & substance abuse services, except office visits.

To find a participating provider outside of NC:
BlueCard®1-800-810-BLUE (2583)
BlueCard® Worldwide1-804-673-1177
www.statehealthplan.state.nc.us: on-line access to detailed Plan and benefit information

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

In most cases Magellan Behavioral Health will coordinate mental health and substance management and administration for HMO, POS, PPO and CMM members. Providers should contact Magellan Behavioral Health to conduct full healthcare management & operations for mental health and substance abuse services by calling **1-800-359-2422**. However, certain employer groups can elect to have BCBSNC handle services directly and some coverage plan types offer mental health and substance management and administration through either BCBSNC healthcare management & operations or Value Options, the most common of these are:

- Mental health and substance abuse services for members enrolled in Blue Advantage®, Access™, and Blue Assurance™ are handled by BCBSNC at **1-800-672-7897**.
- BCBSNC coordinates mental health and substance abuse services for members enrolled in Blue HMO™. To arrange mental health and substance abuse services for Blue HMO™ members, contact BCBSNC at **1-888-298-7575**.
- Mental health and substance abuse services for Federal Employee Program (FEP) members are handled by BCBSNC at **1-800-222-4739**. (Additional information about the Federal Employee Program is located in chapter four of this e-manual.)
- Mental health and substance abuse services for State Health Plan members enrolled in State Health Plan PPO are coordinated by Value Options. Contact Value Options to conduct full health coaching and intervention for mental health and substance abuse services at **1-800-367-6143**.

For more information about mental health and substance abuse delegated services, see chapter seventeen of this e-manual and/or chapter two for contact information.



7.12 Third party health coaching and intervention agreements

7.12.1 Delegation of services

BCBSNC reserves the right to outsource additional health-care management & operations services at its discretion.

7.12.2 Hold Harmless agreement

Hold Harmless is a contractual agreement between BCBSNC and participating providers. This agreement states that the provider may not balance bill a member for services or supplies that were not prior authorized or certified in advance by BCBSNC and/or deemed not medically necessary by BCBSNC. Additional information about Hold Harmless is located in chapter ten of this e-manual (see section 9.16 Hold harmless provision).

7.12.3 Continuity of care

Continuity of care is a process that allows members with ongoing special conditions to continue receiving care from a provider who becomes an out-of-network provider, when the member's employer changes health benefit plans or when their provider is no longer HMO, POS, or PPO network participating. To be eligible for continuity of care, the member must be actively being seen by an out-of-network provider for an ongoing special condition and the provider must agree to abide by BCBSNC's requirements for continuity of care. Once written notification of a provider termination is received by BCBSNC, we are required to notify members by letter at least 30 days prior to the termination effective date. A new member has 45 days from their effective date to request a review for continuity of care. An ongoing special condition means:

- In the case of acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm;

- In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time;
- In the case of pregnancy, the second and third trimesters of pregnancy and postpartum care;
- In the case of a terminal illness, an individual has a medical prognosis that the member's life expectancy is six months or less.

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

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Continuity of care will not be provided when the provider's contract was terminated for reasons relating to quality of care or fraud. To request a continuity of care review call Health Coaching and Intervention at **1-800-672-7897**, with the exception of mental health and substance abuse services. To request a continuity of care review for services related to mental health and substance abuse contact Magellan Behavioral Health at **1-800-359-2422**, (for State PPO members enrolled in State Health Plan, contact Value Options at **1-800-367-6143**).

7.13 Concurrent review documentation

BCBSNC has a business associate agreement with Covisint ProviderLink, a Durham-based health care technology company, to transfer media/documentation in a secure, internet-based format for concurrent review. For more information, visit the Covisint ProviderLink website at <http://www.covisint.com/web/guest/healthcare/providerlink> or call **1-877-884-5775**, option 5.



7.14 ActiveHealth management CareEngine service program

Some of the BCBSNC employer groups have elected to participate in the ActiveHealth management CareEngine service program for patient health tracking. The program is also referred to as the clinical notification opportunities program. This program is aimed at providing you with helpful clinical information regarding your patients and their treatment regimens.

ActiveHealth management is a medical information technology company that aggregates and analyzes patient data. Specifically, ActiveHealth compiles all available patient claims, lab, and pharmacy data into a single patient file, and then uses a sophisticated computer software program to analyze this data employing a continually expanding set of clinical rules. Through this process, ActiveHealth uncovers potential discrepancies between the available patient data and the most recent evidence-based medical literature. ActiveHealth then communicates patient-specific information to the treating physicians. The communications are termed care considerations, and are delivered to the treating physician either through telephone, fax, or letter. When appropriate, ActiveHealth attaches the relevant patient data specific to each care consideration.

Please note that this is not a utilization review or pre-certification program, or a professional medical consultation. This information is being provided to assist you in offering health care to your patient, and should be considered according to your best independent medical judgment.

If you believe the information from ActiveHealth is inaccurate or incomplete, or if you are aware of extenuating circumstances, please use your medical judgment to determine the appropriateness of the care consideration(s).

For further information call the ActiveHealth management clinical information center's toll free number at **1-800-319-4454**.



7.15 Regional fax numbers

Regional teams by county					
Region 1		Region 2		Region 3	
Medical director 1		Medical director 2		Medical director 3	
Fax number 1-800-459-1410		Fax number 1-800-571-7942 <small>(includes out-of-state requests)</small>		Fax number 1-800-672-6587	
Team 1A¹: Asheville		Team 2A²: Raleigh/Chapel Hill <small>(partial)</small>		Team 3A: Raleigh/Durham <small>(partial)</small>	
Alexander	Iredell	Alamance	Lee	Granville	
Alleghany	Jackson	Caswell	Moore	Person	
Ashe	Macon	Chatham	Orange	Vance	
Avery	Madison	Durham	Pitt	Team 3B: Greensboro/Winston-Salem	
Buncombe	Mitchell	Franklin	Wake		
Burke	McDowell	Harnett	Warren	Davidson	Rockingham
Caldwell	Polk	Johnston		Davie	Stokes
Catawba	Rutherford	Team 2B: Greenville		Forsyth	Surry
Cherokee	Swain	Beaufort	Hyde	Guilford	Yadkin
Clay	Transylvania	Bertie	Jones	Randolph	
Cleveland	Watauga	Camden	Lenoir	Team 3C: Wilmington	
Graham	Wilkes	Carteret	Martin	Bladen	New Hanover
Haywood	Yancey	Chowan	Nash	Brunswick	Onslow
Henderson		Craven	Northampton	Columbus	Pender
Team 1B: Charlotte		Currituck	Pamlico	Cumberland	Robeson
Anson	Montgomery	Dare	Pasquotank	Duplin	Sampson
Cabarrus	Richmond	Edgecombe	Perquimans	Hoke	Scotland
Gaston	Rowan	Gates	Tyrrell		
Lincoln	Stanly	Greene	Washington		
Mecklenburg	Union	Halifax	Wayne		
		Hertford	Wilson		
Discharge services for all regions		1-800-228-0838			
State Health Plan PPO		1-866-225-5258			
Pharmacy quantity limitations		1-800-795-9403			

Chapter 8

The **Blue Book**SM
Provider eManual

Care management



Visit us at bcbsnc.com

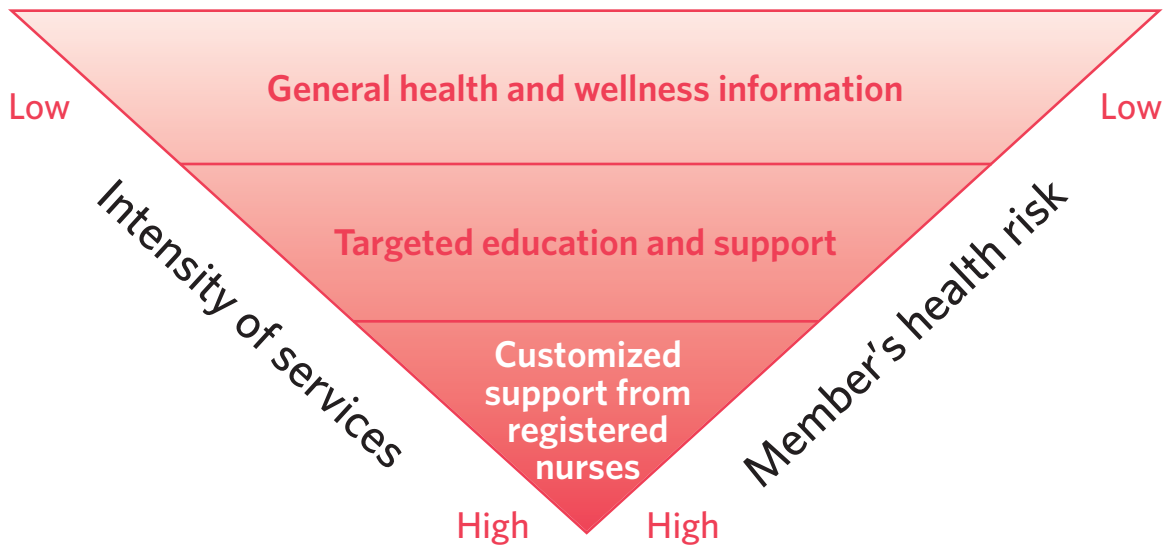


**BlueCross BlueShield
of North Carolina**



8.1 Care management overview

The goal of care management is to ensure that appropriate management interventions are offered to all members. This goal is accomplished by health risk stratification, so that appropriate case management, education and decision support can be provided for these members. For example, members with no current significant medical needs receive prevention and wellness information that enhances their ability to maintain or improve their health status. Members at higher risk receive interventions that improve their ability to manage their condition.



8.2 Case management

Case management is an integral part of both healthcare management & operations and member health partnerships 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 seven, Healthcare management & operations.

8.3 Healthcare Management & Operations program

BCBSNC offers free health management programs to members who have select health conditions. This confidential program is designed to provide members with targeted information and services, which can help them manage their specific health care needs. These programs are available to members enrolled in HMO and PPO products, including Blue Advantage®.

The programs are also available to members enrolled in CDHP products, though benefits are not part of the first dollar preventive care and subject to deductible and coinsurance. Certain employer groups may choose not to offer this program to their employees. Candidates for enrollment into the Healthcare Management & Operations program are identified based on medical and pharmaceutical claims data, physician or provider referrals, calls to Health Line BlueSM and self-referrals via our toll-free number at **1-800-218-5295**. Members can also enroll through our Web site at **bcbsnc.com**, or by sending an e-mail to **partnerships@bcbsnc.com**.

These programs are designed to educate members about how to manage their health conditions in a way that will optimize their health status. Enrolled members receive:

- Comprehensive educational materials which are consistent with nationally-accepted evidence-based standards of medical care
- The opportunity to work with a registered nurse to learn more about their condition and how to manage it.
- Access to medical nutrition therapy from licensed, credentialed dietitians.



Conditions addressed include:

- Asthma
- Coronary heart disease
- Congestive heart failure
- Diabetes
- High blood pressure and high cholesterol
- Fibromyalgia
- Migraines
- Stress
- Tobacco cessation
- Achieving and maintaining a healthy weight

See below for information about our pregnancy and specialty care options.

Members actively participating in the MHP program will receive a health report offering personalized feedback based on responses to an initial health survey that they must complete to become actively enrolled. They also will receive a Healthcare Management & Operations organizer to record results of medical tests and screenings, medical history, pharmacy history and office visits. Condition specific books and access to self-management tools are mailed to members to educate members on how to manage conditions, identify triggers of symptoms, and work with health care providers to treat appropriately. Members will also receive a semi-annual Healthcare Management & Operations magazine, Blueprints to Health, containing strategies for better health.

Additional benefits and waivers include 6 visits for medical nutrition therapy, diabetes deductible waivers, and asthma copay reductions on select asthma medication are also available to actively enrolled members. Members will receive access to free and discounted medical supplies including asthma peak flow meters and spacers, diabetes testing supplies, blood pressure cuffs, and scales.

Lastly, members actively enrolled in Member Health PartnershipsSM will have access to one-on-one health coaching from a nurse if a member has questions about disease, medications or treatment plan, regardless of severity of illness.

Specialty Care

In addition to the Healthcare Management & Operations program, BCBSNC offers Healthcare Management & Operations – Specialty Care that provides personalized support for 14 rare conditions. Members who have one of the following chronic, progressive diseases are eligible for the Healthcare Management & Operations specialty care program.

- Amyotrophic Lateral Sclerosis (ALS)
- Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- Cystic Fibrosis
- Dermatomyositis
- Hemophilia
- Myasthenia Gravis
- Multiple Sclerosis
- Gaucher Disease
- Parkinson's Disease
- Polymyositis
- Rheumatoid Arthritis
- Scleroderma
- Sickle Cell Disease
- Systemic Lupus Erythematosus

Program participants can benefit from customized educational materials, personalized health evaluations and education from registered nurses and other health care professions, and access to www.accordant.com, a patient Web site featuring in depth, disease specific information, live interactive events and additional resources.

Pregnancy

Any member who is pregnant is eligible to have access to the Healthcare Management & Operations – Pregnancy program. This program provides up-to-date information on pregnancy, labor and delivery options and costs, newborn care, and choosing a pediatrician, care seat and day-care with access to one-on-one health coaching from a pregnancy case manager.

8.4 Medical nutrition therapy benefits

As of October 2005, Blue Cross and Blue Shield of North Carolina began covering medical nutrition therapy. The nutrition counseling benefit is available to members actively participating in the Healthcare Management & Operations program and who have Blue Care[®], Blue OptionsSM or Blue Advantage[®]. This benefit is not available to National Carolinas Program or Comprehensive Major Medical (CMM) product lines. The State Health Plan does cover nutrition counseling for diabetics and the FEP provides some coverage. If a member is enrolled in the Blue Options HSASM plan, they may be subject to deductible and coinsurance. Benefits available through Healthcare Management & Operations are subject to a member's current benefit plan and pre-existing waiting periods.



Please note that some self-insured employer groups may choose to omit medical nutrition therapy from coverage for their employees. For this reason, it is always a good idea to verify a member’s eligibility before the member’s first visit.

Coverage Guidelines and Verifying Eligibility

Members enrolled in a BCBSNC Healthcare Management & Operations program may have benefits for six medical nutritional therapy visits. Members with a diagnosis of diabetes may exceed six medical nutritional therapy visits per year. Please note that members diagnosed with diabetes, but not enrolled in a BCBSNC Healthcare Management & Operations program, may be responsible for paying a copayment during the initial six visits. Visits exceeding the sixth visit may be subject to copayments even if the member is enrolled in a BCBSNC Healthcare Management & Operations program. Please see the following charts for guidelines.

Guidelines for coverage of medical nutrition therapy per benefit period for state and commercial products (assuming employer has not carved out and no pre-existing conditions).

Plan	Non-diabetics	Diabetics
State PPO	MNT not covered	Unlimited visits allowed with the first 6 visits copays waived. After the 6 visits, visits will be subject to copay or coinsurance and deductible.
Commercial products (Blue Care®, Blue Options SM , Blue Advantage®)	Member actively participating in MHP, 6 visits are covered with copay waived. Member not actively participating in MHP, no visits are covered.	Member actively participating in MHP, 6 visits are covered with copay waived. After the 6 visits, unlimited visits with applicable copay or coinsurance/deductible. Members not actively participating in MHP, unlimited visits covered, subject to copay or coinsurance and deductible.
HSA product	Member actively participating in MHP, 6 visits subject to coinsurance and deductible, not covered after 6. Member not actively participating in MHP, no visits are covered.	Member actively participating in MHP, 6 visits are subject to coinsurance and deductible; not covered after 6. Members not actively participating in MHP, unlimited visits covered, subject to copay or coinsurance and deductible.



8.5 Verifying eligibility

Before seeing a Blue Cross and Blue Shield of North Carolina (BCBSNC) member, providers should first verify their benefits and eligibility by calling the Provider Blue LineSM at **1-800-214-4844** or by using **Blue eSM**. With **Blue eSM** 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 eSM**, visit BCBSNC electronic solutions on the Web at <http://www.bcbsnc.com/providers/edi/>, or refer to chapter eleven of this e-manual.

Please verify that the member is actively enrolled in the Healthcare Management & Operations program, that the member has no current pre-existing condition, and that the member's employer group has not carved out the benefit.

Copayments, coinsurance and deductible may apply to these visits. Contact the Federal Employee Program customer service at **1-800-222-4739** for more information and to verify benefits and coverage of services for members covered under the Federal Employee Program.

Members receiving nutritional counseling for the treatment of anorexia may not be eligible for benefits when provided by licensed, registered dietitians. Complex eating disorders are primarily considered part of a member's mental health benefit. In addition, BCBSNC currently does not have a Healthcare Management & Operations program for GI conditions.

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

8.6 Guidelines for coverage of medical nutrition therapy per benefit period for FEP

Nutritional counseling for the Federal Employee Program (FEP) for both standard and basic options has a visit limit of 4 visits per year, if the diagnosis is not anorexia or bulimia. If nutritional counseling is provided for the diagnosis of anorexia or bulimia there is no visit limitation. FEP benefits can be provided for nutritional counseling, as long as the member has a condition that may reasonably be expected to improve through nutritional counseling. This means that benefits can be provided for nutritional counseling given for obesity, weight control, or weight reduction. Providers such as covered dietitians and nutritionists - who bill independently for nutritional counseling - can bill for services to the plan. There has not been a change to the benefits from the 2006-year (can be subject to change with quarterly updates).

Below is a chart of benefits nutritional counseling for both preferred providers and non-preferred providers.

Benefit payment levels for nutritional counseling 2006/2007		
The plan pays:		
Provider	Basic Option (group codes 111/112)	Standard Option (group codes 104/105)
Preferred/ in-network	Reimbursed at 100% of the plan allowance after the member pays a \$20 copay licensed dietitian/nutritionist, up to 4 visits per calendar year	Reimbursed at 90% of the plan allowance after the member meets their \$250 deductible, up to 4 visits per calendar year
Non-preferred/ out-of-network	No benefits	Reimbursed at 75% of the plan allowance after the member meets their \$250 deductible. The member is also responsible for any difference between our allowance and the billed amount, up to 4 visits per calendar.

Contact the Federal Employee Program customer service **1-800-222-4739** for more information and to verify benefits and coverage of services for members covered under the Federal Employee Program.

Members receiving nutritional counseling for the treatment of anorexia may not be eligible for benefits when provided by licensed, registered dietitians. Complex eating disorders are primarily considered part of a member's mental health benefit. In addition, BCBSNC currently does not have a Healthcare Management & Operations program for GI conditions.

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



8.7 Health Line BlueSM - 24 hour health information line

BCBSNC is proud to offer an innovative service to HMO and PPO members*. Health Line BlueSM is an interactive health information and decision support resource designed to help patients make more informed medical decisions. Health Line BlueSM'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 BlueSM nurses have access to evidence-based, up-to-date medical information, guidelines and studies. This information is also available to members in easy to understand videotapes, printed materials and online resources.

Health Line BlueSM is backed by The Foundation for Informed Medical Decision Making, a not-for-profit organization founded by physicians, which provides objective, scientific information about medical concerns and treatment choices. Health Line BlueSM nurses foster and facilitate a strong physician and patient relationship, and assist members with navigation through the health care system. Health Line BlueSM 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.

8.7.1 On the phone - toll free at 1-877-477-2424

Members can call Health Line BlueSM 24 hours a day 7 days a week and can request to speak with the same nurse on an ongoing basis. Callers may also ask to have nurses follow up with them regarding a conversation or other health concern.

8.7.2 Online - bcbsnc.com

A comprehensive online resource, the Dialog Center^{SM1}, is available to members. In the Dialog Center^{SM1}, members can search the Healthwise[®] Knowledgebase library of current health information, send secure messages to nurses, track symptoms and medications and use tools that guide them through important health care decisions.

® Healthwise and Healthwise Knowledgebase are federally registered trademarks of Healthwise, Inc. used with permission.

SM Mark of Blue Cross and Blue Shield Association.

SM1 Dialog Center is a service mark of Health Dialog Services Corporation used with permission.

* Health Line BlueSM is a service provided for members of Blue Care[®], Blue OptionsSM and Blue Advantage[®] plans.

Chapter 9

The **Blue Book**SM
Provider eManual

Claims

Billing and reimbursement



Visit us at bcbsnc.com



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 of six actions within 30 days of receiving a claim from a health care provider or facility (referred to as [the claimant]):

1. Pay the claim.
2. Deny the claim.
3. Notify the claimant that there is insufficient information to process the claim (the notice must include all reasons for why the claim has not been paid and an itemization of what information is needed to process the claim).
4. Notify the claimant that the claim was not submitted on the appropriate form.
5. Notify the claimant that coordination of benefits information is needed to pay the claim.
6. Notify the claimant that the claim cannot be processed due to non-payment of fees or premium by either the patient or the patient's employer group.

Claims that are adjudicated after the statutory time limits are subject to 18% annual interest rate. Interest is not due for certain delays, such as when the carrier is waiting for additional information, or when claim payment is delayed due to non-payment of premium. If the insurer does require additional information, it has 30 days to process the claim once the requested information is received. If a claim is pending, the insurer shall deny the claim if the information is not received within 90 days. If a claim is denied because of missing information, it will be re-opened if the required information is submitted to the insurer within one year after the denial date.

A denied claim notice must include all specific denial reasons including, but not limited to, coordination of benefits, lack of eligibility or lack of coverage. If all or part of the claim is contested or cannot be paid because a specific healthcare management & operations or medical necessity standard is not satisfied, the notice must contain the decisions specific clinical rationale or refer to specific provisions in documents readily available through the insurer which provide the specific clinical rationale for that decision. However, if a notice of non-certification has already been provided under NC G.S. §58-50-61(h), then specific clinical rationale for the decision is not required.

The insurer must inform the insured of the claim status if it remains unpaid after 60 days. A status report must be sent to the insured and the claimant every 30 days thereafter until the claim is resolved.

This mandate does not apply to the following programs:

- ASO business (self-funded groups), however, the mandate does apply to Multiple Employer Welfare Arrangement (MEWA) groups
- Medicare Supplement
- BlueCard®
- The Federal Employee Program (FEP)

If you are interested in learning more about the prompt payment mandate and how it affects you, please contact your local BCBSNC Network Management field office (see chapter two, Quick contact information).

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 of these members is treated by a provider and Medicaid pays as primary payor in error, BCBSNC must reimburse Medicaid the amount it would have paid to the provider up to the amount Medicaid paid.

Although the law assigns the provider's right to payment to Medicaid, it does not change the provider's contractual rights. If BCBSNC owes the provider a contracted amount that is more than Medicaid paid the provider, then the provider has the right to submit a claim for the service, and BCBSNC will reimburse the provider for the difference between BCBSNC's payment to Medicaid and the contracted amount, less member liabilities. If BCBSNC owes the provider less than the amount Medicaid paid the provider, then BCBSNC is obligated only to reimburse Medicaid for the amount that BCBSNC owes under the provider contract.



9.3 Disclosure of claim submission and reimbursement policies

North Carolina General Statute (NCGS) §58-3-227, requires health plans to disclose descriptions of their claim submission policies to participating (contracting) providers. This section serves as a resource tool to guide you and members of your office staff as to how you may obtain information regarding our claim submission policies as required under NCGS §58-3-227.

Scope of disclosures

NCGS §58-3-227 applies only to insured business regulated by the State of North Carolina. The statute does not apply to the following: ASO (self-funded group[s]) business, the Federal Employee Program (FEP), the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical (CMM) (indemnity) plan, inter-plan programs (BlueCard® host) or Medicare Supplement.

The provisions apply to the following lines of group business administered on BCBSNC's PowerMHS claims adjudication system:

- Blue Care®
- Blue HMOSM
- Blue OptionsSM
- State Health Plan
- Classic Blue®

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

- Blue Advantage®
- Blue AssuranceSM
- AccessSM
- Short term

The statute does not apply to third parties that process claims on behalf of BCBSNC, including, but not limited to, claims for mental health services processed by Magellan Behavioral Health, claims for pharmacy services processed by Merck-Medco Managed Care LLC., and claims for dental services processed by Dental Benefit Providers, Inc., or ACS Benefit Services, Inc.

Methods of disclosure

BCBSNC uses the following primary means of communicating our claim submission policies:

1. The **Blue Book**SM Provider eManual: this provider e-manual provides comprehensive information to assist BCBSNC network participating health care

providers with effectively administering our BCBSNC products. The e-manual is given to providers when they join a BCBSNC network and is maintained on the BCBSNC Web site for providers at <http://www.bcbsnc.com/providers/>. The 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**SM 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 BCBSNC Web site at <http://www.bcbsnc.com/providers/>, or by using **Blue e**SM. In the event that a provider experiences difficulty accessing or opening the **The Blue Book**SM from our Web site, or if the provider is a **Blue e**SM user and needs assistance with **The Blue Book**SM viewing, providers are requested to please contact their local Network Management field office (field office contact information is available in chapter two of this e-manual). Additionally, providers without access to the BCBSNC Web site or **Blue e**SM are requested to contact their local Network Management field office to receive a copy of the e-manual in another format.

2. **Blue Link**SM: The BCBSNC provider newsletter provides updated information when we change our policies and procedures. Our provider newsletters are available on the providers section of our Web site, [bcbsnc.com](http://www.bcbsnc.com).
3. **bcbsnc.com**: The providers section of our Web site offers access to our medical policies and our electronic claim submission policies, and important news. The important news section of our Web site offers providers information regarding changes in our policies, BCBSNC initiatives, and general updates and news about BCBSNC topics that may affect their business interactions with us. Through the **Blue e**SM portal we offer access to Clear Claim Connection (C-3), a tool that helps providers and their office staff understand better, how claims are reviewed for adjudication on the PowerMHS system.
4. **Provider notice**: As outlined in our provider agreements, we may also send to providers, written notice of changes in our claim submission policies.



Disclosure type	BCBSNC policy	Policy availability
General claim submission	The Blue Book SM Provider Manual: <ul style="list-style-type: none"> • Chapter five, The BlueCard[®] program • Chapter nine, Claims 	The Blue Book SM Provider eManual available on the BCBSNC Web site at http://www.bcbsnc.com/providers/ . If you need assistance obtaining from the Web site, please contact your local Network Management field office. For a list of our Network Management offices, please see chapter two of this e-manual.
Electronic claims	HIPAA companion guide	The providers section of the BCBSNC Web site, bcbsnc.com , under electronic solutions and HIPAA at https://www.bcbsnc.com/providers/edi/hipainfo.cfm
	Blue e SM instructions	The providers section of the BCBSNC Web site, bcbsnc.com , under electronic solutions and Blue e SM at https://www.bcbsnc.com/providers/edi/bluee.cfm
	RealMed instructions	Instructions have been provided to all registered users of RealMed. Your local RealMed representative can provide you with information on how you may receive these instructions and ongoing updates.
Claims bundling and other claims editing processes	Administrative medical policy: <ul style="list-style-type: none"> • Bundling guidelines 	The providers section of our Web site, bcbsnc.com under medical policy at https://www.bcbsnc.com/services/medical-policy/ . If you need assistance obtaining from the Web site, please contact your local Network Management field office. For a list of our Network Management offices, please see chapter two of this e-manual.
	The Blue Book SM Provider Manual: <ul style="list-style-type: none"> • Chapter nine, Claims 	The Blue Book SM Provider Manual available on the BCBSNC Web site at http://www.bcbsnc.com/providers/ . If you need assistance obtaining from the Web site, please contact your local Network Management field office. For a list of our Network Management offices, please see chapter two of this e-manual.

Continued on the following page.



Disclosure type	BCBSNC policy	Policy availability
<p>Claims bundling and other claims editing processes (continued)</p>	<p>Clear Claim Connection* (C-3) (for CMS-1500 professional claims)</p>	<p>Through the Blue eSM portal, available free to BCBSNC contracting providers at https://providers.bcbsnc.com/providers/login.faces. Providers not already signed up for Blue eSM are encouraged to contact their local eSolutions field representative or sign up through the Web at https://www.bcbsnc.com/providers/edi/bluee.cfm#signup. Chapter two of this e-manual contains contact information for your eSolutions local field representative. If you need assistance obtaining from the Web site, please contact your local Network Management field office. For a list of Network Management offices, please see chapter two of this e-manual.</p>
<p>Recognition or non-recognition of CPT modifiers</p>	<p>Administrative policy:</p> <ul style="list-style-type: none"> • Modifier guidelines 	<p>The providers section of our Web site, bcbsnc.com under medical policies at https://www.bcbsnc.com/services/medical-policy/. If you need assistance obtaining from the Web site, please contact your local Network Management field office. For a list of our Network Management offices, please see chapter two of this e-manual.</p>
<p>Payment based on relationship of procedure code to diagnosis code</p>	<p>The Blue BookSM Provider eManual:</p> <ul style="list-style-type: none"> • Chapter nine, Claims 	<p>The Blue BookSM Provider Manual available on the BCBSNC Web site at http://www.bcbsnc.com/providers/. If you need assistance obtaining from the Web site, please contact your local Network Management field office. For a list of our Network Management offices, please see chapter two of this e-manual.</p>

Continued on the following page.



Disclosure type	BCBSNC policy	Policy availability
Other reimbursement policies	BCBSNC medical policies (including but not limited to the following): <ul style="list-style-type: none"> • Clinical trial services for life threatening conditions • Investigational (experimental) services • Medical necessity 	The providers section of our Web site, bcbsnc.com under medical policy at https://www.bcbsnc.com/services/medical-policy/ . If you need assistance obtaining from the Web site, please contact your local Network Management field office. For a list of our Network Management offices, please see chapter two of this e-manual.

* Clear Claim Connection (C-3) is a Web-based code auditing reference tool designed to mirror how ClaimCheck code auditing process, used by BCBSNC, evaluates code combinations during the auditing of claims. Clear claim connection is a tool that indicates only:

- 1) how combinations of codes (including modifiers) will be bundled and/or unbundled; and
- 2) whether the codes are in conflict with the age and gender information that is entered. Edits that occur in the PowerMHS system, outside of ClaimCheck and are not disclosed by clear claim connection. For more information on the additional edits, see BCBSNC’s reimbursement policy entitled code bundling rules not addressed in ClaimCheck at <https://www.bcbsnc.com/services/medical-policy/>.

Additionally, clear claim connection does not take into account many of the circumstances and factors that may affect adjudication and payment of a particular claim, including, but not limited to, a member’s benefits and eligibility, the medical necessity of the services performed, the administration of BCBSNC’s healthcare management & operations program, the provisions of the provider’s contract with BCBSNC, and the interaction in the claims adjudication process between the services billed on any particular claim with services previously billed and adjudicated.

9.4 Health coaching and intervention requirements

Please refer to chapter seven, Healthcare management & operations for instructions on certifications and prior review for BCBSNC membership.

Please note the following two exceptions:

- BlueCard®: For certification requirements for BlueCard® members, please contact the member’s Blue Cross and/or Blue Shield health care plan as described in chapter five, The BlueCard® program of this e-manual.

9.5 Mental health and substance abuse services claims

Note to the reader: Providers are encouraged to review information about our mental health and substance abuse management programs located in chapter seven of this e-manual in advance of providing services.

Claims for HMO and POS members, BCBSNC delegates claims processing for mental health and substance abuse services to Magellan Behavioral Health. For information on where to submit claims to Magellan Behavioral Health, see chapter two, Quick contact information.

Claims for PPO and CMM members, BCBSNC processes mental health and substance abuse claims. All claims should be submitted to BCBSNC according to the guidelines provided in chapter two, Quick contact information.

Providers servicing member’s in the Federal Employee Program can find additional information about mental health and substance abuse administration in chapter four of this e-manual.



9.6 General filing requirements

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

- For fastest claims processing, file electronically! If you're not already an electronic filer, please visit BCBSNC electronic solutions on the Web at <http://www.bcbsnc.com/providers/edi/> and find out how you can become an electronic filer.
- Submit all claims within 180 days.
- Do not submit medical records unless they have been requested by BCBSNC.
- If BCBSNC is secondary and you need to submit the primary payer Explanation of Payment (EOP) with your paper claim, do not paste, tape or staple the explanation of payment to the claim form.
- Always verify the patient's eligibility via the HIPAA 270 inquiry, **Blue eSM**, RealMed or the Provider Blue LineSM. 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 LineSM at **1-800-214-4844**. To find out more about your electronic options, visit BCBSNC electronic solutions on the Web at <http://www.bcbsnc.com/providers/edi/>, or refer to chapter eleven 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 three, Health care benefit plans and member identification cards.
- File under the member's given name, not his or her nickname.
- Watch for inconsistencies between the diagnosis and procedure code, sex and age of the patient.
- Use the appropriate provider/group NPI(s) that matches the NPI(s) that is/are registered with BCBSNC, for your health care business.
- If you are a paper claims filer that has not applied or received an NPI, or if you have not yet registered your NPI with BCBSNC, claims should be reported with your BCBSNC assigned provider number (and group number if applicable).
 - ‡ Remember that a distinct number is assigned for different specialties.

- ‡ Refer to your BCBSNC welcome letter to distinguish the appropriate provider number for each contracted specialty.
- ‡ If your provider number has changed, use your new number for services provided on or after the date your number changed.
- ‡ Terminated provider numbers are not valid for services provided after the assigned end date.
- BCBSNC cannot correct claims when incorrect information is submitted. Claims will be mailed back.
- You are required to follow BCBSNC's claim filing guidelines stated in this provider e-manual. In the absence of specific BCBSNC requirements regarding coding, you are required to follow the general coding guidelines that are published by the issuer of the coding methodology utilized. For example, for CPT code filings, you must file the most accurate CPT codes specific to the services rendered.
- BCBSNC does not cover investigational (or cosmetic) services and will not reimburse for any services, procedures or supplies associated with those investigational (or cosmetic) services.
- Beginning September 1, 2009, all 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 (08-05) claim forms

- All professional claims must be filed on a CMS-1500 (08-05) claim form or the equivalent.
 - ‡ If filling on paper, you get the fastest turnaround time of reimbursement to you by using the red and white CMS-1500 (08-05) claim form.
- Once you have registered your NPI with BCBSNC, you must include your NPI on each subsequent claim submission to us.
 - ‡ If you have not obtained or registered your NPI with us, your BCBSNC assigned provider number must be reported on each paper claim submission
 - ‡ If your physician or provider number changes, use your new number for services provided on or after the date your number was changed.
 - ‡ The tax ID number must correspond to the NPI or provider number filed in field 33.



- Claims will be rejected and mailed back to the provider if the NPI number that is registered with BCBSNC or the BCBSNC assigned provider number is not listed on the claim form.
 - ‡ Once a provider has registered their NPI information with BCBSNC and BCBSNC has confirmed receipt, claims must be reported using the NPI only and the provider's use of the BCBSNC assigned provider number must be discontinued.
 - When submitting an accident diagnosis, include the date that the accident occurred in field 14.
 - File supply charges using HCPCS health service codes. If there is no suitable HCPCS code, give a complete description of the supply in the shaded supplemental block of field 24.
 - If you are billing services for consecutive dates (from and to dates), it is critical that the units must be accurately reported in field 24G.
 - Include drug name, NDC #, and dosage in field 24.
 - ‡ Please note that the supplemental area of field 24 is for the reporting of NDC codes. Report the NDC qualifier "N4" in supplemental field 24a followed by the NDC code and unit definition (UN = unit; GR = gram; ML = milliliter; F2 = international unit).
 - Please note that fields 21 and 24e of the CMS-1500 (version 08-05) claim form are designated for diagnosis codes and pointers/reference numbers. Only four diagnosis codes may be entered into block 24e. Any paper CMS-1500 paper claim form submitted with more than four diagnosis codes or pointers/reference numbers will be mailed back to the submitting provider.
- ### Requirements for institutional UB-04 claim forms
- All claims must be filed electronically using the HIPAA 837 transaction.
 - ‡ If filling on paper, the red and white printed version must be used.
 - For 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 admit 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 48/96 hours
 - Do not file new charges until the new rates have been accepted by BCBSNC.
 - ‡ Rate negotiations for hospital agreements may continue beyond the hospital's new fiscal year. Our claims processing system is not updated with new rates until an agreement is reached between the hospital and BCBSNC. We will notify you when the claims processing system is updated and ready to receive claims at the new reimbursement rates.
 - ‡ Verify the status of rate negotiations with your finance department before filing claims at the beginning of each new fiscal year, including admissions that continue into the new fiscal year.
 - ‡ Do not submit claims with proposed or new charges until advised by BCBSNC.
 - ICU charges must be itemized on a separate line (i.e. nursing increments, equipment, room rate).
 - Plan codes are not required on claims. However if incorrect plan codes are submitted, the claims will error out.
 - Revenue codes for room and board must match the agreed upon room rate.
 - Bill full charges not BCBSNC rates.
 - The primary surgical procedure code must be listed in the principle procedure field locator 74.
 - ‡ ICD-9 code required on inpatient claims when a procedure is performed.
 - ‡ Field locator 74 must not be populated when reporting outpatient services.
 - Do not submit a second/duplicate claim without checking claim status first on **Blue eSM**.
 - ‡ Providers must allow 30 days before inquiring on claim status via **Blue eSM**.
 - ‡ Please wait 45 days before checking claim status through the Provider Blue LineSM.
 - 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, Federal Employee Program and NC Health Choice claims are excluded).
 - ‡ You will be notified via the Explanation of Payment, (EOP), that ER services should be submitted using a bill type 13J.



9.7 Electronic claims filing

The best way to submit claims to BCBSNC is electronically. Electronic claims process faster than paper claims and save on administrative expense for your health care business. For more information about electronic claims filing and other capabilities, please refer to chapter eleven of this e-manual, Electronic solutions, or visit BCBSNC eSolutions on the Web at <http://www.bcbsnc.com/providers/edi/>.

9.8 Claims filing addresses

Please see chapter two of this e-manual (Quick contact information) for mailing instructions for medical health care claims, mental health/substance abuse service claims, and chiropractic care claims.

9.9 Claim filing time limitations

File all claims within 180 days. Institutional/facility claims must be submitted within 180 days of the discharge date.

For State Health Plan PPO members, you are to file all claims within 18-months from the date services were rendered. Institutional/facility claims must be submitted within 18-months of the discharge date.

For FEP claim filing time limitations, see chapter four, section 4.12.4.

9.10 Verifying claim status

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

1. Check claim status from your desk top computer using the HIPAA 276 inquiry, RealMed or **Blue eSM**. **Blue eSM** enables users to verify the status of all claims, including BlueCard[®] and FEP claims. Providers without **Blue eSM** access can call the Provider Blue LineSM at **1-800-214-4844**. To find out more about **Blue eSM**, RealMed and other electronic options visit BCBSNC electronic solutions on the Web at <http://www.bcbsnc.com/providers/edi/>, or refer to chapter eleven of this e-manual.

2. Complete a provider claim inquiry form, (see chapter twenty-two, Forms), and mail it to:
**Blue Cross and Blue Shield of North Carolina
Customer Service Department
PO Box 2291
Durham, NC 27702-2291**

9.11 Incomplete claims

If information necessary to process a claim is missing from the claim form, we will mail the Notification of Payment (NOP) to you requesting submission of additional information or you will receive a provider claim mailback form (see chapter twenty-two, Forms) along with the claim. You should respond as quickly as possible to a request for additional information in order to expedite the processing of the claim.

Professional claims that are electronically submitted, which contain errors, are documented on the provider error report or online via the **Blue eSM** interactive network. You should work your error report daily and resubmit those claims electronically.

Institutional/facility claims that are electronically submitted, which contain errors, are documented on the UB-04 provider error report or online via the **Blue eSM** interactive network. You should work your error report daily and re-submit those claims electronically.

If an institutional/facility claim is for services related to a clinical trial, you should submit the signed informed consent and the clinical protocols.



9.12 Corrected claims and mailbacks

9.12.1 Definitions

Corrected claim:

- In general, a corrected claim is any claim for which you have received a Notification of Payment (NOP)/Explanation of Payment (EOP), and for which you need to make corrections on the original submission. Corrections can be additions (e.g., late charges), a replacement of the original claim, or a cancellation of the previously submitted claim.

If you received an EOP with any of the following codes, **please do not submit a corrected claim**. Submit a **new claim** to allow the claim to be correctly processed.

The following codes apply to claims processed on the Power MHS system

EM0	Incorrect place of service for service.
EM1	Claim denied for invalid procedure code. Please resubmit correct procedure code.
EM2	Claim denied. Please resubmit procedure code for which anesthesia was provided.
EM3	Claim has been mailed back for additional information.
EM4	Claim submitted with incorrect or inactive provider or group number. Please resubmit claim with a correct provider or group number.
EM5	Resubmit split billing for authorized days.
EM6	Services for newborn need to be split into two claims. For normal delivery, split for 48 hours and for c-section, split for 96 hours. Resubmit as two claims.
EM8	Our records indicate for the date of service filed, the individual provider was not part of the group's practice. Please resubmit claim with an active provider or group number.
EM9	Claim denied for incorrect bill type for service(s) rendered. Please resubmit with correct bill type.

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 DCN query. Complete appropriate mailback form, attach to claim and return to responsible party.
M4	Need valid provider number
M5	Split days for approved/non-approved authorizations
M6	Split 48/96 hours newborns
M8	Provider not linked with vendor
M9	Incorrect bill type for service(s). Resubmit with correct bill type.



Mailback:

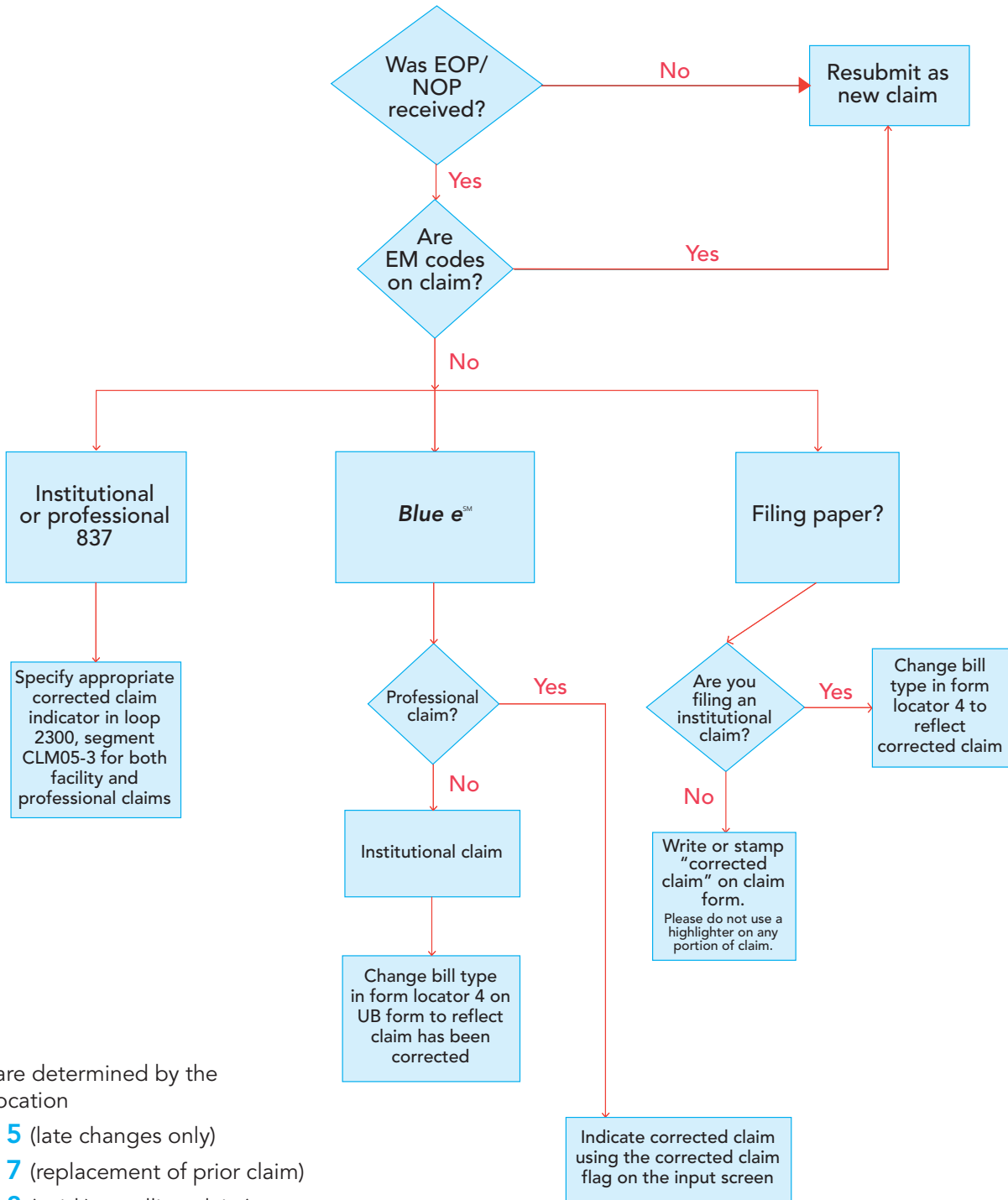
- In general, claims mailed back to you have not been logged into our claims processing systems. We were unable to successfully enter the claim because of missing, incomplete or invalid information. The claim is being returned to you to complete the missing, incomplete or invalid information. In these situations, you must submit a new claim. For 837 mailbacks, you will only receive a mailback form, not a copy of the claim.

Corrected claim	Mailback
<p>Electronic submission</p> <p>HIPAA compliant 837 claims</p> <ul style="list-style-type: none"> • 837 institutional claim Specify appropriate corrected claim indicator** in loop 2300, segment CLM05-3. • 837 professional claim Specify appropriate corrected claim indicator** in loop 2300, segment CLM05-3. <p>**837 corrected claim indicators:</p> <ul style="list-style-type: none"> ‡ 5 – Late charges only ‡ 7 – Replacement of a prior claim ‡ 8 – Void or cancel claim 	<p>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.</p>
<p>Electronic Blue e™ - institutional only</p> <ul style="list-style-type: none"> • Change bill type in form locator four (4) on the UB claims entry screen to reflect that it is a corrected claim. <p>Paper</p> <ul style="list-style-type: none"> • Facility paper claim Change bill type in form locator four (4) to reflect claim has been corrected. • Facility and professional paper claim Write or stamp corrected claim on the top of the claim form.*** <p>*** Please do not use a highlighter on any portion of the corrected claim.</p>	<p>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.</p>



9.12.2 Figure 1 - corrected claims and mailback process flow

Corrected claims and mailbacks



Bill types

Bill types are determined by the 3rd digit location

Bill type = **5** (late changes only)

Bill type = **7** (replacement of prior claim)

Bill type = **8** (void/cancelling claim)



Bill Type Indicators:

- When the 3rd digit of the bill type is five (5 [late charges-only claim]), please only submit the late charges.
- When the 3rd digit of the bill type is seven (7 [replacement of prior claim]), you should submit the original charges plus the new charges.
- When the 3rd digit of the bill type is eight (8 [void or canceling claim]), you should void or cancel claim.

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

Please make sure that facility claims have been filed with a bill type that indicates corrected or adjusted billing. We may deny or return these claims back to your facility if it is determined that the claim should have been filed as a corrected claim. You can file a corrected claim either electronically or by mail.

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.

9.12.3 Tips for corrected claims

- You can correct a claim in one of the following ways:
 1. File a corrected facility claim electronically, or key the corrected UB-04 claim via **Blue eSM**, being sure to change the bill type in form locator four.
 2. Providers who file claims using the HIPAA compliant 837 corrector claim format (professional and institutional) can submit corrected claims electronically.
 3. File a paper UB-04 claim, changing the bill type in form locator four. Do not use a highlighter on any portion of the re-filed claim.
 4. For CMS-1500 forms, stamp corrected claim across the top of the claim form. Corrected claims should be mailed to:

**Blue Cross and Blue Shield of North Carolina
Claims Department
P.O. Box 35
Durham, NC 27702**

- Remember that the corrected claim replaces the original claim. Please do not attach the original claim with the corrected claim(s).
- When filing a corrected claim, submit all charges that were on the original claim rather than just the charge that has changed. If only one charge is resubmitted, it will appear that you intend to remove all previously processed charges and a refund will be requested for previously paid amounts.
- Please submit all charges that are to be considered for payment. If you are removing charges, there is no need to submit a zero charge line to indicate you have removed the charge. Indicate the change by not placing the charge on the corrected claim.
- When submitting late charges only (bill type five [5]), please only submit the late charges.

9.12.4 Mailbacks

In general, claims mailed back to you have not been logged into our claims processing systems. We were unable to successfully enter the claim because of missing, incomplete or invalid information. The claim is being returned to you to complete the missing, incomplete or invalid information. In these situations, you must submit a new claim. Please do not mark these claims as corrected.

- For 837 mailbacks, you will only receive a mailback form, not a copy of the claim.

9.12.5 How to avoid claim mailbacks

Claim mailbacks cause additional work for your organization, as well as delay processing of the claims. When filing claims, make sure the information on your claim is complete and accurate.

We may deny or mailback claims if it is determined that the claim should be filed as a new claim.

The top reasons claims are mailed back are listed below:

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



If you receive a claim mailback form with your returned claim, do not provide the missing information on the mailback form. Please make corrections to the claim and resubmit as a new claim without marking it corrected. If you file electronically, make the corrections and resubmit the claim electronically. Electronic filing reduces processing time.

9.12.6 Mailback claims tips

In general, claims mailed back to you cannot be successfully logged into our claims processing system(s) due to incomplete or invalid information. The claim cannot be processed until all information is submitted.

If a claim is mailed back to you for any reason:

- Make the necessary corrections in your billing system
- Resubmit it as a new claim (electronically, if possible)
- Do not mark the resubmission as a corrected claim

Since a new claim is needed, please do not return the mailback form with your corrections. The mailback form does not contain sufficient information to process a claim.

9.13 Billing BCBSNC members

Participating providers agree not to bill BCBSNC members for services until receipt of the BCBSNC Explanation of Payment (EOP) 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 BCBSNC Explanation of Payment (EOP) 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 Explanation of Payment (EOP) from BCBSNC (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 9.15 of this chapter (upfront collection for deductible and coinsurance-only products).

- A service that BCBSNC verifies as non-covered for a specific member; may be billed to the member, when the provider has advised the member in advance of providing the service that the service will be non-covered and the member has agreed to pay the provider, under the conditions specified within the hold harmless provision of the provider's agreement with BCBSNC. For additional details about the hold harmless provision, please refer to your agreement with BCBSNC or see section 9.16 of this chapter (Hold harmless provision).

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 Explanation of Payment (EOP) from BCBSNC, your discovery of the error, or other form of notification.

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

Providers may not bill or otherwise hold members responsible for payment for services, which are deemed by BCBSNC to be out of compliance with BCBSNC healthcare management & operations programs and policies or medical necessity criteria or are otherwise non-covered, except as outlined within this chapter's (chapter nine) instructions for billing members as a non-network provider.

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

9.13.2 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 BCBSNC. All medical services, administrative services related to prescription refills, and administrative fees associated with providing these administrative services should be billed when applicable as a properly coded claim to BCBSNC.



A provider may charge a fee for administrative services related to but not limited to filling out forms and preparation for FMLA, disability or services not related to BCBSNC benefit plans.

9.13.3 Billing members as a non-network provider

If a provider is participating only in BCBSNC's Comprehensive Major Medical (CMM) (indemnity) insurance plans and provides covered services to an HMO, POS or PPO member, the provider must wait to receive a Notification of Payment (NOP) or Explanation of Payment (EOP) prior to billing the member any coinsurance or deductible amounts. In addition, the member may only be billed for the difference between the amount paid by BCBSNC and the agreed upon allowable charge under the provider's CMM participation agreement with BCBSNC. Providers may not bill members up to their charge.

9.13.4 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 BCBSNC. 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 BCBSNC. The member signs a written acknowledgment that he/she received such notification prior to receiving the specific service at issue. The member acknowledges in advance and in writing that he/she has 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. 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 9.16 for additional details about the hold harmless provision or refer to your provider agreement with BCBSNC).

Service specific waivers may not be utilized as a method to request payment from members for services that require prior authorization from BCBSNC, 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 BCBSNC 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 eSM** or by calling the Provider Blue LineSM at **1-800-214-4844** (see chapter two, Quick contact information). Please note that confirmation of benefit eligibility does not guarantee payment as other factors may affect payment (e.g., BCBSNC healthcare management & operations programs and/or medical necessity).

9.14 Copayments

9.14.1 Services covered with an office visit copayment

- For BCBSNC 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 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 BCBSNC deductible and coinsurance-only products, all services are subject to deductible and coinsurance amounts as specified in section 9.15 of this chapter (upfront collection for deductible and coinsurance-only products).

9.14.2 When to collect an office visit copayment

- A copayment is collected when you charge for an office visit using an Evaluation and Management (E/M) code, surgery in the office, second surgical opinion, or consultation service.
- 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 eSM**, or by calling the Provider Blue LineSM at **1-800-214-4844**.



9.14.3 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.

9.14.4 Note the following with respect to office visit copayments

- Only one 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 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 provider, on the same date of service, must be filed as a single claim and not split into two separate claim submissions.

- OB/GYNs should always collect the primary office visit copayment for BCBSNC copayment products.

9.15 Upfront collection for deductible and coinsurance-only products

For any Blue OptionsSM deductible and coinsurance-only product (non-copayment products), BCBSNC's in-network providers (including physicians, professional providers, hospitals and ancillary providers) may collect an estimated amount from members at the time of service for the member's out-of-pocket costs, as described within this section. 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 OptionsSM deductible and coinsurance-only product (including Blue Options HRASM and Blue Options HSASM).

- 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, RealMed, **Blue eSM**, or BCBSNC customer service. Please note that 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 BCBSNC's receipt and processing of the claim.

9.15.1 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 of the BCBSNC Blue OptionsSM 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 BCBSNC 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 (BCBSNC 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 BCBSNC 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 eSM** and/or RealMed.
- Utilize and take into consideration C-3 bundling logic and BCBSNC 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 BCBSNC, and only amounts reflected on the final EOP (Explanation of Payment) from BCBSNC as member responsibility.
- Any applicable refund for overpayment owed to a member will be issued as soon as identified, but no later than 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 BCBSNC Explanation of Payment (EOP) 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 BCBSNC EOP).

‡ 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 BCBSNC EOP.

• 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 BCBSNC EOP. Additionally, members should not be sent a final bill until after receipt of the BCBSNC EOP.

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

Member 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. BCBSNC requests participating providers to honor these special requests and collect according to the specified amounts.

BCBSNC 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 BCBSNC indicating the correct amount to be collected. However, providers following the guidelines contained here (section 9.15.1 Blue OptionsSM guidelines for upfront collection of member liability), may elect to request estimated amounts from members not enrolled in the BCBSNC Blue OptionsSM deductible and coinsurance-only products, as long as payment is not required or a prerequisite for receiving service.



9.16 Hold harmless provision

Provider agrees not to bill or otherwise hold members, BCBSNC or any third party responsible for payment for health care services and/or supplies provided to members, which are determined by us not to be medically necessary and/or not in compliance with applicable BCBSNC healthcare management & operations programs and policies and/or not eligible under the member's benefit plan, except when the following conditions shall have been met:

- The provider obtained prior authorization or prior certification by BCBSNC in advance of providing the specific services and/or supplies to the member.
- and/or**
- The provider gave specific written notification to the member in advance of providing the non-medically necessary services or other non-covered services, explaining that such service might not be covered by BCBSNC under the member's benefit plan; and the member signed a written authorization stating that:
 - (i) The member received from the provider notification that the specific services and/or supplies may not be covered by his or her benefit plan.
 - (ii) The member received the notification prior to receiving the specific services and/or supplies.
 - (iii) The notification informed the member that the particular services and/or supplies, if not covered by BCBSNC under the member's benefit plan, are provided at the member's own expense, if the member elects to receive the specific services and/or supplies.
 - (iv) The provider obtained the member's written authorization prior to rendering the specific services and/or supplies.
 - (v) The member's authorization includes that such services and/or supplies may not be covered by his or her benefit plan and the member agrees to pay for such services and/or supplies apart from his or her benefit plan.
 - (vi) The member's authorization specifies that the member elects to receive such services and/or supplies at the member's own expense and the provider has obtained the member's written authorization.

The notification by the provider and the authorization by the member, as set forth in the agreement, shall be given regarding a particular service at issue in the specific

treatment of a member and not as a matter of general or standard procedure in all cases.

Providers agree to provide BCBSNC with a copy of any and all such written authorizations upon request.

Refer to your health care businesses' contractual agreement with BCBSNC to review your businesses' hold harmless provision and how the provision applies. If you have questions regarding your health care businesses' hold harmless provision, please contact your local BCBSNC Network Management field office (see chapter two, Quick contact information) for more information.

9.16.1 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 MA plan payment as payment in full or bill the appropriate state Medicaid agency for such amounts.

9.17 Payment guidelines

You are notified of payment guidelines via special messages on the Notification of Payment (NOP) or Explanation of Payment (EOP). For example, a special message will be created for situations in which services that are considered incidental to the primary service are not eligible for separate reimbursement.

Payment for covered services only

As set forth in providers reimbursement section of their agreement, as a participating provider, provider shall be paid by BCBSNC only for medically necessary covered services to members which are in compliance with BCBSNC's healthcare management & operations programs.

Service edits

BCBSNC reserves the right to implement service edits to apply correct coding guidelines for CPT, HCPCS, and ICD-9 diagnosis and procedure codes. Service edits are in place to enforce and assist in a consistent claim review process. The coding edits reflect BCBSNC Medical Coverage Guidelines, benefit plans, and/or other BCBSNC 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 BCBSNC for medically necessary covered services to members which are in compliance with BCBSNC's health coaching and intervention programs either:

- i) the allowed amount, minus deductible, coinsurance, and/or copayment amounts, or
- ii) provider's accepted charge minus deductible, coinsurance, or copayment amounts;

whichever is less. The allowed amount shall be determined in accordance with the following subsections of the provider's reimbursement section of the agreement regarding provider participation and payment.

BCBSNC is establishing reimbursement rates for a limited group of service/procedure codes (primarily supply and drug codes). These codes were previously unpriced by BCBSNC because pricing from external sources (such as Medicare or St. Anthony's) was unavailable at the outset of provider contracting.

Since external source pricing is now available for many of these codes, BCBSNC has notified providers of the application of a pricing procedure that will price these codes consistent with the reimbursement level in your fee schedule for codes in the same range.

Effective April 1, 2005, BCBSNC makes revisions to the reimbursement for the above-referenced service/procedure codes according to the methodology listed in the following section of this 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 your local BCBSNC Network Management office.

9.18 BCBSNC policy for pricing professional claims billed on form CMS-1500

(how to identify the correct policy for your professional charges)

BCBSNC policy for pricing claims can vary based upon a provider's individual or group affiliated agreement with BCBSNC, under which payment consideration is made for a particular claim for service. Participating providers can easily identify the pricing policy that applies for their

professional services, by referencing their individual health care business's participation agreement with BCBSNC for review of its reimbursement exhibit:

- If you're participating with BCBSNC 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 BCBSNC on the CMS-1500 claim form (see section 9.18 of this e-manual).
- If your agreement with BCBSNC 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 BCBSNC on the CMS-1500 claim form (see section 9.18 of this e-manual).

9.18.1 Fee schedules in *Blue e*SM

BCBSNC provides fee schedule information to participating physicians electronically as of the 2nd quarter 2009.

Participating physicians with access to *Blue e*SM have the ability to view their fee schedule through a new transaction located in *Blue e*SM. Participating physicians who do not have internet access, or who wish to view a special or supplemental fee schedule, may contact their Network Management service representative to request either a CD or hard copy of the fee schedule.

Providers not yet signed up for *Blue e*SM access will not be able to view their fee schedule information via *Blue e*SM until they are enrolled in *Blue e*SM. Providers are encouraged to sign up today! Enrollment is easy; just visit <http://www.bcbsnc.com/content/providers/edi/bluee.htm>.

Providers who are already enrolled with *Blue e*SM and have questions about their fee schedule should contact their regional Network Management service representative for assistance.

BCBSNC provides fee schedule information to participating physicians electronically as of the 2nd quarter 2009.

Participating physicians with access to *Blue e*SM have the ability to view their fee schedule through a new transaction located in *Blue e*SM. Participating physicians who do not have internet access, or who wish to view a special or supplemental fee schedule, may contact their Network Management service representative to request either a CD or hard copy of the fee schedule.



Providers not yet signed up for **Blue eSM** access will not be able to view their fee schedule information via **Blue eSM** until they are enrolled in **Blue eSM**. Providers are encouraged to sign up today! Enrollment is easy; just visit <http://www.bcbsnc.com/content/providers/edi/bluee.htm>.

Providers who are already enrolled with **Blue eSM** and have questions about their fee schedule should contact their regional Network Management service representative for assistance.

If after review of your health care business's participation agreement with BCBSNC and your fee schedule information in **Blue eSM**, you are unsure about which pricing policy applies to your professional charges, please contact your regional Network Management representative for assistance.

9.18.2 Pricing policy for procedure/service codes (applicable to all HMO and PPO products) effective April 1, 2005, revised January 1, 2007, revised July 1, 2008

The following policy applies to BCBSNC's payment to contracted providers for procedure/service codes billed on a CMS-1500 or successor claim form.

Previously priced codes

If a price was formally established in your fee schedule based on then-available external source pricing, that pricing will remain in place unless otherwise changed in accordance with your contract or this policy.

General pricing policy

When new CPT/HCPCS codes are published, and an external pricing source exists for such codes, BCBSNC will price these codes in the following manner:

- If available, the most current NC Medicare pricing will be applied to that code. The percentage of such NC Medicare pricing that is applied to the new code will be matched to the percentage that was initially applied to establish your fee schedule for codes in the same range of codes.
- The most current NC Medicare pricing means that pricing in place on the date the code was first eligible for use. If NC Medicare revises the pricing or allowable pricing for any new code retroactive to the date the code was first eligible for use, BCBSNC will review your fee schedule for that code (or codes) within 30 days of the NC Medicare publishing of the revised pricing or allowable pricing. BCBSNC 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 BCBSNC's loading of your revised fee.

- ‡ If NC Medicare pricing is unavailable, BCBSNC will apply the most current Ingenix RVU pricing, using the same methodology described above, to establish your fee schedule.
- For durable medical equipment, prosthetics/orthotics and supplies, the NC DMEPOS fee schedule will be used in place of the above-referenced external pricing sources.
- Drug CPT and HCPCS codes will be priced as outlined below.
- Upon initial pricing of a code as described above, that pricing will remain in place unless otherwise changed in accordance with the terms of your contract or this policy.
 - ‡ Thereafter, on an ongoing basis and within 120 days of the publishing of each new external source pricing, BCBSNC will repeat the above procedure for previously unpriced codes.
- BCBSNC reimburses the lesser of your charge or the applicable pricing in accordance with your contract and this policy.
- Nothing in this policy will obligate BCBSNC to make payment on a claim for a service or supply that is not covered under the terms of the applicable benefit plan. Furthermore, the presence of a code and allowable on your sample fee schedule does not guarantee payment.

External source pricing

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

- NC Medicare pricing
 - ‡ Available at www.cignagovernmentservices.com/partb/index
- Ingenix *The Essential RBRVS*
 - ‡ Available at www.ingenixonline.com
- NC DMEPOS fee schedule
 - ‡ Available at www.cms.hhs.gov/DMEPOSFeeSched/

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



Payment of remaining unpriced codes

Procedure/service codes that remain unpriced after each application of the above procedure will be paid in the interim at the lesser of your charge or the 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 12-month period for which complete data has been received and entered into BCBSNC's claim system. If a NC statewide average charge cannot be determined due to limited claims data, BCBSNC will assign a fee to the service that will be the lesser of your charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable providers for similar services under a similar health benefit plan. BCBSNC's methodology is based on several factors including BCBSNC's payment guidelines and reimbursement policy as described in The **Blue Book**SM, and pricing and adjudication principles for professional providers as described on our medical policy Web site. Under these guidelines, some procedures charged separately by you may be combined into one procedure for reimbursement purposes.

Drug CPT and HCPCS codes

These codes are priced based on a percentage of Average Wholesale Prices (AWPs). A national drug-pricing vendor determines AWPs, and the AWP methodology is as follows:

- For a single-source drug or biological, the AWP equals the AWP of the single-source product. For a multi-source drug or biological, the AWP is equal to the lesser of the median AWP of all the generic forms of the drug or biological or the lowest brand name product of the AWP. A "brand name" product is defined as a product that is marketed under a labeled or proprietary name that may be different than the generic chemical name for the drug or biological. AWPs will be subject to quarterly changes (January 1st, April 1st, July 1st, October 1st) based on national vendor data.
- In the event that new external source pricing generally acceptable in the industry and acceptable to BCBSNC becomes available (e.g., average sales price to determine reimbursement for drug CPT and HCPCS codes), such external source pricing may be incorporated by BCBSNC into this procedure.
- Our specialty pharmacy drugs are priced according to our standard fee schedule. The current list of specialty pharmacy drugs is available at **bcbsnc.com**. Please see the "Injectable drug network: availability" link in the "I'm a provider" section. The list also includes the next quarterly update (January 1st,

April 1st, July 1st, October 1st). Please contact your local Network Management office to obtain fee schedule amounts for specialty pharmacy drugs.

Policy on payment based on charges (applies to all products)

When application of BCBSNC's reimbursement procedures results in payment of a given claim based on your charge or a percentage of your charge, you are obligated to ensure that: (1) all charges billed to BCBSNC are reasonable; (2) all charges are consistent with your fiduciary duty to your patient and BCBSNC; (3) 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 (applies to all products)

If a general code (e.g., 21499, unlisted musculoskeletal procedure, head) or unlisted code is filed because a code specific to the service or procedure is non-existent, BCBSNC will assign a fee to the service which will be the lesser of your charge or a reasonable charge established by BCBSNC using a methodology which is applied to comparable providers for similar services under a similar health benefit plan. BCBSNC's methodology is based on several factors including BCBSNC's payment guidelines and reimbursement policy as described in The **Blue Book**SM, and pricing and adjudication principles for professional providers as described on our medical policy Web site. Under these guidelines, some procedures charged separately by you may be combined into one procedure for reimbursement purposes. BCBSNC may use clinical judgment to make these determinations, and may use medical records to determine the exact services rendered.

Some codes that are listed as specific codes in the CPT/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 BCBSNC 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. BCBSNC will not pay more than 100% of the respective charge for these claims.

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



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

9.18.3 Pricing development and maintenance policy for network fee schedules based upon 2008 North Carolina Medicare

This pricing development and maintenance policy (2008 pricing policy) applies to Blue Cross and Blue Shield of North Carolina's (BCBSNC'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.

Drug services

1. Drug service fees will be updated on a calendar quarter basis.
2. Fees will be determined based upon the following hierarchy and criteria:
 - a. 100% of BCBSNC specialty pharmacy
 - b. 110% of CDC private sector price¹
 - c. 100% of North Carolina Medicare Part B drug fee schedule
 - d. 105% of wholesale acquisition cost
 - e. 95% of average wholesale price
 - f. Individual consideration
 - g. 75% of your reasonable charge

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) services

1. DMEPOS service fees will be updated on a calendar year basis.
2. Fees will be determined based upon the following hierarchy and criteria:
 - a. 100% of North Carolina Medicare DMEPOS fee schedule
 - b. 100% of Ingenix
 - c. 110% of invoice cost

1. All vaccines contained on the CDC price list will be cross-walked to a CPT code. If more than one CDC listed brandname/tradename vaccine maps to a single CPT code, BCBSNC 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 private sector cost/dose for a particular brandname/tradename vaccine, BCBSNC will apply the lowest private sector cost/dose price when determining the fee.

In-office laboratory services

1. 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 BCBSNC with evidence of your CLIA certification.
2. In-office laboratory services fees will be updated on a calendar year basis.
3. Fees for CLIA excluded, CLIA waived or provider performed microscopy procedure services will be determined based upon the following hierarchy and criteria:
 - a. 100% of North Carolina Medicare clinical lab fee schedule
 - b. 100% of North Carolina Medicare Part B physician fee schedule
 - c. 100% of Ingenix
 - d. Individual consideration
 - e. 75% of your reasonable charge
4. Fees for panels and chemistry services will be determined based upon the following hierarchy and criteria:
 - a. 45% of North Carolina Medicare clinical lab fee schedule
 - b. 45% of North Carolina Medicare Part B physician fee schedule
 - c. 45% of Ingenix
 - d. Individual consideration
 - e. 75% of your reasonable charge
5. Fees for hematology and immunology services will be determined based upon the following hierarchy and criteria:
 - a. 60% of North Carolina Medicare clinical lab fee schedule
 - b. 60% of North Carolina Medicare Part B physician fee schedule
 - c. 60% of Ingenix
 - d. Individual consideration
 - e. 75% of your reasonable charge



6. Fees for pathology services will be determined based upon the following hierarchy and criteria:
 - a. 90% of North Carolina Medicare clinical lab fee schedule
 - b. 90% of North Carolina Medicare Part B physician fee schedule
 - c. 90% of Ingenix
 - d. Individual consideration
 - e. 75% of your reasonable charge

Ophthalmologic exam services

1. Ophthalmologic exam service fees will be updated on a calendar year basis.
2. Fees will be determined based upon the following hierarchy and criteria:
 - a. 80% of North Carolina Medicare Part B physician fee schedule
 - b. 80% of Ingenix
 - c. Individual consideration
 - d. 75% of your reasonable charge

Other ophthalmologic services

1. Other ophthalmologic service fees will be updated on a calendar year basis.
2. Fees will be determined based upon the following hierarchy and criteria:
 - e. 100% of North Carolina Medicare Part B physician fee schedule
 - f. 100% of Ingenix
 - g. Individual consideration
 - h. 75% of your reasonable charge

Chiropractic services

1. Chiropractic service fees will be updated on a calendar year basis.
2. Fees will be determined based upon the following hierarchy and criteria:
 - a. 80% of North Carolina Medicare chiropractic fee schedule
 - b. 80% of Ingenix
 - c. Individual consideration
 - d. 75% of your reasonable charge

Physical, Occupational, Speech Therapy (PT/OT/ST) services

1. PT/OT/ST service fees will be updated on a calendar year basis.

2. Fees will be determined based upon the following hierarchy and criteria:
 - a. 70% of North Carolina Medicare Part B physician fee schedule
 - b. 70% of Ingenix
 - c. Individual consideration
 - d. 75% of your reasonable charge

Behavioral health services

1. Behavioral health service fees will be updated on a calendar year basis.
2. Fees will be determined based upon the following hierarchy and criteria:
 - a. 100% of North Carolina Medicare Part B physician fee schedule for physicians
 - b. 100% of North Carolina Medicare Part B clinical psychologist fee schedule for clinical psychologists
 - c. 100% of North Carolina Medicare Part B clinical social worker fee schedule for clinical social workers
 - d. 100% of Ingenix
 - e. Individual consideration
 - f. 75% of your reasonable charge

Other tests and miscellaneous services

1. Other tests and miscellaneous service fees will be updated on a calendar year basis.
2. Fees will be determined based upon the following hierarchy and criteria:
 - a. 100% of North Carolina Medicare Part B physician fee schedule
 - b. 100% of Ingenix
 - c. Individual consideration
 - d. 75% of your reasonable charge

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:
 - a. The percent of 2008 North Carolina Medicare Part B physician fee schedule contained in your contract with BCBSNC
 - b. The percent of 2008 Ingenix contained in your contract with BCBSNC
 - c. Individual consideration
 - d. 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 BCBSNC are reasonable; (2) all charges are consistent with your fiduciary duty to your patient and BCBSNC; (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

- If a general code (e.g., 21499, unlisted musculoskeletal procedure, head) or unlisted code is filed because a code specific to the service or procedure is non-existent, BCBSNC will assign a fee to the service which will be the lesser of 75% of your charge or a reasonable charge established by BCBSNC using a methodology which is applied to comparable providers for similar services under a similar health benefit plan. BCBSNC's methodology is based on several factors including BCBSNC's payment guidelines and reimbursement policy as described in The **Blue Book**SM, and pricing and adjudication principles for professional providers as described in the medical policy section of the BCBSNC Web site. Under these guidelines, some procedures charged separately by you may be combined into one procedure for reimbursement purposes. BCBSNC may use clinical judgment to make these determinations, and may use medical records to determine the 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 BCBSNC in the same manner as general codes, as described in the above paragraph.
- BCBSNC 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. BCBSNC 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, BCBSNC will assign the fee for the more specific code to determine the fee under BCBSNC's applicable reimbursement policies.
- BCBSNC's assignment of a fee for a given general or unlisted code does not preclude BCBSNC from assigning a different fee for a subsequent service or procedure under the same code. BCBSNC'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.

Other fee determinations

- BCBSNC reimburses the lesser of your charge or the applicable fee in accordance with your contract and this 2008 pricing policy.
- Nothing in this 2008 pricing policy will obligate BCBSNC to make payment on a claim for 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 2008 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 2008 pricing policy will be determined based upon the hierarchy and criteria applicable to the service category of the new code.
- For new "all 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).
- All "other services" codes will be reviewed annually. The fee for any code not previously determined based upon the North Carolina Medicare Part B physician fee schedule will be recalculated as if it were a new code if the fee can then be determined based upon the North Carolina Medicare Part B physician fee schedule.



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
- NC Medicare Part B drug fee schedule
- NC Medicare Part B chiropractic fee schedule
- NC Medicare Part B clinical lab fee schedule
- NC Medicare Part B clinical psychologist fee schedule
- NC Medicare Part B clinical social worker fee schedule
 - ‡ <http://www.cignagovernmentservices.com/partb/coverage/fees/index.html>
- NC DMEPOS fee schedule
 - ‡ <http://www.cms.hhs.gov/DMEPOSFeeSched/>
- BCBSNC specialty pharmacy
 - ‡ <http://www.bcbsnc.com/providers/injectable-drugs/available.cfm>
 - ‡ Please contact your local Network Management office to obtain the fee for any drug service code, which was determined by the BCBSNC specialty pharmacy criteria.
- CDC private sector price
 - ‡ <http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm>
- Wholesale acquisition cost
- Average wholesale price
 - ‡ <http://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.
- Ingenix *The Essential RBRVS*
 - ‡ <http://www.ingenixonline.com>
 - ‡ Please contact your local Network Management office to obtain the fee for any service category code, which was determined by the Ingenix criteria.

9.19 Payment based on usual, customary and reasonable (Applies to claims processed for Comprehensive Major Medical (CMM) plans based on UCR and North Carolina Health Choice for Children program)

Reimbursement to CostWise participating providers is dictated by our Usual, Customary and Reasonable (UCR) methodology, which is also outlined in the terms of your provider contract. For the most part BCBSNC has migrated claims processing away from UCR methodology, however, claims processed for CMM products and North Carolina Health Choice for Children program continue to utilize the UCR methodology.

Under usual, customary and reasonable methodology allowable benefits are based on the lesser of:

- The doctor's usual charge,
- The doctor's usual charge on record, or
- The maximum customary allowance

A percentage of the maximum allowed amount in accordance with the subscriber's contract is paid to the doctor participating in CostWise. A usual charge is the fee generally charged by an individual doctor or group practice for a particular service (i.e., the charge submitted on the CMS-1500 claim form). The usual charge on record is a computer-calculated charge, based on usual charges for an individual doctor or group practice for a particular service. Claims are reviewed every six months; approximately half of the services in April and the remainder in October. The April review is based on claims data from the previous April through December; the October review is based on claims data from the previous October through June. The usual charge on record is initially established at the accumulated 90th percentile of charges for a particular service is higher than the established usual charge on record, then the usual charge on record is based on the rise, if any, in the all-items CPI. This increase depends on whether the charge found at the accumulated 90th percentile of usual charges on record for participating doctors is higher than the established maximum customary allowance.

A reasonable charge is an amount that meets the criteria of usual and customary charges or, after appropriate peer review, is justified because of the special circumstances of a case.



A profile is the current listing of usual charges on record of an individual doctor or group practice.

Charges are put on the profile in two ways:

- By automatic review twice a year of paid claims information.
- If sufficient data is not available, by doctors notifying BCBSNC of their charges.

If benefits under UCR coverage are paid at less than the expected percentage of charges for a given service, benefits may have been based on less than the amount charged. BCBSNC is willing to review any determination it makes. Peer review consultants and/or committees representing major specialties review new, unusual, or precedent setting cases and recommend benefit allowances at the request of the subscriber, BCBSNC, or the participating doctor. The participating doctor has the opportunity to provide all pertinent information. The participating doctor is then notified of the result.

The State of North Carolina has contracted with Blue Cross and Blue Shield of North Carolina to administer the NC Health Choice for Children program. The SHP determines the discounts off UCR and providers are informed in writing of any such changes to UCR.

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 LineSM at **1-800-214-4844** to verify benefit coverage.

- Not *medically necessary*
- *Investigational* in nature or obsolete, including any service, drugs, procedure or treatment directly related to an *investigational* treatment
- Any *experimental* drug or any drug not approved by the Federal Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to prescription drugs used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:
 1. The American Medical Association drug evaluations
 2. The American Hospital Formulary Service drug information
 3. The United States Pharmacopeia drug information
- Not prescribed or performed by or upon the direction of a *doctor* or *other provider*
- For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state industrial commission or other applicable regulatory agency approving a settlement agreement.
- For *inpatient* admissions primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy.
- For care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*
- For *custodial* care, domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments or any similar facility or institution
- Received prior to the *member's effective date* or during an *inpatient admission* that began prior to the *member's effective date*, even if *inpatient* care continues beyond the *effective date* except as otherwise required by law
- Received on or after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
- For complications or side-effects arising from services, procedures or treatments excluded from coverage under this health benefit plan
- For care that the *provider* cannot legally provide or legally charge
- Provided and billed by a licensed health care professional who is in training
- Available to a *member* without charge
- For care given to a *member* by a *provider* who is in a *member's* immediate family



- For any condition suffered as a result of any act of war or while on active or reserve military duty
- In excess of the **allowed amount** for services usually provided by one **doctor**, when those services are provided by multiple **doctors**
- For cosmetic purposes except when such care is necessary for the correction of impairment caused by an injury or illness
- For routine foot care - arch supports, support stockings, corrective shoes and care for the treatment of corns, bunions (except capsular or bone surgery), calluses, toe nails (except radical surgery for ingrown nails), flat feet, fallen arches, weak feet, chronic foot strain or other symptomatic conditions of the feet
- For dental care, denture, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by your health benefit plan
- Dental services provided in a **hospital**, except when a hazardous condition exists at the same time, or covered oral **surgery** services are required at the same time as a result of bodily injury
- For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a **member** or for treatment of obesity, except for surgical treatment of morbid obesity
- Wigs, hair pieces and hair implants are typically not covered
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or **group**
- For **sexual dysfunction** unrelated to organic disease
- Treatment or studies leading to or in connection with sex changes or modifications and related care
- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- Hypnosis, acupuncture, acupressure and continuous epidural anesthesia except when used for control of chronic pain associated with terminal cancer
- **Surgery** for psychological or emotional reasons
- Travel, whether or not recommended or prescribed by a **doctor** or other licensed health care professional, except as specifically covered by a health benefit plan
- Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control or to enhance the environmental setting
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, jacuzzis, heated spas, pool or memberships to health clubs
- Vitamins, except for prescriptions for prenatal vitamins or specific vitamin deficiencies
- Eye glasses, contact lenses, or fitting for eyewear, radial keratotomy and other refractive eye **surgery**, and related services to correct vision except as specifically covered by your health benefit plan
- Treatment of developmental dysfunction and/or learning differences
- **Medical** care provided by more than one doctor for treatment of the same condition
- Take-home drugs furnished by a **hospital** or **non-hospital** facility
- Biofeedback except for the treatment of urinary incontinence and the following specific pain syndromes:
 - ‡ muscle contraction headaches
 - ‡ muscle re-education or muscle tension
 - ‡ Reynaud's phenomena
 - ‡ migraine headaches
 - ‡ torticollis, including facial tics
 - ‡ paralumbar or back pain
- For maintenance therapy. Maintenance therapy includes therapy services that are provided over a long period of time in order to keep your condition stable
- For massage therapy services
- For holistic medicine services
- For services primarily for educational purposes, including but not limited to books, tapes, pamphlets, seminars, classroom instruction and counseling, except as specifically covered by your health benefit plan



9.21 Release of medical records

At times, it is necessary for BCBSNC to request medical records from you in order to determine appropriate claims payment, ensure contractual compliance or perform quality improvement activities.

Under HIPAA guidelines, no additional authorization is needed when medical records are requested for purposes of claims processing. Providers participating with Blue Cross and Blue Shield of North Carolina should be aware that medical records requested for the purpose of claims processing fall within BCBSNC’s payment and health care operations as those terms are defined in the HIPAA privacy rule.

Contracting providers have agreed to provide BCBSNC with medical records as requested without further payment or authorization from the member or BCBSNC.

Do not send medical records unless requested by BCBSNC. Complete the BCBSNC record request form provided by BCBSNC when sending records. For more information on releasing medical records, as stated in the enrollment application, see chapter twenty-two, Forms.

9.22 Notification of payment or explanation of payment

We report payment and denial of claims to providers on a notification of payment or explanation of payment report. The table below explains key information on the explanation of payment.

Item	Explanation
Patient number	Number assigned by providers to identify patient accounts
POS or place	Place of service
Type of service	Brief description of the service rendered
PC/days	If facility claims, number of days admitted as an inpatient
Billed charges	Provider’s charges as billed
Contracted charges	The charge after contractual reductions
Non-covered/disallowed	Non-covered amounts/disallowed amount
Deduct amount	The member’s deductible amount owed by the member
Remaining member expense	Amount the member can be billed by the provider
DEN code	The denial or adjustment code that further explains the payments/denial
Remarks	Written explanation for DEN codes
Amount paid	Total amount paid to provider
Contract types of services and special codes	This field indicates special coverage, type of transmission, or other key information: PCN - Provider Communication Network (electronically filed) COB - Coordination of Benefits CONADJ - Contractual Adjustment SPCADJ - Special Adjustment Blue Care® Classic Blue® PS-C - Preferred Care Select CMM - CostWise/Comprehensive Major Medical



9.23 Electronic Remittance Advice (ERA)

BCBSNC offers an electronic remittance using the standard HIPAA 835 transaction to participating providers. See chapter eleven, Electronic solutions for information regarding the HIPAA 835.

9.24 Overpayments

Participating providers agree that in the event of any overpayment, duplicate payment, or other payment in excess of the member's benefits payable according to the member's benefit plan and/or your provider contract, payment will be promptly remitted to BCBSNC. BCBSNC may recover overpayments by offset against current or future amounts payable to you after 45 days of a request for a refund. If within 45 days of the refund request, the requested refund has not been made, BCBSNC may recover the requested overpayment amount by offset of future amounts payable to you. Prior to recovery by offset, we will make best efforts to first recover the overpayment through a written request for the refund.

9.24.1 When you notice an overpayment

Complete form G252 - refund of overpayment form (see chapter twenty-two, Forms)

or

Write a letter including the following information:

- The amount of the overpayment
- The member's ID number associated with the overpayment
- Date of service
- Provider number under which service was paid
- Copy of the EOP/NOP
- The reason you believe the payment is in error

Mail a check, along with a copy of your letter or G252 form to:

Financial Processing Services
Blue Cross and Blue Shield of North Carolina
PO Box 30048
Durham, NC 27702-3048

For questions related to overpayments, call the Provider Blue LineSM 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 45 days. Please return the invoice with your payment. If payment is not received after 45 days of our notification to you, we will deduct the amount owed from future payments to you, and indicate the member's identification number, date of service and a message indicating the reason on the explanation of payment.

9.25 Enterprise business continuity

I. Executive summary

A. BCBSNC has established an enterprise business continuity program, its mission to enhance the overall protection of:

1. Employees
2. Customers and service activities
3. Property and other assets
4. Brand, image and reputation

II. An EBC governance committee has been formed to ensure BCBSNC's enterprise business continuity methodology is derived from and executed according to industry best practices and provides for the specific needs of BCBSNC and its customers. Moreover, the EBC governance committee is responsible for the confluence and oversight of all related business continuity efforts and programs.

III. Pay providers recovery plan

A. In the event of catastrophic systems loss preventing the electronic submission and processing of claims, BCBSNC will implement a plan to pay most participating providers on an interim basis for up to 90 days. Providers meeting a pre-designated level of claims over the most recent three month period will receive a weekly receipts over that period. These interim payments should be tracked by the providers, as they will be subtracted from payments made for adjudicated claims once BCBSNC systems are back in operation.



9.26 Using the corrected NPI or BCBSNC assigned proprietary provider number for reporting your health care services

The National Provider Identifier (NPI) is a HIPAA mandate effective May 2007 for electronic transactions. The NPI is a ten digit unique health care provider identifier, which replaces the BCBSNC Proprietary Provider Number (PPN) on electronic transactions. Additional information about NPI is located in chapter twenty of the e-manual (Health Insurance and Accountability Act [HIPAA]), and on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/NationalProviderStand/>.

If your health care business submits claims using:

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

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

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

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 use only one NPI for both bill types, claims must be reported with the appropriate facility type code/place of service or the services may be processed under the incorrect BCBSNC associated provider number.

BCBSNC accepts NPI on transactions, maps the NPI submission to the appropriate BCBSNC PPN, the PPN continues the transaction through the claims processing system and is mapped back to the NPI, prior to being transmitted back to the provider.

Providers have the option to receive multiple NPIs but if only one NPI is requested, BCBSNC will use a facility type code (filter) to differentiate between two PPNs. (The facility type code is the [bill type] on the UB-04 and the place of service on the CMS-1500.) If a provider has chosen to receive only one NPI but has two BCBSNC PPNs, the FTC is available to identify the appropriate PPN. The provider must agree to use a specific FTC for a specific PPN. If any other FTC is filed the claim will map to the other PPN and the provider must accept the payment as received. We will not be adjusting these claims if the provider files with the incorrect FTC.

9.26.2 NPI – PA and nurse practitioner

If your office staff includes physician assistants or advanced practical nurse practitioners, you may have applied and received National Provider Identifiers (NPI) for them.

However, please do not use physician assistant or advanced practice nurse practitioners NPI when reporting services in claim submissions to BCBSNC unless the physician assistant or advanced nurse practitioner has been approved by BCBSNC for inclusion on the practitioner roster. Otherwise, report services provided by physician assistants and advanced practice nurse practitioners employed in your office, under the NPI and/or BCBSNC assigned provider number of the supervising physician providing the oversight.

Please note that generally, BCBSNC does not directly reimburse physician assistants or advanced practice nurse practitioners for services provided in a physician's office and that filing claims using non-rostered physician assistants or registered nurses NPI can delay claims processing which can also delay payment to your practice.

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

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



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

Provider type/services	Claim form
Providers office	Form CMS-1500 (8-05)
Home Durable Medical Equipment (HDME)	Form CMS-1500 (8-05)
Reference lab	Form CMS-1500 (8-05)
Licensed registered dietitian	Form CMS-1500 (8-05)
Specialty pharmacy	Form CMS-1500 (8-05)
Ambulance provider	Form CMS-1500 (8-05)
Hospital facility	Form UB-04 CMS-1450
Ambulatory surgical center	Form UB-04 CMS-1450
Skilled nursing facility	Form UB-04 CMS-1450
Lithotripsy provider	Form UB-04 CMS-1450
Dialysis provider	Form UB-04 CMS-1450
Home health care: <ul style="list-style-type: none"> • Home health provider • Private duty nursing • Home infusion provider 	Form UB-04 CMS-1450 Form UB-04 CMS-1450 Form CMS-1500 (08-05)

Please note that providers with electronic capability who submit paper claims will be asked to submit claims electronically. In addition, providers who do not file electronic claims will be contacted to discuss electronic filing options.

For more information on the CMS-1500 (version 08/05) claim form, visit the National Uniform Claim Committee (NUCC) Web site at www.nucc.org. For more information on the UB-04 claim form, visit the National Uniform Billing Committee (NUBC) Web site at www.nubc.org.

CMS-1500 (08/05) claim filing instructions

Field #	Description
1	Leave blank
1a	Insured's ID - Enter the member identification number exactly as it appears on the patient's ID card. The member's ID number is the subscriber number and the two-digit suffix listed next to the member's name on the ID card. This field accepts alpha and numeric characters.
2	The patient's name should be entered as last name, first name, and middle initial.
3	Enter the patient's birth date and sex. The date of birth should be eight positions in the MM/DD/YYYY format. Use one character (X) to indicate the sex of the patient.
4	Enter the name of the insured. If the patient and insured are the same, then the word same may be used. This name should correspond with the ID # in field 1a.
5	Enter the patient's address and telephone number.

Continued on the following page.



Field #	Description						
6	Use one character (X) to indicate the patient's relationship to the insured.						
7	Enter insured's address and telephone number. If patient's and insured's address are the same then the word "same" may be used.						
8	Enter the patient's marital and employment status by marking an (X) in one box on each line.						
9	Show the last name, first name, and middle initial of the person having other coverage that applies to this patient. If the same as Item 4, enter same (complete this block only when the patient has other insurance coverage). Indicate none if no other insurance applies.						
9a	Enter the policy and/or group number of the other insured's policy.						
9b	Enter the other insured's date of birth (MM/DD/YYYY) and sex.						
9c	Enter the other insured's employer's name or school name.						
9d	Enter the other insured's insurance company name.						
10 a-c	Use one character (X) to mark yes or no to indicate whether employment, auto accident, or other accident involvement applies to services in item 24 (diagnosis).						
11	Enter member's policy or group number.						
11a	Enter member's date of birth (MM/DD/YYYY) and sex.						
11b	Enter member's employer's name or school name.						
11c	Enter member's insurance plan name.						
11d	Check yes or no to indicate if there is, or not, another health benefit plan. If yes, complete items 9 through 9d.						
12	Have the patient or authorized person sign or indicate signature on file in lieu of an actual signature if you have the original signature of the patient or other authorized person on file authorizing the release of any medical or other information necessary to process this claim.						
13	Have the subscriber or authorized person sign or indicate signature on file in lieu of an actual signature if you have the original signature of the member or other authorized person on file authorizing assignment of payment to you.						
14	Enter the date of injury or medical emergency. For conditions of pregnancy enter the LMP. If other conditions of illness, enter the date of onset of first symptoms.						
15	If patient has previously had the same or similar illness, give the date of the previous episode.						
16	Leave blank.						
17	Enter name of referring physician or provider.						
17a	Enter ID number of referring physician or provider.						
17b	Enter 1B (Blue Shield ID qualifier) in the shaded area and to the immediate right of 17a. Enter the BCBSNC ID number of the referring provider in the shaded box to the right of the ID qualifier. (This field is only required if the NP number is not reported in box 17b.) Example: <table border="1" style="margin-left: 20px;"> <tr> <td style="width: 100px;">17a.</td> <td style="width: 50px;">1B</td> <td>12345</td> </tr> <tr> <td>17b.</td> <td>NP1</td> <td>1234567891</td> </tr> </table>	17a.	1B	12345	17b.	NP1	1234567891
17a.	1B	12345					
17b.	NP1	1234567891					

Continued on the following page.



Field #	Description																																																																																																								
18	If services are provided in the hospital, give hospitalization dates related to the current services.																																																																																																								
19	Leave blank.																																																																																																								
20	Complete this block to indicate billing for clinical diagnosis tests.																																																																																																								
21	<p>Enter the diagnosis/condition of the patient indicated by the ICD-9 code. Enter only the diagnosis code, not the narrative description. Enter up to four codes in priority order (primary, secondary conditions). The primary diagnosis should be reported in diagnosis #1. The secondary in #2. Contributing diagnosis in #3 and #4.</p> <p>When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than 3 beginning digits (e.g., E codes), enter the fourth digit on top of the period.</p> <p>Example:</p> <table border="1" style="margin-left: 20px;"> <tr> <td colspan="4">21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Retype Items 1, 2, 3 or 4 to Item 24E by Line)</td> </tr> <tr> <td>1.</td> <td>998 . 59</td> <td>3.</td> <td>V18 . 0</td> </tr> <tr> <td>2.</td> <td>780 . 6</td> <td>4.</td> <td>E87 . 88</td> </tr> </table>	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Retype Items 1, 2, 3 or 4 to Item 24E by Line)				1.	998 . 59	3.	V18 . 0	2.	780 . 6	4.	E87 . 88																																																																																												
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2.	780 . 6	4.	E87 . 88																																																																																																						
22	Leave blank.																																																																																																								
23	Enter certification of prior review number here if services require it.																																																																																																								
24	<p>The 6 service lines in section 24 have been divided horizontally to accommodate submission of both the NPI number and BCBSNC identifier during the NPI transition, and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Use of the supplemental information fields should be limited to the reporting of NDC codes. If reporting NDC codes, report the NDC qualifier "N4" in supplemental field 24a followed by the NDC code and unit information (UN = unit; GR = gram; ML = milliliter; F2 = international unit).</p> <p>Example:</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th colspan="4">24. A. DATE(S) OF SERVICE</th> <th>B. PLACE OF SERVICE</th> <th>C.</th> <th>D. PROCEDURES, SERVICES, OR SUPPLIES</th> <th>E. DIAGNOSIS POINTER</th> <th>F.</th> <th>G. DAYS OR UNITS</th> <th>H. EPDSI (Family Plan)</th> <th>I. ID. QUAL.</th> <th>J. RENDERING PROVIDER ID. #</th> </tr> <tr> <th>From</th> <th>To</th> <th></th> <th></th> <th>EMG</th> <th>(Explain Unusual Circumstances)</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>CPT/HCPCS</th> <th>MODIFIER</th> <th></th> <th>\$ CHARGES</th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>N400026064871</td> <td>Immune Globulin Intravenous</td> <td>UN2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>10</td> <td>01</td> <td>05</td> <td>10</td> <td>01</td> <td>05</td> <td>11</td> <td>J1563</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>13</td> <td>500</td> <td>00</td> <td>20 N</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1B 12345678901</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI 0123456789</td> </tr> </tbody> </table>	24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS POINTER	F.	G. DAYS OR UNITS	H. EPDSI (Family Plan)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	From	To			EMG	(Explain Unusual Circumstances)								MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER		\$ CHARGES				N400026064871	Immune Globulin Intravenous	UN2											10	01	05	10	01	05	11	J1563															13	500	00	20 N													1B 12345678901													NPI 0123456789
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24a	Enter the month, day, and year (six digits) for each procedure, service and/or supply in the unshaded date fields. Dates must be in the MM/DD/YY format.																																																																																																								
24b	Enter the appropriate place of service codes in the unshaded area.																																																																																																								
24c	Leave blank																																																																																																								
24d	Enter procedure, service, or supplies using the appropriate CPT or HCPCS code in the unshaded area. Also enter, when appropriate, up to four two-digit modifiers.																																																																																																								
24e	Enter the diagnosis reference number (pointer) in the unshaded area. The diagnosis pointer references the line number from field 21 that relates to the reason the service(s) was performed (ex. 1, 2, 3, or 4, or multiple numbers if the service relates to multiple diagnosis from field 21). The field accommodates up to 4 digits with no commas between numbers.																																																																																																								
24f	Enter the total charges for each line item in the unshaded area. Enter up to 6 numeric positions to the left of the vertical line 2 positions to the right. Dollar signs are not required.																																																																																																								

Continued on the following page.



Field #	Description										
24g	Enter days/units in the unshaded area. This item is most commonly used for units of supplies, anesthesia units, etc. Anesthesia units should be 1 unit equals a 1- minute increment. Do not include base units of the procedure with the time units. If you are billing services for consecutive dates (from and to dates) it is critical that you provide the units accurately in block 24g.										
24h	Leave blank.										
24i	Enter 1B (Blue Shield ID qualifier) in box 24i above the dotted line (not required if submitting NPI number).										
24j	<p>Enter the assigned BCBSNC provider identification number for the performing provider in the shaded area. If several members of the group shown in item 33 have furnished services, this item is to be used to distinguish each provider of service. (This field is only required if the NPI number is not being reported.)</p> <p>Enter the NPI number of the performing provider below the dotted line. If several members of the group shown in Item 33 have furnished services, this item is to be used to distinguish each provider of service.</p> <p>Example:</p> <table border="1" style="margin-left: 20px;"> <tr> <td style="font-size: 8px;">I. ID. QUAL.</td> <td style="font-size: 8px;">J. RENDERING PROVIDER ID. #</td> </tr> <tr> <td style="border-top: 1px dashed black;">1B</td> <td style="border-top: 1px dashed black;">01234</td> </tr> <tr> <td style="font-size: 8px;">NPI</td> <td style="font-size: 8px;">12345678901</td> </tr> </table>	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	1B	01234	NPI	12345678901				
I. ID. QUAL.	J. RENDERING PROVIDER ID. #										
1B	01234										
NPI	12345678901										
25	<p>Enter federal tax identification number.</p> <p><input checked="" type="checkbox"/> Indicate whether this number is Social Security Number (SSN) or Employer Identification Number (EIN).</p>										
26	Enter the patient account number assigned by physician's/provider's/supplier's accounting system.										
27	<p>Accept assignment</p> <p><input checked="" type="checkbox"/> Yes must be indicated in order to receive direct reimbursement. Contracting providers have agreed to accept assignment.</p>										
28	Enter the total charges for all services listed on the claim form in item 24F. Up to 7 numeric positions can be entered to the left of the vertical lines and 2 positions can be entered to the right. Dollar signs are not required.										
29	Enter the amount paid by the primary insurance carrier. (Reminder: only copayments may be collected at time of service.)										
30	Enter total amount due - charges minus any payments received.										
31	Signature and date of the physician/provider/supplier. (Stamped signatures are accepted.)										
32	Enter the name and address of the facility site where services on the claim were rendered. This field is especially helpful when this address is different from billing address in item 33.										
32a	Enter the NPI number of the service facility.										
32b	<p>Enter the ID qualifier 1B immediately followed by the BCBSNC assigned five-digit provider identification number for the service facility (this field is not required if submitting the NPI number in field 32a).</p> <p>Example:</p> <table border="1" style="margin-left: 20px;"> <tr> <td colspan="2" style="font-size: 8px;">32. SERVICE FACILITY LOCATION INFORMATION</td> </tr> <tr> <td colspan="2" style="font-size: 8px;">CRABTREE MEDICAL CENTER</td> </tr> <tr> <td colspan="2" style="font-size: 8px;">100 AIRPORT ROAD</td> </tr> <tr> <td colspan="2" style="font-size: 8px;">RALEIGH, NC 27610</td> </tr> <tr> <td style="font-size: 8px;">a. 12344567891</td> <td style="font-size: 8px;">b. 1B01234</td> </tr> </table>	32. SERVICE FACILITY LOCATION INFORMATION		CRABTREE MEDICAL CENTER		100 AIRPORT ROAD		RALEIGH, NC 27610		a. 12344567891	b. 1B01234
32. SERVICE FACILITY LOCATION INFORMATION											
CRABTREE MEDICAL CENTER											
100 AIRPORT ROAD											
RALEIGH, NC 27610											
a. 12344567891	b. 1B01234										
33	Enter the name, address, and phone number for the billing provider or group.										

Continued on the following page.



Field #	Description										
33a	Enter the NPI number of the billing provider or group.										
33b	<p>Enter the ID qualifier 1B immediately followed by the BCBSNC assigned five-digit provider identification number for the billing provider or group (this field is not required if submitting the NPI number in field 33a).</p> <p>Example:</p> <table border="1" data-bbox="453 525 824 638"> <tr> <td colspan="2" data-bbox="453 525 824 546">33. BILLING PROVIDER INFO & PH# ()</td> </tr> <tr> <td colspan="2" data-bbox="453 546 824 567">DR. JUDD KILGORE</td> </tr> <tr> <td colspan="2" data-bbox="453 567 824 588">P O BOX 1678</td> </tr> <tr> <td colspan="2" data-bbox="453 588 824 609">RALEIGH, NC 27610</td> </tr> <tr> <td data-bbox="453 609 641 638">a. 1987654321</td> <td data-bbox="641 609 824 638">b. 1B03456</td> </tr> </table>	33. BILLING PROVIDER INFO & PH# ()		DR. JUDD KILGORE		P O BOX 1678		RALEIGH, NC 27610		a. 1987654321	b. 1B03456
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P O BOX 1678											
RALEIGH, NC 27610											
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9.27.1 Sample CMS-1500 (08-05) claim form

1500

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (ID)</small>					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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)			
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		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) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				SEX M <input type="checkbox"/> F <input type="checkbox"/>			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE				c. INSURANCE PLAN NAME OR PROGRAM NAME			
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.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			
SIGNED _____ DATE _____				SIGNED _____							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. _____ 17b. NPI _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____						22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					
23. PRIOR AUTHORIZATION NUMBER _____											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON 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 <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____	
30. BALANCE DUE \$ _____		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____		33. BILLING PROVIDER INFO & PH # () a. _____ b. _____			
SIGNED _____ DATE _____											

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



9.28 UB-04 claim filing instructions

Form locator number	Description of content
1	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Pay-to name • Pay-to address • Pay-to city, state, zip
3a	Provider assigned patient control number
3b	Provider assigned medical/health record number (if available)
4	<p>Type of bill (4 digit classification)</p> <ul style="list-style-type: none"> • Digit 1: Leading zero • Digit 2: Type of facility <ul style="list-style-type: none"> ‡ 1 = Hospital ‡ 2 = Skilled nursing facility ‡ 3 = Home health ‡ 7 = Clinic ‡ 8 = Special facility • Digit 3: Bill classification <ul style="list-style-type: none"> ‡ 1 = Inpatient ‡ 3 = Outpatient ‡ 4 = Other • Digit 4: Frequency <ul style="list-style-type: none"> ‡ 1 = Admit through discharge claim ‡ 2 = Interim - first claim ‡ 3 = Interim - continuing claim ‡ 4 = Interim - last claim ‡ 5 = Late charge <p>**For further explanation on type of bill, please refer to the NUBC UB-04 official data specifications manual</p>
5	Provider's federal tax identification number
6	Date(s) of service (enter MMDDYY, example 010106)
7	Leave blank
8a	Patient ID (required if different than the subscriber/insured ID in form locator 60)
8b	Patient's name (last name, first name, middle initial)
9a	Patient's address – street
9b	Patient's address – city
9c	Patient's address – state

Continued on the following page.



Form locator number	Description of content																																																				
9d	Patient's address zip																																																				
9e	Patient's address – county code (if outside US) (Refer to USPS domestic mail manual)																																																				
10	Patient's date of birth (enter MMDDYYYY, example 01012006)																																																				
11	Patient's sex (M/F/U)																																																				
12	Admission/start of care date (MMDDYY)																																																				
13	<p>Admission hour</p> <table border="0"> <thead> <tr> <th>Code</th> <th>Time AM</th> <th>Code</th> <th>Time PM</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00-12:59 midnight</td> <td>12</td> <td>12:00-12:59 noon</td> </tr> <tr> <td>01</td> <td>01:00-01:59</td> <td>13</td> <td>01:00-01:59</td> </tr> <tr> <td>02</td> <td>02:00-02:59</td> <td>14</td> <td>02:00-02:59</td> </tr> <tr> <td>03</td> <td>03:00-03:59</td> <td>15</td> <td>03:00-03:59</td> </tr> <tr> <td>04</td> <td>04:00-04:59</td> <td>16</td> <td>04:00-04:59</td> </tr> <tr> <td>05</td> <td>05:00-05:59</td> <td>17</td> <td>05:00-05:59</td> </tr> <tr> <td>06</td> <td>06:00-06:59</td> <td>18</td> <td>06:00-06:59</td> </tr> <tr> <td>07</td> <td>07:00-07:59</td> <td>19</td> <td>07:00-07:59</td> </tr> <tr> <td>08</td> <td>08:00-08:59</td> <td>20</td> <td>08:00-08:59</td> </tr> <tr> <td>09</td> <td>09:00-09:59</td> <td>21</td> <td>09:00-09:59</td> </tr> <tr> <td>10</td> <td>10:00-10:59</td> <td>22</td> <td>10:00-10:59</td> </tr> <tr> <td>11</td> <td>11:00-11:59</td> <td>23</td> <td>11:00-11:59</td> </tr> </tbody> </table>	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
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01	01:00-01:59	13	01:00-01:59																																																		
02	02:00-02:59	14	02:00-02:59																																																		
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11	11:00-11:59	23	11:00-11:59																																																		
14	<p>Type of admission/visit</p> <ol style="list-style-type: none"> 1. Emergency 2. Urgent 3. Elective 4. Newborn 5. Trauma 9. Information not available 																																																				
15	<p>Source of admission or visit</p> <ol style="list-style-type: none"> 1. Physician referral 2. Clinic referral 3. HMO referral 4. Transfer from a hospital 5. Transfer from a skilled nursing facility 6. Transfer from another health care facility 7. Emergency room 8. Court/law enforcement 9. Information not available A. Transfer from a critical access hospital B. Transfer from another home health agency C. Readmission to same home health agency D. Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer 																																																				

Continued on the following page.



Form locator number	Description of content																																																				
15 (continued)	<p>For newborns</p> <ol style="list-style-type: none"> 1. Normal delivery 2. Premature birth 3. Sick baby 4. Extramural birth 																																																				
16	<p>Discharge hour:</p> <table border="0"> <thead> <tr> <th>Code</th> <th>Time AM</th> <th>Code</th> <th>Time PM</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00-12:59 midnight</td> <td>12</td> <td>12:00-12:59 noon</td> </tr> <tr> <td>01</td> <td>01:00-01:59</td> <td>13</td> <td>01:00-01:59</td> </tr> <tr> <td>02</td> <td>02:00-02:59</td> <td>14</td> <td>02:00-02:59</td> </tr> <tr> <td>03</td> <td>03:00-03:59</td> <td>15</td> <td>03:00-03:59</td> </tr> <tr> <td>04</td> <td>04:00-04:59</td> <td>16</td> <td>04:00-04:59</td> </tr> <tr> <td>05</td> <td>05:00-05:59</td> <td>17</td> <td>05:00-05:59</td> </tr> <tr> <td>06</td> <td>06:00-06:59</td> <td>18</td> <td>06:00-06:59</td> </tr> <tr> <td>07</td> <td>07:00-07:59</td> <td>19</td> <td>07:00-07:59</td> </tr> <tr> <td>08</td> <td>08:00-08:59</td> <td>20</td> <td>08:00-08:59</td> </tr> <tr> <td>09</td> <td>09:00-09:59</td> <td>21</td> <td>09:00-09:59</td> </tr> <tr> <td>10</td> <td>10:00-10:59</td> <td>22</td> <td>10:00-10:59</td> </tr> <tr> <td>11</td> <td>11:00-11:59</td> <td>23</td> <td>11:00-11:59</td> </tr> </tbody> </table>	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
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11	11:00-11:59	23	11:00-11:59																																																		
17	<p>Patient discharge status</p> <ul style="list-style-type: none"> 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) 																																																				

Continued on the following page.



Form locator number	Description of content
18-28 (as applicable)	<p>Condition codes</p> <ul style="list-style-type: none"> 09 – Neither patient nor spouse is employed 11 – Disabled beneficiary but no LGHP 71 – Full care in unit C1 – Approved as billed C5 – Post payment review applicable C6 – Admission preauthorization <p>**For additional condition codes, please refer to the NUBC UB-04 official data specifications manual</p>
29	<p>Accident state (situational)</p> <p>‡ 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</p>
30	<p>Leave blank</p>
31-34 (as applicable)	<p>Occurrence codes and dates</p> <ul style="list-style-type: none"> 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 <p>Medical condition codes</p> <ul style="list-style-type: none"> 09 – Start of infertility treatment cycle 10 – Last menstrual period (only applies for maternity related care) 11 – Onset of symptoms/illness <p>Insurance related codes</p> <ul style="list-style-type: none"> 24 – Date insurance denied 25 – Date benefits terminated by primary payer <p>Covered by EGHP</p> <ul style="list-style-type: none"> 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 <p>**For additional occurrence codes, please refer to the NUBC UB-04 official data specifications manual</p>
35-36 (as applicable)	<p>Occurrence span codes and dates</p> <ul style="list-style-type: none"> 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 <p>**For additional occurrence span codes, please refer to the NUBC UB-04 official data specifications manual</p>

Continued on the following page.



Form locator number	Description of content
37	Leave blank
38	Responsible party name and address
39-41	<p>Value codes</p> <ul style="list-style-type: none"> 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 <p>** For additional value codes, please refer to the NUBC UB-04 official data specifications manual</p>
42	Revenue code (refer to UB-04 manual)
43	Revenue description (refer to UB-04 manual)
44	<p>HCPCS/rates</p> <ul style="list-style-type: none"> • The level I (CPT) or level II (HCPCS) is required for outpatient claims • The accommodation rate for inpatient bills
45	<p>Service date (MMDDYY)</p> <ul style="list-style-type: none"> • Applies to lines 1-22 <p>Creation date (MMDDYY)</p> <ul style="list-style-type: none"> • Applies to line 23 – the date bill was created/printed
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)	<p>Insurance carrier name (payer)</p> <ul style="list-style-type: none"> • Line A - primary payer • Line B - secondary payer • Line C - tertiary payer
51	Health plan identification number (leave blank until mandated)
52 (A, B, C)	<p>Release of information</p> <ul style="list-style-type: none"> • 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

Continued on the following page.



Form locator number	Description of content
53 (A, B, C)	<p>Assignment of benefits</p> <ul style="list-style-type: none"> • N = No • Y = Yes (must be indicated in order to receive direct reimbursement) • Contracting providers have agreed to accept assignment
54 (A, B, C)	<p>Prior payments/source</p> <ul style="list-style-type: none"> • A - Primary payer • B - Secondary payer • C - Tertiary payer
55 (A, B, C)	Estimated amount due (not required)
56	National Provider Identifier (NPI) – billing provider
57 (A, B, C)	Other billing provider ID (BCBSNC provider number on appropriate line) – required if NPI is not reported on FL56
58 (A, B, C)	Subscriber's/insured name (last name, first name)
59 (A, B, C)	<p>Patient's relationship to subscriber/insured</p> <ul style="list-style-type: none"> 01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 – Organ donor 40 – Cadaver donor 53 – Life partner G8 – Other relationship
60 (A, B, C)	Subscriber's/insured identification number
61 (A, B, C)	Subscriber's/insured group name
62 (A, B, C)	Subscriber's/insured group number
63 (A, B, C)	Treatment authorization code
64 (A, B, C)	Document Control Number (DCN) [leave blank]
65 (A, B, C)	Subscriber's/insured employer name
66	Diagnosis and procedure code qualifier (ICD version indicator) – this will be ICD-9 until ICD-10 is in effect
67	<p>Principal diagnosis code "ICD-9" (do not enter decimal, it is implied)</p> <ul style="list-style-type: none"> • Eighth position indicates Present on Admission indicator (POA) – required for inpatient claims <ul style="list-style-type: none"> • Y = Yes • N = No • U = No information in the record • W = Clinically undetermined

Continued on the following page.



Form locator number	Description of content
67 (A-Q)	Other diagnosis codes "ICD-9" <ul style="list-style-type: none"> • Eighth position indicates Present On Admission indicator (POA) – required for inpatient claims <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • ICD-9 code required on inpatient claims when a procedure was performed (do not enter decimal, it is implied) • Leave blank for outpatient claims • Date format MMDDYY
74 (A-E)	Other procedures codes and dates (procedures performed during the billing period other than those coded in FL74) <ul style="list-style-type: none"> • ICD-9 code required on inpatient claims when a procedure was performed (do not enter decimal, it is implied) • Leave blank for outpatient claims • Date format (MMDDYY)
75	Leave blank
76	Attending physician (NPI, last name and first name) <ul style="list-style-type: none"> • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
77	Operating physician (NPI, last name and first name) <ul style="list-style-type: none"> • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
78-79	Other physician (NPI, last name and first name) <ul style="list-style-type: none"> • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
80	Remarks
81 (A-D)	Code - code field (overflow field to report additional codes)

Chapter 9

Claims - billing and reimbursement



9.28.1 Sample UB-04 claim form

1	2	3a PAT. CNTL #	4 TYPE OF BILL
b	c	d	e
8 PATIENT NAME	9 PATIENT ADDRESS	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
10 BIRTHDATE	11 SEX	12 DATE	13 HR
14 TYPE	15 SRC	16 DHR	17 STAT
18	19	20	21
22	23	24	25
26	27	28	29 ACDT STATE
30	31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE
34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE SPAN FROM THROUGH	37
38	39 VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES AMOUNT
a	b	c	d
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / NPPS CODE	45 SERV. DATE
46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	2	3	4
5	6	7	8
9	10	11	12
13	14	15	16
17	18	19	20
21	22	23	24
PAGE	OF	CREATION DATE	TOTALS
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASSO. BEN.
54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
58 INSURED'S NAME	59 F.REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
66 DX	67	68	69
70 PATIENT REASON DX	71 PPS CODE	72 EQ	73
74 PRINCIPAL PROCEDURE DATE	75	76 ATTENDING NPI	77 OPERATING NPI
78 OTHER NPI	79 OTHER NPI	80 REMARKS	81CC a b c d

UB-04 CMS-1450 OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC8213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF



9.29 Split claim guidelines

BCBSNC reserves the right to request a split claim where necessary to support correct adjudication of the claim.

In certain situations it may be necessary to divide a claim into sections by either date range or service, in order to process a claim and apply member benefits correctly. The below chart has been designed to assist you to identify the types of claim situations that can result in a split claim being required.

	Claim situation	BCBSNC HMO, POS, PPO and CMM <small>(includes fully insured, State PPO and ASO)</small>	Medicare Supplement <small>(CMM legacy)</small>	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 DRG (case pay)	No	No	No
8	When authorized and non-authorized days are in the same admission and reimbursement is DRG (percent of charge)	Yes	No	No

Continued on the following page.



	Claim situation	BCBSNC HMO, POS, PPO and CMM (includes fully insured, State PPO and ASO)	Medicare Supplement (CMM legacy)	Federal Employee Program PPO
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 plan but not for another.

Definitions

- **Case pay:** A prospective payment methodology for facility inpatient service in which the allowance for covered services is negotiated for the entire inpatient stay. (A fixed dollar amount is agreed to for the entire inpatient stay.)
- **Per diem rate:** A prospective payment methodology for facility inpatient service in which the allowance for covered services is a negotiated daily rate. (An agreed allowance amount is reimbursed for each BCBSNC-approved inpatient day.)
- **Percent of approved charges:** A payment methodology in which the allowance for covered services is calculated on BCBSNC approved charges.

Please note that BCBSNC reserves the right to request a split claim where necessary to support correct adjudication of the claim.

9.30 Notification of payment or explanation of payment

We report payment and denial of claims to providers on a notification of payment or explanation of payment report. The table below explains key information on the explanation of payment.

Item	Explanation
Patient number	Number assigned by providers to identify patient accounts
POS or place	Place of service
Type of service	Brief description of the service rendered
PC/days	If facility claims, number of days admitted as an inpatient
Billed charges	Provider’s charges as billed
Contracted charges	The charge after contractual reductions
Non-covered/disallowed	Non-covered amounts/disallowed amount
Deduct amount	The member’s deductible amount owed by the member

Continued on the following page.



Item	Explanation
Remaining member expense	Amount the member can be billed by the provider
DEN code	The denial or adjustment code that further explains the payments/denial
Remarks	Written explanation for DEN codes
Amount paid	Total amount paid to provider
Contract types of services and special codes	<p>This field indicates special coverage, type of transmission, or other key information:</p> <ul style="list-style-type: none"> PCN - Provider Communication Network (electronically filed) COB - Coordination of Benefits CONADJ - Contractual Adjustment SPCADJ - Special Adjustment Blue Care[®] Blue OptionsSM Classic Blue[®] PCP - Personal Care Plan MPT - MedPoint PS-C - Preferred Care <i>Select</i> CMM - CostWise/Comprehensive Major Medical



9.30.1 Sample EOP



**BlueCross BlueShield
of North Carolina**

An Independent Licensee of the
Blue Cross and Blue Shield Association

EXPLANATION OF PAYMENT

Provider Name: **FEEL GOOD FAMILY CARE**
Provider Number: **00123**

02/22/2001

Page: 001 of 003

Patient's Name Type of Service	ID Number		Dates of Service		Patient Number		Medical Rec Number		Place		Amount Paid
	PC/Days	Prov ID	Billed Charges	Contracted Charges	Noncovered/ Disallowed	Deductible Amount	Copay Amount	Remaining Mbr Expense	Den Code		
JONES SUBSCRIBER H EMERGENCY ROOM CONSULATATION	00111022201 99821	12345	12/20/2000 200.00 12/15/2000	12/20/2000 120.00 12/15/2000	80.00	0.00	20.00	20.00	EMERGENCY ROOM A03/A04	100.00	
INTEREST ACCURAL BEING PAID ON THIS INSURED'S CLAIM BASED ON TIME PROCESSING GUIDELINES AS SPECIFIED BY NORTH CAROLINA STATE LAW 58-3-100(C), BLUE OPTIONS CLAIM #: 0112290050022 EFT BATCH #: 00000001904									CLAIM RECEIPT DATE: 12/29/2000 INTEREST: 15.00 CLAIM TOTAL: 115.00		

Notice: Confidential and Proprietary Information of Blue Cross and Blue Shield of North Carolina, an independent licensee of the Blue Cross and Blue Shield Association. This document may not be copied or reproduced without prior consent of Blue Cross and Blue Shield of North Carolina.



Physicians office

9.31 Maternity claims

A global charge should be billed for maternity claims. Prenatal care is considered an integral part of the global reimbursement and will not be paid separately. However, prenatal care may be filed alone if that is the only care provided by that particular physician. In the event you provide prenatal care for only part of the nine months and you do not perform the delivery (such as when a patient moves during her pregnancy), you may file using the antepartum care only codes applicable to the number of times the patient was seen prior to the delivery.

Applicable codes:

- 59425 Antepartum care only (4-6 visits)
- 59426 Antepartum care only (7 or more visits)

For more information, please refer to the BCBSNC maternity reimbursement medical policy, on our Web site at https://www.bcbsnc.com/services/medicalpolicy/pdf/guidelines_for_global_maternity_reimbursement.pdf. If these codes should change after the publication of this e-manual, please use the most current code.

9.32 Filing immunizations

Vaccines for immunizations can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered. BCBSNC members are not to pick-up vaccines from the pharmacy for transport to a provider's office, as this may result in unsafe temperature changes. Vaccines may only be obtained by the administering provider and never by a BCBSNC member. Providers with questions are encouraged to contact their local Network Management representative.

Participating providers are encouraged to participate in the State of North Carolina immunization program, which reimburses serum cost for specific immunizations.

The purpose of the immunization filing procedure is to permit BCBSNC's quality improvement staff to monitor the immunization status of our members for HEDIS reporting. BCBSNC submits immunization data concerning its members to the National Committee for Quality Assurance (NCQA) and the North Carolina Department of Insurance (NCDI).

You should file immunizations as follows:

- Each immunization given must be filed on a single line of the CMS-1500 using one CPT-4 code:

- ‡ 90657 Flu shot for 6 months of age to 35 months
- ‡ 90658 Flu shot for 3 years
- ‡ 90660 Flu mist
- ‡ 90663 Influenza virus vaccine, pandemic formulation, H1N1

If these codes should change after the publication of this e-manual, please use the most current code.

- The -25 modifier must be used with all evaluation and management services except preventive services CPT 99381-99397, when reporting a significant, separately identifiable service in addition to the immunization services.
- It is inappropriate to use the unlisted vaccine code CPT 90749 to report immunization administration services.
- The invoice from the laboratory or pharmacy the vaccine has been purchased from may be requested for claim review.
- **BCBSNC HMO, POS, PPO and CMM products:**
 - ‡ Submit state-supplied vaccines with the immunization code and a (zero) charge amount. Claims for vaccines that are not supplied by the state should indicate the cost of the vaccine.
 - ‡ CPT codes CPT 90471 or CPT 90472 are the preferred method of requesting payment for administering all immunizations. A practice may use the specific CPT code with the (52) modifier to request payment for the administration of state-supplied vaccines.
- **North Carolina Health Choice for Children program:**
 - ‡ Submit state-supplied vaccines with the immunization code affixed with the -52 modifier (do not use 90471 or 90472).

The Blue Cross and Blue Shield of North Carolina (BCBSNC) preventive care guidelines are updated regularly and available to providers on the [bcbsnc.com](https://www.bcbsnc.com/members/guidelines.cfm) Web site for providers at: <https://www.bcbsnc.com/members/guidelines.cfm>.

Providers should note that although guidelines exist, benefit allowances are subject to the terms and limitations of the member's eligibility and preventive care benefits at the time service is provided. Providers are encouraged to verify a member's benefits and eligibility in advance of providing service.



Physicians office

9.32.1 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 52-modifier, are considered for reimbursement according to the providers contracted fee schedule. Please note that this reimbursement method does not apply to the North Carolina Health Choice for Children program or Federal Employee Program products.

9.32.2 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 BCBSNC on a HCFA-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. BCBSNC members are not to pick-up vaccines from the pharmacy for transport to a provider's office, as this may result in unsafe temperature changes. Vaccines may only be obtained by the administering provider and never by a BCBSNC member.

Medicare Part D vaccine manager for claims filing

Participating providers have an easy online option to submit Medicare Part D vaccine claims to 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 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-step process:

- **Step 1** – select an authorized staff member who is most likely to be the primary user of the system to enroll the practice. This person should be prepared to provide the following information about the practice:
 - ‡ Tax identification number
 - ‡ National Provider Identifier (NPI)
 - ‡ Medicare ID number
 - ‡ Drug Enforcement Administration (DEA) number
 - ‡ State medical license number
- **Step 2** – Go to Dispensing Solutions' Web site and complete a single onetime online enrollment application at enroll.edispense.com.

Providers can contact Dispensing Solutions directly for assistance with enrollment and claims by calling their customer support center at **1-888-522-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. BCBSNC offers network providers access to eDispense™ vaccine manager for Medicare Part D transactions through our pharmacy benefits manager Medco Health Solutions, Inc. (Medco) by agreement between Medco and Dispensing Solutions, Inc. (DSI).

9.33 Venipuncture and handling fee

BCBSNC has established allowances for laboratory services inclusive of venipuncture and usual supplies.

BCBSNC's medical policy does not allow separate reimbursement for venipuncture. Handling and/or conveyance of a specimen is eligible for payment when the laboratory service is not performed in the provider's office and the independent laboratory bills BCBSNC directly for the test.



Physicians office

Handling fees are paid to HMO/POS providers by BCBSNC only when the laboratory specimen is sent to an outside reference lab for processing and that lab bills BCBSNC directly for the laboratory services. Use CPT code 99000 to bill BCBSNC for the handling fee.

9.34 Participating labs and billing

Any contracting laboratory, physician office or hospital laboratory may provide and bill laboratory services for all BCBSNC lines of business. The physician office should not bill for the same lab service they have asked a contracted lab to bill.

9.35 Hearing aid screenings

*See section 9.58 for complete details on hearing aid coverage.

9.36 Anesthesia services

Anesthesia services include the following:

- General anesthesia
- Spinal block anesthesia
- Regional block anesthesia (nerve trunk block and IV anesthesia proximal to elbow and knee)
- Monitored anesthesia care (when used in lieu of general anesthesia)

Regional block and monitored anesthesia care are regarded as equivalent to general anesthesia. Anesthesia services must be administered by a medical doctor or a qualified anesthetist under the direction of a medical doctor.

The anesthesia service is considered to include all services incidental to the anesthesia including pre- and post-operative visits, administration of anesthetic, fluids and/or blood administered by the Medical Doctor of Anesthesiology (MDA) or qualified anesthetist, and necessary drugs and materials provided by the MDA, interpretation of invasive and/or non-invasive monitoring procedures including: EKG, EEG, EMG, blood gases, capnography, oxygen saturation, evoked potentials and recovery room supervision. Additional reimbursement is not available for the above-referenced procedures when they are billed separately from the anesthetic

administration. Reimbursement is not provided for administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant. All anesthesia services are subject to BCBSNC's bundling requirements.

The following anesthesia services may be considered medically necessary:

- General anesthesia
- Spinal block anesthesia
- Regional block anesthesia (nerve trunk block and IV anesthesia proximal to elbow and knee)
- Monitored anesthesia care (when used in lieu of general anesthesia)

Regional block and monitored anesthesia care are regarded as equivalent to general anesthesia. Anesthesia services must be administered by an anesthesiologist or a qualified anesthetist under the direction of an anesthesiologist.

The following components are considered an integral part of the anesthesia service and additional benefits are not provided:

- Pre-anesthesia evaluation
- Postoperative visits
- Administration of anesthetic, fluids and/or blood administered by the Medical Doctor of Anesthesiology (MDA) or qualified anesthetist and necessary drugs and materials provided by the MDA
- Interpretation of invasive and/or non-invasive monitoring procedures including: EKG, EEG, EMG, blood gases, capnography, oxygen saturation, evoked potentials
- Services administered in recovery room

When anesthesia services are not covered:

- The administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant is considered incidental to the surgical procedure. This includes sedation given for endoscopic procedures including colonoscopy. Separate reimbursement is not provided for incidental services. (Refer to separate policy number ADM9020, Bundling Guidelines.)
- Monitoring of IV sedation by an anesthesiologist for gastrointestinal endoscopy, arteriograms, CT scans, MRIs, cardiac catheterizations, and PTCA is generally considered not medically necessary. Please review the medical policy for anesthesia services at bcbsnc.com.



Physicians office

Please note: If service begins on one day and ends on another day, provider must bill based upon the beginning service date.

9.36.1 CRNAs

Filing:

BCBSNC does not assign CRNAs individual provider numbers. Claims must be filed under the directing MDA's individual provider number and group number along with the appropriate modifier, which will then be recognized for reimbursement.

BCBSNC secondary to Medicare:

BCBSNC provides benefits for Certified Registered Nurse Anesthetists (CRNA) (or other qualified anesthetists, henceforth referred to as anesthetist) services on behalf of its members who are Medicare beneficiaries. These claims should be submitted through the Medicare Crossover program, which forwards the claims to the Medicare carrier for determination of Medicare benefits. The Medicare carrier will forward the necessary data to BCBSNC for processing of secondary benefits.

9.36.2 Anesthesia time

Anesthesia time must be reported in one-minute increments. Anesthesia time should begin when the MDA begins personal and continuous preparation of the patient for induction of anesthesia in the operating room or an equivalent area (i.e., holding area). It is recognized that services rendered in the holding area will result in variance of operating room time when compared to actual time of anesthesia administration. Anesthesia time ends when the patient's condition can safely be managed by post-operative supervision other than the personal attention of the MDA.

Anesthesia time units are calculated at one unit for each minute of anesthesia time. Anesthesia base units and the anesthesia provider's Conversion Factor (CF) are adjusted by BCBSNC (internally) relative to this one minute time unit, i.e., the base unit value is multiplied by fifteen and the CF is divided by fifteen.

BCBSNC considers the following list of codes to be non-timed procedures, which differs from the ASA relative value guide:

Code	Description
01960	Anesthesia for vaginal delivery
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery

Please note: CFs are based on 15-minute increments. For example, in a procedure with an anesthesia base unit value of 4 requiring 2 hours and 12 minutes of anesthesia time (properly reported as "132" in the claim's units field) the time units (132) are added to the base unit value of 60, (or 4 x 15), producing a total unit value of 192 units for this anesthesia service.

This total unit value is then multiplied by the provider's CF (CF divided by 15 and rounded to the nearest cent). See Example 1 below:

Example 1:
Method for calculating reimbursement for timed anesthesia procedures

Scenario:

- CF = \$30.00
- Base unit = 4
- Time units = 2 hrs, 12 mins (or 132 min)

Calculation:

$$\begin{aligned}
 \text{Allowance:} &= (\$CF/15) \times ((\text{base unit} \times 15) + \text{minutes}) \\
 &= (\$30.00/15) \times ((4 \times 15) + 132) \\
 &= \$2.00 \times (60 + 132) \\
 &= \$2.00 \times 192 \\
 &= \mathbf{\$384.00}
 \end{aligned}$$

9.36.3 Anesthesia modifiers

All anesthesia services are reported by use of the anesthesia five-digit procedure code plus the addition of a modifier(s). Modifiers are added to modify or give additional definition to the service performed, and in certain circumstances add additional units to the base unit values. The anesthesia modifier must be submitted first after the procedure, before other non-anesthesia modifiers. Please include all modifiers for a procedure code on one line.



Physicians office

1. Modifiers for timed anesthesia: The following modifiers must be used with the appropriate anesthesia codes. Every timed service must have a modifier. Choose the appropriate modifier from the following:

- “AA” Physician personally performed
- “AD” Medically supervised by a physician for more than four concurrent procedures
- “AD” Direction of residents in furnishing not more than two concurrent anesthesia procedures
- “QK” Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- “QS” Monitored anesthesiology care services
- “QX” CRNA with medical direction by a physician
- “QY” Medical direction of one CRNA by an anesthesiologist
- “QZ” CRNA without medical direction by a physician

2. Physical status modifiers: When filed with a five-digit procedure code, the following modifiers will add additional unit(s) to the base unit value. In order to receive additional base units, these modifiers must be filed in the first position on the claim form or electronic transaction.

P1 – A normal healthy patient	0
P2 – A patient with mild systemic disease	0
P3 – A patient with severe systemic disease	1
P4 – A patient with severe systemic disease that is a constant threat to life	2
P5 – A moribund patient who is not expected to survive without the operation	3
P6 – A declared brain-dead patient whose organs are being removed for donor purposes	0

The above six levels are consistent with the ASA's ranking of patient physical status. Physical status is included in CPT-4 to distinguish between various levels of complexity of the anesthesia service provided.

Please note: These lists are subject to change as nationally recognized code sets change.

9.37 Assistant surgeon

Benefits are allowed when medical necessity and appropriateness of services are met. Generally, Medicare guidelines are used to determine this, although cases may be reviewed on an individual consideration basis. Benefits for a covered procedure is 20% of the maximum allowed for the procedure. Applicable modifier is – 80.

Benefits are allowed when medical necessity and appropriateness of assistant surgeon services are met. An assistant surgeon must be appropriately board certified or otherwise highly qualified as a skilled surgeon and licensed as a physician in the state where the services are being provided.

Physician assistants not employed by a hospital may act as an assistant surgeon when the above criteria are met. RN-LPN-first assistants and physician assistants employed by a hospital are not eligible for reimbursement as surgical assistants. BCBSNC corporate medical policy regarding assistant surgeons may be viewed online at bcbsnc.com.

9.38 Physician assistant

Benefits are allowed when medical necessity and appropriateness of assistant surgeon services are met, and when the physician assistant is under direct supervision of the performing surgeon. The PA must be appropriately certified or licensed in the state where the services are rendered, and be credentialed in the facility where the procedure is performed. The physician assistant benefits for a covered procedure is 85% of the maximum allowed for an assistant surgeon. Applicable modifier for surgical assistant is “AS.”

RN-first assistant and nurse practitioners are not eligible for reimbursement as surgical assistants.

Please refer to our online medical policy on co-surgeon, assistant surgeon and physician assistant guidelines for complete details.



Physicians office

9.39 Telemedicine

Telemedicine is defined as the exchange of medical information between sites via electronic communication for the purpose of transmitting clinical information.

The terms “telemedicine” and “telehealth” are often used interchangeably, although “telehealth” is intended to include a broader range of services such as videoconferencing and transmission of still images. The main proposed advantage of telehealth is the capability of delivering medical services to distant areas with low access to medical specialists.

Telehealth services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technology. This may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

North Carolina has enacted Senate Bill 780 which requires that nonresident physicians who treat patients through the use of electronic or other media shall be licensed in this state and shall be subject to reasonable regulations by the North Carolina Medical Board. This bill went into effect September 17, 1997. Interpretation of lab or radiology services by providers who are not licensed in the state of North Carolina is not covered.

BCBSNC corporate medical policy regarding Telemedicine can be viewed online at <https://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/telemedicine.pdf>.

9.39.1 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.

Practitioners who use electronic communication systems should be in compliance with online secure transmission of private patient health information (e.g., HIPAA regulations, encryption). The handling of electronic patient information is considered the same as for an in-office environment, and patient privacy must be maintained. Secured electronic channels have been developed commercially to meet AMA guidelines and HIPAA regulations.

BCBSNC corporate medical policy regarding E-visits can be viewed online at http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/evisits_online_medical_evaluation.pdf.

9.40 Billing for missed appointments

BCBSNC does not cover charges for missed appointments. You may bill members directly for missed appointments only if this is a standard procedure for your practice, and the member has previously received a written statement of this procedure, or your standard procedure for missed appointments is posted in your office in a prominent location.



Physicians office

1500

HEALTH INSURANCE CLAIM FORM

Sample CMS-1500 (08/05) claim form

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Physician's office

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (ID)		1a. INSURED'S I.D. NUMBER 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 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 550 Nobel Avenue	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER QT0321		11. INSURED'S POLICY GROUP OR FECA NUMBER QT0321	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY 02 08 1919 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		b. EMPLOYER'S NAME OR SCHOOL NAME First Bank	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield - NC	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below.		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 DATE 4/28/1999		SIGNED Signature on file	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 04 28 1999		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 04 28 1999	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Lackey, James M.D.		17a. ICD-9-CM PROCEDURE CODE 1B C4612	
17b. NPI 1234567891		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE			
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 250.0 Diabetes		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04 27 99 04 27 99		B. PLACE OF SERVICE 11	
C. EMG 11		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 99214	
E. DIAGNOSIS POINTER 1		F. \$ CHARGES 50 00	
G. DAYS OR UNITS 1		H. EPSON Family Plan 1	
I. ID. QUAL. 1B NPI		J. RENDERING PROVIDER ID. # 040X0 0123456789	
25. FEDERAL TAX I.D. NUMBER 56-9876543		26. PATIENT'S ACCOUNT NO. 987654321	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 50 00	
29. AMOUNT PAID \$ 0 00		30. BALANCE DUE \$ 50 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature of Claim Preparer		32. SERVICE FACILITY LOCATION INFORMATION Regis Medical Center 999 Event Drive Charlotte, NC 28220	
33. BILLING PROVIDER INFO & PH # (704) 555-1111 Regis Medical Center 999 Event Drive Charlotte, NC 28220		a. 1123456789 b. 1B040X0	

NUCC Instruction Manual available at: www.nucc.org

CARRIER
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Ancillary providers

9.41 Participating reference labs and billing

Definition

Laboratory services - reference clinical laboratory testing services as may be requested by BCBSNC participating providers. This would include, but not be limited to, consulting services provided by provider, courier service, specimen collection and preparation at designated provider locations, and all supplies necessary solely to collect, transport, process or store specimens to be submitted to provider for testing.

Billing

- Bill on CMS-1500 claim form using CPT/HCPCS coding
- Specify services provided and include all of the statistical and descriptive medical, diagnostic and patient data
- File claims after complete services have been provided
- Laboratory procedure reimbursement includes the collection, handling and conveyance of the specimen
- All services provided should be billed as global



Ancillary providers

1500

HEALTH INSURANCE CLAIM FORM

Sample reference laboratory claim form

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Ancillary providers

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) BLK LUNG <input type="checkbox"/> (ID) OTHER <input type="checkbox"/>		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) SEX 04 15 1970 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 123 Any Street	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER 615	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX 10 01 2003 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME Working Group	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield - NC	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE 10012003		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 10 01 2003	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 10 01 2003		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 250 0 Diabetes		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 10 22 03 10 22 03 82131		25. FEDERAL TAX I.D. NUMBER SSN EIN 00-0000000 <input checked="" type="checkbox"/>	
26. PATIENT'S ACCOUNT NO. 000000000-0		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$		29. AMOUNT PAID \$	
30. BALANCE DUE \$		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
32. SERVICE FACILITY LOCATION INFORMATION Any Lab Name 1234 Street Name Any City, NC USA		33. BILLING PROVIDER INFO & PH # () Any Lab Name 1234 Street Name Any City, NC USA	
SIGNED _____ DATE _____		a. 1123456789 b. _____	

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Ancillary providers

9.42 Licensed dietitian nutritionist services

Definitions

- Routine supplies and services: The following services are considered routine supplies and services for which payment is included in the reimbursement for licensed dietitian nutritionist services. These items are not separately billable:
 - ‡ Educational materials

General billing guidelines

Provider agrees to:

- Bill only those codes for services indicated as billable licensed dietitian nutritionist services.
- Submit claims either electronically or on a typed red and white CMS-1500 (version 08/05).
- Bill us your retail charges.
- File claims within 180 days of providing service.

Billable licensed dietitian nutritionist services

Billing code	Service description	Unit
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	1 unit (1 unit equals 15 minutes)
97803	Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	1 unit (1 unit equals 15 minutes)
97804	Group (2 or more individual[s]), each 30 minutes	1 unit (1 unit equals 30 minutes)
S9465	Diabetic management program, dietitian visit	Per visit
S9470	Nutritional counseling, dietitian visit	Per visit



Ancillary providers

1500

HEALTH INSURANCE CLAIM FORM

Sample LDN claim CMS-1500 (08-05)

Ancillary providers

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>												PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (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 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 123 Any Street														
CITY City				STATE NC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>				CITY City				STATE NC									
ZIP CODE 12345				TELEPHONE (Include Area Code) (000) 111-2222				9. EMPLOYED <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				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) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY 10 01 2003 M <input checked="" type="checkbox"/> F <input type="checkbox"/>											
b. OTHER INSURED'S DATE OF BIRTH MM DD YY						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)						b. EMPLOYER'S NAME OR SCHOOL NAME Working Group											
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield - NC											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE 10012003												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____											
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 10 01 2003				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 10 01 2003				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 250 0 Diabetes												22. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 06 07 03 06 07 B. PLACE OF SERVICE 11 C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 97802 E. DIAGNOSIS POINTER F. \$ CHARGES 20 00 G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL. 1B 566XY J. RENDERING PROVIDER ID. # NPI 0123456789												25. FEDERAL TAX I.D. NUMBER SSN EIN 00-0000000 <input type="checkbox"/> <input checked="" type="checkbox"/>											
26. PATIENT'S ACCOUNT NO. 000000000-0				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 20 00				29. AMOUNT PAID \$				30. BALANCE DUE \$							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____						32. SERVICE FACILITY LOCATION INFORMATION Dietitian Care 123 Blue Street Blue Town, NC 12345 a. 0123456789 b.						33. BILLING PROVIDER INFO & PH # () Dietitian Care 123 Blue Street Blue Town, NC 12345 a. 0123456789 b. 1B 566XY											

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Ancillary providers

9.43 Home health billing and reimbursement

Please note that home health services are included in BCBSNC's prior review requirements. Please refer to chapter eight, Healthcare management & operations in this e-manual to learn more about prior review for BCBSNC members and see our most current prior review listing, available on the BCBSNC Web site at <https://www.bcbsnc.com/providers/ppa/>.

9.43.1 Definition

Home health services are defined as follows:

- Visits to the home to provide skilled services, including:

Home health services	Must be rendered by
Skilled Nursing (SN)	Registered nurse or licensed practical nurse
Physical Therapy (PT)	Licensed physical therapist
Occupational Therapy (OT)	Licensed occupational therapist
Speech Therapy (ST)	Licensed speech pathologist
Medical Social Service (MSW)	Medical social worker
Home Health Aide (HHA)	Home health aide

- Patient must be homebound
- Postpartum early discharge
If a covered service, when mother and newborn are discharged from an inpatient facility before the expiration of 48 hours for a normal vaginal delivery or 96 hours for a cesarean section, provider may bill a skilled nursing visit if rendered no later than 72 hours following discharge. Prior review must be obtained for this service.

9.43.2 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 9.43.3, Billable non-routine home health supplies	Unit of supply

Home health billing

Provider agrees:

- To bill BCBSNC, and BCBSNC agrees to pay provider, for professional home health services and non-routine home health supplies subject to the terms of the agreement, and specifically the reimbursement terms set forth in this reimbursement exhibits and table 3, incorporated herein by reference, and all applicable BCBSNC programs, policies and procedures as set forth in the agreement, including those policies and rules set forth in the provider e-manual and BCBSNC billing, claims submission, reimbursement and medical policies.

Home health services not billable as separate services (integral part of home health visit):

- Services and supplies that are not billable as separate services (integral part of home health visit) are set out in the provider e-manual and BCBSNC policies and procedures, any of which may be enacted and revised from time to time, including but not limited to, BCBSNC billing, claims submission, reimbursement and medical policies.



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9.43.3 Billable non-routine home health supplies

Routine medical supplies provided in conjunction with home health services including those left at the member's home are considered an integral part of the home health visit reimbursement and cannot be billed separately (under HDME provider number or any other provider number).

Listed on the following page is a list of billable non-routine home health supplies. These non-routine supplies are the only supplies home health providers may separately bill to BCBSNC.

Billable non-routine home health supplies		
The following services are to be billed using the applicable revenue code and HCPCS code		
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, two-way latex with coating	0272	A4311
Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone	0272	A4311
Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	0272	A4313
Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)	0272	A4314
Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone	0272	A4315
Insertion tray with drainage bag with indwelling catheter, Foley type, three-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

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Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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
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 three-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

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Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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
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 4x4 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

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Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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 4x4 or equivalent, extended wear, without built-in convexity, each	0272	A4385
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 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

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Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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, 4x4 inches or smaller, each	0272	A4407
Ostomy skin barrier, with flange (solid, flexible or accordian), extended wear, with built-in convexity, larger than 4x4 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 4x4 inches, each	0272	A4410
Ostomy skin barrier, solid 4x4 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 accordian), without built-in convexity, 4x4 inches or smaller, each	0272	A4414
Ostomy skin barrier, with flange (solid, flexible or accordian), without built-in convexity, larger than 4x4 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

Continued on the following page.



Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
Ostomy pouch, closed; without barrier attached, with filter (1 piece), each	0272	A4418
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
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

Continued on the following page.



Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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
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

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Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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, 6x6 or equivalent, each	0272	A5121
Skin barrier, solid, 8x8 or equivalent, each	0272	A5122
Adhesive or non-adhesive; disk or foam pad	0272	A5126
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	A6021
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

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Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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
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

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Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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
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

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Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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
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

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Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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
Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	0272	A6441
Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	0272	A6442
Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five 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

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Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard	0272	A6445
Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	0272	A6446
Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard	0272	A6447
Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	0272	A6448
Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	0272	A6449
Light compression bandage, elastic, knitted/woven, width greater than or equal to five 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 three inches and less than five 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 three inches and less than five inches, per yard	0272	A6452
Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard	0272	A6453
Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard	0272	A6454
Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard	0272	A6455
Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five 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	0279	A6545

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Ancillary providers

Billable non-routine home health supplies

The following services are to be billed using the applicable revenue code and HCPCS code

Description	Revenue code	HCPCS code
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	A7520
Tracheostomy/laryngectomy tube, 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	0279	E0191
Dry pressure pad for mattress, standard mattress length and width	0279	E0199



Ancillary providers

9.44 Home health reimbursement

9.44.1 Eligible services

- Patients must be homebound to be eligible for coverage. A patient is considered homebound by BCBSNC if the patient:
 1. Has a condition or injury restricting his or her ability to leave home
 2. Has a condition or injury for which leaving the home is medically contraindicated; and/or
 3. Would require the physical assistance and significant supervision of another person in order to leave the home
 4. Transportation issues do not determine if a member is homebound
- You may bill for each home health visit and only the non-routine supplies as identified in your contract and reimbursement schedule.
- **Post-partum early discharge services** - if a covered service, when mother and newborn are discharged from an inpatient facility before the expiration of 48 hours for a normal vaginal delivery or 96 hours for a cesarean section, you may bill a skilled nursing visit if rendered no later than 72 hours after discharge. Prior review must be obtained for this service.

A skilled nursing visit will not be covered if an office visit occurred on the same day. Additional services are subject to medical necessity review. **Note:** This coverage is not available for NC Health Choice members and FEP members at this time.

9.44.2 Ineligible services

- The following services may not be billed under home health and are not part of your home health contract with BCBSNC. This is not an exhaustive list.
 - ‡ Any services when patient is not homebound (refer to medical policy on skilled nursing visits)
 - ‡ Services rendered to a hospice patient under care of a BCBSNC contracting hospice agency (billed by hospice)
 - ‡ Home durable medical equipment (billed by HDME provider)
 - ‡ Respiratory therapy (billed by HDME provider)
 - ‡ Oral prescription drugs (billed by pharmacy)
 - ‡ Aerosolized drugs (billed by pharmacy)
 - ‡ Blood draw nursing visits for home infusion patients (billed as bundled service by home infusion provider)
 - ‡ EKGs
 - ‡ Holter monitoring
 - ‡ Psychiatric services
- Visit our Web site at bcbsnc.com to view our corporate medical policy on home nursing services.



Ancillary providers

1 PRN Nurses 25 Harvest Street Wilson, NC 28214 (919) 000-0000		2		3a PAT. CNTL. # 0000000		4 TYPE OF BILL 331	
8 PATIENT NAME Patient Name		9 PATIENT ADDRESS Any Street, USA Any Town, USA					
10 BIRTHDATE 03221946	11 SEX M	12 DATE 100103	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT 01
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 CODE		37 CODE		38	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / NPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1 0551	Skilled Nursing		10/01/03	1	75.00		
2 0551	Skilled Nursing		10/01/03	1	75.00		
4 0001	Total Charges				150.00		
<p>Sample home health claim UB-04</p>							
PAGE		OF		CREATION DATE		TOTALS	
50 PAYER NAME BCBSNC		51 HEALTH PLAN ID 03X0X		52 REL. INFO Y		53 ASSO. BEN. Y	
54 PRIOR PAYMENTS 0.00		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME John Doe		59 F.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		68		69 ADMIT DX 70 PATIENT REASON DX		71 PPS CODE	
72 EQ		73		74 PRINCIPAL PROCEDURE DATE		75	
76 ATTENDING NPI		77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
80 REMARKS		81CC a b c d		82		83	



Ancillary providers

9.45 Private Duty Nursing (PDN)/ skilled nursing services, billing and claims submission

Please note that all PDN services require prior review from BCBSNC in advance of services being provided. Please refer to chapter eight, Health coaching and intervention in this e-manual to learn more about prior review for BCBSNC members and see our most current prior review listing, available on the BCBSNC Web site at <https://www.bcbsnc.com/providers/ppa/>.

9.45.1 Definition

Private Duty Nursing (PDN) is defined as follows:

- Patient requires four or more hours of continuous skilled nursing care per day in the home.
- Patient must be homebound.
- Services must be rendered by Registered Nurse (RN) or Licensed Practical Nurse (LPN).

9.45.2 Billing codes and unit definitions

Revenue codes	Services	Units
0552	RN per hour (PDN)	Hour
0559	LPN per hour (PDN)	Hour

9.45.3 Private Duty Nursing (PDN) billing

Provider agrees to:

- Bill on UB-04 claim form.
- File claims after complete services have been provided.
- Bill us your retail charges.

Provider agrees that:

- All medical supplies provided in conjunction with PDN services are considered an integral part of the PDN reimbursement and cannot be billed separately (under Home Durable Medical Equipment [HDME] provider number or any other provider number)
- Skilled nursing visits may not be billed on the same days as private duty nursing visits.
- Use your appropriate provider number.
- File claims after complete services have been provided.
- Bill us your retail charges.

Provider agrees that:

- All medical supplies provided in conjunction with PDN services are considered an integral part of the PDN reimbursement and cannot be billed separately (under Home Durable Medical Equipment [HDME] provider number or any other provider number)
- Skilled nursing visits may not be billed on the same days as private duty nursing visits.

9.46 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.
- Include Resource Utilization Groups (RUGs) on all inpatient claim forms, consistent with CMS requirements. For outpatient SNF claims, appropriate revenue codes must be placed in Form Locator 42 for each line item and must include CPT/HCPCS codes in Form Locator 44 to describe specific procedures, when and if, appropriate codes are available.

The following services are not part of your skilled nursing facility contract with BCBSNC and must be billed by a provider contracted with BCBSNC to provide:

- Medical care rendered by a physician.
- Services rendered in a place of setting other than the skilled nursing facility while the member is an inpatient.

Skilled nursing services include but are not limited to the following components:

- Assessing the total needs of the patient.



Ancillary providers

- Planning and managing of a patient treatment plan involving services where specialized health care knowledge must be applied in order to attain the desired result.
- Observing and monitoring the patient's response to care and treatment.
- Teaching, restoring, and retraining the patient.
- Providing direct services to the patient where the ability to provide the services requires specialized education and skills.

Providers should not file claims unless a covered level of care has been provided.

Providers with traditional contracts should bill the rates listed in the contract using the following grid to determine the appropriate revenue code, services and units.

Reimbursement schedule		
UB-04 description	Revenue code	Unit
Room and board - semi-private Routine service charges incurred for accommodations with two beds.	120	Per diem
Physical therapy	420	15 minutes
Occupational therapy	430	15 minutes
Speech-language pathology	1440	15 minutes
All other ancillary services	Various	15 minutes

9.47 Private duty nursing/ skilled nursing services reimbursement

9.47.1 Eligible services

- Patients must be homebound to be eligible for coverage. A patient is homebound if the patient:
 1. Has a condition or injury restricting his or her ability to leave home
 2. Has a condition or injury for which leaving the home is medically contraindicated
 3. Would require the physical assistance and significant supervision of another person in order to leave the home
 4. Transportation issues do not determine if a member is homebound

- PDN patients must require 4 or more hours of continuous skilled nursing care per day.
- All PDN services require certification for all BCBSNC plans.

9.47.2 Eligible healthcare providers

- PDN services must be performed by individuals licensed in North Carolina as a Registered Nurse (RN) or Licensed Practical Nurse (LPN). You must include the names, license numbers, and shifts on each claim.
- PDN services provided by home health aides are ineligible for reimbursement for all BCBSNC lines of business.



Ancillary providers

1 Nursing Station 2053 Olive Boulevard Nashville, NC 27210		2		3a PAT. CNTL #		4 TYPE OF BILL 331	
8 PATIENT NAME Patient Name		9 PATIENT ADDRESS Any Street, USA Any Town, USA		5 FED. TAX NO. 00-0000000		6 STATEMENT COVERS PERIOD 100103 100103	
10 BIRTHDATE 09011925	11 SEX M	12 DATE 100103	13 HR	14 TYPE 01	15 SRC	16 DHR	17 STAT
31 OCCURRENCE DATE 01	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE SPAN FROM	37 OCCURRENCE SPAN THROUGH	38
38 Any Person Any Street Any Town, USA				39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT	
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / NPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0552	Skilled Nursing		10/01/03	5	150.00		
2 0552	Skilled Nursing		10/01/03	4	120.00		
3 0001	Total Charges				270.00		
<p>Sample private duty nursing/ skilled nursing services claim</p> <p>UB-04</p>							
PAGE OF		CREATION DATE		TOTALS			
50 PAYER NAME BCBSNC AETNA		51 HEALTH PLAN ID 002XV 123446	52 REL. INFO Y Y	53 ASSO. BEN. Y Y	54 PRIOR PAYMENTS 0.00 00.00	55 EST. AMOUNT DUE	56 NPI 57 OTHER PRV ID
58 INSURED'S NAME Insured Name One Insured Name Two		59 F.REL. 02 02	60 INSURED'S UNIQUE ID XXXW12345678 XXXW12345678		61 GROUP NAME Ford Equipment		62 INSURANCE GROUP NO. 325 x431
63 TREATMENT AUTHORIZATION CODES 76431			64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME Ford Equipment		
66 DX 67 A B C D E F G H T J K L M N O P Q							
69 ADMIT. DX 74	70 PATIENT REASON DX	71 PPS CODE	72 EQ	73	76 ATTENDING NPI	QUAL	
74 PRINCIPAL PROCEDURE DATE 707.0		75 OTHER PROCEDURE DATE		76 ATTENDING NPI LAST FIRST			
75 OTHER PROCEDURE DATE		76 OTHER PROCEDURE DATE		77 OPERATING NPI LAST FIRST			
76 OTHER PROCEDURE DATE		77 OTHER PROCEDURE DATE		78 OTHER NPI LAST FIRST			
77 OTHER PROCEDURE DATE		78 OTHER PROCEDURE DATE		79 OTHER NPI LAST FIRST			
78 OTHER PROCEDURE DATE		79 OTHER PROCEDURE DATE		80 REMARKS A5			
79 OTHER PROCEDURE DATE		80 REMARKS		81 CC a b c d			



Ancillary providers

9.48 Ambulance and medical transport services billing and claims reimbursement

Definitions:

- Ambulance and medical transport services involve the use of specially designed and equipped vehicles to transport ill or injured patients. Ambulance and medical transports may involve:
 1. The emergency ambulance transport of a patient to the nearest hospital with appropriate facilities for the treatment of the patient's illness or injury; or
 2. The non-emergency medical transport of a registered hospital inpatient to another location to obtain medically necessary specialized diagnostic or treatment services.
- Ambulance services typically involve ground transportation, but may, in exceptional circumstances involve air or sea transportation.

Billing

Provider agrees to:

- Bill only for contracted services as defined in their most current BCBSNC ambulance services provider agreement.
- Submit claims to BCBSNC within 180 days of the date of service.
- Bill electronically or on a typed CMS-1500 (version 08/05) claim form using the appropriate HCPCS code and billing unit.

Eligible services

- Ground emergency ambulance services are eligible for the transport of a patient when all of the following criteria are met:
 - ‡ The ambulance must be equipped with appropriate emergency and medical supplies and equipment; the patient's condition must be such that any other form of transportation would be medically contraindicated; the patient must be transported to the nearest hospital with the appropriate facilities for the treatment of the patient's illness or injury.

- Non-emergency medical transport services for the transport of a hospital inpatient to another facility for specialized services are eligible for the transport of a patient when all of the following criteria are met:
 - ‡ The patient is a registered inpatient in an acute care hospital; the specialized services are not available in the hospital in which the patient is registered; the provider of the specialized services is the nearest one with the required capabilities.
- Air or sea ambulance services are eligible in exceptional circumstances when all of the criteria pertaining to ground transportation are met, as well as one of the following additional conditions:
 - ‡ The patient's medical condition must require immediate and rapid ambulance transport to the nearest appropriate medical facility that could not have been provided by land ambulance; the point of pick-up is inaccessible by land vehicle; great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities for treatment; the patient's condition is such that the time needed to transport a patient by land to the nearest appropriate medical facility poses a threat to the patient's health.

Ambulance or medical transport services are considered eligible for coverage if the patient is legally pronounced dead after the ambulance was called, but before pickup, or enroute to the hospital.

Ineligible services

Ambulance and medical transport services are not covered for:

- A patient legally pronounced dead before the ambulance is called.
- Air or ground transportation provided for patient convenience.

Bundled services

- Reusable devices are considered an integral part of the general ambulance and medical transport services and are not eligible for coverage as separate services.



Ancillary providers

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Sample CMS-1500 (08-05) claim form Ambulance and medical transport

PICA <input type="checkbox"/>												PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPVA <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>												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 02 08 1919 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 550 Nobel Avenue														
CITY Charlotte			STATE NC			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY Charlotte			STATE NC											
ZIP CODE 28220			TELEPHONE (Include Area Code) (704) 555-9099			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH 02 08 1919 M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____						b. EMPLOYER'S NAME OR SCHOOL NAME First Bank											
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME Blue Cross Blue Shield - NC											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>											
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 04/28/1999												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File											
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 04 28 1999						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 04 28 1999						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Lackey, James M.D.						17a. 1B C4612			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
17b. 12345678910						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.											
19. RESERVED FOR LOCAL USE PT Xport to Dialysis, Stretcher D/T PT HX: ESRD, Bilateral AKA, CHF						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 585 End State Renal Disease (ESRD) 3. 428 1 Congestive Heart Failure (M) 2. 897 6 Amputation, Bilateral (LEGS) 4. _____						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. EPSON Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #			
1 03 26 07 03 26 05		41		9		BLS NonEmerg Transport - BER A0428 RJ				1.2.3		175 00		1				NPI					
2 03 26 07 03 26 05		41		9		BLS Mileage - BERT A0425 RJ				1.2.3		153 00		17				NPI					
3 03 26 07 03 26 05		41		9		BLS Disp Supplies - BERT A0382 RJ				1.2.3		42 00		1				NPI					
4																		NPI					
5																		NPI					
6																		NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 370 00				29. AMOUNT PAID \$ 305 53				30. BALANCE DUE \$ 64 47			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature of Claim Preparer						32. SERVICE FACILITY LOCATION INFORMATION From: 111 Blue Road Blue Town, NC 12345 To: 4 Blue Street Blue City, NC 12356						33. BILLING PROVIDER INFO & PH # ()											
SIGNED _____ DATE _____						a. _____ b. _____						a. _____ b. _____											

NUCC Instruction Manual available at: www.nucc.org

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



Ancillary providers

9.49 Billing

General billing guidelines

Provider agrees:

- To bill BCBSNC and BCBSNC agrees to pay provider for home infusion therapy service as defined in this reimbursement schedule, subject to the terms of the agreement and subject to all applicable BCBSNC programs, policies and procedures as set forth in section 2.6.1 of the agreement, including but not limited to, those policies and rules set forth in the provider e-manual and BCBSNC billing, claims submission, reimbursement and medical policies.
- To bill BCBSNC provider's typical retain 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 BCBSNC policies and procedures, including but not limited to BCBSNC billing, claims processing and reimbursement policies, provider agrees to bill home infusion therapy requiring regular nursing services in three 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 a Registered Nurse (RN) or Licensed Practical Nurse (LPN), and
 - ‡ **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 24 hours, but less than 48 hours, are equal to one per diem. If the continuous infusion is equal to or greater than 48 hours, is equal to two per diems.
- Bill on the CMS-1500 claim form.
- Use your appropriate national provider identifier.
- 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 BCBSNC 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 BCBSNC:

- Services and supplies that may not be billed under home infusion and are not part of provider's home infusion contract with BCBSNC are set out in the provider e-manual and BCBSNC policies and procedures, any of which may be enacted and revised from time to time, including but not limited to, BCBSNC 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)



Ancillary providers

- ‡ Durable medical equipment not directly related, as determined by BCBSNC, to the home infusion (billed by HDME provider)
- ‡ Drugs not referenced in the fee schedule (billed by pharmacy)
- ‡ Drugs not related, as determined by BCBSNC, to the home infusion therapy (billed by pharmacy)
- ‡ Any other service, drugs, or equipment identified in the provider e-manual or BCBSNC policies and procedures

9.49.1 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.

9.50 Specialty pharmacy billing and reimbursement

Definitions:

The dispensing of physician prescribed, member specific, pharmaceuticals intended to improve clinical outcomes. Including utilization of information systems to perform safety checks, drug interaction screening and generic substitution (when appropriate).

Billing requirements:

- Bill on typed CMS-1500 (version 08/05) claim form using the appropriate HCPCS or CPT billing code and billing unit.
- Provide the NDC number when there is not a specific code available for a drug, as these drugs will suspend to medical review for individual consideration. Medical review uses the AWP for the specific NDC number, subject to provider contract discounts.

- File claims after complete services have been provided.
- Bill retail charges.

9.51 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 of the following routes: intravenous, intraspinal, epidural, or subcutaneous;
- Home infusion therapy must be supervised by a Registered Nurse (RN) or Licensed Practical Nurse (LPN); and
- 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 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 provider through this agreement.

9.52 Home durable medical equipment billing and reimbursement

Definitions

- Home durable medical equipment is any equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses that can withstand repeated use and is primarily and customarily used to serve a medical purpose and is appropriate for use in the home.



Ancillary providers

- 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 the reaching the listed purchase price of the item. If an item is converted from rental to purchase prior to the rental reaching the purchase price, it is considered the property of the member and is not returned to the provider.

Please note that the HDME supplier must meet eligibility and/or credentialing requirements as defined by BCBSNC, in order to be eligible for reimbursement. HDME when eligible for coverage is considered as part of the member's HDME benefits provision.

Home durable medical equipment billing requirements – general

- Bill on a typed CMS-1500 (version 08/05) claim form.
- Bill maintenance and repair modifier codes first after the procedure code.
- Submit all claims for repairs with a complete description of services provided.
- Use E1399 or other miscellaneous HCPCS codes only if no suitable HCPCS billing code exists. Each claim with such codes must include special documentation:
 - ‡ Always submit a complete description of the item.
 - ‡ With the initial claim, submit a factory invoice for the item (catalogs and retail price listings are not acceptable) and, if appropriate, a certificate of medical necessity form with physician's signature (use appropriate form in chapter 23, Forms).
 - ‡ Do not staple this documentation to the claim form.
 - ‡ Submit all initial claims on paper to ensure the appropriate documentation is received in the same envelope. Electronically submitted claims do not transmit the additional documentation.

Billing requirements – rentals

- Always include modifier code on rental claim forms.
 - ‡ Always include the modifier "RR" in the first modifier location of field 24D on claims for rented items.
 - ‡ Bill for services already provided to a member.
 - ‡ Bill each 30 days of rental as one unit.
 - ‡ Indicate beginning and ending dates of a rental period.

- ‡ If an item is still being rented at the time of the claim, indicate the last day of the billing cycle as the ending date of service.
- ‡ Items filed without the rental modifier and rental dates are assumed to be purchases and are paid accordingly.

Billing requirements – repairs and maintenance

- Use only standard codes and identifiers (HCPCS) when submitting maintenance and repair claims.
- Bill the labor component of the repair under the appropriate repair code.
- Bill all replacement parts separately under the appropriate repair code.
- Bill repairs only on purchased items; they may not be billed on rented equipment.
- When submitting a claim with a repair or maintenance modifier code and other modifier codes, list the repair or maintenance modifier code first after the procedure code.
- For claims with a repair code, submit a complete description of the services provided.
- Failure to provide appropriate documentation when using repair codes can result in processing delays and/or denials.

Reimbursement – general

- **Medical review documentation:** All services that are not authorized in advance (i.e., certification number obtained) will be subject to medical review. The medical review process will be expedited if your files include:
 - ‡ Physician's plan of treatment, including anticipated time frame that the equipment will be needed
 - ‡ Predicted outcomes (therapeutic benefit)
 - ‡ Physician's involvement in supervising the use of the prescribed item
 - ‡ Detailed description of the member's clinical and functional status so that a determination of medical necessity can be made.
- Additional detail can be found in the BCBSNC corporate medical policy for durable medical equipment (policy number: DME0040) located on our Web site for providers at [http://www.bcbsnc.com/services/medical-policy/pdf/durable_medical_equipment_\(dme\).pdf](http://www.bcbsnc.com/services/medical-policy/pdf/durable_medical_equipment_(dme).pdf).



- Reimbursement for new or revised HCPCS codes will be reviewed and adjusted as pursuant to BCBSNC pricing policy. For example, if a new HCPCS code is reviewed and approved, it will automatically be added to the fee schedule (for specific details and instructions, please refer to your contract with BCBSNC and see in chapter 10 of this e-manual the pricing policy for procedure/service codes).

Reimbursement – rentals

- BCBSNC will reimburse rentals up to the purchase price.
- Rental rates are all inclusive. They include all equipment, accessories, supplies, delivery, shipping and handling, labor, set-up, visits, education, maintenance, repairs and replacement parts of HDME.
- Rental rates are monthly. Rental claims that are ongoing will only be processed at the end of each month of service.
- Indicate the last day of the billing cycle as the ending date of service if an item is still being rented at the time you file the claim to BCBSNC.

Reimbursement – repairs and maintenance

Certain items are eligible for maintenance fees after the items have been purchased or if rented to the extent that the combined rental fees have reached or exceeded the price had the item been purchased. Non-routine repairs that require the skill of a technician may be eligible for reimbursement.

Ownership of rental items

- A rented item is considered the property of the provider and should be returned to the provider after it is no longer medically necessary for the member.
- However, a member will retain possession of a rented item until it is no longer considered medically necessary. Providers may not retrieve a rented item until this time.
- The conversion of a rental to a purchase may be done at any time prior to reaching the listed purchase price of the item. If an item is converted from rental to purchase prior to the rental reaching its purchase price, it is considered the property of the member and is not returned to the provider.
- Covered supplies relating to an item that has reached the purchase price will be reimbursed according to the provider's contract.

9.52.1 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.
- When equipment is purchased, coverage for a maintenance or service agreement will be subject to the terms of the provider's contracted maintenance agreement.
- 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.

9.52.2 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; and these services are not eligible for separate reimbursement. Payment of eligible fees will begin on the day the device is delivered to our 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. Monthly rental fees allow for the replacement costs, and are not eligible for separate reimbursement.
- 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.



9.52.3 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 which enhance standard or basic equipment usually serve a convenience function.

9.52.4 Home 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 prorated basis, based on provider contracted rates, when a full 30 days are not utilized by the member.

9.52.5 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.

9.52.6 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 a purchase price that does not exceed \$200. Examples may 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**, 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 may include, but are not limited to: low pressure and positioning equalization pads, home blood glucose monitors, braces for legs, arms, cast boots, cervical brace, and Jobst stockings.

- More expensive DME not classified as "Routinely Purchased DME" (costing above \$200) may be purchased when all of the following criteria are met:
 - a. long term use is expected based on the patient's prognosis (rental is anticipated to exceed purchase price) and
 - b. maintenance of DME
 - c. a rental trial period (applied toward purchase price) has documented patient compliance, patient tolerance, and clinical benefits.

9.52.7 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.

DME may be rented when:

- DME is not classified as "Routinely Purchased DME" (costing above \$200) or **Inexpensive DME** and anticipated medical need is for a limited time frame; or equipment requires high maintenance (requires specialized skills to service the item).
- Examples include, but are not limited to the following: apnea monitors, hospital beds, bili lights and bili blankets, Continuous Passive Motion (CPM), traction, infusion pumps, IPPB, Nebulizers, CPAP, BiPAP, DPAP, lymphedema pumps, oxygen equipment (portable and stationary), ventilators, and 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 prorated basis, based on provider contracted rates, when a full 30 days are not utilized by the member.



Ancillary providers

9.53 Claim form detail for home infusion and durable medical equipment

The following patient and subscriber information is required on the CMS-1500 (version 08/05) claim form:

Field number	Description
1	Put <input checked="" type="checkbox"/> in group health plan or other box
1a	Subscriber's BCBSNC I.D. number
2	Patient's name (last name, first name, middle initial)
3	Patient's date of birth (MM/DD/YYYY) and sex
4	Subscriber's name (last name, first name, middle initial)
5	Patient's address and telephone number
6	Patient's relationship to the subscriber
7	Subscriber's address and telephone number
8	Patient's marital and employment status
9	Additional subscriber's name (last name, first name, middle initial)
9a	Additional subscriber's policy or group number
9b	Additional subscriber's date of birth (MM/DD/YYYY) and sex
9c	Additional subscriber's employer's name or school name
9d	Additional subscriber's insurance plan name
10	Is patient's condition related to employment or accident?
11	Subscriber's policy or group number
11a	Subscriber's date of birth (MM/DD/YYYY) and sex
11b	Subscriber's employer's name or school name
11c	Subscriber's insurance plan name
11d	Does patient have an additional health insurance policy?
12	Patient's or authorized person's signature
13	Subscriber's or authorized person's signature

- For field 12, it is acceptable to indicate signature on file in lieu of an actual signature if you have the original signature of the patient or other authorized person on file authorizing the release of any medical or other information necessary to process this claim.
- For field 13, it is acceptable to indicate signature on file in lieu of an actual signature if you have the original signature of the subscriber or other authorized person on file authorizing assignment of payment to you.



Ancillary providers

The following provider information is required on the CMS-1500 claim form:

Field 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 I.D. number
18	Leave blank
19	<ul style="list-style-type: none"> • Enter national drug code (NDC#) for each drug billed for home infusion • Leave blank for DME
20	Leave blank
21	Diagnosis code and description
22	Leave blank
23	<p>HMO and POS (POS membership ended 6/1/05) certification number</p> <ul style="list-style-type: none"> • Prior plan approval is required for all home infusion therapy services for HMO and POS (POS membership ended 6/1/05) members • Specific HDME services require prior plan approval (see certification list in section 7.5.1.5)
24A	Date(s) of service (MM/DD/YYYY) (start DOS, end DOS)
24B	Place of service 12 Home
24C	Type of service 9 Other medical service A Used DME L Rental supplies in the home
24D	<p>BCBSNC billing code(s)</p> <p><u>Home infusion</u></p> <ul style="list-style-type: none"> • 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 <p><u>DME</u></p> <ul style="list-style-type: none"> • HCPCS or BCBSNC billing code(s) for supplies / equipment • Use "RR" modifier in the first modifier field to indicate that an item is a rental • If no "RR" modifier is used, the item will be considered a purchase
24E	Diagnosis code from block 21 as it relates to each item in 24D

Continued on the following page.



Ancillary providers

Field number	Description
24F	<ul style="list-style-type: none"> • 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	<p>Enter days/units. Units of items listed in 24D If you are billing services for consecutive dates (from and to dates) it is critical that you provide the units accurately in block 24G</p> <p>DME</p> <ul style="list-style-type: none"> • Rental items should be listed as 1 unit / month • See HDME fee schedule for unit information on specific items
24H-K	Leave blank
25	<p>Enter provider's federal tax identification number</p> <p><input checked="" type="checkbox"/> Indicate whether this number is Social Security Number (SSN) or Employer Identification Number (EIN)</p>
26	For provider's record keeping purposes
27	<p>Accept assignment</p> <p><input checked="" type="checkbox"/> Yes must be indicated in order to receive direct reimbursement</p> <ul style="list-style-type: none"> • 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	<p>Enter total amount due</p> <ul style="list-style-type: none"> • Total contracted rates minus any payments received
31	Provider's signature and date
32	Name and physical address of provider
33	<p>Provider's name, billing address, telephone number</p> <p>BCBSNC home infusion therapy or durable medical equipment provider number (PIN#)</p>



Ancillary providers

1500

HEALTH INSURANCE CLAIM FORM

Sample CMS-1500 (08-05) claim form

Home infusion therapy

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		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		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Last Name, First Name	
3. PATIENT'S BIRTH DATE (MM DD YY) 06 15 1976 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. INSURED'S ADDRESS (No., Street) Any Street	
5. PATIENT'S ADDRESS (No., Street) Any Street		8. PATIENT STATUS CITY Any City STATE NC Single <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER 615	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		12. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		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 DATE 10012003	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 10012003		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 10 01 2003	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE D.M. Smith, MD		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 10 01 2003	
19. RESERVED FOR LOCAL USE NDC# 00074653301		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 486		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
B. PLACE OF SERVICE		22. MEDICAD RESUBMISSION CODE ORIGINAL REF. NO.	
C. EMG		23. PRIOR AUTHORIZATION NUMBER 127643	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		24. F. \$ CHARGES	
E. DIAGNOSIS POINTER		25. G. DAYS OR UNITS	
1. 10 01 03 10 01 03 12 9 J3370 1 AWP* 5 NPI		26. H. EPSON Family Plan	
2. 10 01 03 10 01 03 12 9 S9497 1 43 00 5 NPI		27. I. ID. QUAL.	
3. 10 01 03 10 01 03 12 9 99601 1 61 00 1 NPI		28. J. RENDERING PROVIDER ID, #	
4. NPI		29. BALANCE DUE	
5. NPI		30. BALANCE DUE	
6. NPI		31. BALANCE DUE	
25. FEDERAL TAX I.D. NUMBER 56-7774321 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 654320198-1	
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		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
32. SERVICE FACILITY LOCATION INFORMATION PRN Services 4444 Olive Road Any Town, USA		28. TOTAL CHARGE \$ 0 00	
33. BILLING PROVIDER INFO & PH # () a. 04X01		29. AMOUNT PAID \$	
SIGNED DATE		30. BALANCE DUE \$	

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CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



Ancillary providers

1500

HEALTH INSURANCE CLAIM FORM

Sample CMS-1500 (08-05) claim form

HDME rental

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) YPAW12345678	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Last Name, First Name		3. PATIENT'S BIRTH DATE MM DD YY SEX 10 28 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) Any Street	
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. INSURED'S ADDRESS (No., Street) Any Street	
10. IS PATIENT'S CONDITION RELATED TO: Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER R56273	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 10012003		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 10 01 2003		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 10 01 2003	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE D.M. Smith, MD		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE NDC# 1098576822		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 486 2 COPD		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 10 01 03 10 01 03		22. MEDICARD RESUBMISSION CODE ORIGINAL REF. NO. 127643	
B. PLACE OF SERVICE 12 L		23. PRIOR AUTHORIZATION NUMBER 127643	
C. EMG L		24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E0601 RR	
E. DIAGNOSIS POINTER 1		F. \$ CHARGES 105 00	
G. DAYS OR UNITS 1		H. EPSON Family Plan NPI	
I. ID. QUAL. NPI		J. RENDERING PROVIDER ID. # NPI	
25. FEDERAL TAX I.D. NUMBER 56-1234567		26. PATIENT'S ACCOUNT NO. 123456789	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 105 00	
29. AMOUNT PAID \$ 0 00		30. BALANCE DUE \$ 105 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature of Claim Preparer		32. SERVICE FACILITY LOCATION INFORMATION Home Medical Supplier, Inc. 2945 Fern Drive Any Town, USA	
33. BILLING PROVIDER INFO & PH # () Home Medical Supplier, Inc. 2945 Fern Drive Any Town, USA		a. 04XXX	

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Ancillary providers

1500

HEALTH INSURANCE CLAIM FORM

Sample CMS-1500 (08-05) claim form HDME purchase

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (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 MM DD YY M F 05 20 1953 M 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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) Any Street	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Last Name, First Name	
10. IS PATIENT'S CONDITION RELATED TO: Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER T0321	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 10012003		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on File	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 10 01 2003		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 10 01 2003	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE D.M. Smith, MD		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17a. NPI 17b. NPI C46124-0X	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 250.0 Diabetes		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
22. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER 127643	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSTI Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE	
1 10 01 03 12 E0607 51 00 1 NPI		\$ 51 00 \$ 0 00 \$ 51 00	
2 Blood Glucose Monitor		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
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 082903 DATE		32. SERVICE FACILITY LOCATION INFORMATION Equipment Depot 62 North Main Street Any Town, USA	
33. BILLING PROVIDER INFO & PH # () a. 040X0 b.		30. BALANCE DUE \$ 51 00	

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Ancillary providers

9.54 Hospice billing and claims submission

Definition

- **Hospice care services** – services for the care of the terminally ill member with a life expectancy of six months or less. Hospice is a continuum of palliative and supportive care, directed by the patient's physician and coordinated by the hospice care team. The services must be provided according to a doctor-prescribed treatment plan. Hospice care services shall be available 24 hours a day, seven days a week. All covered services must be performed by appropriately qualified/licensed personnel. Continuity of care must be assured for the patient and family (considered a unit of care) regardless of setting (home, inpatient or residential).
- **Levels of care** – there are four levels of care provided by a licensed hospice program, and each level of care includes all services rendered to the member:
 1. Routine home care is home care provided by the hospice program when fewer than 8 hours of care during a 24-hour period is necessary. This may not be billed on days when the patient is an inpatient.
 2. Continuous home care is care provided in the home during a period of crisis necessary to maintain the patient in the home setting. The patient requires mainly nursing care to achieve relief of acute medical symptoms. A minimum of 8 hours of care during a 24-hour period must be necessary to qualify for this level of care. Continuous home care begins with the 9th hour of care rendered within a 24-hour period, and is in addition to the routine home care (per diem) that was rendered during the initial 8 hours.
 3. Inpatient respite care is when the patient is admitted to a hospice unit for no greater than 5 days to provide relief to the regular family caregivers.
 4. General inpatient care is when the patient is admitted to a hospice for round-the-clock care. Situations which may require general inpatient care are medication adjustment which cannot be

provided in another setting and stabilization of treatment. This level of care is short-term and is not intended to be a permanent solution when the patient doesn't have a caregiver in the home.

Per diem rate – the per diem rate (routine home care, inpatient respite care or general inpatient care) will be paid each day during which the member is under a comprehensive program of care. The routine home care per diem is billable regardless of whether direct services are provided on a given day. The per diem rate includes all services rendered to the member.

Billing

Provider agrees to:

- File claims electronically using the HIPAA 837 format or:
 - ‡ Bill on UB-04 claim form.
 - ‡ Bill us the CMM allowed amount.
 - ‡ Bill only one per diem per day.
 - ‡ File claims after complete services have been provided.
- Bill the retail charge for hospice services, not contracted rates.
- The routine home care per diem is billable regardless of whether direct services are provided on a given day.

9.55 Hospice reimbursement

9.55.1 Eligible services

- Providers may bill for each day the member is under hospice care as identified in your contract and reimbursement schedule.
- Services for the care of a terminally ill member with a life expectancy of six months or less. Hospice is a continuation of palliative and supportive care, directed by the patient's physician and coordinated by the hospice care team.
- The services must be provided according to a doctor-prescribed treatment plan.
- The covered services must be performed by appropriately qualified/licensed personnel.



Ancillary providers

9.55.2 Ineligible services

- Medical care rendered by a physician
- The maximum number of hours of continuous home care per day is 16 hours.

Please refer to your contract with BCBSNC for specific details and instructions.

Visit our Web site at bcbsnc.com to view our corporate medical policy on hospice care.

9.55.3 Billing codes and unit definitions

- **Levels of care** - There are four levels of care provided by a licensed hospice program, and each level of care includes all services rendered to the member:

Revenue codes	Services	Units
0651	Routine home care	Per diem
0652	Continuous home care	Per hour (beginning with the ninth hour)
0655	Inpatient respite care	Per diem
0656	General inpatient care	Per diem

- Routine home care is home care provided by the hospice program when fewer than eight hours of care during a 24-hour period is necessary. Routine home care may not be billed on the same day as general inpatient respite care.
- Continuous home care is care provided in the home during a period of crisis necessary to maintain the patient in the home setting. The patient requires mainly nursing care to achieve relief of acute medical symptoms. A minimum of eight hours of care during a 24-hour period must be necessary to qualify for this level of care. Continuous home care begins with the ninth hour of care rendered within a 24-hour period and is in addition to the routine home care (per diem) which was rendered during the initial eight hours.

- Inpatient respite care is when the patient is admitted to a hospice unit for no greater than five days to provide relief to the regular family caregivers.
- General inpatient care is when the patient is admitted to a hospice unit for round-the-clock care. Situations which may require general inpatient care are medication adjustment which cannot be provided in another setting and stabilization of treatment. This level of care is short-term and is not intended to be a permanent solution when the patient does not have a caregiver in the home.

9.55.4 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



Ancillary providers

1 Hospice Station 222 Medical Drive Riverview, NC 99211		2		3a PAT. CNTL # 000000		4 TYPE OF BILL 331	
8 PATIENT NAME Patient Name		9 PATIENT ADDRESS Any Street, USA Any Town, USA		5 FED. TAX NO. 00-000000		6 STATEMENT COVERS PERIOD FROM 100103 THROUGH 100103	
10 BIRTHDATE 09251965		11 SEX M		12 DATE 100103		17 STAT 50	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 CODE		37 CODE		38	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES 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		50 PAYER NAME	
0651 Routine Home Care				10/01/03		1 50 :00	
0651 Routine Home Care				10/01/03		1 50 :00	
0652 Continuous Home Care				10/01/03		16 160 :00	
0651 Routine Home Care				10/01/03		1 50 :00	
0001 Total Charges						310 :00	
50 PAYER NAME BCBSNC		51 HEALTH PLAN ID XX223		52 REL INFO Y		53 ASG BEN. Y	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME Insured's Name		59 F.REL 01		60 INSURED'S UNIQUE ID 000-00-0000-00		61 GROUP NAME First Bank	
62 INSURANCE GROUP NO. QT7777		63 TREATMENT AUTHORIZATION CODES 99999999		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME First Bank	
66 DX 67 A B C D E F G H		68		69 ADMIT DX 586		70 PATIENT REASON DX a b c	
71 PPS CODE V56.0		72 EQ 080300		73		74 PRINCIPAL PROCEDURE DATE 586	
75 OTHER PROCEDURE DATE		76 ATTENDING NPI D.M. Smith, MD		77 OPERATING NPI		78 OTHER NPI	
79 OTHER NPI		80 REMARKS		81CC a b c d		76 QUAL FIRST	

Sample home health claim
UB-04



Ancillary providers

9.56 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: <ul style="list-style-type: none"> • Treatment room services (mobile lithotripter) • Ancillary services delivered in mobile lithotripter unit (including KUB, anesthesia supplies and drugs, and medical surgical supplies) • Use of lithotripter
Billing for institutional lithotripsy services	Services would be billed via the UB-04 claim form using: <ul style="list-style-type: none"> • ICD-9 diagnosis codes 592.0 or 592.1 • Revenue code 790 • A single global bill will be submitted for all services listed above
Professional employed "CRNA" services	All services of an employed CRNA are included in the institutional lithotripsy services rate
Professional urology services	All services of the urologist, notwithstanding location, including: <ul style="list-style-type: none"> • Routine operative and other services delivered on the date of the ESWL procedure • Routine post-operative services delivered after the date of the ESWL procedure. (The currently accepted post-operative period for CPT number 50590 is 90 days.)
Billing for professional urology services	Services will be billed via the CMS-1500 claim form using: <ul style="list-style-type: none"> • ICD-9 diagnosis codes 592.0 or 592.1 • CPT-4 procedure code number 50590 • A single global bill will be submitted for all services listed above.
Institutional facility services	Hospital inpatient services <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Routine and non-routine pre-ESWL services delivered before the day of the ESWL procedure, including diagnostic studies and laboratory tests • Routine and non-routine, post-ESWL services delivered after day of the ESWL procedure, including diagnostic studies and laboratory terms • All other hospital facility services not delivered in the mobile lithotripter unit • Observation room
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 the following page.



Ancillary providers

Specific services included	
Institutional professional services (hospital based physician services)	<ul style="list-style-type: none"> All services of the anesthesiologist, pathologist, and radiologist on the day of the lithotripsy All services of the anesthesiologist, pathologist, and radiologist not delivered on the day of the lithotripsy
Retreatments	Follow up treatment on the same stone or stone fragments, or subsequent treatment on other stones will be reimbursed in the same manner and at the same level as stand-alone initial services, whether or not the re-treatment of subsequent treatment occurred within 90 days of the initial treatment or beyond 90 days of the original treatment.
Bilateral treatments	Treatment to stones on both kidneys on the same date of service will be reimbursed in the same manner and at the same level as stand-alone services.

Revenue codes	Services	Units
790	Institutional lithotripsy services (as defined above)	1
50590 (CPT-4 code)	Professional urology services (current suite of products)	1
50590 (CPT-4 code)	Professional urology services (Blue Edge suite of products)	1

9.57 Dialysis billing and reimbursement

BCBSNC conducts audits of claims to ensure appropriate billing of these services. Please note claims submission reflecting variances in billing patterns not outlined in your current provider agreement, can subject providers to recovery of excess payments/overpayments.

Please refer to the most current version of your contract to review contractual obligations and responsibilities and detailed instructions for billing and claims submission.

9.58 Hearing aid coverage

As of January 1, 2011, hearing aid coverage is available for members under the age of 22 by state mandate. Coverage is provided to members under the age of 22 for one hearing aid for each hearing-impaired ear up to \$2,500 per ear every 36 months. Coverage includes hearing aid evaluation, fittings and adjustments, or supplies such as ear molds. Coverage includes a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered individual. Member liability will apply to deductible and coinsurance before applicable hearing aid benefits are applied.



Ancillary providers

1 Feel Better Health Care Department at 00000 Atlanta, GA 00000-0000 (000) 000-0000		2		3a PAT. CNTL # 0000000		4 TYPE OF BILL 331	
8 PATIENT NAME Patient Name		9 PATIENT ADDRESS Any Street, USA		5 FED. TAX NO. 00-0000000		6 STATEMENT COVERS PERIOD FROM 100103	
10 BIRTHDATE 07111943		11 SEX M		12 DATE 100103		13	
14 TYPE 3		15 SRC		16 DHR		17 STAT 01	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35		36 OCCURRENCE SPAN FROM		37	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
Any Person Any Street Any Town, USA		49		32 10 68		65100 00	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / NPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
821		Hemo/Composite		90935		7 2898 :00	
636		Drugs Requiring Specific		90658		1 8 :95	
636		Drugs Requiring Specific		90747		1 275 :92	
636		Drugs Requiring Specific		J1955		14 504 :00	
636		Drugs Requiring Specific		J3370		4 43 :88	
635		Epoetin, More Than 9,999		Q9932		20 240 :00	
634		Epoetin, Less Than 10,000		Q9932		45 541 :20	
001		Total Charge				4511 95	
PAGE		OF		CREATION DATE		TOTALS	
50 PAYER NAME BCBSNC		51 HEALTH PLAN ID 0059T		52 REL. INFO		53 ASSO. BEN.	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME Insured's Name		59 F.REL. 01		60 INSURED'S UNIQUE ID XXXW12345678		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES 992361010		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME First Bank	
66 DX 585		A V04.8		B V05.3		C 263.1	
D 425.4		E 996.62		F 285.9		G P	
H Q		I R		J S		K T	
69 ADMIT. DX		70 PATIENT REASON DX		71 PPS CODE		72 EQ	
74 PRINCIPAL PROCEDURE DATE		a. OTHER PROCEDURE DATE		b. OTHER PROCEDURE DATE		75	
c. OTHER PROCEDURE DATE		d. OTHER PROCEDURE DATE		e. OTHER PROCEDURE DATE		76 ATTENDING NPI D.M. Smith, MD	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		QUAL	
LAST		FIRST		LAST		FIRST	
80 REMARKS Dialysis Dates 01 03 08 10 26 29 Services Rendered in State of NC		81CC a		b		c	
d		e		f		g	

Sample dialysis claim
UB-04 for PPO members



9.59 Mandated benefits for services related to ovarian/cervical cancer

- Use the following revenue codes:
 - ‡ 0306 - Laboratory/bacteriology and microbiology
 - ‡ 0402 - Ultrasound
 - ‡ 0311 - Cytology
- Always file a V72.3 diagnosis code when an exam is performed for a member to obtain a pap smear.
- File the specific revenue codes when seeking reimbursement for screening mammograms or pap smear services:
 - ‡ 0403 - screening mammograms
 - ‡ 0923 - for pap smears

9.60 New services to hospital's charge master

BCBSNC must be notified for the following types of modifications to a hospital's charge master:

- New hospital services.
- Changes to the existing charge schedule not reflecting a price increase to BCBSNC members (i.e., price decreases, service description changes, service code changes).
- Pharmacy or medical/surgical supply additions to the charge master.
- Pharmacy and medical/surgical supplies are to be priced through the approved pricing formula on file with BCBSNC.

As required by the contracting hospital agreement and hospital participation agreement, modifications to the charge master must be submitted in writing 30 days prior to the proposed effective date. Approval of the modifications is contingent on the extent they meet the Plan's coverage policies as outlined in the coverage and billing policies and procedures and specific group and non-group certificates.

Payment for specific charges will be dependent upon the terms of the member's certificate, less any applicable discount. Correspondence regarding changes should be sent to:

Hospitals and facilities

Health Care Analyst, Network Management
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702-2291

If BCBSNC does not approve the proposed changes, the facility will be notified within thirty days of our receipt of your letter requesting the new service.

9.61 UB-04 claims filing and billing coverage policies and procedures for BCBSNC

For a complete listing of our policies and procedures, refer to our Web site at **bcbsnc.com**.

9.61.1 Anesthesia supplies

- May be charged individually as used or included in a charge, based on time, in one minute increments.
- A charge that is based on time must be computed from the induction of anesthesia (time of first drug given in O.R. by anesthesiologist to induce sedation) until surgery is complete. This charge includes the use of equipment (e.g., monitors), all supplies and all gases.
- Anesthesia stand-by services are not covered unless they are actually used. Bill anesthesia services using revenue code 0370.

The following anesthesia services may be considered medically necessary:

- General anesthesia
- Spinal block anesthesia
- Regional block anesthesia (nerve trunk block and IV anesthesia proximal to elbow and knee)
- Monitored anesthesia care (when used in lieu of general anesthesia)

Regional block and monitored anesthesia care are regarded as equivalent to general anesthesia. Anesthesia services must be administered by an anesthesiologist or a qualified anesthetist under the direction of an anesthesiologist.

The following components are considered an integral part of the anesthesia service and additional benefits are not provided:

- Pre-anesthesia evaluation
- Postoperative visits



Hospitals and facilities

- Administration of anesthetic, fluids and/or blood administered by the Medical Doctor of Anesthesiology (MDA) or qualified anesthesiologist and necessary drugs and materials provided by the MDA
- Interpretation of invasive and/or non-invasive monitoring procedures including: EKG, EEG, EMG, blood gases, capnography, oxygen saturation, evoked potentials
- Services administered in recovery room

When anesthesia services are not covered:

- The administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant is considered incidental to the surgical procedure. This includes sedation given for endoscopic procedures including colonoscopy. Separate reimbursement is not provided for incidental services. (Refer to separate policy number ADM9020, Bundling Guidelines.)
- Monitoring of IV sedation by an anesthesiologist for gastrointestinal endoscope, arteriograms, CT scans, MRIs, cardiac catheterizations, and PTCA is generally considered not medically necessary. Please review the medical policy for anesthesia services at bcbsnc.com.

9.61.2 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.

9.61.3 Autopsy and morgue fee

- Autopsy and morgue fees are not covered under BCBSNC certificates.

9.61.4 Certified Registered Nurse Anesthetist (CRNA)

- Hospital employed CRNA services are reimbursed as a hospital technical fee.

- Use revenue code 0370 to bill for CRNA services (do not file a separate UB-04 claim form for CRNA services).

9.61.5 Critical care units

The following conditions must be met to be considered a critical care unit:

- The unit must be in a hospital and physically separate from general patient care areas and ancillary service areas.
- There must be specific written policies that include criteria for admission to and discharge from the unit.
- Registered nursing care must be furnished on a 24-hour basis. A nurse-patient ratio of one nurse to two patients per patient day must be maintained.
- A critical care unit is not a post-operative recovery room or a post-anesthesia room.

The charge for critical care unit (i.e., coronary care or intensive care unit) has two components:

- The room charge includes all items listed under acute care.
- The nursing increment/equipment charge includes the use of special equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.) cardiac defibrillators, oxygen, supplies (e.g., electrodes, guidewires, telemetry pouches) and additional nursing personnel.

To ensure appropriate benefit payments, the critical care room charge should equal the corresponding routine room rate (i.e., either the routine semi-private or private rate). An accurate breakdown of these components ensures correct claims processing. Any claims received without a breakdown of these components may be returned for correction.

9.61.6 Diabetes education (inpatient)

- Admissions solely for the purpose of diabetic education are not covered under BCBSNC certificates.

9.61.7 Dietary nutrition services

- Dietary evaluation and other nutritional assessment services (e.g., Optifast) are not covered under BCBSNC certificates.
- If included on the UB-04 claim form use UB-04 revenue code 0940.



Hospitals and facilities

9.61.8 Durable Medical Equipment (DME)

- Our current certificates provide benefits for the rental of DME up to but not exceeding the total purchase price of the equipment.

9.61.9 EKG

- The charge for EKG services includes the use of a room, qualified technicians and supplies (e.g., electrodes, gel).

9.61.10 Handling/collection fee

- Generally, BCBSNC does not cover handling/collection fees as separate line ancillaries, unless the specimens are sent to an outside lab for testing. If the hospital does the testing, the handling fees are considered part of the procedure charge. Any markup applied to outside lab send outs must cover all services associated with the send outs (e.g., handling, collection, preparation).

9.61.11 Hearing aid evaluation

- Hearing aid evaluation, hearing aid fitting and hearing screening are not covered under BCBSNC certificates.
- If included on the UB-04 claim form use revenue code 0940.

9.61.12 Intensive outpatient programs

- BCBSNC does provide coverage for intensive outpatient programs. Since intensive outpatient programs are treatment programs, BCBSNC cannot accept individual unbundled charges for the programs. Patients must attend a minimum of a half day to be considered as intensive outpatient treatment. A half day is defined as 3-6 hours. Hospitals are required to negotiate a half and full day program charge with BCBSNC prior to providing this service. The therapies included in the program charge are listed for daily psychiatric services.
- The description for intensive outpatient programs includes:
 - ‡ Adult - full day
 - ‡ Adult - half day
 - ‡ Adolescent - full day
 - ‡ Adolescent - half day
 - ‡ Child - full day

‡ Child - half day

- Use revenue code 0944 to bill for drug rehabilitation and 0945 for alcohol rehabilitation.

9.61.13 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.

9.61.14 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.

9.61.15 Labor and delivery rooms

The labor room charge and delivery room charge must include the cost of:

- The use of the room
- The services of qualified technical personnel
- Linens, instruments, equipment and routine supplies

The hospital should not bill BCBSNC for an obstetrics room in addition to the labor room when patient is still in the labor room at the time of patient census.

9.61.16 Leave of absence days

- BCBSNC does not provide coverage for therapeutic leave of absence days occurring during an inpatient admission whether in connection with the convenience of the patient or the treatment of the patient.
- This charge should be billed directly to the patient as it is the patient's liability.
- If billed on the UB-04 claim form use revenue code 0180 with zero charge in form locator 47.

9.61.17 Clinic billing

BCBSNC will no longer recognize revenue codes 0510 - clinic billing, 0519 - other clinic billing, or 0520 - free standing clinic billing for payment when submitted on a UB-04 by a contracted provider.



Hospitals and facilities

Charges to BCBSNC for these services will be billable only on the professional CMS-1500 claim form from the physician. BCBSNC members should not be billed for denials related to this policy.

9.61.18 Mobile services

- Mobile lithotripsy services are reimbursed through all-inclusive fees. Claims should be submitted with a 0790 revenue code with the surgery code in the primary surgical field of the UB-04 (locator 80). A single global bill will be submitted for all services. For additional information please refer to section 9.56, Lithotripsy billing and claims submission.

9.61.19 Observation services

Observation beds are covered outpatient services when it is determined that the patient should be held for observation, but not admitted to inpatient status.

Use the following guidelines when billing observation charges:

- Bill observation services under revenue code 0762.
- The charges related to an observation bed may not exceed the most prevalent semi-private daily room rate.
- BCBSNC should not be billed for both an observation charge and a daily room charge for the same day of service.
- Observation charges must include all services and supplies included in the daily room charge.
- The daily room rate should not be billed for an observation patient sent home before the midnight census hour.
- When a patient receives services in, and is admitted directly from an observation holding area, such services are considered part of inpatient care.
- Fees for use of emergency room or observation holding area and other ancillary services provided are covered as a part of inpatient ancillaries.

9.61.20 Occupational therapy

- Occupational therapy is a covered ancillary service in a general medical and surgical short-term hospital and rehabilitation hospital, when ordered by a physician to restore function following stroke, trauma, surgery or congenital conditions.

- Occupational therapy is not a covered ancillary service when used in the treatment of mental and nervous illnesses, whether provided in a general short-term hospital or specialty hospital. In these cases, it is considered part of daily general services and reimbursed by the daily accommodation and general services allowance.
- The itemization must be submitted on the claim.
- Fees for use of emergency room or observation holding area and other ancillary services provided are covered as a part of inpatient ancillaries.

9.61.21 Operating room

- The operating room charge may be based on time or per procedural basis. When time is the basis for the charge, it must be calculated from the induction of anesthesia to the completion of the procedure. BCBSNC will allow reimbursement of up to 15 minutes after the documented end of procedure to permit time for any needed prep of the member for the transportation to the recovery area when the care delivered to the patient during this time is documented in the appropriate medical record to substantiate the need for the additional time.
- Operating room services should be billed using revenue code 0360.
- The operating room charge includes, but is not limited to, the cost of:
 - a. Use of the operating room
 - b. Qualified technical and nursing personnel
 - c. Surgical clamps, connectors, connecting tubing
 - d. Surgical gloves, anti fog devise
 - e. Surgical marking pens
 - f. Surgical packs
 - g. Surgical sheets
 - h. Surgical sponges
 - i. Surgical towels
 - j. Surgical retractors
 - k. Surgical blades (exception cuda and gator blades)
 - l. Surgical needles (e.g., spinal needles), needle book holder, needle counter
 - m. Drapes
 - n. Table covers
 - o. Sterile sleeves and leggings
 - p. Syringes



Hospitals and facilities

- q. Test tube cultures
- r. Vaginal bibs
- s. Surgeon's gowns
- t. Surgery prep kits, skin prep.
- u. Surgery pads
- v. Surgery kits, trays and packs.
- w. Warming systems (e.g. Baer Hugger patient warming system, hypo/hyperthermic unit, radiant warmer, etc.)
- x. Bovie/cautery
- Sutures and staples may be billed as operating room supplies or included in the operating room time charge.

9.61.22 Outpatient surgery

- All ancillaries and supplies associated with an outpatient surgical procedure should be billed on one claim. This includes use of facility (pre-operative area, operating room, recovery room), all surgical equipment, anesthesia, surgical supplies, drugs and nourishment.
- All charges associated with preoperative testing performed within 72 hours of the surgical procedure should also be billed on the same claim with the ancillaries and supplies for outpatient surgery.

9.61.23 Behavioral health treatment - partial hospitalization

BCBSNC provides coverage for psychiatric partial hospitalization therapy. Since partial hospitalization is a treatment program, BCBSNC cannot accept individual unbundled charges for this program. Patients must attend a minimum of a half day to be considered for partial hospitalization benefits. A half day is defined as 3-6 hours. Hospitals are required to negotiate a half and full day program charge with BCBSNC prior to providing this service.

Therapies included in the program charge are:

- Activity therapy
- Psychiatric and psychological services
- Individual therapy
- Group therapy
- Family therapy
- Psychiatric social worker
- Adjunctive therapy
- Art therapy

- History and physical
- Music therapy
- Occupational therapy
- Psychotherapy

Use revenue code 0912 to bill for partial hospitalization.

9.61.24 Personal supplies

- Personal supplies include items not ordered by the physician or not medically necessary.
- These items are not covered by BCBSNC health insurance. These items should be billed using UB-04 revenue code 0999.
- Example of personal supplies include:
 - ‡ Hair brush
 - ‡ Mouthwash
 - ‡ Nail clippers
 - ‡ Powder
 - ‡ Razor
 - ‡ Shampoo and conditioner
 - ‡ Shaving cream
 - ‡ Shoe horn
 - ‡ Toothpaste
 - ‡ Toothbrush

9.61.25 Pharmacy

- Take-home drugs should not be filled.
- All pharmacy charges should be billed to BCBSNC using revenue code 0250.
- BCBSNC covers all drugs fully approved by the Food and Drug Administration for general public use.
- Pricing expensive drugs such as Tissue Plasminogen Activator (TPA) using the pharmacy formula would not be reasonable.
- A separate markup may be negotiated for expensive drugs.
- The pharmacy pricing formula must cover the cost of covered drugs prescribed by the attending physician, the cost of materials necessary for their preparation and administration (IV pumps, secondary IV tubing, saline flushes, etc.) and the services of registered pharmacists and other pharmacy personnel.



Hospitals and facilities

- Medications furnished to patients must be billed at the negotiated with no additional charge either for administration of drugs (e.g., IV admixture fee, administration or infusion fees, dispensing fee, etc.) or to cover pharmacy overhead (e.g. pharmacy profile fee, drug assessment fee, dosage consultation, etc.).

- The provider’s written policy and practice is to manage single-use drugs and biologicals and bill all payers in the same manner; and
- The amount billed to BCBSNC as discarded drug is not administered to another patient.

9.61.26 Drug Wastage

Billing BCBSNC for discarded drugs and biologicals

As noted above, BCBSNC will provide payment for discarded drugs or biologicals when certain criteria are met. Specifically, BCBSNC 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 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 BCBSNC for discarded drugs if none of the drug was initially administered to a patient (e.g. BCBSNC beneficiary misses an appointment).
- The amount wasted is recorded in the patient chart or a separate waste report log;

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.

BCBSNC requests providers report the drug amount administered on one 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, HCPCS J2175 descriptor states meperidine hydrochloride, per 100 mg. Therefore, one 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’ts regarding billing for drug wastage.

Do’s	Don’ts
Do bill BCBSNC 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 BCBSNC 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 BCBSNC 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 a dose(s). The use of modifier JW is appropriate for services rendered in all non-inpatient places of service.	Do not bill BCBSNC for drug wastage if none of the drug was initially administered. BCBSNC will not reimburse for unused drugs or biologicals that result from a missed patient appointment.
	Do not bill BCBSNC for discarded drugs or biologicals for multi-use vials.



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9.61.27 Physical therapy

- Physical therapy services should be billed using UB-04 revenue code 0420.
- The itemization must be submitted with the claim.
- The charge for physical therapy must include services of qualified technicians, use of the room and all supplies related to the procedure.
- These charges may be established on a per day treatment basis.
- Physical therapy services are limited to one hour of treatment and/or evaluation or three treatment modalities on a given day.
- To be considered eligible for coverage, the physical therapy services must be delivered by a qualified provider of physical therapy services. A qualified provider is one who is licensed where required and is performing within the scope of the license.

9.61.28 Professional fees

- Professional fees using revenue codes 096X, 097X and 098X should not be billed on the UB-04 claim form.
- Professional charges should be filed on the CMS-1500 (version 08-05) claim form.

9.61.29 Psychiatric room and board

- The psychiatric daily room charge includes the cost of all items listed in acute care as well as the following therapy services:
 - ‡ Adjunctive therapy
 - ‡ Art therapy
 - ‡ Group therapy
 - ‡ History and physical head
 - ‡ Occupational therapy
 - ‡ Psychiatric social worker
 - ‡ Psychotherapy
 - ‡ Music therapy

9.61.30 Recovery room

- The charge for recovery room includes the costs of nursing personnel, routine equipment (e.g., oxygen) and supplies, monitoring equipment (e.g., blood pressure, cardiac, and pulse oximeter), defibrillator, etc.
- Warming systems (e.g., Bair Hugger patient warming system, hypo/hyperthermic unit, radiant warmer, etc.) should not be billed to BCBSNC or the patient.
- Any time after the initial recovery phase should be as observation if billed at all.
- In instances whereby a facility elects to leave BCBSNC members in a recovery room setting versus transferring the patient to observation status following an outpatient/day surgery, the total of the hourly charges associated with the extended recovery room stays (regardless of tier level) cannot exceed the charges we would expect to receive for observation stays following an outpatient surgery.

Reminder: Charges related to an observation stay may not exceed the most prevalent semi-private room rate.

9.61.31 Rehabilitation room

- The rehabilitation room charge includes the cost of all items listed in acute care plus the psychiatric room therapy services.

9.61.32 Emergency room services

- Charges for ER visits and services resulting in an admission must be billed on the UB-04 for the inpatient admission. These charges should not be split out and billed separately.
- Charges for ER visits that do not result in an approved admission must be submitted separately for consideration of payment. These services will be subject to existing prudent layperson language and if approved will reimburse according to the current outpatient reimbursement for your facility.
- Emergency room services can be billed on a UB-04 outpatient claim with a bill type of 13J whenever the inpatient services are denied for non-authorized services or certification is not obtained. This applies to HMO, PPO, POS and CMM claims processed on the PowerMHS claims processing system.



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- The following should be included in the E.R. charge and should not be billed as separate items to BCBSNC or its members:
 - ‡ Administration of medications including IVs. IV Therapy fees, drug administration fees, injection or infusion fees.
- You will be notified via explanation of payment to submit the ER services with a bill type of 13J.
 - ‡ Thermometers, blood pressure apparatus, gloves, tongue depressors, cotton balls and other items typically used in the examination of patients
 - ‡ Thermometers, blood pressure apparatus, gloves, tongue depressors, cotton balls and other items typically used in the examination of patients
 - ‡ Use of examining and/or treatment rooms for routine examination
 - ‡ Routine supplies as a part of normal patient care
 - ‡ Administration of enemas and medications including IVs
 - ‡ Postpartum services
 - ‡ Recreation therapy
 - ‡ Enterostomal therapy (the costs of enterostomal supplies are covered ancillary items)

9.61.33 Room accommodation

- Bill the appropriate rate and corresponding UB-04 revenue code as shown on the BCBSNC hospital participation agreement Statement of Accommodation (SOA). See example of SOA in chapter 23, Forms (form number S133).

9.61.34 Room and board

- The following are included in daily hospital service acute care and should not be billed as separate items to BCBSNC or its members:
 - ‡ Room and complete linen service
 - ‡ **Dietary service:** meals, therapeutic diets, required nourishment, dietary consultation and diet exchange list
 - ‡ General nursing services include patient education such as instruction and materials. This does not include or refer to private duty nursing
 - ‡ All equipment needed to weigh the patient (e.g., scales)

- The following are included in daily hospital service acute care and should not be billed as separate items to BCBSNC or its members:
 - ‡ Room and complete linen service
 - ‡ **Dietary service:** meals, therapeutic diets, required nourishment, dietary consultation and diet exchange list
 - ‡ General nursing services include patient education such as instruction and materials. This does not include or refer to private duty nursing
 - ‡ All equipment needed to weigh the patient (e.g., scales)
 - ‡ Thermometers, blood pressure apparatus, gloves, tongue depressors, cotton balls and other items typically used in the examination of patients
 - ‡ Thermometers, blood pressure apparatus, gloves, tongue depressors, cotton balls and other items typically used in the examination of patients
 - ‡ Use of examining and/or treatment rooms for routine examination
 - ‡ Routine supplies as a part of normal patient care
 - ‡ Administration of enemas and medications including IVs
 - ‡ Postpartum services
 - ‡ Recreation therapy
 - ‡ Enterostomal therapy (the costs of enterostomal supplies are covered ancillary items)

9.61.35 Special beds

- Bill t+-Dyne bed
 - ‡ Clinitron bed
 - ‡ Flexicare bed
 - ‡ Fluidair bed
 - ‡ Just Step mattress
 - ‡ Ken-Air bed
 - ‡ Kinetic therapy bed
 - ‡ Pegasus airwave system
 - ‡ Restcure bed (Hill-Rom EFICA CC)
 - ‡ Roto-Rest bed
 - ‡ Therapulse bed
- Clensicair incontinence management system and Keane specialty beds are not covered as separate line ancillaries. These beds are covered only as part of the approved daily hospital services charge.



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- Nelson patient handling bed is a part of routine orthopedic care and is covered only in the daily accommodation allowance. Do not bill as a separate charge to BCBSNC or our members.
- Burke beds and Big-boy beds are not covered. The charges for these beds should be billed to the patient as they are the patient's liability.
- When the bed is covered, the charge must include the bed itself, the delivery fee, set up and scales.
- Charges for special beds will be reimbursed as a flat fee and should not be priced through the medical and surgical supply pricing formula.

9.61.36 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.

9.61.37 Speech therapy

- Covered speech therapy services should be billed using UB-04 revenue code 0440.
- The itemization must be submitted on the claim.
- Speech therapy is covered only when used to restore function following surgery, trauma or stroke.
- Speech therapy is not considered medically necessary treatment for the following diagnoses:
 - ‡ Attention disorder
 - ‡ Behavior problems
 - ‡ Conceptual handicap
 - ‡ Mental retardation
 - ‡ Psychosocial speech delay
 - ‡ Developmental delay

- To be considered eligible for coverage, speech therapy services must be delivered by a qualified provider of speech therapy services. A qualified provider is one who is licensed where required and is performing within the scope of the license.

9.61.38 Take-home drugs

- Covered take-home drugs should be billed using UB-04 revenue code 0253.
- BCBSNC health benefit plans do not provide inpatient hospital benefits for take-home items.

9.61.39 Take-home supplies

- Covered take-home supplies should be billed using UB-04 revenue code 0273.
- BCBSNC health plan benefits do not cover take-home supplies.
- Benefits are provided for take-home items when the member's health care coverage type includes extended benefits when these items are properly identified on the claim.

9.61.40 Transport services

- Transport services (e.g., nurse transport, attendant's fee and nursing support) are not covered under BCBSNC certificates.
- Services necessary for transporting the patient are provided by the ambulance service.
- These charges should be billed directly to the patient as they are the patient's liability. The patient may then submit a claim for individual consideration using the subscriber submitted claim form.

9.61.41 Transfer services

- Transfers within a participating facility are considered a continuous episode of care and will be included in a single complete claim and reimbursed as one payment. Facilities who have separate provider numbers for inpatient care such as rehabilitation or psychiatric care may bill each episode of care with the appropriate provider number.



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9.62 Fraud and abuse

Fraud and abuse may include, but is not limited to, the following:

- Performing an unnecessary or inappropriate service;
- Billing a service that was not received or misrepresenting a service;
- Billing duplicate claims;
- Unbundling claims;
- Charging in excess of contracted or reasonable fees;
- Accepting referral fees (i.e. kickbacks);
- Collecting monies except for deductible amounts, coinsurance amounts, copayment amounts, and non-covered items as permitted pursuant to BCBSNC's final notification of payment.

Your submission of a claim for payment constitutes a representation by you that the services or supplies reflected on the claim submission, including all quantities set forth on that claim, indeed (1) were medically necessary in your reasonable judgment (except with respect to cosmetic services), (2) were actually performed by you to the member, (3) were filed accurately and using appropriate coding, and (4) have been properly documented in the medical records of the member. Your submission of a claim for payment also constitutes your representation that the claim is not submitted as a form of, or as a part of a practice of, fraud and abuse as described above. Additionally, you agree not to repeatedly and intentionally waive members' deductibles, coinsurance, and copayments. You are responsible for, and these provisions likewise apply to, the actions of your staff members and agents.

Any amount billed by you in violation of this section, if paid by us, constitutes an overpayment by us that is subject to the overpayment recovery process pursuant to your contract. Additionally, any amounts billed to members in violation of this section, if paid by such members, must be immediately refunded to members. Members should not be billed for amounts due resulting from a violation of this section.

Please call the BCBSNC Special Investigation Unit at **1-800-324-4963**, if you suspect fraud and abuse.

9.63 Departmental revenue analysis general instructions

The coverage and billing policies and procedures have been updated to include Blue Cross and Blue Shield of North Carolina (BCBSNC) coverage policies. These coverage policies apply to all participants covered under your current hospital agreement; they do not apply to other third party payors or self-paying patients. Our coverage policies are based on the BCBSNC's insurance certificates, which have been filed with and approved by the North Carolina insurance department. BCBSNC benefits are payable only for covered services as defined in your current hospital agreement and as further explained in this section.

The coverage presented in this document is not all-inclusive of BCBSNC's policies and procedures. It is here to serve as a guide in developing charges for BCBSNC members. This document is not a substitute for your complete charge master. For more information regarding our policies and procedures, visit our Web site at bcbsnc.com.

The hospital must bill for covered hospital services rendered to BCBSNC participants in accordance with the approved charge schedule. It is our understanding that pharmacy and medical/surgical supplies are priced using the approved pricing formula. Any charge code with a corresponding dollar amount of \$0.00 will be considered a hospital service requiring no additional charge to BCBSNC or the patient unless the hospital specifically requests and receives approval from BCBSNC to use miscellaneous codes. When miscellaneous codes are used, actual cost information must be well documented in patient files to support the amount billed. BCBSNC and its participant-patients cannot accept liability for miscellaneous items where the cost is not adequately documented.

Changes to the approved charge schedule must be submitted to BCBSNC, in writing, at least 30 days in advance of the effective date of the proposed change. BCBSNC and its participant-patients will not accept liability for charges, which have not been agreed to by the hospital and BCBSNC in accordance with your hospital agreement.

Professional fees using revenue codes 96X, 97X, and 98X are not recognized on the UB-04 claim form. Professional charges should be filed on the CMS-1500 claim form.



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Job related injuries are covered by Workers' Compensation. Workers' Compensation cases must not be billed to BCBSNC.

Benefits are excluded for procedures determined by BCBSNC to be experimental or investigative in nature. When a medical or surgical procedure is determined to be experimental or investigative, benefits are excluded for all hospital services associated with the procedure. Complications arising from any experimental or investigative procedures are also not covered. Experimental or investigative procedures are patient liabilities.

Uniform billing codes

Copies of the uniform billing (UB-04) may be ordered from:

The North Carolina Hospital Association
Post Office Box 4449
Cary, North Carolina 27519-4449

If you have questions, please call the North Carolina hospital association at **(919) 677-4224**. All hospital services must be billed on the UB-04 claim form.

9.63.1 General coverage determinations

Clinic billing revenue code updates

The following revenue codes are not reimbursable when submitted on a UB-04 form:

- 510 – clinic billing
- 519 – other clinic billing
- 520 – free-standing clinic billing

Positron Emission Tomography (PET):

For our complete medical policy, refer to our Web site at **bcbsnc.com**. When billing for covered services, please use UB-04 revenue code 0404.

Stand-by services and call-back services are covered only when actually received by the patient. Stand-by services that are not used are considered overhead costs. A hospital's overhead costs must be incorporated into its charges for services that are actually rendered to and received by the patient. BCBSNC and its members cannot accept liability for services not received.

Stat and after-hours services are covered only when they are ordered by the physician to be done immediately. Charges for after-hours services are not to be billed to BCBSNC just because they are incurred outside normal working hours.

Observation beds are covered outpatient services when it is determined that the patient should be held for observation but it has not been determined that the patient should be admitted as an inpatient. For our complete medical policy, refer to our Web site at **bcbsnc.com**.

- Bill observation services under revenue code 762.
- The charges related to an observation bed may not exceed the most prevalent semi-private daily room rate.
- BCBSNC would not expect to be billed for both an observation charge and a daily room charge for the same day of service.
- Observation charges must include all services and supplies included in the daily room charge.
- The daily room rate should not be billed for an observation patient sent home before the midnight census hour.
- When a patient receives services in and is admitted directly from an observation holding area, such services are considered part of inpatient care. Fees for use of emergency room or observation holding area and other ancillary services provided are covered as a part of inpatient ancillaries.

Collection (e.g., venipuncture) and handling fees are not covered unless an outside lab performs the test. If the hospital does the testing, the fee is considered part of the procedure charge.

Items specially built for handicapped patients (e.g., hair and toothbrushes, knives, forks, spoons) are non-covered under our present certificate. Non-covered services are the patient's liability and should be billed directly to the patient.

The goal of **total parenteral nutrition, hyperalimentation**, is to replace and maintain all essential nutrients by intravenous infusion in patients for whom oral or tube feedings are contraindicated or inadequate. Hyperalimentation solutions used with a long-term parenteral nutrition system are covered as drugs by BCBSNC certificates.

Special monitoring equipment (e.g., dinemapp, swan ganz, cardiac, pressure monitor, and telemetry) charges must include the use of the supplies (e.g., electrodes, guidewires, and telemetry pouches). When special monitoring equipment is used by a patient in routine or general accommodations, a separate monitoring equipment charge may be billed.



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When a patient is using special monitoring equipment in the operating room, recovery room, or anesthesia department and is transported to another ancillary department or a room, a separate monitoring equipment charge must not be billed. Monitoring equipment used during transport is considered a continuation of services.

Set up fees that represent personnel time only are considered part of the procedure/treatment fee. A separate fee must not be billed to BCBSNC or the participant-patient.

9.63.2 Charge-to-charge comparison

Daily hospital service-acute care - Daily hospital service is recommended as a replacement for the phrase "Room and Board." Services and supplies included in the daily hospital service charge are:

- a. Room and complete linen service. Examples include: bath cloth, pillow case, soap, blanket, sheets, towels
- b. Dietary service: meals, therapeutic diets, required nourishment, dietary consultation, and diet exchange list.
Dietary supplements are especially formulated products designed to increase the amount of various food elements required to maintain or to correct a deficiency, which may exist. BCBSNC certificates generally do not provide benefits for dietary supplements. These supplements are considered to be a part of daily hospital service and are not to be billed for separately either to BCBSNC or to its participant-patients. Examples of dietary supplements and/or tube feeding supplements are: Ensure, Isocal, Sustagen, Forta, Osmolite, Vivonex
- c. General nursing services including patient education (e.g., instructions and materials). This does not include private duty nursing.
- d. All equipment needed to weigh the patient (e.g., scales). A separate fee must not be billed to BCBSNC or the participant-patient.
- e. Thermometers, blood pressure apparatus, gloves, tongue blades, cotton balls, and similar items used in the examination of patients.
- f. Use of examining and/or treatment rooms for routine examinations.

- g. Routine supplies provided as a part of routine care. Examples are: all tape, wipes, swabs, scrubs, bib, scales, body lotion, bedpans, bedside commode, urinals, toilet tissue, elevated toilet seat, air freshener, deodorizing machine, water pitcher, patient gown, facial tissues, emesis basin, breast pump and supplies, nursing pads, petroleum jelly, hydrogen peroxide, alcohol, epsom salts, adult diapers, specimen traps, hot water bottles, ice bags, heating pads, humidifiers, vaporizers, limb restraints, chux, and underpads.
- h. Administration of enemas and medications including IV/administration/infusion or IV ad mixture. Please note that the costs of the medication and administration sets are covered ancillary items.
- i. Postpartum services.
- j. Recreation therapy.
- k. Enterostomal therapy. Please note that the costs of the enterostomal supplies are covered ancillary items.

Special monitoring equipment (e.g., dinemapp, swan ganz, cardiac, pressure monitor, and telemetry) charges must include the use of the supplies (e.g., electrodes, guidewires, and telemetry pouches). Special monitoring equipment charges may be billed separately when used by a patient in routine or general accommodations.

Special beds

The following beds are covered as a separate charge when medically necessary:

- a. Bio-Dyne bed
- b. Clinitron bed
- c. Flexicare bed
- d. Fluidair bed
- e. Just Step mattress
- f. Ken-Air bed
- g. Kinetic Therapy bed
- h. Pegasus Airwave System
- i. Restcure bed (Hill-Rom EFICA CC™)
- j. Roto-Rest bed
- k. Therapulse bed

Clensicair incontinence management system and Keane specialty beds are not covered as separate line ancillaries. These beds are covered only as part of the approved daily hospital service charge.



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Nelson patient handling bed is a part of routine orthopedic care and is covered only in the daily accommodation allowance. Do not bill as a separate charge to the BCBSNC or our members.

Burke beds and big-boy beds are not covered. The charges for these beds should be billed to the patient as they are the patient's liability.

When the bed is covered the charge must include the bed itself, the delivery fee, set up, and scales.

Charges for special beds will be reimbursed as a flat fee and are not to be priced through the medical and surgical supply pricing formula. These beds must be billed using UB-04 revenue code 0946 or 0947.

Nursery - The services and supplies indicated in the daily hospital service charge for acute care are also included in the daily hospital service charge for nursery plus other similar items necessary in the routine care of infants such as bottles, diapers, baby powder, sterile safety pins, isolettes, and radiant warmers.

Labor and delivery room - The labor room charge and delivery room charge each must include the cost of:

- a. The use of the room.
- b. The services of qualified technical personnel.
- c. Linens, instruments, equipment, and routine supplies.

The hospital must not bill the plan for an OB room in addition to the labor room fee when the patient is still in the labor room at time of census.

Psychiatric room - The psychiatric room charge includes the cost of all items listed in acute care as well as the following therapy services:

- a. Adjunctive therapy
- b. Art therapy
- c. Group therapy
- d. History and physical
- e. Music therapy
- f. Occupational therapy
- g. Psychiatric social worker
- h. Psychotherapy
- i. Recreation therapy

Leave of absence days

BCBSNC does not provide coverage for therapeutic leave of absence days occurring during an inpatient admission whether in connection with the convenience of the patient or the treatment of the patient.

This charge should be billed directly to the patient as it is the patient's liability. If billed on the UB-04 claim form, please use revenue code 0180.

Partial hospitalization/intensive outpatient programs -

The program charges include the therapy services listed for daily psychiatric services. Partial hospitalization must be billed using UB-04 revenue code 0912. Intensive outpatient must be billed using UB-04 revenue codes 0944 for drug rehab and 0945 for alcohol rehab. Patients must attend a minimum of a half-day to be considered as partial hospitalization/intensive outpatient.

Rehabilitation room - The rehabilitation room charge includes the cost of all items listed in acute care plus the psychiatric room therapy services listed above.

Critical care units - Critical care units represent special treatment areas of a hospital for critically ill patients. Care includes continuous observation by specially trained nurses and the availability of special equipment and lifesaving techniques. To be considered a critical care unit, the unit must meet the following conditions:

- a. The unit must be in the hospital.
- b. The unit must be physically separate from general routine patient care areas and ancillary service areas.
- c. There must be specific written policies that include criteria for admission to, and discharge from, the unit.
- d. Registered nursing care must be furnished on a continuous 24-hour basis.
- e. A minimum nurse-patient ratio of one nurse to two patients per patient day must be maintained.
- f. The unit must be equipped, or have available for immediate use, lifesaving equipment necessary to treat the critically ill patients for whom it was designed. This equipment includes, but is not limited to, respiratory and cardiac monitoring equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.), cardiac defibrillators, and wall or canister oxygen.

A critical care unit is not a post-operative recovery room or a post-anesthesia room.

The charge for a critical care unit, though generally stated as a single dollar amount, has two components:

- a. The room charge includes the cost of all items listed under acute care.



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- b. The nursing/equipment charge includes the use of special equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.) cardiac defibrillators, oxygen, supplies (e.g., electrodes, guidewires, telemetry pouches) and additional nursing personnel.

Ventilators are billable separate line ancillaries. The ventilator charge must include the use of the equipment and **all** supplies.

Recovery room - The charge for recovery room includes the costs of nursing personnel, routine equipment (e.g., oxygen) and supplies, monitoring equipment (e.g., blood pressure, cardiac, and pulse oximeter), defibrillator, etc.

When a patient is using monitoring equipment in the recovery room and is transported to another ancillary department or a room, a separate monitoring equipment charge should not be billed for use of this equipment during transport. Monitoring equipment used during transport is considered a continuation of recovery room services.

Warming systems (e.g., Bair Hugger patient warming system, hypo/hyperthermic unit, radiant warmer, etc.) are considered part of the departmental overhead cost where it is used (e.g., recovery room). A separate fee must not be billed to BCBSNC or the participant-patient.

Operating room - The operating room charge may be based on time or on a procedural basis. When time is the basis for arriving at the charge, it must be calculated from the induction of anesthesia to the completion of the procedure. The operating room charge includes the cost of:

- a. Use of the operating room
- b. Qualified technical and nursing personnel
- c. Surgical clamps or connectors
- d. Surgical gloves
- e. Surgical marking pens
- f. Surgical packs
- g. Surgical sheets
- h. Surgical sponges
- i. Surgical towels, utility towels
- j. Surgical retractors
- k. Surgical blades
- l. Surgical needles (e.g., spinal needles)
- m. Drapes
- n. Table covers

Sutures and staples may be billed as operating room supplies or included in the operating room time charge.

- o. Sterile sleeves and leggings
- p. Syringes
- q. Test tube cultures
- r. Vaginal bibs
- s. Surgeon's gowns
- t. Surgery prep kits, pads, trays

Stand-by services are not covered unless they are actually used.

Stereotactic radiosurgery: For our complete medical policy, refer to our Web site at bcbsnc.com.

Operating Room Services

Sutures and staples may be billed as operating room supplies or included in the operating room time charge.

Certified Registered Nurse Anesthetist (CRNA) -

Hospital employed CRNA services are considered to be hospital services under your current hospital agreement and will be reimbursed as a hospital technical fee. The hospital should bill for CRNA services on the hospital UB-04 form using UB-04 revenue code 0370.

Anesthesia services - Anesthesia supplies may be charged individually as used or included in a charge based on time. A charge that is based on time must be computed from the induction of anesthesia until surgery is complete. This charge includes the use of equipment (e.g., monitors), all supplies, and all gases. Anesthesia stand-by services are not covered unless they are actually used.

Anesthesia supplies may be either charged individually as used or included in a charge based on time, but not both.

Diagnostic services - The charges for radiology, CT scans, ultrasound, MRI, nuclear medicine, and other diagnostic tests must include the use of a room, qualified technicians, films, dyes (e.g., ionic contrast agents, other enhancing agents), and supplies. Separate charges will be negotiated for injection fees and expensive dyes (e.g., non-ionic contrast agents).

• Call-back and stat charges

Call-back and stat charges are not to be billed just because they are incurred outside normal working hours. These charges are covered only when the procedure is ordered by the physician to be done immediately.



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EKG - The charge for EKG services includes the use of a room, qualified technicians, and supplies (e.g., electrodes, gel).

- **Cerebral death EEG**

Cerebral death EEG is not covered under our present BCBSNC certificates. This charge must not be billed as a separate line ancillary to BCBSNC.

- **Stat charges**

Stat charges must not be billed just because they are incurred outside normal working hours. These charges are to be billed to BCBSNC only when the procedure is ordered by the physician to be done immediately.

Lab/blood bank services - The charge for clinical laboratory must include the cost of all supplies related to the tests performed and a fee for the administration of the department. The charge for tissue (pathology) should include the cost of all supplies (e.g., arterial blood gas kits) related to the tests performed. Arterial puncture charge should be included in charge for test.

- **Stat charges**

Stat charges should not be billed just because they are incurred outside normal working hours. These charges should be billed to BCBSNC only when the procedure is ordered by the physician to be done immediately.

Handling/collection fee

Generally, BCBSNC does not cover handling/collection fees as separate line ancillaries, unless the specimens are sent to an outside lab for testing. If the hospital does the testing, the handling fees are considered part of the procedure charge. Any markup applied to outside lab send outs must cover all services associated with the send outs (e.g., handling, collection, preparation).

American Red Cross (ARC)

Charges for blood units received from the ARC should include pass through costs from the ARC, minor supplies, administrative costs, and additional lab tests performed on blood by the hospital.

Autologous blood

Charges for autologous donations are covered when such services are rendered for a specific purpose (e.g., surgery is scheduled or the need for using autologous blood is documented) and then only if the patient actually receives the blood.

Prophylactic autologous donations and long-term storage (e.g., freezing of components) for an indeterminate time period in case of future need are not considered eligible for benefits. Blood used must be billed on the same claim as the related surgery charges.

Directed blood donations

Directed blood donations (e.g., from relatives) are covered only to the extent that regular homologous blood donations are covered. No additional charges for directing the blood is covered. This would be the patient's liability.

Central supply - The medical and surgical supply pricing formula must cover the cost of the supplies and the cost of preparing, handling, and storing the supplies.

Special supplies are those given directly to patients for whom a charge is made, e.g., sterile trays and the use of equipment.

General supplies are those used by other departments, the cost of which is included in the charge for the department where it is used, such as operating room supplies and daily hospital service supplies.

Personal supplies

Personal supplies include items not ordered by the physician or not medically necessary. These items are not covered by BCBSNC health insurance. These items should be billed using UB-04 revenue code 0999. The liability for payment of these charges is that of the patient and not BCBSNC. Examples of personal supplies include:

- Baby car seat
- Baby oil
- Batteries
- Bedroom shoes
- Books
- Clothes bag
- Combs
- Cot or bed rental
- Denture cup
- Deodorant
- Father's supplies
- Guest meals
- Hair brush
- Hair spray
- Home humidifier
- Key holder



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- Linen saver
- Mirror stand
- Mouthwash
- Nail clippers
- Patient's gown
- Patient education books
- Pillow paws (disposable shoes)
- Powder
- Razor
- Shampoo and conditioner
- Shaving cream
- Shoe horn
- Shoe laces
- Sunglasses
- Telephone calls
- Television
- Toothpaste
- Toothbrush

Take-home supplies

BCBSNC certificates do not provide inpatient or patient hospital benefits for take-home items. Benefits are provided for take-home items by comprehensive and supplemental major medical and extended benefits when these items are properly identified on the claim. Please use UB-04 revenue code 0273 when billing supplies for take-home use.

Isolation supplies

Isolation supplies related to patient care are covered when the patient must be isolated due to a contagious disease or infection. Isolation supplies used for the convenience or protection of visitors are not covered and should be billed directly to the patient.

Tampons, sanitary pads, and sanitary belts are covered for OB/GYN patients only.

Durable Medical Equipment (DME)

BCBSNC certificates provide benefits for the rental of Durable Medical Equipment (DME) up to but not exceeding the total purchase price of the equipment. Charges for these items will be reimbursed as a flat fee and should not be priced through the medical and surgical supply pricing formula. Charges for durable medical equipment should be billed using UB-04 revenue code 0291 so that claims may be processed promptly and accurately.

Pharmacy - Generally, BCBSNC covers all drugs fully approved by the FDA for general public use.

Pricing expensive drugs such as Tissue Plasminogen Activator (TPA) using the pharmacy formula would not be reasonable. A separate markup may be negotiated for expensive drugs.

The pharmacy pricing formula must cover the cost of covered drugs prescribed by the attending physician, the cost of materials necessary for their preparation and administration, and the services of registered pharmacists and other pharmacy personnel. Medications furnished to patients must be billed at the negotiated rate with no additional charge either for the administration of drugs (e.g., I.V. admixture fee, dispensing fee, etc.) or to cover pharmacy overhead (e.g., pharmacy profile fee, drug assessment fee, dosage consultation, etc.).

Take-home drugs

BCBSNC certificates do not provide inpatient or patient hospital benefits for take-home items. Benefits are provided for take-home items by comprehensive and supplemental major medical and extended benefits when these items are properly identified on the claim. Please use UB-04 revenue code 0253 when billing for prescriptions filled by the pharmacy for take-home use.

Inhalation therapy - The charge established for this service must include the use of any special room, qualified technicians, and supplies.

Physical therapy - The charge must include the use of a room, qualified technicians, and all supplies related to the procedure. These charges may be established on a per treatment basis, a modality basis, or a time basis. Physical therapy services are limited to one hour of treatment and/or evaluation or three treatment modalities on a given day. To be considered eligible for coverage, the physical therapy services must be delivered by a qualified provider. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered physical therapy services should be billed using UB-04 revenue code 0420.

Activities in daily living and home programs

Activities in daily living/and or home programs instruction are not covered under the present BCBSNC certificates. These services should be billed to the patient as they are the patient's liability.



Hospitals and facilities

Occupational therapy - Occupational therapy is physical medicine primarily directed to restoration of functional activities and coordination, and prevention of deformities through exercise, muscle strengthening, retraining, and/or re-education.

Occupational therapy is a covered ancillary when ordered by a doctor and delivered by a qualified provider of occupational therapy services to restore function following stroke, trauma, surgery, or congenital conditions. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered occupational therapy services should be billed using UB-04 revenue code 0430.

Occupational therapy is not a covered ancillary when used in the treatment of mental and nervous illnesses. In these cases, it is considered a part of daily general services and reimbursed by the daily accommodation and general services allowance.

Speech therapy - Speech therapy is treatment for the correction of speech impairment resulting from disease, surgery, injury, or congenital anomaly. Speech therapy is covered only when used to restore a function following surgery, trauma, or stroke. There is no benefit coverage for the following diagnoses:

- a. Attention disorder
- b. Behavior problems
- c. Conceptual handicap
- d. Mental retardation
- e. Psychosocial speech delay

To be considered eligible for coverage, these services must be delivered by a qualified provider. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered speech therapy services should be billed using UB-04 revenue code 0440.

Hearing aid

Hearing aid evaluation and hearing aid fitting are not covered under our present BCBSNC certificates. If included on the UB-04 claim form, please use revenue code 0940. Otherwise these charges should be billed to the patient.

Consultations/evaluations

Consultations/evaluations for physical therapy, inhalation therapy, occupational therapy, and speech therapy are covered only if they are actually for tests and measurements with appropriate reports. However, if the evaluation is just a consultation, it is not covered.

Outpatient services -

Outpatient cardiac rehabilitation programs

BCBSNC reimburses hospitals for outpatient cardiac rehabilitation programs only when the programs are certified by the North Carolina Cardiac Rehabilitation Plan. Covered outpatient services should be billed using UB-04 revenue code 0943.

Inpatient cardiac rehabilitation is considered part of routine care for a cardiac patient and is reimbursed through the daily hospital service charge.

Outpatient services

1. The outpatient cardiac rehabilitation program must be certified by the North Carolina Cardiac Rehabilitation Plan.

Outpatient diabetes program

BCBSNC provides reimbursement for outpatient diabetes self-care services. Reimbursement will be made for the three types of services listed below. One total charge should be made for each program, not a per visit charge:

- a. Outpatient diabetic self-care program: 3-6 hours of individual counseling for survival skills to include medication administration, diet basics, potential emergencies (e.g., diabetic, ketosis, hypoglycemia, acute illness), and glucose testing.
- b. Comprehensive outpatient diabetic self-care program: 12-16 hours (with a minimum of 4 hours of individual counseling) to include pre and post assessment, review of survival skills, medication adjustment, exercise, pathophysiological teaching, and preventive aspects.
- c. Follow-up review of diabetic self-care program: minimum of 2 hours, to be performed at 6 months, 12 months, and annually thereafter.

Covered services should be billed using UB-04 revenue code 0949.

Inpatient diabetes education

Admissions solely for the purpose of diabetic teaching are not covered under our present certificates.

Dietary/nutrition services

Dietary evaluation and other nutritional assessment services (e.g., Optifast) are non-covered under our present BCBSNC certificates. If included on the UB-04 claim form, please use UB-04 revenue code 0940.

Autopsy and morgue fee

Autopsy and morgue fees are not covered under our present BCBSNC certificates.



Hospitals and facilities

Transport services

Transport services (e.g., nurse transport, attendant’s fee, and nursing support) are not covered under our present BCBSNC certificates. We would expect services necessary to transport the patient to be provided by the ambulance service. These charges should be billed directly to the patient as they are the patient’s liability. The patient may then submit a claim for individual consideration using the subscriber submitted claim form. The patient can obtain this form from their nearest BCBSNC service office.

Mobile services

Mobile cardiac catheterization and mobile lithotripsy services will be reimbursed through all-inclusive fees.

Lithotripsy

Extracorporeal Shock Wave Lithotripsy (ESWL) is generally accepted medical practice for removal of stones in the renal calyx, pelvis, and upper half of the ureter when the following indications are present:

- a. Patient would undergo a surgical procedure to remove the stone if ESWL were not performed;
- b. Stones are at least 3 millimeters in diameter;
- c. The stone-containing kidney is functional;
- d. Contraindications are not present.

Treatment of stones that are asymptomatic or likely to pass spontaneously is not medically necessary.

The plan expects stones of the size 1½ cm or less to be successfully removed by a single ESWL treatment. Therefore, there will be no additional reimbursement for professional or hospital charges for subsequent treatments of stones that were originally 1½ cm or less in size unless documentation of extenuating circumstances is provided.

Extracorporeal shock wave lithotripsy devices for gallstones have not received FDA approval; therefore, ESWL for gallstones is considered investigational and is not covered by BCBSNC. Charges for this service should be billed to the patient.

9.64 Hospital agreements

- The Contracting Hospital Agreement (CHA) typically provides the basis for BCBSNC’s other hospital agreements except for those with a Hospital Participation Agreement (HPA).
- Changes to a hospital’s approved charge master schedule or the addition of new services must be submitted to BCBSNC in writing at least 30 days before the effective date of the proposed change, as stated in section VII B of the CHA and attachment 3 of the HPA.
- Acceptance of a hospital’s price increase is conditional upon the return of the signed Statement of Accommodation (SOA) charges form, Exhibit I (for an example of the SOA, please see chapter 23, Forms).

9.65 Standard reimbursement methodologies

Inpatient services	Outpatient services
Per case rate by type of case with additional per die payments for outlier cases Per diem rate by type of case Payment based on Diagnosis Related Groups (DRG) Percentage of CHA or HPA approved charges	Case rate for select procedures Percentage of CHA or HPA approved charges Percentage of CHA or HPA approved charges with a maximum cap



Ambulatory surgical centers

9.66 Claims submission

All ancillary services and supplies provided in conjunction with an ambulatory surgical procedure, including those delivered within seventy-two (72) hours prior to the surgical procedure, must be billed to BCBSNC on the same UB-04 form using revenue code 0490. The following requirements also apply to ASC claims:

- The principle procedure must be listed in form locator 80.
- The principle procedure must also be placed in the first position of form locator 44.
- Secondary procedures should be listed in form locator 44, following the placement of the primary procedure. (Up to seven secondary procedures may be considered in addition to the primary procedure.)
- ASC providers should file with the revenue code 490 with the bill type 831.
- Except for non-grouped procedures, ASC reimbursements are all-inclusive and are not reimbursed separately for ancillary charges in addition to the surgical procedure.
- ASC providers should file corrected claims with bill type 837 to indicate the replacement of a prior claim.

Health benefit plans	Reimbursement methodology
<p>Comprehensive Major Medical (includes the State of NC Teachers' and State Employees' Comprehensive Major Medical Plan)</p>	<ul style="list-style-type: none"> • The case-type categories are based upon CPT-4 codes that are paid on a fixed amount per procedure • For surgical CPT-4 codes falling outside these defined ASC groupings, reimbursement is based on a negotiated percentage of the ASC provider's accepted charge • For multiple surgical procedures, the provider is reimbursed 100% of the BCBSNC allowance for the procedure listed on the first line of the claim, and 50% of the BCBSNC allowance for the remaining eligible procedures. • Procedures performed in conjunction with the primary surgical procedure considered by BCBSNC to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures generally include secondary procedures performed by the same physician through the same incision or by the same operative approach.
<p>PPO products</p>	<ul style="list-style-type: none"> • Prospective reimbursement based upon a negotiated discount from the lesser of a) the traditional/comprehensive major medical indemnity level or b) retail charges • For multiple surgical procedures, the provider is reimbursed 100% of the BCBSNC allowance for the procedure listed on the first line of the claim, and 50% of the BCBSNC allowance for the remaining eligible procedures. • Procedures performed in conjunction with the primary surgical procedure considered by BCBSNC to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures generally include secondary procedures performed by the same physician through the same incision or by the same operative approach.

Continued on the following page.



Ambulatory surgical centers

Health benefit plans	Reimbursement methodology
<p>HMO and POS products</p>	<ul style="list-style-type: none"> • Prospective reimbursement based upon a negotiated discount from the lesser of a) the comprehensive Major Medical indemnity level or b) retail charges • For multiple surgical procedures, the provider is reimbursed 100% of the BCBSNC allowance for the procedure listed on the first line of the claim, and 50% of the BCBSNC allowance for the remaining eligible procedures. • Procedures performed in conjunction with the primary surgical procedure considered by BCBSNC to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures generally include secondary procedures performed by the same physician through the same incision or by the same operative approach.

9.67 Billing

Payment of an all inclusive fixed charge per procedure group includes, but is not limited to, the use of the facility including the following:

- Pre-operative complete blood count and urinalysis
- Pre-operative preparation
- Use of facility including pre-operative area, operating rooms and recovery rooms - primary and secondary
- All surgical equipment, anesthesia, surgical supplies, drugs and nourishment
- Donor services, EKG, implants, pumps, labs, radiology, etc.
- Extended stay/recovery
- Services of staff

In order to receive the expected contractual reimbursement, ASC claims should be filed with an amount equal to the indemnity rate and CPT code as indicated in the contract.

9.68 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.

9.69 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.

9.70 Integral procedures

Procedures considered integral occur in multiple surgery situations when one or more of the procedures are considered an integral part of the major or principle procedure. Integral procedures are considered to be those commonly carried out as part of a total service and will not be reimbursed separately.



Ambulatory surgical centers

9.71 Non-grouped procedures

If the first procedure on the first line of form locator #44 is a non-grouped CPT code and falls outside of the defined ASC groupings, this will be considered the primary procedure.

Non-grouped primary surgical procedures will be allowed at a percent of the provider's accepted charge for indemnity members "CMM."

Non-grouped primary surgical procedures will be allowed at the applicable managed care allowance for managed care members.

If the non-grouped procedure(s) is on the second or subsequent lines of form locator #44, it is considered a secondary procedure(s) and if eligible for payment, will be allowed at 50% of the provider's accepted allowance for that member's line of business (i.e., PPO, HMO, POS, CMM).

9.72 Modifiers

For bilateral procedures, BCBSNC will accept modifier - 50 in conjunction with CPT codes on the UB-04 claim form in form locator #44. Form locator #44 may have a separate line for each CPT code with 1 unit in form locator #46 or a single line CPT code in form locator #44 with 2 units reflected in form locator #46. RT and LT modifiers may be used when applicable.

BCBSNC allows additional reimbursement for secondary procedures according to Clear Claim Connection (C-3) logic. C-3 is accessible through current **Blue eSM** applications. The billing of modifier 59 on a secondary procedure will not allow additional reimbursement if C-3 logic disallows the code or bundles the code into the primary procedure code. To learn more about signing up for **Blue eSM** and obtaining C-3 access, visit BCBSNC electronic solutions on the Web at <http://www.bcbsnc.com/providers/edi/>, or refer to chapter 12 of this e-manual.

9.73 Ambulatory Surgical Center (ASC) reimbursement

Any amounts collected erroneously by you from a member for any reason will be refunded to the member within forty-five (45) days of your receipt of notification or your discovery of such error.

Participating providers agree to accept as full and final payment by BCBSNC for medically necessary covered services which are in compliance with BCBSNC healthcare management & operations programs for either of the following:

- The allowed amount, minus deductible, coinsurance, and/or copayment amounts;
- The provider's accepted charge minus deductible, coinsurance, or copayment amounts;
- A percent of the provider's accepted charge minus deductible, coinsurance, or copayment amounts, whichever amount is less.

Ambulatory Surgical Center (ASC) claims are reimbursed according to an internally developed ASC grouping system. The ASC groupings were created by identifying surgical CPT-4 codes that can generally be performed in an outpatient setting and then grouped according to the amount of resources required to perform the procedure. These groupings are updated for changes, additions and deletions in CPT-4 codes.

BCBSNC ASC groupings are similar in concept to Medicare's current ASC groupings, but are more comprehensive, and utilize more payment groups. The BCBSNC ASC groupings are unique to BCBSNC.

If the ASC files a code which conflicts with coding submitted by the attending physician one of the following actions will be taken by BCBSNC:

- Mail the claim back.
- Request operative notes.

Coordination of Benefits (COB)





10.1 Coordination of Benefits (COB)

Generally, Coordination of Benefits (COB) is the method of combining payments when more than one health insurance carrier covers the same person (the patient) such that total benefits paid are limited to 100% of eligible charges. When there is an indication of additional health insurance coverage, and when COB is legally and contractually permissible, it is the policy of BCBSNC to seek to identify the other coverage and to establish the order of benefits prior to adjudicating the claim. This process is known as pursue and pay.

BCBSNC's policies on COB are generally intended to make sure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources.

BCBSNC may determine that we do not have primary liability for a covered service based on the coordination of benefits provisions in the member's benefit plan or that we have partial liability under other provisions of the member's benefit plan. When this occurs our payment to you will not exceed the amount necessary to bring your total payment including but not limited to all amounts paid by us under other benefit plans or by third party benefit plans or by the member to the amount that you are entitled to receive as payment in full under your current provider agreement.

This section will provide general guidelines for determining order of benefits. The COB processes described in this document reflect BCBSNC's current policies and are intended to comply with current law as applicable. These descriptions are general, and may not take into account all that apply.

Under BCBSNC policy, when a provider submits a claim for a spouse or a dependent child of a BCBSNC subscriber that reports other coverage but BCBSNC has not received or does not have in its records definitive information to correctly determine liability, BCBSNC will deny the claim and request additional information pertaining to the other coverage. BCBSNC will re-open the claim when the requested information is received within 18 months of the date of service (per the member's benefit booklet) or one year from the date of denial, whichever is later.

10.2 BCBSNC as secondary carrier

For BCBSNC to determine our liability as the secondary carrier, all claims must be filed with the primary insurance carrier first, then filed electronically with primary payment information or sent via paper to BCBSNC with an Explanation of Benefits (EOB) from the primary insurance carrier. Whether the primary insurance carrier paid or denied the claim, BCBSNC must receive an official indication of this determination to determine liability. Even though some members with dual coverage may wish to use a particular plan because it may have better benefits than the other plan, claims still must be filed with primary insurance carrier first. In order for BCBSNC to pay secondary liability with respect to any service or benefit, the member must follow our applicable rules and guidelines. That means member must follow same authorization/approval procedures as if we were the only carrier. In all cases, the amount owed by BCBSNC as secondary liability will be no more than BCBSNC's allowed amount.

If BCBSNC is secondary, the following rules apply:

Procedural rules:

- All prior review and certification policies and procedures must be followed according to the member's BCBSNC plan. A member is considered a member whether they are a primary, secondary or tertiary subscriber of a Blue Cross and/or Blue Shield insurance policy. Your contract applies whether the member is primary, secondary or tertiary. File with the primary plan first.
- After the primary plan pays its benefits, you must electronically file the secondary claim along with the primary payment information. Please refer to the electronic filing section for additional instructions if needed.
- If you do not submit claims electronically, forward the primary plan's Explanation of Payment/Notification of Payment (EOP/NOP) along with a paper claim form to BCBSNC. Please do not staple EOB to claim form.

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 BCBSNC 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 BCBSNC's and member's payment amount:

- BCBSNC may determine that we do not have primary liability for a covered service based on the coordination of benefits provisions in the applicable member's benefit plan. When this occurs, participating providers agree that the BCBSNC payment to you will not exceed the amount necessary to bring the total payment including but not limited to all amounts paid by BCBSNC under other benefit plans, or by third party benefit plans, or by the member, as to the amount you are entitled to receive as payment in full under the agreement you have with BCBSNC.
- If BCBSNC receives a claim for which BCBSNC is secondary, the claim will be suspended pending BCBSNC's receipt of an official record of the primary plan's payment or denial. When the claim is suspended for this reason, a message will appear on the EOP/NOP. BCBSNC will coordinate benefits up to the contractual allowance as defined by the contract. In accordance with your contract, payments received by the provider from the primary carrier or by any other third party are considered payment towards the contractual allowance under your BCBSNC contract. The member's liability is always limited to the member's deductible, coinsurance and/or co-payment under the BCBSNC policy. Additionally, BCBSNC and our member's combined liability is always further limited to the amount that remains unpaid toward the contractual allowance under your BCBSNC contract. The amounts payable by BCBSNC and by the member are as specified in the NOP. Disallowed amounts/services cannot be billed to the member.
- If the primary carrier has paid as much or more than BCBSNC's contractual allowance, the member should not have any liability.

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 co-pays, deductibles, and coinsurance. This applies both to coordination with other group coverage as well as Medicare. This type of coordination puts greater financial liability on the member. Under MOB, the member's liability is generally calculated as other coverage allowed minus BCBSNC allowed amount minus BCBSNC deductible, coinsurance and co-pay. If anything remains, it will be paid towards coordination. You, as a provider, should come out whole; greater financial liability is on the member.

10.4 BCBSNC as dual coverage

If a member has dual BCBSNC coverage (i.e., BCBSNC is both primary and secondary), the secondary BCBSNC coverage is typically responsible for covering any member co-payments, coinsurance and deductibles, but not responsible for any disallowed amounts as a consequence of our contractual agreement.

When BCBSNC is both primary and secondary, you must submit two (2) separate claims. Submit the first claim to the primary BCBSNC plan using the member's complete identification number (alpha prefix and subscriber number including suffix, if applicable). Upon receipt of the primary EOP/NOP, submit another claim to the secondary BCBSNC plan using the member's complete second identification number (alpha prefix and subscriber number including suffix, if applicable) indicating the primary EOP/NOP payment amount for electronic claims.

For paper claims, submit a copy of the primary payer's EOP/NOP with the secondary claim. If our records indicate the BCBSNC is secondary and the primary plan's (including BCBSNC) EOP/NOP information is not received, we will deny the claim and request that the primary plan's EOP/NOP information (for electronic claims) or EOP/NOP copy (for paper claims) be submitted with the secondary claim filing to BCBSNC.



10.5 BlueCard®

All secondary BlueCard® claims should be filed through BlueCard®. Refer to chapter five, The BlueCard® program for more COB information.

10.6 Worker's compensation

BCBSNC will not pay for services provided for any illness or injury sustained by a member if benefits (in whole or in part) are either payable or required to be provided under any worker's compensation or occupational disease laws. If a claim is received for specific illnesses or injuries, a letter will be sent to the member to obtain additional information. When benefits for an occupational condition, disease, or injury are no longer available under the worker's compensation law, the exclusion no longer applies. However, maximum benefits are allowed only if all applicable referral and certification requirements are met. Once you receive your EOP/NOP from BCBSNC, you may file with the secondary carrier.

10.7 Non-COB list

In most cases, BCBSNC will not coordinate with the following types of policies. The following is a partial list of the non group plans we do not coordinate with:

- AFLAC
- AARP
- CHAMPUS
- EDS Federal
- Carolina Alternatives
- Carolina Access
- NC Access
- Medicaid
- School insurance policies
- TRICARE
- Workman's compensation policies

10.8 Order of benefit determination – commercial

COB for subscriber or spouse:

1. If one of the two insurance carriers does not have a COB clause in its policy that plan is primary. Blue Advantage® does not have a COB clause, meaning that Blue Advantage® will coordinate only with Medicare as the primary policy.
2. If both carriers have a COB clause in their policies, the carrier covering the patient as its subscriber or policyholder is primary, and the carrier covering the patient as a spouse of the policyholder is secondary.

COB for dependent children:

When the parents are not separated or divorced, determining primary/secondary carrier when a dependent child is the patient is done by applying the parent's birthday rule. The parent whose birthday comes first during the year is primary; the parent's birth month that comes first is primary. If both parents have the same birth month then the primary carrier is based on the birth whichever parent's birthday comes first during that month. If both parents have the same birthday, the parent's carrier whose coverage has been in effect longer is primary. If the other plan has a rule based upon the gender of the parent instead of the birthday rule, the rule in the other plan determines the order of primary or secondary carrier.

When the parents are separated or divorced, the following order of benefit determination applies, unless a court decree indicates otherwise:

When one parent has custody:

1. The parent with custody is primary. The certificate of the parent with court ordered financial responsibility for medical, dental, or health care expenses is determined primary
2. The step-parent with custody is secondary
3. The parent without custody is third carrier to pay
4. The step-parent without custody is the fourth carrier to pay

When parents have joint custody:

1. Primary – parent with the earliest birthday (not year)
2. Secondary – parent with the latest birthday (not year)
3. Third – step-parent married to the parent with the earliest birthday (not year)
4. Fourth – step-parent married to the parent with the latest birthday (not year)



When custody is not indicated:

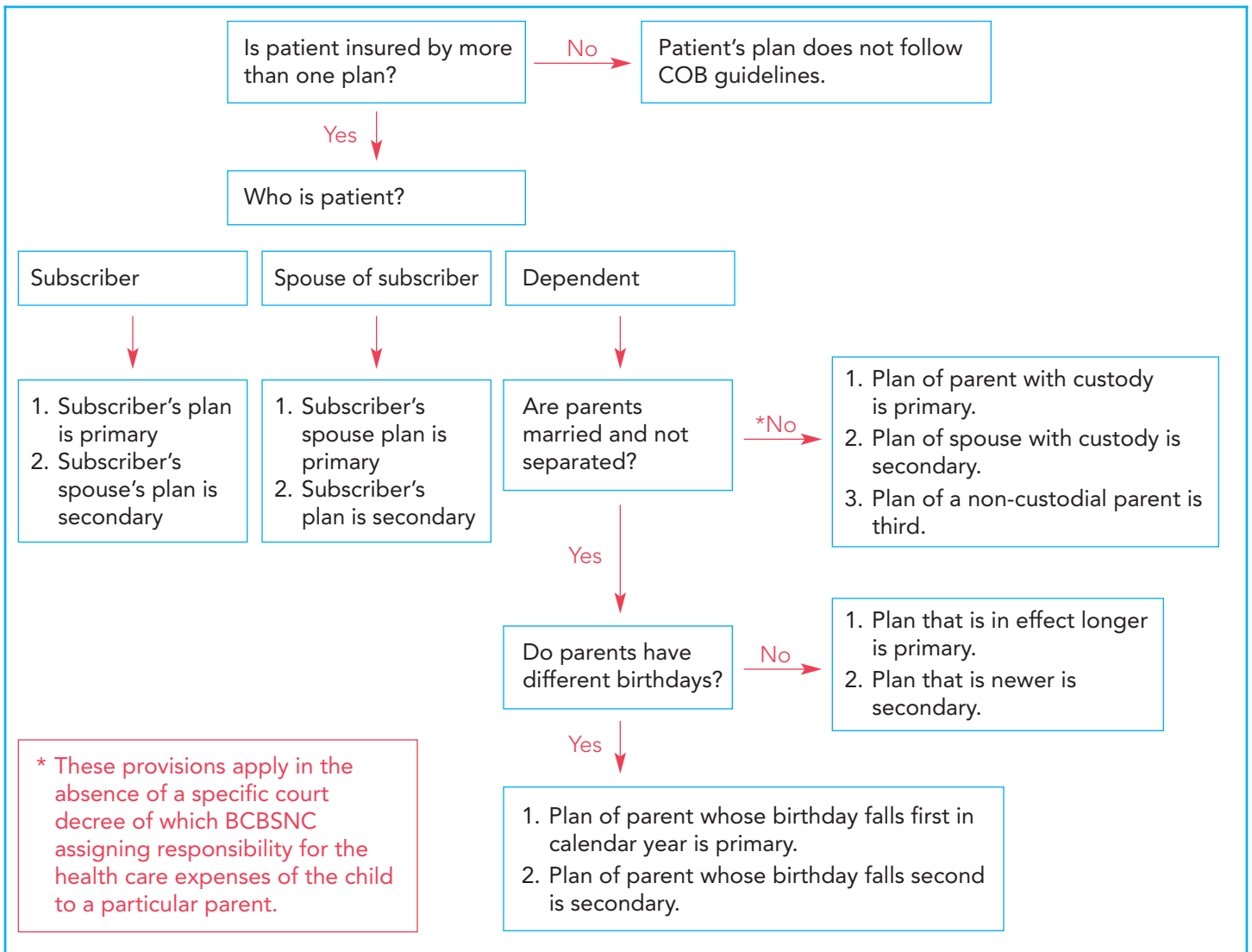
When custody has not been indicated, BCBSNC assumes custody is held by the parent with whom the child resides, and determines the order of benefits as follows:

1. Primary – parent where the child resides
2. Secondary – step-parent married to the parent where the child resides
3. Third – parent where the child does not reside
4. Fourth – step-parent married to the parent where the child does not reside

COB for newborns:

Please wait until after the birth of the child to file a claim in order to determine which policy applies using the birthday rule.

Order of benefits determination chart





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 BCBSNC for the following circumstances.

- BCBSNC is primary for individuals with End-Stage Renal Disease (ESRD) during the first 30 months of Medicare eligibility.
- For individuals 65 and over, that are covered by employers that employ 20 or more employees, BCBSNC is primary if the individual or the individual’s spouse (of any age) has current employment status.
- For disabled individuals under 65 that are covered by employers that employ 100 or more employees, BCBSNC is primary if the individual or a member of the individual’s family has current employment status.
- For individual policies, once Medicare is effective, Medicare becomes primary.

Medicare beneficiary is... Over 65	Medicare primary	Group primary
Actively working and the employer has less than 20 employees	X	
Actively working and the employer has 20 or more employees		X

Retired and has group coverage through a spouse who is actively working for an employer with less than 20 employees	X	
Retired and has group coverage through a spouse who is actively working for an employer with 20 or more employees		X
Retired and has group coverage through a spouse who is retired	X	
Retired employee	X	
Has COBRA coverage	X	

Medicare beneficiary is... Under 65 and disabled	Medicare primary	Group primary
Actively working and the employer has less than 100 employees	X	
Actively working and the employer has 100 or more employees		X
Not actively employed	X	
Not actively employed and has group coverage through a spouse who is actively working for an employer with less than 100 employees	X	
Not actively employed and has group coverage through a spouse who is actively working for an employer with 100 or more employees		X
Has COBRA coverage	X	



ESRD entitlement Beneficiary is receiving dialysis treatment at a treatment center	Medicare primary	Group primary
Beneficiary has group coverage, including a retirement plan or COBRA coverage. First 30 months of Medicare entitlement. Entitlement starts 3 months after the first date of dialysis unless beneficiary has received self-dialysis training. Example: A person starts a regular course of dialysis on July 15th they would be entitled to Medicare on October 1st.		X
Beyond 30 months of Medicare entitlement.	X	
Medicare eligibility due to age or disability occurred prior to ESRD eligibility and Medicare was appropriately the primary payer following the age and disability rules above.	X	

ESRD entitlement Beneficiary is receiving self-dialysis	Medicare primary	Group primary
Beneficiary has group coverage, including a retirement plan or COBRA coverage. First 30 months of Medicare entitlement. Entitlement starts with first date of month in which dialysis begins.		X
Beyond the first 30 months of Medicare entitlement.	X	
Medicare eligibility due to age or disability occurred prior to ESRD eligibility and Medicare was appropriately the primary payer following the age and disability rules above	X	

Note: For multiple employer arrangements (including labor union plans) if any employer within the group has 100 or more employees the plan is considered a large group health plan for purposes of applying the disability rules set out above, and Medicare due to disability is secondary to the group coverage for employees of all employers within that group.

Caution: Fluctuations in the group size may occur for small group and major accounts. Be aware that these fluctuations can affect the Medicare primary status.



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. If you have questions regarding your hold harmless provision, please contact your local BCBSNC Network Management field office (see section 2.12, BCBSNC Network Management – local offices) for more information.

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	\$1000.00
Commercial carrier paid	\$ 800.00
Group allowance	\$ 900.00
Group liability	\$ 100.00

(We pay secondary up to our liability/allowance. If the other carrier has paid more than the group’s allowance, we will not make a secondary payment. Claims are still subject to the SHP deductible and coinsurance, if applicable. We will apply deductible and coinsurance to any payments)

UB-04:

Charge amount	\$1000.00
Commercial carrier paid	\$ 800.00
Group allowance	\$1000.00
Group liability	\$ 200.00

(Benefits will be applied)

Medicare primary

CMS-1500:

If provider accepts Medicare’s assignment

Charge amount	\$1000.00
Medicare allowed	\$ 800.00
Medicare paid	\$ 640.00
Group liability (Medicare allowed, less Medicare payment)	\$ 160.00

If provider does not accept Medicare’s assignment

Charge amount	\$1000.00
Group allowed	\$ 800.00
Medicare paid	\$ 640.00
Group liability (Charge, less Medicare payment)	\$ 360.00

UB-04:

If provider accepts (or does not accept) Medicare’s assignment

The group plans liability is Medicare’s coinsurance and/or deductible. Our payment may not equal 100% of Medicare’s coinsurance and deductible. (The provider’s participation with Medicare does not affect our secondary liability.)

10.12 Individual business COB examples

Medicare is always primary once member becomes effective with Medicare.

CMS-1500:

If provider accepts Medicare assignment:

- I.

Charge amount	\$545.00
Medicare allowed	\$247.51
Medicare paid	\$198.01
BCBSNC liability (Medicare allowed, less Medicare payment. Our payment may not equal 100% of Medicare’s coinsurance and deductible)	\$ 49.50
- II.

Charge amount	\$2456.00
Medicare allowed	\$ 0.00
Medicare paid	\$ 0.00
BCBSNC liability (see scenario’s a and b below)	\$?



- a. EOB shows charges as denied, verify Medicare action code. If Medicare will reconsider the charge we will deny the claim awaiting the Medicare EOB.
- b. If Medicare will not reconsider the charge will pay BCBSNC liability.

If provider does not accept Medicare assignment:

Charge amount	\$1000.00
Medicare allowed	\$ 800.00
Medicare paid	\$ 640.00
BCBSNC liability	\$ 360.00
Provider charge minus the Medicare payment.	

UB-04:

Accept assignment or not, plan's liability is coinsurance and/or deductible amounts. Our payment may not equal 100% of Medicare's coinsurance and deductible.

- A1 = Inpatient deductible
- A2 = Inpatient coinsurance
- B1 = Outpatient deductible
- B2 = Outpatient coinsurance

The following deductibles apply under 2006 Medicare;

- Inpatient deductible = \$952.00 (Medicare Part A)
- Outpatient deductible = \$124.00 (Medicare Part B)

If provider does accept Medicare's assignment

Charge amount	\$1000.00
Medicare allowed	\$ 800.00
BCBSNC contract allowed	\$ 700.00
Medicare paid	\$ 640.00
State's liability "SHP"	\$ 60.00

BCBSNC coordinates based on the lesser of the allowed amounts

Allowed - Medicare Payment = SHP Liability
(The SHP's liability is still subject to deductibles and co-payments)

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 co-payments.

- A1 = Inpatient deductible
- A2 = Inpatient coinsurance
- B1 = Outpatient deductible
- B2 = Outpatient coinsurance

10.13 State Health Plan (SHP) COB examples

**Administrative Services Only (ASO)/
Commercial carrier primary:**

CMS-1500:

Charge amount	\$1000.00
Commercial carrier paid	\$ 800.00
SHP liability	\$ 200.00
(the SHP's liability is still subject to deductibles and co-payments)	

Medicare primary:

CMS-1500:

If provider does not accept Medicare's assignment

Charge amount	\$1000.00
BCBSNC 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 co-payments)	

10.14 Federal Employee Program (FEP) COB examples

**Administrative Services Only (ASO)/
Commercial carrier primary:**

CMS-1500:

Charge amount	\$1000.00
Commercial carrier paid	\$ 800.00
FEP allowance	\$ 900.00
FEP liability	\$ 200.00
(the FEP's liability is still subject to deductibles and coinsurance)	

UB-04:

Charge amount	\$1000.00
Commercial carrier paid	\$ 800.00
FEP liability	\$ 200.00
(the FEP's liability is still subject to deductibles and coinsurance)	



Medicare primary:

CMS-1500:

If provider accepts Medicare’s assignment

Charge amount	\$1000.00
Medicare allowed	\$ 800.00
Medicare paid	\$ 640.00
FEP’s liability	\$ 160.00
(Medicare allowed, less Medicare payment)	

If provider does not accept Medicare’s assignment

Charge amount	\$1000.00
Medicare allowed	\$ 800.00
Medicare paid	\$ 640.00
FEP’s liability	\$ 160.00
(Please note for FEP the physicians who do not accept Medicare assignment can only bill up 115% of the Medicare approved amount called the limiting charge.)	

UB-04:

BCBSNC primary carrier:

Total billed amount	\$1500.00
BCBSNC allowed amount	\$1000.00
BCBSNC paid amount	\$ 800.00
FEP’s liability	\$ 200.00

10.17 HIPAA – 837 professional batch claims

When filing an 837 professional claim to BCBSNC as the secondary or tertiary payer, please note the following for proper claim handling:

- At the claim level, file only the actual amount paid by the other carrier in the 2300 AMT segment for payer amount paid. Do not include deductible, coinsurance, co-payments, or other adjustments in the payer paid amount field. (See table below.)
- File all other adjustments in the CAS segment with the appropriate reason code.
- Include the allowed amount in the appropriate AMT segment.
- At the line level, provide the actual amount paid by the other carrier in the 2430 SVD segment for line adjudication information if possible. All other adjustments should be filed in the 2430 CAS segment with the appropriate reason code.

837 professional claim					
Loop ID	Segment type	Segment designator	Element ID	Data element	BCBSNC business rules
2320	SBR	Other subscriber information			

10.15 Coordination of Benefits (COB) rules

When a member is covered by more than one insurance carrier, one plan must be designated as primary and the other as secondary. Coordination of benefits rules are used to determine which plan pays first on the claim. BCBSNC prior review and certification requirements apply whether we are primary or secondary. Please refer to the order of benefits determination section for further information.

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 of the carriers does not have a Coordination of Benefits (COB) provision, that plan is considered primary and always pays first. Otherwise, please refer to the order of benefits determination section to determine which carrier is primary.

10.16.1 BCBSNC as primary

If BCBSNC is primary, and another insurance plan is secondary, use the following guidelines:

- All prior review and certification policies and procedures must be followed according to the member’s BCBSNC plan.
- You should first file with BCBSNC.

Continued on the following page.



837 professional claim					
Loop ID	Segment type	Segment designator	Element ID	Data element	BCBSNC business rules
			SBR01	Claim filing indicator code	P =
	CAS	Line adjustment			
			CAS01	Claim adjustment group code	CO = CR = Correction and reversals OA = Other adjustments PI = Payer initiated reductions PR = Patient responsibility
	AMT	COB payer paid amount			
			AMT01	Monetary amount	D =
			AMT02	Monetary amount	Fill the actual amount paid by the other carrier. Do not include deductible, coinsurance, copayments, or other adjustments in the payer paid amount field.
	AMT	Coordination of Benefits (COB) allowed amount	AMT01	Amount qualifier code	B6 = Allowed - actual
2330B	NM1	Other payer name			
			NM101	Entity type qualifier	PR = Payer
			NM103	Payer name	Use last name or organization name
	DTP	Claim adjudication date			
			DTP01	Date/time qualifier	573 = Date claim paid

Continued on the following page.



837 professional claim					
Loop ID	Segment type	Segment designator	Element ID	Data element	BCBSNC business rules
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 = CR = Correction and reversals OA = Other adjustments PI = Payer initiated reductions PR = Patient responsibility
2430	DTP	Line adjudication information			
			DTP01	Date/time qualifier	573 = Date claim paid



10.18 HIPAA - 837 institutional claim

When filing an 837 institutional claim to BCBSNC as the secondary or tertiary payer, please note the following for proper claim handling:

- At the claim level, file only the actual amount paid by the other carrier in the 2300 AMT segment for payer amount paid. Do not include deductible, coinsurance, co-payments, or other adjustments in the payer paid amount field. (See table below.)
- File all other adjustments in the CAS segment with the appropriate reason code.
- Include the allowed amount in the appropriate AMT segment.

837 institutional claim					
Loop ID	Segment type	Segment designator	Element ID	Data element	BCBSNC business rules
2320	SBR	Other subscriber information			
			SBR01	Claim filing indicator code	P =
	CAS	Line adjustment			
			CAS01	Claim adjustment group code	CO = CR = Correction and reversals OA = Other adjustments PI = Payer initiated reductions PR = Patient responsibility
	AMT	Payer prior payment			
	AMT	Coordination of Benefits (COB) total allowed amount			
			AMT01	Amount qualifier code	B6 = Allowed - actual
2330B	NM1	Other payer name			
			NM101	Entity type qualifier	PR = Payer

Continued on the following page.



837 institutional claim					
Loop ID	Segment type	Segment designator	Element ID	Data element	BCBSNC business rules
			NM103	Payer name	Use last name or organization name
	DTP	Claim adjudication date			
			DTP01	Date/time qualifier	573 = Date claim paid

Blue eSM – CMS-1500 health care claims filing

At this time we are unable to process secondary HCFA claims via **Blue eSM**. Please submit these claims on your 837 professional batch file.

Blue eSM – UB-04 health care claims filing

To file a BCBSNC secondary claim via **Blue eSM**, please follow the same guidelines as you would when filing a paper claim. BCBSNC payer information should show on line A for payer name "FL50," insured's name "FL58," and certificate number "FL60." The primary payer information should show on line B for the same information. Please remember to complete the prior payments field "FL54" for line B.

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 two-digit suffix listed next to the member's name on the ID card. This field accepts alpha and numeric characters. (Suffixes apply to New Blue products only.)	File the most current member ID number. Please be sure to update your system to reflect the most recent ID information.
9	Other insured's name (last name, first name, middle initial)	Show the last name, first name, and middle initial of the person having other coverage that applies to this patient.	Complete this block only when the patient has other insurance coverage.
9a	Other insured's policy or group number	Enter the policy and/or group number of the other insured's policy.	

Continued on the following page.



Block	Field name	Description	Comments
9b	Other insured date of birth	Either the other insured's date of birth (MM/DD/YYYY) and sex.	
9c	Employee's name or school name	Enter the other insured's employer's name or school name.	
9d	Insurance plan name or program name	Enter the other insured's insurance company name.	
10a-10c	Is patient's condition related to: a) Employment? (current or previous) b) Auto accident? c) Other accident?	Use one character (X) to mark "yes" or "no" to indicate whether employment, auto liability, or other accident involvement applies to services in item 24 (diagnosis).	
24f		Enter the total charges for each line item. Enter up to 7 numeric positions. Dollar signs are not required.	Professional claims must be filed line by line to assist correct coordination.
27		Accept assignment <input checked="" type="checkbox"/> YES must be indicated in order to receive direct reimbursement. Contracting providers have agreed to accept assignment.	
29		Enter the amount paid by the primary insurance carrier. (Reminder: only co-payments may be collected at time of service.)	For State Health Plan use only.

* You will still need to fill out the entire claim. This section only emphasizes COB.



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 professional 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 payer A A2 - Coinsurance payer A B1 - Deductible payer B B2 - Coinsurance payer B C1 - Deductible payer C C2 - Coinsurance payer C	
50a,b,c	Insurance carrier name Line A - Primary payer Line B - Secondary payer Line C - Tertiary payer	
51a,b,c	Provider number Enter BCBSNC provider number on appropriate line	
52a,b,c	Permission to release medical/billing information to process this claim <input type="checkbox"/> Y or <input type="checkbox"/> N	
53a,b,c	Accept assignment "Yes" must be indicated in order to receive direct reimbursement <ul style="list-style-type: none"> Contracting providers have agreed to accept assignment 	
54a,b,c	Prior payments/source P - Patient A - Primary payer B - Secondary payer C - Tertiary payer	
55a,b,c	Estimated amount due from each payer	Information in this section is only used by State Health Plan.
60a,b,c	Subscriber's identification number	

* You will still need to fill out the entire claim. This section only emphasizes COB.



10.21 Filing Medicare crossover claims

Medicare crossover claims

The Medicare crossover program is a program that automatically files electronic claims for secondary payment, saving your facility the time and expense of filing a paper claim to BCBSNC. Under the Medicare Crossover program, you need to submit only one claim to the Medicare Part B carriers. The Medicare Part B carriers will process as the secondary payer.

The Medicare remittance advice will indicate whether a paper claim needs to be filed with BCBSNC.

If the claim was crossed over by Medicare, the Medicare payment advice/EOMB should have remark code MA 18 printed on it, which states: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

The remark code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

Claim not crossed over

If the Medicare payment advice/EOMB does not indicate the claim was crossed over and you accepted Medicare assignment, file the claim to BCBSNC if the claim has a prefix.

If no prefix, file the claim to the address on the back of the card. BCBSNC or the member's BCBS Plan will pay you the Medicare supplemental benefits. If you did not accept assignment, the member will be paid and you will need to bill the member.

Blue Card® Medicare services

The Medicare crossover program is not designed to cover out-of-state Medicare patients. The Medicare crossover program does not automatically file electronic claims for secondary payments for out-of-state patients. Notify BCBSNC Network Management field office if there are any changes in your Medicare provider number or participation status.

More information regarding Medicare and BlueCard® COB can be found in chapter five, The BlueCard® program and chapter six, Medicare supplemental products.

Please note: There is a 15-day processing time for Medicare intermediaries before claims are crossed over to BCBSNC.

10.22 Explanation of Payment or Notification of Payment (EOP/NOP)

We report payment and denial of claims to providers on an EOP/NOP report. This information may be available electronically through the 835 Remittance transaction (see chapter eleven, Electronic solutions, for additional information).

Please note: Your contract overrides information on the EOP/NOP especially where BCBSNC is the secondary payer.

10.23 Overpayments

10.23.1 When you notice an overpayment

Call the Provider Blue LineSM 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 twenty-two, Forms)

or

Write a letter including the following information:

- The amount of the overpayment
- The member's ID number associated with the overpayment
- Date of service
- Provider number under which service was paid
- Copy of the EOP/NOP
- The reason you believe the payment is in error

Note: If you receive a refund request, please make sure that you return the invoice with your check.



10.23.2 Disbursement of overpayments

The following products licensed by Blue Cross Blue Shield of North Carolina only coordinate benefits when Medicare is the primary carrier. Any overpayments related to coordination of benefits, excluding Medicare, received by providers on the following products should be forwarded to our member.

- Blue Advantage[®]/associated group number IADV01 & IADV15
- Blue AccessSM/associated group number IACC01-IACC12
- Blue AssuranceSM/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 30 days after the receipt of all information required to process the claim. In the case of coordination of benefits, primary payer information or an EOB is a required piece of information for claim processing. Prompt payment penalties may apply 30 days after the receipt of all required information including primary payer information or the EOB.

The prompt payment mandate does not apply to the following programs:

- ASO business (self-funded groups)
However, the mandate does apply to Multiple Employer Welfare Arrangement (MEWA) groups.
- Medicare supplement
- BlueCard[®] claims
- Federal Employee Program

If you are interested in learning more about the prompt payment mandate and how it affects you, please contact your local Blue Cross and Blue Shield of North Carolina Network Management field office (see section 2.12, BCBSNC Network Management – local offices).

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 payers need to pay claims

Although each plan and payer may have slightly different requirements, there are some requirements that are nearly universal. For example, nearly all plans require a copy of the EOB from the primary payer prior to paying a claim as the secondary payer – or appropriate primary carrier payment information (filed through the 837) if the claim is not already submitted to the secondary carrier through Medicare crossover. Most plans and payers publish their requirements and the information should be available in provider e-manuals, online, and by contacting provider representatives.

3) Determine primary and secondary payers

It is important for providers to determine primary and secondary payers so that claims can be sent to the primary payer first. Some plans will be able to tell providers whether they are primary or secondary at the time the provider contacts the plan to verify eligibility. Typically, the following rules are used by plans and payers to determine the primary and secondary payer:

- a) The payer covering the patient as a subscriber will be the primary payer.
- b) If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the birthday rule.

4) Include primary payment amounts from primary payers when submitting claims to secondary

After the primary plan pays its benefits, electronically file the secondary claim along with the primary payment information. Please refer to the electronic filing section for additional instructions if needed.



A special consideration for Medicare claims

Many health plans receive Medicare claims automatically when they are the secondary payer. In this case, the Explanation of Medicare Benefits (EOMB) will indicate that the claim has been automatically crossed over for secondary consideration. Providers should look for this indication on their EOMBs and should not submit a paper claim to the secondary payer. A paper claim submitted in this circumstance would be coded as a duplicate and rejected by the secondary payer.

Please note: There is a 15-day processing time for Medicare intermediaries before claims are crossed over to BCBSNC.

Electronic solutions (using EDI services)





In 2006, the EDI services team adopted a name change to Electronic Solutions (eSolutions). This change reflects the increasing scope of transactions that are now offered by BCBSNC. For purposes of this e-manual, eSolutions will be used as the term to describe these services.

eSolutions enables the transmission of electronic files for the business processing of health care information. BCBSNC provides electronic solutions in both batch and real-time modes to our contracted health care providers. These health care transactions, include claims, remittances, admission notifications, eligibility and claim status inquiries. eSolutions provides customer support for all of our trading partners that submit electronic transaction files.

eSolutions also offers two Web-based products, **Blue eSM** and RealMed, for making interactive inquiries about eligibility and claim status, admission notifications and claims entry. BCBSNC has developed electronic solutions that allow contracted health care providers to access detailed claim management information from BCBSNC, and customize that information to the workflows in their organizations.

Health care providers, clearinghouses, billing services and practice management system vendors who wish to send electronic transactions to BCBSNC can obtain resources and required forms on the Electronic Solutions Web site at bcbsnc.com/providers/edi/. All direct senders of batch files will need to sign and submit a Blue Cross and Blue Shield of North Carolina trading partner agreement and an electronic connectivity request form. **Blue eSM** interactive network agreements are also available at this Web site. Information regarding RealMed can be found at www.realmed.com.

This chapter outlines the range of electronic solutions offered by BCBSNC.

11.1 HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) mandates the standardization of data exchange formats for health care data transmission, including claims, authorizations, remittances, eligibility and claim status inquiries. The HIPAA 837 format replaces proprietary electronic formats with ASC X12N transactions.

eSolutions has produced a companion guide to assist trading partners in understanding Blue Cross and Blue Shield of North Carolina code and situation handling used in processing the ANSI ASC X12N transactions. This companion guide is available at bcbsnc.com/providers/edi/.

11.1.1 BCBSNC HIPAA companion guide

Blue Cross and Blue Shield of North Carolina accepts the following HIPAA-compliant transactions:

BCBSNC companion guide chapters and/or HIPAA transaction

Introduction to the companion guide to EDI transactions (for all trading partners)

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 BCBSNC companion guide chapters that are essential to understanding issues applicable to all transmissions with BCBSNC.

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**
This contract establishes the formal relationship between a direct sender of electronic files and Blue Cross and Blue Shield of North Carolina. This agreement, along with the electronic connectivity request form, needs to be completed by all trading partners and submitted to EDI services before electronic transmissions are exchanged.
- **Electronic Connectivity Request (ECR) form**
Any health care provider wishing to transmit files electronically to BCBSNC, either directly or via a business associate, needs to complete the form pertinent to the transmission that is to be sent.
- **ECR: information and instructions**
These instructions include information about who needs to complete the form, to whom it is sent and what other forms need to be included for setup to occur.



HIPAA sample documents

- **Claims audit report sample**

Trading partners can download their claims audit reports from their BCBSNC electronic mailboxes. The claims audit report is returned for 837 transactions only.

- **997 transaction sample**

The 997 transaction serves as both a positive acknowledgement and a report of HIPAA implementation guide errors within a functional group "GS/GE" or a transaction set "ST/SE."

- **TA1 acknowledgement sample**

The TA1 transaction serves as both a positive acknowledgement and a report of HIPAA implementation guide errors within an interchange control "ISA/IEA."

11.1.3 EDI Electronic Connectivity Request (ECR) form

Electronic Connectivity Request (ECR) forms must be completed for any organization or provider that wants to submit or receive electronic transactions with BCBSNC. The following ECR forms are available:

- Master ECR for 837 claim, 27X inquiry and 235 remit
- The 835 payment/remittance advice for Medicare crossover

Commonly asked questions about ECR forms

1. Who completes an EDI Electronic Connectivity Request (ECR) form?

Every health care provider wishing to exchange electronic information with BCBSNC, whether submitting information directly or via another party, must complete an ECR form. However, an ECR form must be accompanied by a BCBSNC trading partner agreement.

Only direct senders of electronic transmissions need to file a trading partner agreement. Verify with your vendor/clearinghouse that a trading partner agreement has been established with BCBSNC on your behalf.

Providers who do not transmit transactions directly to BCBSNC may have their vendor/clearinghouse or billing service complete the detail information on the ECR form; however, each provider must sign the form. Clearinghouses or billing services cannot sign the ECR form on behalf of the provider they are servicing.

Each form contains sections that are clearly marked as provider, vendor/clearinghouse or billing service information.

2. Which forms should be submitted?

- Each ECR form is transaction-specific. Providers should complete those forms that are applicable to their business needs and the specific transaction sets that they wish to send to BCBSNC.

3. What information is required for HIPAA transactions that was not previously needed?

- The ECR form requires sender or receiver ID qualifiers, depending upon the transaction being sent, and the actual sender or receiver ID. BCBSNC requires direct senders of transactions to use their federal tax ID for their sender or receiver ID. The qualifier code for the federal tax ID is "30." Direct senders who may not have a federal tax ID may use the "ZZ" sender ID qualifier and their social security number for the sender ID.
- The type of transaction box includes an effective date – the date by which the sender will be ready to transmit. This section also includes an X12 version indicator. At this time, only the ASC 4010A1 version is available.

4. What do I do with the completed ECR form(s)?

Completed forms may be faxed to BCBSNC EDI services at **1-919-765-7101**. BCBSNC EDI services returns a notification letter to the contact person listed in the form, verifying receipt of the ECR form(s), the information submitted, and the date submitters can expect to transmit.

11.2 Electronic claims filing

BCBSNC encourages you to file claims electronically whenever possible. Electronic claims submission improves the turnaround time for reimbursement to you and reduces expensive administrative tasks for your staff.

Claims can be submitted electronically for all BCBSNC policies, Federal Employee plans, State Health Plan and BlueCard® policies.

- If you are interested in submitting the HIPAA compliant 837 claim transaction as a direct submitter, please reference the HIPAA information page on our Web site at bcbsnc.com/providers/edi for resources and the necessary forms. You must complete a Trading Partner Agreement (TPA) as well as an Electronic Connectivity Request (ECR) form for the



transaction. (Please note that the electronic connectivity request forms are transaction specific. If you want to submit transactions other than claims, more than one ECR form may be required.)

- All BCBSNC trading partners are required to test their file submission formats with BCBSNC before submitting production files. The BCBSNC companion guide to EDI transactions is available at the BCBSNC Web site, and can assist with test preparation and execution.
- If you are currently utilizing the services of a vendor/clearinghouse that submits claims electronically on your behalf, you do not need to complete a TPA. However, you or your vendor/clearinghouse do need to complete the ECR form for electronic connectivity, and you as the provider must sign this form to authorize your set up.
- If you are currently utilizing the services of a vendor/clearinghouse, but not yet filing electronic claims, contact your vendor to begin filing claims electronically.
- You should contact your vendor or clearinghouse to determine their ability to transmit all of the HIPAA transactions on your behalf, as well as their ability to retrieve and route acknowledgements to you.

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

11.3 Tips for electronic claims filing

- Submit correct and complete member ID numbers, including any alpha prefixes and numeric suffixes, (see chapter three, Health care benefit plans and member identification cards) or the BCBSNC companion guide chapters on 837 transactions (see identification codes and numbers) for more information.
- The provider should retrieve claims audit reports electronically. If you cannot retrieve this report, contact EDI services customer support at **1-888-333-8594** or contact your EDI services field consultant for more information.
- Correct all electronic claim errors on your internal system and resubmit those claims electronically via the 837 transaction.
- The claims error listing is contained in the claims audit report. You may electronically access your claims audit report for the 837 health care claim transaction. Paper copies of the 837 claims error listing are not available.

- Professional corrected claims can be submitted electronically using the 837 professional claim transaction or by direct data entry through the **Blue eSM** CMS-1500 transaction. Specify the corrected claim indicator in loop 2300, segment CLM05-3 on the 837 professional claim transaction or indicated corrected claim by setting the corrected claim flag to "Yes" on the **Blue eSM** CMS-1500 transaction.
- Institutional corrected claims can be submitted electronically using the 837 institutional claim transaction or by direct data entry through the **Blue eSM** UB-04 transaction. Specify the corrected claim indicator in loop 2300, segment CLM05-3 on the 837 institutional claim transaction or indicate corrected claim by setting the frequency code which is the last digit of the bill type on the **Blue eSM** UB-04 transaction. On the UB-04, the bill frequency code is in form locator 4.
- BCBSNC professional secondary claims can now be submitted electronically using the 837 professional claim transaction. Include the COB payer paid amount in loop 2320; AMT segment, AMT01 qualifier = D; AMT02 = \$ amount, COB payer allowed amount qualifier B6; AMT02 = \$ amount allowed may also be included.
- Prior to electronically submitting claims for a newly assigned group or individual provider number, contact the EDI services customer support department at **1-888-333-8594** to verify that the connectivity request form has been completed.

11.4 Electronic Funds Transfer (EFT)

BCBSNC financial services offers a setup to contracted health care providers that allows direct transfer of funds for claim payments to the provider's bank account. Generally, EFT funds are accessible by providers sooner than remittances received through a traditional process of paper checks deposited by the provider. The following outlines the process steps for setup of an EFT stream to the provider.

- Health care provider submits request for EFT set up to BCBSNC financial services on their letterhead at the following address:
BCBSNC Financial Services
PO Box 2291 - HQ2
Durham, NC 27702-2291
Attention: Electronic Funds Transfer
 Phone number **1-919-765-7678**



- Financial services, upon receipt of request from provider, will send provider an authorization form to be completed and returned to BCBSNC.
- Information from the request form is verified by financial services including:
 - ‡ Bank name
 - ‡ Transit number
 - ‡ Account number
- After verification, EFT status is loaded to the BCBSNC claims system. The average time to set up a provider is 5 days from receipt of all documentation by BCBSNC.
- All EFT payments are made to the vendor (group provider number) level.
- Under special circumstances, an EFT provider can be issued a special check (paper check) while designated an EFT provider.
- A paper copy of the check and the EOP is issued to the provider through normal distribution channels.

11.5 Blue eSM

Blue eSM is a Web-based tool available on the internet, free of charge, for physicians, hospitals and other health care providers. It allows health care providers to access a secure electronic network and perform a variety of interactive transactions from their own desktops.

With **Blue eSM**, you can do the following from your desktop:

- Search for a member's ID number by name, including FEP members
- Obtain detailed member eligibility including FEP and BlueCard[®] members
- Submit and list claims
- View status of submitted claims, including BlueCard[®] claims
- View check/payment amounts for the past seven days

BCBSNC encourages your participation in this interactive network for exchanging information and simplifying administrative tasks. Complete information on **Blue eSM**, a user agreement and technical template are available online at bcbsnc.com/providers/edi/bluee.cfm. You may also contact your local EDI field consultant for more information regarding the **Blue eSM** interactive network.

11.6 RealMed

RealMed is a North Carolina based IT company that contracts with physician practices to use a software application that integrates to BCBSNC systems. This product allows claim submission, claim status and member eligibility inquiries to be sent to BCBSNC and many other health care payers for a response in real time. It is a cost-effective and easy to use internet based application. RealMed is compatible with most practice management systems without deep integration, and provides the additional resource of back-end reporting capability that quickly captures the status of all claims that are processed through the RealMed system. The result is a significant reduction in administrative expenses related to claims creation, submission and followup for your organization. Using RealMed, your staff can also:

- Verify BCBSNC member eligibility
- Complete a professional claim
- Submit a claim to BCBSNC
- Receive notification of the acceptance and adjudication of the claim from BCBSNC

RealMed has developed capabilities for taking paper claims print files and turning them into electronic claims. RealMed can take non-compliant NSF and CMS-1500 professional claim formats and turn them into realtime claims or compliant HIPAA 837 professional transactions. RealMed allows providers to check eligibility and submit claims electronically to many national health care payers. For this multi-payer access, providers pay RealMed a monthly fee based on the size of their organization. To learn more about RealMed Corporation, their product, or to schedule a demonstration for your organization, visit the RealMed Web site at www.RealMed.com. A local RealMed representative can work with EDI Services field staff to help you decide if RealMed is right for you.



11.7 EDI services contact list

The address at our Durham headquarters is:

Blue Cross and Blue Shield of North Carolina

EDI Services - CSC1N

PO Box 2291

Durham, NC 27702-2291

Phone **1-919-765-3514** (main)

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

Customer support **1-888-333-8594**

EDI customer support is available Monday through Friday, 8:00 am to 5:00 pm.

EDI field consultants are located in each BCBSNC regional field office and may be reached directly at the following address and telephone numbers. **Note** – because field consultants travel extensively within their territory, you may be placed into voice-mail. EDI field consultants are dedicated to returning phone messages within one business day.

EDI field contact information

Region	Address	Phone/Fax	Counties
West - Charlotte	3530 Toringdon Way Suite 404 Charlotte, NC	1-704-561-2751 1-704-676-0501 (fax)	Alexander, Allegheny, Anson, Ashe, Avery, Burke, Cabarrus, Caldwell, Catawba, Cleveland, Davidson, Davie, Forsyth, Gaston, Iredell, Lincoln, McDowell, Mecklenburg, Mitchell, Rowan, Rutherford, Stanly, Stokes, Surry, Union, Watauga, Wilkes, Yadkin, Yancey
Triad/ Triangle	PO Box 2291 Durham, NC 27702-2291	1-919-765-4635 1-919-765-2564 (fax)	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Guilford, Harnett, Hoke, Johnston, Lee, Montgomery, Moore, Orange, Person, Randolph, Richmond, Rockingham, Scotland, Vance, Wake, Warren
Wilmington	P.O. Box 2291 Durham, NC 27702-2291	1-910-509-0605 1-919-765-2564	Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, Polk, Swain, Transylvania
Asheville	P.O. Box 2291 Durham, NC 27702-2291	1-877-889-0002 1-919-765-7109	Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, Polk, Swain, Transylvania
East – Raleigh/ Greenville	P.O. Box 2291 Durham, NC 27702-2291	1-919-765-2584 1-919-765-2564 (fax)	Beaufort, Bertie, Bladen, Camden, Chowan, Columbus, Craven, Cumberland, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Robeson, Sampson, Tyrrell, Washington, Wayne, Wilson

Provider review

Hospitals

Ambulatory
surgical centers

Skilled
nursing facilities





12.1 Provider review overview

Upon request and at reasonable times, your contract grants BCBSNC and our authorized representatives the right to inspect and conduct periodic reviews of your medical and administrative records relating to services and/or supplies provided to our members. Hospital fees for these reviews/audits are not billable to BCBSNC or our members.

BCBSNC currently contracts with outside vendors to conduct post-payment hospital bill reviews for both inpatient and outpatient claims. The purpose of these reviews is to ensure appropriateness of billings, identify inappropriate billing practices and recognize areas where education is needed.

The audit staff consists of nurses, CPT coding specialists and physicians who have a thorough knowledge of medical practices, medical terminology and CPT coding.

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. BCBSNC warrants that our members have given us the contractual right to obtain information about the services and/or supplies provided them through their enrollment application, therefore no further authorization will be required from either BCBSNC or their representatives for release of records or audit of those records.
- The hospital agrees to make all medical and financial records (including UB-04s and itemized bills prior to audit) available to the auditor without audit fees, and upon request make copies of these records at no additional charge to BCBSNC or their representatives.
- All medical and financial information will be kept in the strictest confidence.
- The auditor will schedule the review at a convenient time for all parties: the auditor, the medical records department and the patient account representatives. BCBSNC reserves the right to conduct non-scheduled audits.
- The hospital agrees to provide the auditor with a comfortable work area, including access to a telephone and power outlet during the scheduled review time.
- The auditor will give a complete, impartial and factual account of member services, institutional charges and reimbursement. The auditor will validate documented unbilled services discovered during the audit. These services become eligible for payment if they are submitted to the auditor before the audit period has expired.
- The auditor will review and evaluate all supporting documentation submitted by you.
- The auditor will inform you of all detected billing discrepancies within 30 days of completing the review.
- You may ask for a higher level of review within 15 days from the notice of discrepancies by requesting an appeal from the outside vendor conducting the review.
- Upon finalization and receipt of the audit results in our office, BCBSNC will proceed with our normal adjustment process to recover the audit findings.
- BCBSNC members are not responsible for billing discrepancies and should not be subsequently billed.
- When new audit vendor contracts are secured by BCBSNC, a letter of introduction will be furnished to you.
- Please call the BCBSNC special investigation unit at **1-800-324-4963**, if you suspect a provider of fraudulent, abusive or otherwise improper billing practices.



12.3 Eligibility requirements for managed care products

- To be eligible for participation in BCBSNC managed care networks, facility providers must meet the eligibility criteria listed below.
- All credentials must be maintained in good standing to remain a contracting provider.

The National Committee for Quality Assurance (NCQA) will require initial credentialing of any provider who seeks reinstatement in any of our networks after being out-of-network for more than 30 days. Please note that this is a change from the previous timeframe of 90 days.

Eligibility requirements for managed care networks	Accredited hospitals and ambulatory surgical centers	Non-accredited hospitals and ambulatory surgical centers	Birthing centers	Skilled nursing facility
1. Current North Carolina license	Required	Required	Required	Required
2. Current JCAHO, AAAHC or CARF certificate or letter of recommendation (for birthing centers, JCAHO or NACC certification)	Required	—	Required	Required
3. Medicare/Medicaid certificate	Required	Required	Required	Required
4. Copy of anesthesia or sedation policy	—	Required	—	—
5. Report or medical review of NC denials by type for the most recent 12 months	—	Required	—	—
6. Quality management program	—	Required	—	—
7. Health coaching and intervention program	—	Required	—	—
8. Organizational structure, including the level and reporting relationship of full time quality and utilization management staff	—	Required	—	—

Continued on the following page.



Eligibility requirements for managed care networks	Accredited hospitals and ambulatory surgical centers	Non-accredited hospitals and ambulatory surgical centers	Birthing centers	Skilled nursing facility
9. Report of disciplinary actions if any taken within the last 5 years by any licensing or accrediting body against the facility (provide action plans and outcome)	—	Required	—	—
10. Letters of recommendation from the medical staff president, a member of the facility’s board of trustees, and a community leader not directly employed by or associated with the facility. Letters should attest to the quality, accessibility, and cost effectiveness of medical care rendered by the facility.	—	Required	—	—
11. An on-site quality assessment of the facility conducted by utilizing BCBSNC criteria	—	Required	—	—
12. Documented policy and procedure for coverage arrangements (participating provider and hospital), in the event of an emergency situation	—	—	Required	—
13. Copy of current liability insurance certificate, verification of effective and expiration dates, and coverage in the amounts of \$1 million per occurrence and \$1 million aggregate.	Required	Required Non-JCAHO exemption form required	Required	Required

Quality improvement program for physician office





13.1 Quality improvement overview

BCBSNC's quality improvement program is an important component of our HMO, POS and PPO products.

The quality improvement program supports BCBSNC's ongoing commitment to quality health care.

Consistent with current professional knowledge, BCBSNC defines quality of care for individual populations as the degree to which health services increase the likelihood of desired health outcomes. Quality of service is defined as the ease and consistency with which customers obtain high quality care, as measured by customer perception and objective benchmarks.¹

In determining the scope and content of our quality improvement program, BCBSNC recognizes the factors that influence the delivery of health care, such as:

- Quality of care and service is a crucial and integral component of health care delivery
- Existing and potential customers' unique needs and expectations must be satisfied and exceeded
- Physician and provider relationships with patients and BCBSNC must be continually improved
- Legislative and regulatory requirements must be met, while aiding governmental efforts in health care reform

Our quality improvement program is ongoing and designed to be proactive. Its purpose is to objectively and systematically monitor the quality and appropriateness of the care and service provided to members. Our quality improvement program then identifies, implements and monitors appropriate interventions to improve the quality of care and service. In other words, the quality improvement program is designed to link the concern for quality and demonstrated improvement. The program goals are:

- To continuously improve the care and service delivered to our members
- To increase the accountability for results of care and service
- To protect patient confidentiality and member rights as health care processes are evaluated and clinical outcomes are assessed
- To meet or exceed customer expectations for quality and service, utilizing evaluative feedback from members and providers to assess and continually enhance care
- To improve clinical effectiveness

- To incorporate quality improvement program results into the selection and recredentialing of network providers and enhance the network providers' ability to deliver appropriate care and meet or exceed the expectations of the patient/member
- To enhance the overall marketability and positioning of BCBSNC by showing it to be the best HMO, POS and PPO programs in North Carolina
- To promote healthy lifestyles and reduce unhealthy behaviors in our members and throughout the communities we serve
- To minimize the administrative cost and burden incurred throughout the spectrum of health care service delivery
- To maintain and enhance quality improvement processes and outcomes that merit the highest accreditation status from the National Committee for Quality Assurance (NCQA) accreditation

1 Adapted from the Institute of Medicine's statement about quality of medical care.

13.2 Medical policy

Our corporate medical policy consists of medical guidelines and payment guidelines. Medical guidelines detail when certain medical services are medically necessary, and whether or not they are investigational. (For more information concerning medical necessity and investigational criteria, please see these specific policies.) Our medical guidelines are written to cover a given condition for the majority of people. Each individual's unique, clinical circumstances may be considered in light of current scientific literature. Medical guidelines are based on constantly changing medical science, and we reserve the right to review and update our policies periodically. Payment guidelines provide editing logic for CPT and HCPCS coding. Payment guidelines are developed by clinical staff, and include yearly coding updates, periodic reviews of specialty areas based on input from specialty societies and physician committees, and updated logic based on current coding conventions. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Therefore, medical policy is not an authorization, certification, explanation of benefits, or a contract. Benefits are determined by the group contract and the subscriber certificate that is in effect at the time services are rendered.



When the company reviews medical policy, supportive information sources can include a comprehensive literature search, consultant physician review, recommendations from a physician advisory group, or legislative enactments. Benefits for medical services are reviewed in terms of our definition of medical necessity and investigational as well as the benefit provisions of the member's policy.

Note that corporate medical policy is separate and distinct from utilization review criteria or practice guidelines, although they may at times appear very similar. Corporate medical policy is available to assist you in understanding how we administer benefit coverage.

The dynamic and changing field of medicine requires us to continually update our corporate medical policies. Due to the evolving nature of our corporate medical policy, the most up-to-date policies are available online at **bcbsnc.com**. Corporate medical policy is also available by calling the Provider Blue LineSM 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 BCBSNC members. This list is distributed to members annually in the member magazine, Active Blue and is available online at **bcbsnc.com**. These rights and responsibilities are important guides to help all members use and receive health care services in a convenient and appropriate manner.

Member rights and responsibilities, as distributed to members, appear below:

As a Blue Cross and Blue Shield of North Carolina member, you have the right to:

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

As a BCBSNC member, you should:

- Present your BCBSNC ID card each time you receive a service.
- Read your BCBSNC benefit booklet and all other BCBSNC member materials.
- Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear.
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide BCBSNC and your doctors complete information about any illness, accident or health care issues which may be needed in order to provide care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor's office at least 24 hours' notice.



- Play an active part in your health care.
- Be polite to network doctors, their staff and BCBSNC staff.
- Tell your place of work and BCBSNC if you have any other group coverage.
- Tell your place of work about new children under your care or other family changes as soon as you can.
- Protect your ID card from improper use.
- Comply with the rules outlined in your member benefits guide.

13.4 Reassigning a member

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

- The member consistently refuses to follow a recommended procedure or treatment and you believe there is no professionally acceptable alternative.
- The member consistently misses appointments without prior notification to you (you should give the member, in advance, a written explanation of your appointment policy).
- The member consistently refuses to maintain a good financial standing for any copayments and balances due (you should give the member, in advance, a written explanation of your collection/bad debt policy).
- The member is violent or threatening to you or your staff.

Providers should follow their office procedure for notifying a patient of the need to find a new primary care physician. A copy of the member letter should be forwarded to your regional Network Management office (see chapter two, Quick contact information).

13.5 Network quality

At least every three years, in conjunction with the re-credentialing process, our quality management consultants visit primary care and OB/GYN physician practices to assess compliance to established access to care, facility and medical record standards. Quality management consultants also play an educational role for physicians, assisting them in keeping up-to-date with our latest documentation and facility requirements and keeping communication lines open between BCBSNC and the network physicians.

The initiative described above has been recommended by community physicians who are members of our Provider Advisory Group (PAG) and the Triad Quality Improvement Team (TQIT).

The following components of our network quality program are discussed below:

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

13.5.1 Access to care standards (primary care physicians)

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

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

1. Waiting time for appointment (number of days)

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

Pediatrics	see within 24 hours
Adult	see within 24 hours

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

Pediatrics	within 3 calendar days
Adult	within 3 calendar days

C. Follow-up of urgent care

Pediatrics	within 7 days
Adult	within 7 days

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

Pediatrics	within 14 days
Adult	within 14 days



1. Waiting time for appointment (number of days)

E. Complete physical/health maintenance

Pediatrics	within 30 calendar days
Adult	within 60 calendar days

2. Time in waiting room (minutes)

(A) Scheduled	30 minutes After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time = 60 minutes
(B) Walk-ins	BCBSNC discourages walk-ins, but reasonable efforts should be made to accommodate patients. Life threatening emergencies must be managed immediately.
(C) Work-ins	(called that day prior to coming) Pediatrics and adults - after 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling; maximum waiting time = 90 minutes

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

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

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

4. Office hours

indicates the posted hours during which appropriate personnel (i.e., MD, DO, FNP, PA) is available, to care for members within the above standards for waiting times.

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

5. Mechanism

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

14.5.2 Access to care standards (specialists including non-MD specialists)

The following access to care standards for specialists have been established by the BCBSNC physician advisory group. Non-MD specialists are Chiropractors (DC), Podiatry (DPM), Physical Therapy (PT), Speech Therapy (ST), and Occupational Therapy (OT).

1. Waiting time for appointment (number of days)

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

Pediatrics	within 24 hours
Adult	within 24 hours



1. Waiting time for appointment (number of days)

B. Regular

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

2. Time in waiting room (minutes)

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

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

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

4. Office hours

Indicates hours during which appropriate personnel are available to care for members, i.e., MD, DO, FNP, PA.

Daytime hours/week	15 hours/week minimum covering at least 4 days
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5. Availability hours

Daytime hours/week	40 hours/week
Night hours/week	24 hour/day coverage of some sort

13.5.3 Facility standards

The following standards for the facilities of practices participating in our managed care programs have been adopted by Blue Cross and Blue Shield of North Carolina and endorsed by the physician advisory group for use in assessing the environment in which health care is provided to our members. Please note new standards (effective September 1, 2003) printed in italics.

1. The general appearance of the facility provides an inviting, organized and professional demeanor including, but not limited to, the following:
 - a. The office name is clearly visible from the street.
 - b. The grounds are well maintained; patient parking is adequate with easy traffic flow.
 - c. The waiting area(s) are clean with adequate space and provide privacy for patients and family members.
 - d. Exam and treatment rooms are clean, have adequate space and provide privacy for patients. Conversations in the office/treatment area should be inaudible in the waiting area.
2. There are clearly marked handicapped parking space(s) and handicapped access to the facility.
3. A smoke-free environment is promoted and provided for patients and family members.
- 4a. A fire extinguisher is clearly visible and is readily available.



- 4b. Fire extinguishers are checked and tagged yearly.
- 4c. Smoke detectors are recommended.
5. There is a private area for confidential discussions with patients.
6. Health related materials are available (i.e., patient education, office and insurance information is displayed).
7. Designated toilet and bathing facilities are easily accessible and equipped for the handicapped (i.e., grab bars).
- 8a. There is an evacuation plan posted in a prominent place or exits are clearly marked, visible and unobstructed.
- 8b. There is an emergency lighting source.
9. Halls, storage areas, and stairwells are neat and uncluttered.
10. There are written policies and procedures to effectively preserve patient confidentiality. The policy specifically addresses 1) how informed consent is obtained for the release of any personal health information currently existing or developed during the course of treatment to any outside entity, i.e., specialists, hospitals, 3rd party payers, state or federal agencies; and 2) how informed consent of release of medical records, including current and previous medical records from other providers which are part of the medical record, is obtained.
- 11a. Restricted, biohazard, or abusable materials (i.e., drugs, needles, syringes, prescription pads, and patient medical records) are secured and accessible only to authorized office/medical personnel. Archived medical records and records of deceased patients should be stored and protected for confidentiality.
- 11b. Controlled substances are maintained in a locked container/cabinet. A record is maintained of use.
- 11c. There is a procedure for monitoring expiration dates of all medications in the office.
- 12a. At least one staff member is certified in CPR or basic life support.
- 12b. Emergency procedures are in place and are periodically reviewed with staff members.
- 12c. Emergency supplies include, but are not limited to, emergency medications, oxygen, mask, airway and ambu bag.
- 12d. Emergency supplies are checked routinely for expiration dates. A log is maintained documenting the routine checks.
13. There is a written procedure that is in compliance with state regulations for oversight of mid-level practitioners.
14. There is a procedure for ensuring that all licensed personnel have a current, valid license.
- 15a. A written infection control policy/program is maintained by the practice.
- 15b. There is periodic review and staff in service on infection control.
- 15c. Sterilization procedures and equipment are available.



13.5.4 Medical records standards for primary care providers and OB/GYN providers*

The National Committee for Quality Assurance (NCQA) has identified the bold italicized elements as critical components of a medical record.

Standard	Supporting documentation
1. All pages contain patient identification.	1. Each page in the medical record must contain the patient's name or I.D. number.
2. Each record contains biographical/personal data.	2. Biographical/personal data is noted in the medical record. This includes the patient's address, employer, home and work telephone numbers, date of birth, and marital status. This data should be updated periodically.
3. The provider is identified on each entry.	3. Each entry in the medical record must contain author identification (signature or initials).
4. All entries are dated.	4. Each entry in the medical record must include the date (month, day, and year).
5. The record is legible.	5. The medical record must be legible to someone other than the writer.
6. There is a completed problem list.	6. The flow sheet includes age appropriate preventive health services. A blank problem list or flow sheet does not meet this standard.
7. Allergies and adverse reactions to medications are prominently displayed.	7. Medication allergies and adverse reactions are prominently noted in a consistent place in each medical record. If significant, allergies to food and/or substances may also be included. Absence of allergies must also be noted. Use NKA (No Known Allergy) or NKDA (No Known Drug Allergy) to signify this. It is best to date all allergy notations and update the information at least yearly.
8. The record contains an appropriate past medical history.	8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, illnesses. For children and adolescents (age 18 and younger) past medical history relates to prenatal care, birth, operations and childhood illness. The medical history should be updated periodically.
9. Documentation of smoking habits and alcohol use or substance abuse is noted in the record.	9. The medical record should reflect the use of or abstention from smoking (cigarettes, cigars, pipes, and smokeless tobacco), alcohol (beer, wine, liquor), and substance abuse (prescription, over-the-counter, and street drugs) for all patients age 14 and above who have been seen three or more times. It is best to include the amount, frequency, and type in use notations.

Continued on the following page.



Standard	Supporting documentation
10. The record includes a history and physical exam for presenting complaints.	10. The history and physical documents appropriate subjective and objective information for presenting complaints.
11. Lab and other diagnostic studies are ordered as appropriate.	11. Lab and other diagnostic studies are ordered as appropriate to presenting complaints, current diagnosis, preventive care, and follow-up care for chronic conditions. It is best to note if the patient refuses to have recommended lab or other studies performed.
12. The working diagnoses are consistent with the diagnostic findings.	12. The working diagnosis is consistent with the findings from the physical examination and the diagnostic studies.
13. Plans of action/treatments are consistent with the diagnosis(es).	13. Treatment plans are consistent with the diagnosis.
14. Each encounter includes a date for a return visit or other follow-up plan.	14. Each encounter has a notation in the medical record concerning follow-up care, calls, or return visits. The specific time should be noted in days, weeks, months, or PRN (as needed).
15. Problems from previous visits are addressed.	15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. Appropriate use of consultant services is documented.	16. Documentation in the record supports the appropriateness and necessity of consultant services for the presenting symptoms and/or diagnosis.
17. Continuity and coordination of care between primary and specialty physicians or agency documented.	17. If a consult has been requested and approved, there should be a consultation note in the medical record from the provider (including consulting specialist, SNF, home infusion therapy provider, etc).
18. Consultant summaries, lab and imaging study results reflect review by the primary care physician.	18. Consultation, lab, and x-ray reports filed in the medical record are initialed by the primary care physician or some other electronic method is used to signify review. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.
19. Care is demonstrated to be medically appropriate.	19. Medical record documentation verifies that the patient was not placed at inappropriate risk as a result of a diagnostic or therapeutic process.
20. A complete immunization record is included in the chart.	20. Pediatric medical records contain a completed immunization record or a notation that immunizations are up-to-date.

Continued on the following page.



Standard	Supporting documentation
21. Appropriate use of preventive services is documented.	21. There is evidence in the medical record that age appropriate preventive screening and services are offered in accordance with the organization’s practice guidelines. (Refer to the medical policy section of your provider e-manual.) It is best to note if patient refuses recommended screenings and/or services.
22. Charts are maintained in an organized format.	22. There is a record keeping system in place that ensures all charts are maintained in an organized and uniform manner. All information related to the patient is filled in the appropriate place in the chart.
23. There is an adequate tracking method in place to insure retrievability of every medical record.	23. Each medical record required for patient visit or requested for review should be readily available.
24. Review of chronic medications if appropriate for the presenting symptoms.	24. There is documentation in the record, either through the use of a medication sheet or in the progress notes.

* OB/GYN medical records reviews taking on new depth.

We have historically performed only a medical record assessment on OB/GYN practices. Since so many of our female members are choosing OB/GYN practices to serve as their primary care providers, we feel it is important to conduct more thorough reviews of the medical records. OB/GYN practices will be monitored against the preceding medical records standards. The compliance goal established for 2004 is 85%. In addition to the medical record standards, OB/GYN practices will be monitored for use of and compliance to the preventive health guidelines.

13.6 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.

- Heart failure
- Hypertension
- Overweight and obesity
- Tobacco counseling
- Additional guidelines for:
 - ‡ Prenatal care
 - ‡ Depression
 - ‡ Attention Deficit Disorder (ADD)
 - ‡ Attention Deficit Hyperactivity Disorder (ADHD)
- Coronary Artery Disease (CAD)

Please note that guidelines are subject to change and that the most current guidelines are published and made available to providers at the BCBSNC Web site:

<http://www.bcbsnc.com/members/guidelines.cfm>

Providers are encouraged to visit the **bcbsnc.com** Web site regularly to receive the most current and up to date information available.

13.6.1 Nationally accepted guidelines

BCBSNC endorses the following nationally recognized clinical practice and preventive care guidelines:

- Asthma
- Cholesterol management
- Diabetes



13.6.2 Preventive care guidelines

The Blue Cross and Blue Shield of North Carolina (BCBSNC) preventive care guidelines are updated regularly and available to providers on the **bcbsnc.com** Web site for providers at: <http://www.bcbsnc.com/members/guidelines.cfm>.

Providers should note that although guidelines exist, benefit allowances are subject to the terms and limitations of the member's eligibility and preventive care benefits at the time services is provided. Providers are encouraged to verify a member's benefits and eligibility in advance of providing service.

13.7 Quality of care concern process

Definitions and application

BCBSNC maintains an active and comprehensive quality concerns program that includes review of individual cases in which concern is expressed regarding the quality, service and/or access to care. These concerns may be identified internally by the Plan or externally by our members or providers.

13.7.1 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

13.7.2 Pattern of care reviews

When any provider complaint is received, a review of the quality database will be done to determine how many complaints have been filed relating to the involved provider. Provider complaints falling into the following patterns, regardless of disposition, will be forwarded to the BCBSNC medical director for a pattern of care review:

- 3 complaints within 6 months
- 5 complaints within 1 year
- 8 complaints within 2 years

Any complaint reviewed that results in a disposition of Standard of Care (SOC) was met or controversial standard of care met with minor or major injury will be forwarded to the medical director for a pattern of care review if any of the following patterns are identified:

- 2 in 6 months and additional complaints, regardless of disposition within 6 months
- 3 in 1 year and 2 additional complaints, regardless of disposition within 1 year
- 5 in 7 years and 4 additional complaints, regardless of disposition within 2 years

Any complaint reviewed that results in a disposition standard of care not met will be forwarded to the medical director for SOC review and then to the QI coordinator to prepare for the credentialing committee review.

Follow-up by the BCBSNC medical director may include, but not be limited to:

- A letter to the provider
- Request for a plan of action from the provider by the medical director
- Reporting the involved provider information to the credentialing committee or law and regulatory affairs department

See chapter fourteen, Credentialing for professional providers, to review the process followed once an issue is referred to the credentialing committee.

Visit BCBSNC's Web site at **bcbsnc.com** for the latest information and updates regarding preventive care guidelines including vaccine schedules.



13.8 Quality improvement initiatives prevention and health education

13.8.1 Behavioral health initiatives

- **Follow-up after hospitalization for mental illness:**

This HEDIS measure looks at appropriate follow-up care after discharge from a hospital with a mental health diagnosis. Magellan Behavioral Health, BCBSNC's mental health vendor, implements initiatives associated with this measure, with oversight provided by BCBSNC.

- **Postpartum depression screening:**

Magellan sends new mothers the Edinburgh postnatal depression scale, which can be returned to Magellan for scoring. Members scoring above a threshold are contacted by a master's-level representative and assisted in seeking treatment.

- **Offspring depression screening:**

Magellan sends parents with depression a screening tool to assess whether their child(ren) also might be suffering from the disorder. Parents can return the tool to Magellan for scoring; those who score above a threshold are assisted in getting the child(ren) into treatment.

13.8.2 Colorectal cancer screening initiatives

- Practice guidelines sent to primary care providers along with patient education tear sheets to help discuss screening options.
- Reminder letters or automated phone calls sent to members age 50 and older that may be in need of a colorectal cancer screening. The reminder emphasizes the importance of routine screening as well as information regarding screening options.

13.8.3 Men's health initiatives

- Men's health chart stickers distributed to primary care physicians to remind them to perform preventive care screenings on their male patients, as appropriate.
- Reminder letters are sent to male members who are in need of preventive care screenings. The mailing includes a letter outlining the recommended preventive health screenings as appropriate by age, as well as a men's health pamphlet that presents health and lifestyle information.

- Loved one-targeted postcard sent to the homes of male members in need of preventive care screenings, outlining the preventive care needs of men at appropriate ages.

13.8.4 Women's health initiatives

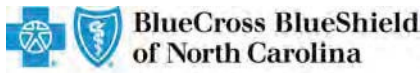
- Birthday reminder postcards or telephone reminder calls are sent to women to remind them to have their annual pap test and/or mammogram.
- Mammography counseling tools for providers who performed lower than their peers for breast cancer screening; includes breast health education tool kit containing beads representing the different lump sizes found through various screening methods, posters for patient waiting areas, and member education brochures. Physician training on mammography counseling skills is also available to practices with low screening rates.
- Prospective report to all primary care and OB/GYN providers listing women who are due for their pap tests and mammograms in the coming year.
- Preventive health reminder stickers placed in medical charts of women who are due for a pap test or mammogram, or who may need menopause counseling.
- Chlamydia screening outreach intervention sent to both members and providers. Young women due for a chlamydia screening are mailed an educational brochure. Providers also receive an educational packet including chlamydia screening and treatment guidelines, member education brochures, and a guide to sexual history taking.
- Breast health at worksites intervention sent to large employer groups encouraging routine breast cancer screening. The packet includes a listing of local radiology facilities as well as breast health posters.

13.8.5 Provider toolkits

Provider toolkits are available free to providers upon request. Please use the following order form to make a request.



Sample BCBSNC provider toolkit order form



An independent licensee of the Blue Cross and Blue Shield Association

BCBSNC Provider Toolkits

A majority of the items in our Providers Toolkits are **only** available for download at www.bcbsnc.com/providers/toolkit.

Some items must be ordered using the form below and will be shipped to you. Place a check next to the item you wish to order, fill out the shipping information below and fax your completed order form to Member Health Partnerships at (919) 765-1927. **Limit 1 per item.**

Toolkit	✓ to Order	Toolkit	✓ to Order
Achieving a Healthy Weight for Adults		Tobacco Cessation	
BMI Wheel		Clinical Practice Guidelines	
Tape measure		Smoking Cessation tip card	
Clinical guidelines for Assessment and Treatment of Obesity	Available for download	Starting the Conversation (English – patient education)	Available for download
Pocket Guidelines for Assessment and Treatment of Obesity		Starting the Conversation (Spanish – patient education)	
Pre-diabetes (patient education)		NC Quitline Referral tearsheets	
Healthy weight (patient education)		Tobacco cessation counseling reimbursement information	
Achieving a Healthy Weight for Children		Depression Screening	
BMI Wheel		Zung Scale assessment tool	
Get up and move poster		American Psychiatric Association Pocket Guidelines	
Growth charts for boys and girls	Available for download	Understanding Depression (patient education)	Available for download
Healthy Habits by age (patient education)		Breast Cancer Screening	
Clinical guidelines		Breast Cancer Awareness Poster	
Weekly activity log (patient education)		Breast Health Bead Necklace	
Chlamydia Screening		Mammography Counseling tip card	
CDC Guidelines on Chlamydia screening	Available for download	Colon cancer screening	
Guide to taking a sexual history		Colorectal cancer guidelines	Available for download
Evidence-based steps for increasing Chlamydia screening		Colorectal cancer benefit flyer	
CDC fact sheet on Chlamydia (patient education)		CDC fact sheet on colon cancer screening (patient education)	
Stress Management			
Belly Breathing (patient education)	Available for download		
ABCs of Managing Stress (patient education)			

Practitioner’s Name: _____ Phone Number: _____
 Practice Address: _____
 (We need your street address for UPS shipping.)
 Email address _____

Providers Toolkit materials are available for download at www.bcbsnc.com/providers/toolkit

Credentialing for professional providers





14.1 Credentialing/recredentialing

The purpose of credentialing physicians and providers is to exercise reasonable care in the selection and retention of competent, participating providers. The initial credentialing process can take up to 60 days for completion from the date a completed application is received by BCBSNC. BCBSNC deems an application to be complete when all applicable sections of the uniform application are completed accurately along with all required supporting documentation. This process includes, but is not limited to, verification and/or examination of:

- North Carolina license
- Uniform application to participate as a health care practitioner
- DEA
- Malpractice insurance
- Medicare/Medicaid sanctions
- National Practitioner Databank (NPDB)
- Health Care Integrity Protection Databank (HIPDB)
- Hospital privileges or letter stating how patients are admitted
- Board certification**
- Other pertinent documentation
- In some instances a letter of recommendation from the chief of staff or department chair may be required (i.e., if malpractice settlements exceeding \$200,000 and/or 2 or more malpractice settlements)

Initial credentialing requires a signed and dated uniform application to participate as a health care practitioner and the supporting documentation. Full instructions by medical specialty along with a copy of the uniform application can be found on our Web site at bcbsnc.com. All documents should be sent to the BCBSNC credentialing department for verification and processing. To ensure that our quality standards are consistently maintained, providers are recredentialled at least every three years. We agree to make best efforts to process all recredentialing information within 30 days of receipt of all required information.

Additional information required by network management includes the following:

- Individual provider number application* and/or group provider number application*
- Substitute W-9 form*

Any practitioner who seeks reinstatement in any of our networks after being out-of-network for more than 30 days is required to undergo initial credentialing.

* Samples of these forms may be found in chapter twenty-two, Forms.

** For physicians that are not board certified, letters of reference will be required in support of the application.

14.1.1 Locum tenens

For purposes of a locum tenens provider, a practice must submit the Statement of Supervision form to Network 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 90 days.

14.2 Policy for practitioners pending credentialing

Blue Cross and Blue Shield of North Carolina's (BCBSNC) current credentialing policy states that in order to receive the contracted reimbursement for covered services provided to a BCBSNC HMO, POS or PPO member, a practitioner must be credentialed by BCBSNC.

Claims for covered services provided to BCBSNC HMO, POS or PPO members by a non-participating practitioner in a participating provider group will be denied. The BCBSNC member will be held harmless, including any copayments, coinsurance or deductibles.

14.2.1 Credentialing process

Participating practitioners are encouraged to consider the time required to complete the credentialing process as you add new practitioners to your practices. To assist you in maintaining accessibility in circumstances where your practice, and/or the new practitioner, is unable to submit the credentialing application in a timely manner, we have created a standard operating procedure that will allow reimbursement for covered services provided by a non-participating practitioner who is in the process of joining a BCBSNC participating practice. The following must apply:

- A credentialing application must have been submitted to BCBSNC and a determination on such application is pending, and
- The new practitioner must provide covered services to BCBSNC members under the direct supervision of a BCBSNC-similarly licensed and credentialed practitioner at the practice who signs the medical record related to such treatment and files the claim under his or her current provider number, and



- A statement of supervision form is completed and submitted to your local BCBSNC Network Management office (the form may be obtained by contacting your local Network Management office, if needed).

For a copy of the standard operating procedure outlining the details of this process, or if you have questions, please call your local Network Management field office for further assistance (see chapter two, Quick contact information).

14.3 Credentialing grievance procedure

There are times when BCBSNC must take immediate action to terminate a provider's contract in order to maintain the integrity of the HMO/POS/PPO networks and/or to maintain the availability of quality medical care for members. Reasons justifying immediate terminations are specified in the provider's contract, and may include:

- Loss of license to practice (revocation or suspension)
- Loss of accreditation or liability insurance
- Suspension or termination of admitting or practice privileges of a participating physician
- Actions taken by a court of law, regulatory agency, or any professional organization which, if successful, would materially impair the provider's ability to carry out the duties under the contract
- Insolvency, bankruptcy, or dissolution of a practice

Upon receipt of notification of these actions the affected provider will be notified of BCBSNC's intent to terminate him/her from the HMO/POS/PPO networks. In addition to the circumstances outlined above, other information may be received regarding a network provider which may impact the participation status of that provider. This would include reports on providers describing serious quality of care deficiencies. Whenever information of this nature is received, it is evaluated through the normal credentialing review process which includes review and recommendation by our credentialing committee.

14.3.1 Provider notice of termination for recredentialing (level I appeal)

If the credentialing committee's recommendation is to terminate a provider from the HMO/ POS/PPO networks for documented quality deficiencies or failure to comply with recredentialing policies and procedures, the provider file is forwarded for an expedient review by law and regulatory affairs.

- The provider is formally notified, via certified mail, of our intent to terminate and the specific reason for the proposed action. The provider is informed of his or her right to appeal.
- The provider may request a level I appeal by providing additional written documentation which may include further explanation of facts, office or other medical records or other pertinent documentation within 30 days from the date or the initial notification of termination.
- Our credentialing committee will review the additional information provided and make a recommendation to either uphold or reverse the original determination. The provider will be notified via certified mail of the decision and of his/her right to request a level II appeal if the decision is unchanged.

14.3.2 Level II appeal (formal hearing)

A request for a level II appeal must be made within 15 days of the date of the certified letter from the results of the level I appeal.

Practitioners requesting hearings within the specified timeframe will be sent an acknowledgement letter within 5 days giving notice as to the date, time and location of the hearing. The date of the hearing should not be less than 30 days after the date of the notice.

A list of witnesses (if any) expected to testify on behalf of BCBSNC's credentialing committee should be given to the practitioner and similar information requested from the practitioner, i.e., notice of representation, witness(es).

BCBSNC will determine if the hearing will be held before an arbitrator mutually acceptable to the provider and the Plan, before a hearing officer who is appointed by the Plan and is not in direct economic competition with the practitioner, or before a panel of Plan appointed individuals not in direct competition with the practitioner involved.

A description of the formal hearing process includes, but may not be limited to, the following:

- **Representation:** The practitioner/provider and BCBSNC may be represented by counsel or other person of their choice.
- **Court reporter:** BCBSNC may arrange for a court recorder to provide a record of the hearing. If BCBSNC does not arrange for a court recorder, it will arrange for an audio-taped record to be made of the hearing. Copies of this record will be made available to the practitioner/provider upon payment of a reasonable charge.



- Hearing officer's statement of the procedure:** Before evidence or testimony is presented, the hearing officer of the level II appeals committee will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- Presentation of evidence by BCBSNC:** BCBSNC may present any oral testimony or written evidence it wants the appeals committee to consider. The practitioner/provider or his/her representative will have the opportunity to cross-examine any witness testifying on BCBSNC's behalf.
- Presentation of evidence by practitioner/provider:** After BCBSNC submits its evidence, the practitioner/provider may present evidence to rebut or explain the situation or events described by BCBSNC. BCBSNC will have the opportunity to cross-examine any witness testifying on the practitioner's/provider's behalf.
- BCBSNC rebuttal:** BCBSNC may present additional witnesses or written evidence to rebut the practitioner's/provider's evidence. The practitioner/provider will have the opportunity to cross-examine any additional witnesses testifying on BCBSNC's behalf.
- Summary statements:** After the parties have submitted their evidence, first BCBSNC and then the practitioner/provider will have the opportunity to make a brief closing statement. In addition, the parties will have the opportunity to submit written statements to the appeals committee. The appeals committee will establish a reasonable time for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
- Examination by the appeals committee:** Throughout the hearing, the appeals committee may question any witness who testifies.

The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear. In the hearing the practitioner has the right to representation by an attorney or other person of the practitioner's choice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated in preparation thereof, to call, examine, and cross-examine witnesses, to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and to submit a written statement at the closing of the hearing.

Upon completion of the hearing, the practitioner involved has the right to receive a written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendation, and to receive a written decision of the health care entity, including a statement of the basis for the decision.

The practitioner will be notified via certified letter within 5 days from the date of the hearing of the final determination.

If a request for reconsideration or a formal hearing is not made by the practitioner within 30 days of the receipt of the initial notification or 15 days from the receipt of the notification of the level I appeal decision, BCBSNC will assume the provider has forfeited their appeal rights and proceed with the termination as stated in the initial notification letter. A copy of the original notification will be sent to Network Management operations to proceed with termination from all managed care networks (HMO/POS/PPO). Communication will be sent from Network Management operations to the credentialing manager's administrative assistant to confirm the termination of the provider with copies sent to the managers of credentialing, Network Management, marketing, and customer service.

If a request is made by the practitioner, the termination process will be suspended awaiting the outcome of the reconsideration or formal hearing.

The practitioner may be reinstated if so indicated by the outcome of the hearing. If the decision is unchanged the Plan will proceed with termination.

Based on the credentialing committee recommendation to decredential the practitioner, a report is made to the appropriate licensing board. The report details the disciplinary action taken against the practitioner resulting in their loss of privileges to participate in the BCBSNC managed care network.

If BCBSNC identifies quality concerns related to a delegated practitioner, the complaint will be forwarded to the delegated practitioner's credentialing department for follow up. Any actions taken by the delegated practitioner as follow up must be documented and a copy forwarded to BCBSNC to be placed in the subscriber file.

Quality and credentialing programs for ancillary providers





15.1 Services standards for all networks

Home care providers must meet the following service standards:

- Initial response times for:
 - ‡ home infusion of less than or equal to four hours as required
 - ‡ home health and private duty nursing of less than or equal to 24 hours
- 24-hour per day telephone access for emergencies
- Specialized nursing care available for pediatrics, maternity, ventilator and other patients as necessary

HDME providers must meet the following service standards:

- Delivery response time for oxygen and related supplies of four hours or less
- Delivery response time for non-custom equipment of 24 hours or less

Hospice providers must meet the following service standards:

- Care must be available 24 hours per day seven days per week
- Continuity of hospice care must be assured for the patient and family (considered a unit of care regardless of setting - home, inpatient or residential)

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 his/her physician.
- Patient should have 24 hour emergency telephone access to at least one member of the dialysis team (i.e., nephrologist, nurse, dietitian or social worker).
- Patient's dietitian must chart patient's progress at least once a month (more often if patient is not considered stable.)
- Patient's social worker must chart patient's progress a minimum of once every six (6) months (more often if patient is not considered stable).
- One member of the dialysis team (preferable the social worker) must be available as BCBSNC's primary contact regarding patient's care management.

15.3 Eligibility requirements for traditional/comprehensive major medical products

- To be eligible for participation in BCBSNC traditional network, providers must meet the eligibility criteria listed below.
- All credentials must be maintained in good standing to remain a contracting provider.

Home care agency eligibility for traditional/comprehensive major medical	Home health services	Home infusion therapy	Private duty nursing services
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1. Current home care license issued by NC Department of Health and Human Services, division of facility services for:

Nursing services	required		optional
Physical therapy	required		
Speech therapy	required		

Continued on the following page.



Home care agency eligibility for traditional/comprehensive major medical	Home health services	Home infusion therapy	Private duty nursing services
Occupational therapy	required		
Medical social services	required		
Home health aide	required		
Infusion nursing		required	
Private duty nursing			required
2. Current pharmacy permit from NC Board of Pharmacy or contact with NC licensed pharmacy		required	
3. Current commercial liability insurance with the following minimum coverage:			
\$1 million per occurrence	required	required	required
\$1 million per aggregate	required	required	required
4. Completion of ancillary provider application for participation	required	required	required

Hospice credentials for traditional/comprehensive major medical	Hospice services
1. Current home care or hospice license issued by NC Department of Health and Human Services, division of facility services for:	
Hospice home services	required
Inpatient hospice	required
2. Copy of Medicare certification	required
3. Current commercial liability insurance with the following minimum coverage:	
\$1 million per occurrence	required
\$1 million in aggregate	required
4. Completion of ancillary provider application for participation	required



Dialysis eligibility for traditional/comprehensive major medical	Dialysis services
1. Copy of current Medicare/Medicaid certification	required
2. Current commercial liability insurance with the following minimum coverage:	
\$1 million per occurrence	required
\$1 million in aggregate	required
3. Completion of ancillary provider application for participation	required
4. Completion of W-9 form	required

- Each provider will be re-evaluated at a minimum of every 3 years to ensure criteria continues to be met.

HDME credentials for traditional/comprehensive major medical	Medical equipment and devices	Orthotics and prosthetics
1. At least one of the following current North Carolina permits or licenses: <ul style="list-style-type: none"> • NC Board of Pharmacy <ul style="list-style-type: none"> ‡ Device dispensing permit ‡ Device and/or medical equipment dispensing permit ‡ Pharmacy permit • NC Department of Health and Human Services, division of facility services home care license for directly related supplies and appliances 	required	
2. Copy of letter from NC Board of Pharmacy verifying exemption from licensing		required
3. Current commercial liability insurance with the following minimum coverage:		
\$1 million per occurrence	required	required
\$1 million per aggregate	required	required
4. Completion of ancillary provider application for participation	required	required



15.4 Eligibility requirements for managed care products (credentialing)

- To be eligible for participation in BCBSNC PPO, POS and HMO networks, providers must meet the credentialing criteria listed below.
- All credentials must be maintained in good standing to remain a contracting provider.
- Contracting providers will be recredentialed every three years.
- When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner’s participation in the health benefit plan network shall be the date the insurer approves the practitioner’s credentialing application.

Home care agency credentials for managed care products	Home health services	Home infusion therapy	Private duty nursing services
1. Current home care license issued by NC Department of Health and Human Services, division of facility services for:			
Nursing services	required		optional
Physical therapy	required		
Speech therapy	required		
Occupational therapy	required		
Medical social services	required		
Home health aide	required		
Infusion nursing		required	
Private duty nursing			required
2. Current pharmacy permit from NC Board of Pharmacy			
		required	
3. Current accreditation from at least of the following agencies:			
<ul style="list-style-type: none"> • JCAHO • Community Health Accreditation Program (CHAP) • NC Accreditation Commission for Home Care (ACHC) 	required	required	required
4. Current commercial liability insurance with the following minimum coverage:			
\$1 million per occurrence	required	required	required
\$1 million in aggregate	required	required	required
5. Completion of ancillary provider application for participation			
	required	required	required
6. Medicare/Medicaid certification			
	required*	required*	required*



* Certification not required if provider can provide documentation from Medicare/Medicaid that application for certification was made but not granted because Medicare/Medicaid ceased offering certifications for their area because Medicare/Medicaid's access of care standards have already been met.

HDME credentials for managed care products	Medical equipment and devices	Orthotics and prosthetics
1. At least one of the following current North Carolina permits or licenses: <ul style="list-style-type: none"> • NC Board of Pharmacy <ul style="list-style-type: none"> ‡ Device dispensing permit ‡ Device and/or medical equipment dispensing permit ‡ Pharmacy permit • NC Department of Health and Human Services, division of facility services home care license for directly related supplies and appliances 	required	
2. Copy of letter from NC Board of Pharmacy verifying exemption from licensing	if applicable	required
3. Current accreditation from at least one of the following agencies: <ul style="list-style-type: none"> • Also, The Compliance Team Inc.'s Exemplary Provider Award Program (ISO) • JCAHO • Community Health Accreditation Program (CHAP) • NC Accreditation Commission for Home Care (ACHC) • American Board of Certification (ABC) in Orthotics and Prosthetics or the Board of Orthotics and Prosthetics (BOC) • Women's Prosthetics Accreditation, Inc. (ACHC) – breast prosthesis only (orthotics and prosthetics) 	required	required
4. Current commercial liability insurance with the following minimum coverage:		
\$1 million per occurrence	required	required
5. Completion of ancillary provider application for participation	required	required
6. Medicare/Medicaid certification or exemption form	required	required



Hospice credentials for managed care products	Hospice services
1. Current home care or hospice license issued by NC Department of Health and Human Services, division of facility services for:	
Hospice home services	required
Inpatient hospice	required
2. Current accreditation/certification from at least one of the following agencies: <ul style="list-style-type: none"> • JCAHO or ACHC • Medicare/Medicaid or Medicare/Medicaid exemption form 	required
3. Current commercial liability insurance with the following minimum coverage:	
\$1 million per occurrence	required
\$1 million in aggregate	required
4. Completion of ancillary provider application for participation	required

Dialysis credentials for managed care products	Dialysis services
1. Copy of current Medicare/Medicaid certification	required
2. Current commercial liability insurance with the following minimum coverage:	
\$1 million per occurrence	required
\$1 million in aggregate	required
3. Completion of ancillary provider application for participation	required
4. List of all current services provided	required
5. Copy of current quality and outcomes data to include the following Dialysis Outcomes Quality Initiative (DOQI) indicators: URR ($\geq 65\%$), K+/V (≥ 1.2), Hematocrit (33%-36%), albumin (3.5-5.2) and/or an equivalent indicator. Infection rates and transfers from the dialysis center(s) to acute care facilities is required when available as stated in the facility's QI or UM program. Copy of the UM, QM and infection control policy copy of CLIA Current copy of ESRD report Copy of ACCRED (if applicable)	required

Appeal and grievance procedures





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 LineSM at **1-800-214-4844** or visit our Web site at **bcbsnc.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, BCBSNC requires the member's written authorization in order for a third party, including the member's provider, to pursue an appeal or grievance on the member's behalf. The appeal and grievance processes are available to address member concerns about:

- Adverse medical necessity decisions (non-certifications)
- BCBSNC decisions related to the availability, delivery or quality of health care
- Claims payment, handling, or reimbursement
- The relationship between BCBSNC and the member

In order for you, the provider, to represent the member in a level I member appeal, a written authorization must be obtained from the member. The member may obtain the member appeal representation authorization form by calling the customer service phone number located on the back of their ID card. A copy of this form is also included in chapter twenty-two, member appeal representation authorization form. Requests for review should also include pertinent additional medical records information not previously supplied to BCBSNC.

Member authorization must be received by BCBSNC for a specific issue. A blanket authorization statement for appeal cannot be used. A signed authorization will remain valid until the particular issue is resolved or until authorization is rescinded by the member. Providers should submit documents for a level I appeal along with the appeal representation form to the following address:

**Blue Cross and Blue Shield of North Carolina
Level I Member Appeals
PO Box 30055
Durham, NC 27702-3055**

or you can fax your inquiries to:
Member Appeals: **919-765-4409**.

16.3 Appeals and grievances for mental health and substance abuse services

Because BCBSNC delegates claims processing for mental health and substance abuse claims for Blue Care[®] to Magellan Behavioral Health, courtesy review and first level appeals must be filed with Magellan Behavioral Health. After completing the formal appeal process with Magellan, if a member still believes a claim has not been processed correctly, a request may be made to BCBSNC for an additional review of the appeal. For information on how to file a mental health or substance abuse appeal on behalf of a member, call Magellan Behavioral Health at **1-800-359-2422**.

For Blue OptionsSM and Classic Blue[®], BCBSNC processes mental health and substance abuse claims. However, Magellan Behavioral Health will handle and communicate all first level appeals related to health coaching and intervention programs for Blue OptionsSM and Classic Blue[®].

Note: Please be aware that self-funded employer groups have the option of delegating the administration of mental health and substance abuse services to a provider of their choosing. Therefore, please check the member's identification card for the name of the provider.

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 LineSM at **1-800-672-7897, x57078**. A decision will be made within 72 hours of receiving all information, and a written decision from the Plan will be forwarded to you and the member within (2) business days, but no later than 3 days from the date all information necessary to review the appeal was received.



16.5 Member grievance policy

Occasionally, BCBSNC receives complaints from members about a provider or their staff regarding quality of care issues. In order to appropriately respond to our members, BCBSNC may ask you to review and provide a written response to such cases. You are required to cooperate with BCBSNC member grievance policies and must respond to BCBSNC direct inquiries within the time frame specified in each request. This will ensure the best service to our mutual customer, our member/your patient.

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 seven, Healthcare management & operations.

Level I provider appeals consist of retrospective reviews and do not require a member signed authorization. A post-service level I provider appeals of claims is performed based on your belief that a claim has been denied or adjudicated incorrectly. The provider appeal process is separate from BCBSNC'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 a written request for appeal. To request a claim review regarding a processed claim related to:

- Medical necessity
- Coding, bundling, or fees
- Cosmetic services
- Investigational/experimental services
- Certification not obtained for inpatient hospital admissions

Providers will have 90 calendar days from the adjudication date to submit the level I billing/coding dispute.

Providers will have 90 calendar days from the adjudication date to submit the level I medical necessity provider appeal.

To request a review, contact BCBSNC using one of the following methods:

- Call the Provider Blue LineSM at **1-800-214-4844**
- Complete the level I provider appeal form including objective medical documentation
- Mail a letter of explanation, including objective medical documentation, to the following address:

**Blue Cross and Blue Shield of North Carolina
Provider Appeals Unit
PO Box 2291
Durham, NC 27702-2291**

All inquiries regarding the status of the appeal should be routed through customer service. Customer service will forward appropriate issues to the appeals department for a provider appeal review. A provider appeal review is a formal review of a payment or denial of a claim. Provider appeal reviews are handled within 30 days from the date of receipt of all information. Supporting objective medical documentation should be submitted for provider appeal reviews. Providers may reduce administrative cost associated with records submissions by first verifying that the records document information consistent with BCBSNC medical policy, payment policy and claim check clinical edit rationale.

Types of post-service provider appeals available to providers are disputes of post-adjudicated claims related to coding, bundling, fees, cosmetic, investigational, experimental 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
 - ‡ Mutually exclusive
 - ‡ Services not eligible for separate reimbursement
 - ‡ Incidental denials
 - ‡ Surgical global denials
- Level I provider appeal process for medical necessity applies to processed claims related to:
 - ‡ Medical necessity
 - ‡ Cosmetic services
 - ‡ Investigational/experimental services
 - ‡ No pre-authorization for inpatient hospital admission

All inquiries for processed claims that pertain to one of the above reasons should be directed to:

**Blue Cross and Blue Shield of North Carolina
Provider Appeals Unit
PO Box 2291
Durham, NC 27702-2291**



or you can fax your inquiries to:

Provider billing/coding

(bundling and fees): **919-287-8708**

Provider medical necessity: **919-287-8709**

State PPO: **919-765-2322**

16.7 Level II post-service provider appeals

Level II post-service provider appeals are available to physicians, physician groups, and physician organizations and will be performed by an independent review organization. Physicians, physician groups, and physician organizations may file a level II post-service provider appeal for medical necessity or billing disputes with MES Solutions, an independent review organization. There is a filing fee associated with all requests for a level II post-service provider appeal.

Please refer to chapter 24, sections 24.3 and 24.4 for instructions on filing a level II post-service provider appeal and a filing fee matrix.

16.7.1 Process for submitting a post-service level II provider appeal

The level II post-service provider appeal request should clearly identify the issue that is in dispute and rationale for the appeal. Demographic information including subscriber name, patient name, patient BCBSNC ID number, provider name, and provider ID number should also be included with any request for appeal. Level II post-service provider appeals require a filing fee to be submitted before the review can begin. Providers may reduce administrative cost associated with records submission by first verifying that the record document information is consistent with BCBSNC medical policy, payment policy and clinical edit clarification guidelines. A physician, physician group, or physician organization may file a level II post-service provider appeal if an adverse determination was given on a level I post-service provider appeal billing dispute or medical necessity denial, as described below. Level II post-service provider appeal for billing disputes:

The BCBSNC billing dispute resolution process is available to resolve disputes over the application of coding and payment rules and methodologies to specific patients. Physicians, physician groups, or physician organizations must submit a written request for level II post-service provider billing dispute appeal within ninety (90) calendar days of the date of the level I post-service provider appeal denial letter.

Physicians, physician groups, or physician organizations must exhaust BCBSNC's level I post-service provider appeal process before submitting a level II post-service provider appeal. A physician, physician group, or physician organization is deemed to have exhausted BCBSNC's level I post-service provider appeal process if BCBSNC does not communicate a decision within thirty (30) calendar days of BCBSNC's receipt of all documentation reasonably needed to make a determination on the level I post-service provider appeal. You may access BCBSNC's pricing and adjudication principles for professional providers at: https://www.bcbsnc.com/services/medicalpolicy/pdf/pricing_and_adjudication_principles_for_professional_providers.pdf.

Requests for level II post-service provider appeals may relate to the following issues:

- Integral part of a primary service
- Mutually exclusive services
- Services not eligible for separate reimbursement
- Incidental procedures denials
- Surgical global period denials

Physicians, physician groups, or physician organizations should contact MES Solutions directly to submit a level II post-service provider appeal for a billing dispute.

Mailing address:

MES Solutions
100 Morse Street
Norwood, MA 02062
 Phone: **800-437-8583**
 Fax: **888-868-2087**
www.mesgroup.com

The level II provider appeal requests for billing disputes administered by an independent review organization, will be reviewed based on the information previously submitted with the level I provider appeal. BCBSNC will supply all documentation from the level I provider appeal to the billing dispute reviewer. For additional questions, please contact MES Solutions directly.

Level II post-service provider appeal for medical necessity: Level II post-service provider appeals are available to physicians, physician groups, and physician organizations to resolve disputes over the denial of investigational, experimental, cosmetic, and medical necessity determinations based on medical policy.

Physicians, physician groups, or physician organizations must submit a written request for a level II post-service provider medical necessity appeal within sixty (60) calendar



days of the date of the level I post-service provider appeal denial letter. Physicians, physician groups, or physician organizations must exhaust BCBSNC level I post-service provider appeal process before submitting a level II post-service provider appeal. You may access BCBSNC's medical policy at: <http://www.bcbsnc.com/services/medical-policy>.

Physicians, physician groups, or physician organizations should contact MES Solutions directly to submit a level II post-service provider appeal for medical necessity.

Mailing Address:

MES Solutions
100 Morse Street
Norwood, MA 02062
 Phone: **800-437-8583**
 Fax: **888-868-2087**
www.mesgroup.com

16.7.2 Filing fee matrix

Billing dispute	
Amount of dispute	Filing fee calculation
\$1000 or less	Filing fee shall be equal to \$50
Greater than \$1000	Filing fee shall be equal to \$250

Medical necessity dispute	
Amount of dispute	Filing fee calculation
\$1000 or less	Filing fee shall be equal to \$50
Greater than \$1000	Filing fee shall be equal to \$250

Note: For level II post-service provider appeals related to billing disputes, the disputed amount must exceed \$500.00. In instances where the disputed amount is less than \$500, the physician, physician group, or physician organization may submit similar disputes to the independent review organization within one (1) year of the original submission date. If the physician, physician group, or physician organization intends to submit additional similar disputes during the year, the physician must contact the billing dispute reviewer to notify that additional similar submissions will be sent. If the 1 year lapses and the disputes submitted are not in excess of \$500 in the aggregate, the original dispute will be dismissed.

The filing fee will be refunded in the event that the physician, physician group, or physician organization prevails in the level II post-service appeal process.

16.8 Provider resources

The provider Web site contains a form for requesting provider appeal reviews regarding coding, bundling, fees, cosmetic, investigational, experimental, no pre-authorization for hospital admission. This form is located at bcbsnc.com/provider. BCBSNC provides resources that are readily available which may provide immediate resolution to questions for how a particular claim was considered. Your BCBSNC Notification of Payment (NOP) and Explanation of Payment (EOP) provide a detailed summary of how a claim was adjudicated. **Blue eSM**, accessed via the internet allows you to search from your desktop: status of submitted claims, including payment amounts, member co-payment, co-insurance, deductible amounts, and status code explanations. Please refer to chapter eleven, Electronic solutions for additional information and services provided via **Blue eSM**. Clear Claim Connection (C3) provides to your desktop a Web-based connection to ClaimCheck claims payment policies, related rules, clinical edit clarifications, and source information in an easily accessible application. To view how ClaimCheck auditing evaluates code combinations, participating providers may access clear claim connection through the C3 pass through page via the **Blue eSM** connection. Please refer to chapter nine, Claims for additional information on payment guidelines and clear claims connection. Medical policy consists of medical guidelines and payment guidelines. Medical guidelines detail when certain medical services are medically necessary, and whether or not they are investigational. Payment guidelines provide (claims payment) editing logic for CPT, HCPCS, and ICD-9-CM coding. Payment guidelines are developed by clinical staff, and include yearly coding updates, periodic reviews of specialty areas based on input from specialty societies and physician committees, and current coding conventions. Medical policy is available on the BCBSNC Web site located on the providers section, and may be searched by policy name, number, CPT code, or keyword. To view a specific medical policy or find out more, visit the BCBSNC Web site at <http://www.bcbsnc.com/services/medical-policy/>.

Specialty networks





17.1 Pharmacy

This chapter does not apply to FEP, BlueCard® or State Health Plan.

17.1.1 Formularies

BCBSNC currently maintains three open formularies:

- 4 tier formulary
- 3 tier formulary
- 2 tier formulary

The formularies are developed through the efforts of the BCBSNC pharmacy and therapeutics committee, comprised of North Carolina practicing physicians and pharmacists.

The 4 tier formulary is intended to reflect current clinical practice in North Carolina and has three levels of member copayments:

Tier 1: All generic drugs. These have the lowest copayment.

Tier 2: Brand-name drugs that are clinically effective, cost-effective and meet the needs of most patients.

Tier 3: Brand-name drugs that have been reviewed by the BCBSNC pharmacy and therapeutics committee and determined not to have a significant therapeutic advantage over existing tier 2 drugs; new drugs that have not been reviewed by the pharmacy and therapeutics committee; drugs that are not usually recommended as first-line therapy and for which there are existing therapeutic alternatives; brand-name drugs that have a generic equivalent. These drugs have the highest copayment.

Tier 4: Specialty drugs: Includes covered biotechnical, gene therapies or other costly medications that are classified by the BCBSNC P&T committee as specialty medications, and generally have other therapeutic options available that are well-accepted and cost-effective. Those medications classified by BCBSNC as specialty drugs generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies.

Tier 4 drugs have the highest co-payment or coinsurance amount.

Members who have the 4 tier formulary benefit will have three pharmacy copayments listed on their identification cards (see chapter three, Health care benefit plans and member identification cards).

You may receive calls from members or pharmacists as members seek ways to lower their copayments by having tier 1 and tier 2 drugs prescribed. The 4 tier formulary is an open formulary and we encourage you to make treatment selections based on your clinical judgment, your knowledge of the patient's condition, medical history, and individual patient needs. The 3 and 2 tier formulary (using different copayments or coinsurance for generic and brand drugs) may be maintained for some groups. We discourage the use of drugs designated as Not-Endorsed (NE) in the formulary. This formulary will continue to promote the use of the most clinically- and cost-effective pharmaceutical products.

For your convenience, the most current list of drugs in the fourth tier will be posted online at bcbsnc.com. You may also find the searchable formulary helpful as well. Our formulary is updated on a quarterly basis, after careful review by the pharmacy and therapeutics committee, which is a group of practicing physicians and pharmacists in North Carolina.

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 brand (Tier 3 or 4) copayment or coinsurance, and also be responsible for paying the difference in cost between the brand name and generic alternative drug. However, if you indicate that a brand name drug must be used, the member will only be responsible for the applicable brand copayment or coinsurance up to the coinsurance maximum.

We encourage you to prescribe lower cost, equally effective generic drugs, where appropriate, and to promote their use by your patients.

17.1.3 Requesting a formulary

We are pleased to offer several ways to access the BCBSNC formulary.

BCBSNC printed formulary: To request a printed formulary, please call your regional Network Management representative.

BCBSNC online formulary: Searchable online formulary is available on our Web site at bcbsnc.com.



BCBSNC formulary for PDA: BCBSNC hosts its formulary with eProcrates, a clinical drug reference software for use on handheld computing devices. For more details on this free application, go to our online formulary at bcbsnc.com and follow the link to download formulary to PDA.

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 3 tier formulary are included in the Blue LinkSM, our quarterly provider newsletter, and online at bcbsnc.com.

17.1.5 Certification

BCBSNC may require certification for certain pharmaceuticals. Pharmaceuticals that require certification or have quantity limitations that require certification for greater quantities may be updated at any time without prior notification. For an up-to-date listing of the medications that may require certification or have quantity limitations please refer to our Web site, bcbsnc.com.

17.1.6 Quantity limitations

These programs apply to Blue Advantage[®], Blue Care[®], and Blue OptionsSM members. Quantity limits may apply to coverage of certain drugs with the goal of optimizing patient outcomes. This program, which applies coverage limits to drugs that have the potential for abuse or misuse, provides an immediate feedback mechanism to alert the physician to prescription purchasing patterns of members. If those patterns are different from what you intended, you will have the opportunity to intervene before the prescription is dispensed to the member.

BCBSNC will pay for quantities of limited drugs up to the allowed amount in a defined time period. If based on your clinical judgement, your knowledge of the patient's condition, medical history and individual needs, you think the patient should receive a quantity greater than that covered by BCBSNC, you may request certification for a greater quantity. Members may choose to pay cash for quantities that exceed BCBSNC's approved quantities.

The list of pharmaceuticals that have quantity limitations that require certification for greater quantities may be updated at any time without prior notification. For an up-to-date listing of the medications that may require certification or have quantity limitations, please refer to our Web site, bcbsnc.com.

Requests for prior approval for any of the above prescription drugs or requests for quantity limit considerations that exceed the dosage limits should be directed to our member health partnership operations department at **1-800-672-7897**.

17.1.7 Days supply of prescriptions

For members enrolled in Blue Care[®], Blue OptionsSM, Classic Blue[®] and Blue Advantage[®], each prescription drug copay will cover up to a 30-day supply. Physicians are asked to write new prescriptions for a 30-day supply or less to help minimize patient out-of-pocket expenses.

17.1.8 Extended supply prescriptions

Blue Care[®], Blue OptionsSM, Classic Blue[®] and Blue Advantage[®]:

After first filling an initial 30-day supply of the same prescribed medication, members may obtain up to a 90-day supply of their medication from any participating pharmacy. A prescription for the initial 30-day supply must first be written before a prescription for a 90-day supply.

Medicare supplement:

Members may obtain up to a 90-day supply of their medication from pharmacies participating in the extended supply network. Extended supply prescriptions must be written for a 90-day supply rather than a 30-day supply, regardless of the number of refills.

17.1.9 Drug utilization review

BCBSNC conducts quarterly retrospective drug utilization reviews. You will periodically receive correspondence from us or our vendor detailing member utilization of targeted drugs. Member-specific data is obtained from claims submitted by pharmacies. These letters are designed to notify you of prescribing patterns that are inconsistent with national treatment guidelines or peer prescribing trends. Please review the letters and make changes to member drug therapy as appropriate based on your clinical judgment, your knowledge of the patient's condition, medical history, and individual patient needs.



17.1.10 Over-The-Counter (OTC) medication online resources

An OTC medication online resource is now available on the Blue Cross and Blue Shield of North Carolina pharmacy services Web page to help members navigate the world of OTC medications. This free resource can be accessed by clicking on *Find a Drug* on the **bcbsnc.com** home page. This online resource provides members with:

- Education information on the uses and benefits of OTC medications
- Information on common conditions that may be managed/treated by OTC medications
- Examples of OTC medications that may effectively treat the symptoms of these conditions

This resource is a value-added service and is not part of the member's health insurance contract.

17.2 Mental health and substance abuse services

For HMO and POS members with mental health and substance abuse benefits, BCBSNC provides coverage for services through Magellan Behavioral Health.

For members in PPO and CMM products, access to services for mental health and substance abuse is through the BCBSNC provider network.

17.2.1 Referrals/prior review/health coaching and intervention

Mental health and substance abuse services do not require a referral from the primary care physician, but prior review and certification for service must be issued by Magellan Behavioral Health for the following products:

- Blue Care[®]
- Blue OptionsSM
- Classic Blue[®]

Prior approval and inpatient admission certification for mental health and substance abuse services is not required for the following products:

- Blue Advantage[®]
- Blue AssuranceSM
- AccessSM
- CMM conversion

To arrange for mental health and substance abuse services:

- The member or physician must call Magellan Behavioral Health at **1-800-359-2422** prior to arranging for services by the mental health provider.
- Some HMO and POS contracts do not access mental health and substance abuse services through Magellan Behavioral Health. Members with access through Magellan Behavioral Health have this information on their member ID card. Eligibility and benefits for mental health and substance abuse services may also be verified via Provider Blue LineSM at **1-800-214-4844**.

Magellan Behavioral Health is responsible for healthcare management & operations functions for the following products:

- Blue Care[®]
- Blue HMOSM
- Blue OptionsSM
- Classic Blue[®]

17.2.2 Mailing address for Magellan appeals/grievances

**Attention: Appeals Coordinator
Magellan Behavioral Health
PO Box 1619
Alpharetta, Georgia 30009**

17.2.3 Member relations

Please call Magellan Behavioral Health at **1-800-359-2422**.

17.2.4 Participating providers

Providers may call the Provider Blue LineSM for assistance locating participating PPO and CMM mental health and substance abuse providers. For PPO and CMM providers, call **1-800-214-4844**, or access our provider directories online Web site at **bcbsnc.com**.

- For HMO and POS members call **1-800-359-2422**



17.3 Chiropractic services

BCBSNC subcontracts provider network services for chiropractic care to Health Network Solutions (HNS) (formerly known as Chiropractic Network of the Carolinas [CNC]) for HMO and PPO products. All HNS participating chiropractors must submit claims to HNS for services provided to BCBSNC HMO and PPO members (including claims for BlueCard® eligible PPO members). HNS forwards submitted claims to BCBSNC for processing. Payment is then routed back to HNS and HNS makes payments directly to HNS participating chiropractic providers.

Claims for BCBSNC CMM plans, as well as, claims from non-HNS participating chiropractors should be filed directly to BCBSNC.

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 an 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 BCBSNC 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
PO 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 Health Network Solutions (HNS), HNS policies and procedures for claims administration, and BCBSNC chiropractic care guidelines through its vendor HNS, visit the HNS Web site located at www.healthnetworksolutions.net/bcbsnc.htm.

Blue extras for BCBSNC members





The following special programs are made available to BCBSNC members as value-added services. These services are not covered benefits or otherwise a part of the member's health insurance contract and therefore are payable solely by the member. Additional information about each program is available.

18.1 Alt Med BlueSM

Alt Med BlueSM is a program offered through American Whole Health that provides discounts up to 25%, on popular alternative medicine services.

Services available include:

- Acupuncture
- Biofeedback
- Chiropractic services
- Fitness centers
- Guided imagery
- Health and fitness magazines
- Health spas
- Massage therapy
- Nutritional counseling
- Personal trainers
- Somatic education
- Stress management
- Yoga

The discount varies by service type and is deducted from the charge to the member at the time of service.

- Services are available to BCBSNC members simply by showing their BCBSNC ID card to participating providers.
- Services must be received through a participating Alt Med BlueSM network practitioner. Participating practitioners are available throughout the country.
- BCBSNC does not accept claims or reimburse providers for these services. Members are fully responsible for paying all bills.
- For more information on available services or to locate a participating practitioner, visit bcbsnc.com or call **1-888-336-2583**.
- To become a participating Alt Med BlueSM provider, contact the vendor directly at **1-888-336-2583**.

18.2 Vita BlueSM

Vita BlueSM is a mail order service offering vitamins, minerals and herbal supplements at discounts of up to 40% off of market prices.

- Members can order products online
- For more information visit bcbsnc.com or call **1-888-234-2413**

18.3 Blue PointsSM

Blue PointsSM, our online physical activity incentive program, rewards members for staying active through exercise. Members exercise for just 30 minutes a day and earn points toward great prizes.

- Members log on to bcbsnc.com to register. Once a registered Blue PointsSM member, Blue PointsSM users log in their 30 minutes of activity in their online log.
- There are four levels in all: B, L, U and E. For each 250 point level, members are then prompted to choose a prize.

For more information visit bcbsnc.com or call **1-888-705-7050**.

18.4 Optic BlueSM

Optic BlueSM is a corrective laser eye surgery discount program.

- Members receive discounts of about 20% off the market price for laser eye surgery through a network of participating ophthalmologists.
- The price paid by the member is a global charge of \$1,249 per eye that includes the initial consultation, the laser procedure, all follow up visits and any procedures for over/under correction.
- For more information or to locate a network provider, visit bcbsnc.com or call **1-800-755-0507**.



18.5 Cosmetic Surgery BlueSM

Cosmetic Surgery BlueSM is a program offering a cosmetic surgery discount, information and provider referrals available to eligible Blue Cross and Blue Shield of North Carolina members. It is the first discount program of its kind in North Carolina and one of the first in the country.

Cosmetic Surgery BlueSM provides members easy access to a network of credentialed plastic surgeons that have agreed to offer members a 15% discount on their services. Cosmetic Surgery BlueSM also provides members easy access to information and resources to make educated, safe choices about cosmetic surgery procedures. The information includes procedure descriptions and expectations, potential risks, and questions to ask their plastic surgeon.

For more information on Cosmetic Surgery BlueSM, visit bcbsnc.com or call **1-877-755-1111**.

18.6 Audio BlueSM

Thanks to Audio BlueSM, members can save \$250 or 25% on a single hearing aid. Members can choose from a variety of hearing aid models and prices. With a discount of 25% off hearing aid MSRP or \$250 off usual and customary fees, whichever provides greater savings, members will also save on:

- Hearing aid fittings
- Follow-up visits up to one year
- One-year warranties for service, loss or damage
- Free hearing aid cleanings and checks up to one year
- One-year supply on batteries

To receive the discount, members simply show their BCBSNC ID card to a participating provider at one of many locations throughout North Carolina. Members can find the closest participating audiologist by visiting our Web site at bcbsnc.com or by calling **1-877-979-8000**.

18.7 Get Fit BlueSM

Get Fit BlueSM is a nutrition and fitness resource and discount program. Get Fit BlueSM offers discounts on nutrition and fitness products, programs and services. Plus, BCBSNC members have fast, easy access to recipes, calorie counters, nutrition and exercise advice and more.

Get Fit BlueSM can help BCBSNC members save money with discounts on the following and more:

- Select weight management programs
- Scales, heart rate monitors, body fat analyzers, blood pressure monitors and electronic pulse massagers

18.8 Cosmetic Dentistry BlueSM

Cosmetic Dentistry BlueSM is an innovative program offering discounts on cosmetic dental procedures. Cosmetic Dentistry BlueSM provides members easy access to a statewide network of credentialed dentists who have agreed to offer members up to 30% discounts on the following services:

- Bonding
- Implants
- Teeth whitening
- Tooth colored fillings
- Tooth contouring and reshaping
- Veneers



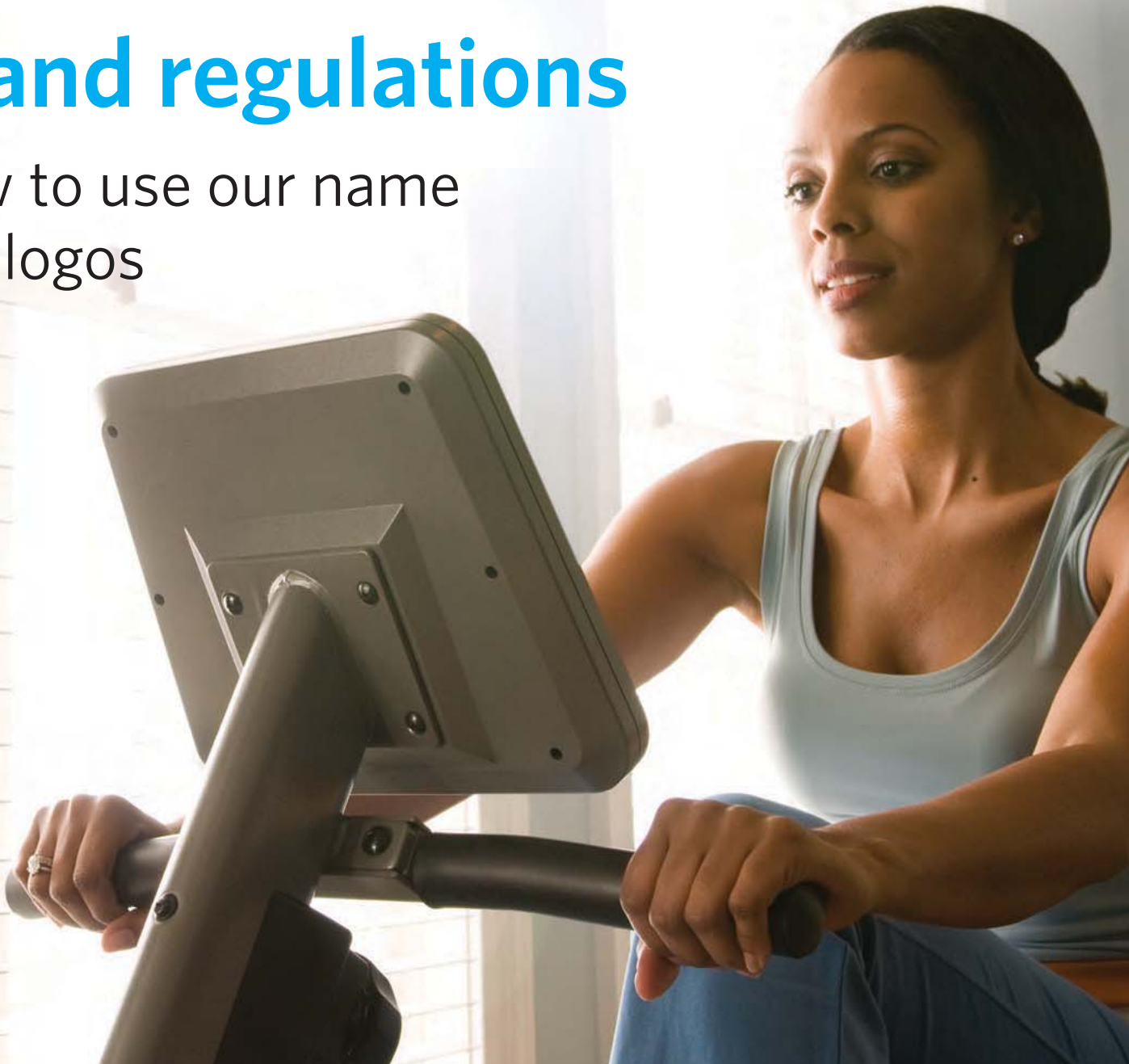
18.9 Program availability by product

The following chart summarizes which programs are available by product:

	Alt Med Blue SM	Vita Blue SM	Blue Points SM	Optic Blue SM	CSB	Audio Blue SM	Get Fit Blue SM	Healthline Blue SM	Cosmetic Dentistry Blue SM
Blue Care [®]	X	X	X	X	X	X	X	X	X
Blue Options SM	X	X	X	X	X	X	X	X	X
Classic Blue [®]	X	X	X	X	X	X	X	X	X
Blue Advantage [®]	X	X	X	X	X	X	X	X	X
Medicare supplement	X								X
Short-term									X
Access SM	X	X		X	X	X	X		X
Conversion	X	X	X	X	X	X	X		X
Blue Assurance SM	X	X		X	X	X	X		X
BlueCard [®]	X	X		X	X	X	X		
NC Health Choice	X	X		X	X	X	X		
Federal Employee Plan	X	X		X	X	X	X		X

Brand regulations

How to use our name
and logos





Brand regulations are the legal rules that must be followed when using the Blue Cross and Blue Shield (BCBS) brands and must be consistent with the terms of the BCBS license agreement (executed by all licensees). To download BCBSNC corporate logos, visit bcbsnc.com/news/onlinepr/comp-logos1.cfm. Or, visit our corporate style guide at bcbsnc.com/inside/style-guide/. These are the only sources for downloading the BCBSNC corporate logos.

19.1 How to use the Blue Cross and Blue Shield of North Carolina (BCBSNC) name correctly

The following guidelines should be used when using the BCBSNC name:

19.1.1 Using the BCBSNC name in text

As an independent licensee, we are legally obligated to disclose our brand and location. If you are using our company name in text, it must be written as follows:

Blue Cross and Blue Shield of North Carolina

Variations such as BlueCross BlueShield, Blue Cross/Blue Shield of NC or Blue Cross & Blue Shield/NC are not acceptable.

If you are producing a long text document (e.g., a newspaper article), you may use the acronym “BCBSNC” for secondary mentions. Make sure you use the full name the first time it is mentioned in any communication.

19.1.2 Logos

The BCBSNC logo is available in two formats, flush-left and centered. Both are available in one-color (black, white) and two-color (cyan logos with either black or white type) versions. Do not alter any elements within the logos.





19.1.3 Licensee disclosure

Licensee disclosure is also a Blue Cross and Blue Shield Association (BCBSA) requirement. One of the following two statements must be included whenever the company name is mentioned.

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

or

An independent licensee of the Blue Cross and Blue Shield Association.

The statement can be placed anywhere on the piece. The type can be small (e.g., six point), as long as it remains legible and relatively independent of other copy or graphics.

19.1.4 Camera ready art

BCBSNC's logos are available in both hard-copy (Photostat) and electronic (Mac or PC) formats. They can be delivered by overnight mail, standard mail, or e-mail. Contact Creative Studio at **1-919-765-3858** with questions or for assistance.

19.1.5 Approvals

All pieces that are being developed for dissemination to the public must be approved by BCBSNC's creative studio department and the law and regulatory affairs department. Contact Creative Studio at **1-919-765-3858** for coordination of approvals from creative studio department and the law and regulatory affairs department.

19.2 How to use registered marks (®) and service marks (SM) correctly

If any other registered mark is shown on a piece, they must be differentiated from our registered marks. To do this add a numeral to the other registered marks: ®1, ®2 etc.

Disclose multiple registered marks as follows:

- ® Registered marks of the Blue Cross and Blue Shield Association
- ®1 Registered mark of (mark owner's name)

If any other service mark is shown on a piece, they must be differentiated from our service marks. To do this add a numeral to the other service marks: SM1, SM2 etc.

Disclose multiple registered marks as follows:

- SM Service mark of the Blue Cross and Blue Shield Association
- SM1 Service mark of (mark owner's name)

Health Insurance Portability and Accountability Act (HIPAA)





The Health Insurance Portability and Accountability Act of 1996 (HIPAA) calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans, and employer groups.

HIPAA impacts:

- Electronic transactions
- Code sets and identifiers
- Security of protected health information
- Privacy of protected health information

20.1 Electronic transactions

The administrative simplification provisions mandate of HIPAA requires that all payers, providers, and clearinghouses use specified standards when exchanging data electronically. Providers and payers must be able to send and receive transactions in the designated EDI format. Providers will be able to send and receive information from health plans and payers, using the following standardized formats:

- Claims
- Claims status
- Remittance
- Eligibility
- Authorizations/referrals

Specific information about standard transactions to BCBSNC is discussed in chapter eleven, Electronic solutions and at the eSolutions Web site, bcbsnc.com/providers/edi.

20.2 Code sets and identifiers

Providers should use the following standardized codes to submit claims to health plans:

- ICD-9 – CM
- CPT
- HCPCS
- CDT (formerly HCPCS dental codes, but now ADA codes, pre-fixed with “D”)

These common code sets enable a standard process for electronic submission of claims by providers. BCBSNC has adopted consistent standards, code sets and identifiers for claims submitted electronically and on paper. Code sets must be implemented by the effective date to avoid claims denials.

BCBSNC will maintain taxonomy or specialty codes currently in use and will continue to assign these codes for new providers. The codes are determined during the credentialing and contracting process.

BCBSNC only accepts active codes from national code set sources such as ICD-9, CPT, and HCPCS, as part of our HIPAA compliance measures. As new codes are released, please convert to them by their effective date in order to prevent claims from being mailed back for recoding or resubmission. Deleted codes will not be accepted for dates of service after the date the code becomes obsolete. Contact your local Network Management representative if you have questions regarding this process.

20.3 Security

The HIPAA security rule, sets forth the standards for the security of **electronic** Protected Health Information (**ePHI**). Health plans, health care providers and health care clearinghouses are required to develop and implement appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of ePHI. In addition to implementing and complying with the security rule, BCBSNC is also subject to the requirements of the North Carolina customer information safeguards act, which provides protection for customer information, whether maintained in paper or electronic form. BCBSNC has implemented appropriate safeguards as required by the security rule and applicable North Carolina laws.

National Provider Identifier (NPI)

NPI is the 10-digit unique health identifier for health care providers as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A health care provider is defined as any provider of medical or health services and any other person or organization who furnishes, bills, or is paid for health care. NPI is required for the processing of all electronic transactions effective May 23, 2008. The NPI replaces all legacy provider identifiers such as UPIN, Medicaid number, Medicare number, BCBSNC number, and other carrier numbers on all HIPAA-defined electronic transactions. The national versions of both professional CMS-1500 and institutional UB-04 claim forms have also been revised to include the NPI as an element to identify health care providers. For more information about NPI please access the Centers for Medicare and Medicaid Services at www.cms.gov/hipaa or call **1-410-786-3000**.



20.4 Privacy

The HIPAA privacy rule addresses the way in which a health plan, provider that transmits PHI electronically and health care clearinghouse may use and disclose individually identifiable health information, including information that is received, stored, processed or disclosed by any media, including paper, electronic, fax or voice. The privacy rule permits the sharing of information for treatment, payment and health care operations, including such BCBSNC required functions as quality assurance, utilization review or credentialing, without patient consent or authorization.

Please refer to our notice of privacy practices enclosed in this provider e-manual for a complete understanding of the ways in which BCBSNC may use and disclose its members' protected health information.

20.5 Additional HIPAA information

- Additional HIPAA information is available through the following organizations:
 - ‡ Department of Health and Human Services at **www.hhs.gov**
 - ‡ North Carolina Health Care and Information and Communications Alliance at **www.nchica.org**
 - ‡ Centers for Medicare and Medicaid Services at **www.cms.gov/hipaa** or call **1-410-786-3000**
 - ‡ BCBSNC will provide additional information in future Blue LinkSM provider newsletters, or other targeted communications.
- Check with individual payers, clearinghouses, etc. for their individual plans, state of readiness, and updates.

A list of clearinghouses that are capable of submitting transactions to BCBSNC is located at the EDI services Web page at **www.bcbsnc.com/providers/edi**.

Privacy and confidentiality





At Blue Cross and Blue Shield of North Carolina, we take very seriously our duty to safeguard the privacy and security of our members Protected Health Information (PHI), as we know you do. BCBSNC has developed corporate privacy policies and procedures that address all applicable privacy laws and regulations. The highlights of these policies are described below. As contracting providers, we want you to understand how we protect our members' information.

- We protect all personally identifiable information we have about our members, and disclose only the information that is legally appropriate. Our members have the right to expect that their PHI will be respected and protected by BCBSNC.
- Our privacy and security policies are intended to comply with current state and federal law, and the accreditation standards of the national committee for quality assurance. If these requirements and standards change, we will review and revise our policies, as appropriate. We also may change our policies (as allowed by law) as necessary to serve our members better.
- To make sure that our policies are effective, we have designated a privacy official and a privacy committee that are charged with approving and reviewing BCBSNC's privacy policies and procedures. They are responsible for the oversight, implementation and monitoring of the policies.

21.1 Our fundamental principles for protecting PHI

- We will protect the confidentiality and security of PHI, in all formats, and will not disclose any PHI to any external party except as we describe in our privacy notice or as legally permitted or required.
- Each of our employees receives training on our policies and procedures and must sign a statement when they begin work with us, acknowledging that they will abide by our policies. Only employees who have legitimate business needs to use members' PHI will have access to personal information.
- When we use outside parties (business associates) to perform work for us, as part of our insurance business, we require them to sign an agreement, stating that they will protect members' PHI and will only use it in connection with the work they are doing for us.
- We communicate our practices to our members, through our privacy notice, newsletter articles and during the enrollment process they follow when becoming a BCBSNC member.
- We will disclose and use PHI only where:
 - ‡ required or permitted by law
 - ‡ we obtain the member's authorization
- We will respect and honor our members' rights to inspect and copy their PHI, request an amendment or correction to their PHI, request a restriction on use and disclosure of PHI, request confidential communications, file a privacy complaint, request an accounting of disclosures and request a copy of our notice of privacy practices.

Please read the following notice of privacy practices for more information about our privacy policies. Our notice may be updated from time to time. Please visit our Web site, bcbsnc.com, for the most current version.



21.1.1 Sample notice of privacy practices form (page 1)

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 and other personal information we keep regarding our members. We call this information **Protected Health Information** or “PHI.” 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 took effect on April 14, 2003** and was updated as of September 30, 2010. This notice will remain in place until we replace it.

We reserve the right to change this notice and our privacy practices at any time. We also reserve the right to make changes to our privacy practices and to the new notice effective for all PHI that we already have about you, as well as for PHI we may receive in the future. Before we make a material change in our privacy practices, we will update this notice and send the new notice to our health plan subscribers within 60 days of the time we make the change. You may request a copy of this notice by calling the customer service number on the back of your identification card. You may also obtain a copy from our Web site, www.bcbsnc.com. For more information or questions about our privacy practices please contact the Privacy Official by writing to P.O. Box 2291, Durham, NC 27702.

How We Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information as permitted by federal and state privacy laws and regulations. We describe below how we are most likely to use and disclose your protected health information under these laws and regulations. Generally, we will only use and disclose your PHI as authorized by you or as permitted or required by law. If you cease to be a member, we will no longer disclose your PHI, except as permitted or required by law.

The federal health care privacy regulations known as “HIPAA” generally do not take precedence over state or other applicable privacy laws that provide individuals with greater privacy protections. As a result, when a state law requires us to impose stricter standards to protect your health information, we will follow the state law rather than the HIPAA Privacy Regulations. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of Protected Health Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing or reproductive rights.

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PAGE 1 of 4

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Visit us at bcbsnc.com





Sample notice of privacy practices form (page 2)

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 responsibility to provide coverage and provide benefits as established under your policy. For example, we may use or disclose your PHI to pay claims from your health care providers for services that are covered under your health plan, to determine your eligibility for benefits, to coordinate benefits, to determine the medical necessity of the treatment that you received or plan to receive, to obtain premiums, to issue explanations of benefits to the person who subscribes to the health plan in which you participate, and to other purposes related to payment.

Health Care Operations. We may use and disclose your PHI to support our business functions that enable us to provide services to you. These functions may include but are not limited to conducting health plan quality assessment and improvement activities; reviewing the competence or qualifications of your health care provider; rating our risk and determining the premiums for your health plan; legal services and auditing; business management and general administrative activities. For example, we may use or disclose your PHI (i) to inform you about one of our disease management programs; (ii) to respond to a customer service inquiry from you; (iii) in connection with our fraud and abuse investigations program; or (iv) to survey you about how effectively we are providing services. We may also disclose your PHI to the North Carolina Department of Insurance during a review of our health insurance operations. We may also disclose your PHI to non-affiliated third parties where allowed by law and as necessary to help us fulfill our obligations to you.

Your Authorization. You may give us written authorization to use or disclose your PHI for any purpose. If you give us an authorization, you may revoke it at any time by giving us written notice. Your revocation will not affect any use or disclosure permitted by your authorization while it is in effect. Without your authorization, we may not use or disclose your PHI for any reason except as described in this notice.

Your Family and Friends. We may disclose PHI to a family member, a friend or other persons you indicate are involved in your care or in the payment for your care. We may use or disclose your name, location, general condition or death to notify or help with the notification of a family member, your 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 treatment or payment activities. For example, we may disclose your PHI when needed by a health care professional to render medical treatment to you.

Underwriting. We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us. If the contract is placed with us, we will only use or disclose your PHI as described in this notice. 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 they have agreed, in writing, to safeguard your PHI. For example, we may disclose your PHI to a business associate who will administer your health plan's prescription benefits, or perform pre-enrollment medical screenings.

Required by Law and Law Enforcement. We may use or disclose your PHI when we are required to do so by state or federal law. We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with federal privacy laws. We may disclose your PHI in connection with legal proceedings, such as in response to an order from a court or administrative tribunal, or in response to a subpoena. We may also disclose your PHI for law enforcement purposes.

Abuse or Neglect. We may disclose your PHI to a government authority 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.

PAGE 2 of 4



Sample notice of privacy practices form (page 3)

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 treatment alternatives that may be of interest to you.

Employer or Organization Sponsoring a Group Health Plan. We may disclose your PHI and the PHI of others enrolled in your group health plan to the employer or other organization that sponsors your group health plan. Please see your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration. We may also disclose summary information about the enrollees in your group health plan to the plan sponsor, to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

Death and Organ Donation. We may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization to assist them in performing their duties.

Military Activity, National Security, Protective Services. If you are or were in the armed forces, we may disclose your PHI to military command authorities. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President of the United States, other federal officials or foreign heads of state.

Correctional Institutions. If you are an inmate, we may disclose your PHI to a correctional institution or law enforcement official for: (i) providing health care to you; (ii) your health and safety and the health and safety of others, 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 various sources: (i) **You**, (through information you give us on your applications for insurance or on other forms, through telephone or in-person interviews with you, and through information you provide to an insurance agent or your employer such as your address, telephone number, or your health status, or other types of insurance coverage you have); (ii) **Your Transactions** with us, such as your claims history; (iii) **Other Insurance Companies** that currently insure you or that have insured you in the past and have your claims history; (iv) **Your Employer**, such as information your employer receives from you for purposes of eligibility for insurance coverage; or (v) **Your Health Care Providers** who currently treat you or have treated you in the past and have information about your health status.

Our Policies for Protecting Your Protected Health Information

We protect the PHI that we maintain about you by using physical, electronic, and administrative safeguards that meet or exceed applicable law. When our business activities require us to provide PHI to third parties, they must agree to follow appropriate standards of security and confidentiality regarding the PHI received. Access to your PHI is restricted to appropriate business purposes.

We have developed privacy policies to protect your PHI. All employees receive training on these policies and must sign a privacy acknowledgment form, binding them to abide by our policies and procedures.

In addition to these safeguards, we have developed a variety of other protections, including: (i) using only aggregate or non-identifiable information for research or quality measurement purposes whenever possible; (ii) using confidentiality provisions in our contracts with third parties to protect the confidentiality of your personal information and restrict use and disclosure of this information. (iii) restricting access to personal information through internal procedures and pass code access to computer systems; and (iv) restricting access to personal information by physical security measures in certain areas of our business operations, including employee badges, and restricted business areas.

PAGE 3 of 4



Sample notice of privacy practices form (page 4)

Your Rights**The following is a list of your rights with respect to your PHI.**

Right to Access, Inspect and Copy Your PHI. You have the right to see or get a copy of the PHI that we maintain about you. Your request must be in writing. You may visit our office to look at the PHI, or you may ask us to mail it to you. We will charge a reasonable fee to cover the cost of copying the information. We will contact you to review the fee and obtain your agreement to pay the charges. If you wish to access your PHI, please call the number on the back of your identification card and request an access to PHI form.

Right To Correct, Amend or Delete Your PHI. You have the right to ask us to correct, amend or delete your PHI. Your request must be in writing. We are not required to agree to make the correction, amendment or deletion. For example, we will not generally make a correction, amendment or deletion if we did not create the PHI or if we believe that the PHI is correct. If we deny your request, we will provide you a written explanation. You have the right to file a statement explaining why you disagree with our decision and setting forth what you believe is the correct, relevant and fair information. We will file the statement with your PHI and provide it to anyone who receives any future disclosures of your PHI. If we accept your request to correct, amend or delete your PHI, we will make reasonable efforts to inform others, including people you name, of the amendment and include the changes in any future disclosures of your PHI. If you wish to correct or amend your PHI, please call the telephone number on the back of your identification card and request an amendment of PHI form.

Right to Request an Accounting of Disclosures. You have a right to receive a list of certain instances in which we or our business associates disclosed your PHI for purposes other than our treatment, payment or health care operations and certain other activities. You are entitled to this accounting of disclosures for the six years prior to the date you make the request, but not for disclosures made before April 14, 2003. We will provide you with the date on which we made a disclosure, the name of the person or entity that received your PHI, a description of the PHI that we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for preparing the list. Your request must be in writing. You may call the number on the back of your identification card to request an accounting of disclosures form.

Right to Request Restrictions. You have the right to ask us to place additional restrictions on our use or disclosure of your PHI for our treatment, payment and health care operations. *We are not required to agree to these restrictions.* In most instances, we will not agree to these restrictions unless you have requested Confidential Communications as described below.

Right to Confidential Communications. If you believe that a disclosure of your PHI could endanger you, you may ask us to communicate with you confidentially at a different location. For example, you may ask us to contact you at your work address or other place instead of your home address. You may call the number on the back of your identification card to request a confidential communications form. Once we have received your confidential communications request, we will only communicate with you as directed on the form. We will also terminate any prior authorizations that you have filed with us.

Right to File a Privacy Complaint. You may complain to us if you believe 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 in Washington, D.C. 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 have a right to request a copy of this notice at any time by calling the number on the back of your identification card or you may obtain a copy from our Web site. Even if you agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Chapter 22

The **Blue** BookSM
Provider eManual

Forms



Visit us at bcbsnc.com



The following forms are referenced in the preceding chapters of this e-manual.

We have included copies of the following forms for your convenience:

- **V508 – Individual Provider Enrollment Application**
- **V510 – Group Provider Enrollment Application**
- **G102 – Provider Claim Inquiry**
- **Level One Provider Appeal Form**
- **BCBSNC Certification/Prior Review Request Form**
- **BCBSNC Certificate of Medical Necessity Form**
- **BCBSNC Provider and Institutional Mailback Form**
- **BCBSNC Provider and Institutional Mailback Form** (two pages)
- **G291 – Provider and Institutional Electronic Mailback Form**
- **G292 – Provider and Institutional Paper Mailback Form**
- **G252 – Refund of Overpayment Form**
- **G293 – Inter-Plan Programs Par/Host Plan Form**
- **S115 – Coordination of Benefits Questionnaire** (Inter-Plan Programs)
- **ENROLL1 – Enrollment and Change Application** (with health questions)
- **ENROLL2 – Enrollment and Change Application** (without health questions)
- **EDI Services Batch Connectivity Request**
 - ‡ **ECR270 – 270/271 - Eligibility Inquiry, 276/277-Claim Status Inquiry**
 - ‡ **ECR835 – 835 - Payment/Remittance Advice**
 - ‡ **ECR837 – 837 - Claim/Encounter**
- **Member Appeal Representation Authorization Form**
- **S133 – Statement of Accommodation Charges**



V508 Sample individual provider enrollment application

**Blue Cross and Blue Shield of North Carolina
Individual Provider Enrollment Application
(please print or type)**

(Internal Use Only) BCBS#: _____
Analyst: _____ Eff Date: _____ Date rec: _____
Comp date: _____ Date board called: _____

Name: _____ Degree: _____ Specialty: _____
Last First Mid Init

National Provider Identifier (NPI): _____ Taxonomy Code/Description: _____

Soc. Sec. No.: _____ Phone Number: _____

DEA Number: _____ License Number:*** _____ Date Originally Issued: _____
Month/Day/Year

*****Please attach a copy of your original license and your most recent license renewal slip**

UPIN Number: _____ Medicare Provider No.: _____

Actual Office Location: _____

Street/Suite No./Apt. No., etc.

City State Zip County

Billing Address: _____

(if different from above): Street/Suite No./Apt. No., etc.

City State Zip

If individual practice, specify date practice established: _____

Have you ever had a BCBSNC provider number before? Yes _____ No _____

If you checked "Yes", then list number(s): _____

Are you a member of a group, clinic or partnership? Yes _____ No _____ If you checked "Yes", then specify the following:

BCBSNC Group Provider Number (if applicable) Group Tax Identification Number (IRS #) Date You Joined Group, Clinic, etc.

Indicate place(s) service(s) will be rendered:

- 1. _____ Inpatient Hospital
- 2. _____ Outpatient Hospital
- 3. _____ Office
- 4. _____ Home or Skilled Nursing Facility
- 5. _____ All of the above
- 6. _____ Other

Specify: _____

In order to insure compliance with Internal Revenue Service regulations, we must have your tax identification information to process your application. Please complete the enclosed W9 form and include it with your completed application. The W9 must indicate the name of the individual, group, corporate entity or partnership that is on record with the Internal Revenue Service.

Assignment of a Blue Cross and Blue Shield of North Carolina provider number does not indicate participation with any product. If you are interested in participation with a product you must contact your professional relations field office.

Field Office Use Only

Date Mailed: _____ Initials: _____



V510 Sample group provider enrollment application

**Blue Cross and Blue Shield of North Carolina
Group Provider Enrollment Application**
(please print or type)

(Internal Use Only) BCBS#: _____
Analyst: _____ Eff Date: _____ Date rec: _____
Comp date: _____ Date board called: _____

Group Name: _____ Specialty: _____
Tax ID (IRS #): _____ Medicare Number: _____ Phone Number: _____
National Provider Identifier (NPI): _____ Taxonomy Code/Description: _____

Actual Office Location: _____ Date Group Established: _____
Street/Suite No./Apt. No., etc.

City State Zip County

Billing Address: _____
Street/Suite No./Apt. No., etc.

(if different from above):
City State Zip

Indicate place(s) service(s) will be rendered:

- 1. _____ Inpatient Hospital
- 2. _____ Outpatient Hospital
- 3. _____ Office
- 4. _____ Home or Skilled Nursing Facility
- 5. _____ All of the above
- 6. _____ Other Specify: _____

(Internal Use Only)
Notes:

Please complete for each individual provider in the group (attach additional pages as necessary):

Name	BCBSNC Prov #	License Number	Year Licensed	Specialty	UPIN

In order to insure compliance with Internal Revenue Service regulations, we must have your tax identification information to process your application. Please complete the enclosed W9 form and include it with your completed application. The W9 must indicate the name of the individual, group, corporate entity or partnership that is on record with the Internal Revenue Service.

Assignment of a Blue Cross and Blue Shield of North Carolina provider number does not indicate participation with any product. If you are interested in participation with a product you must contact your professional relations field office.

Field Office Use Only Date Mailed: _____ Initials: _____



G102 Sample provider claim inquiry

Provider/Doctor Claim Inquiry

Provider Information		Same Patient Information
TELEPHONE NUMBER	FAX NUMBER	PATIENT NAME
GROUP PROVIDER NUMBER	INDIVIDUAL PROVIDER NUMBER	CERTIFICATE HOLDER
TO: _____ _____ _____ FROM: _____ _____ _____		SUBSCRIBER ID WITH ALPHA PREFIX
		DATE OF SERVICE
		TOTAL CHARGE
Place of Service		Program
<input type="checkbox"/> Office <input type="checkbox"/> Ambulatory surgical center <input type="checkbox"/> Inpatient facility <input type="checkbox"/> Outpatient facility		<input type="checkbox"/> HMO <input type="checkbox"/> BlueCard® <input type="checkbox"/> PPO <input type="checkbox"/> Blue Advantage® <input type="checkbox"/> SHP – PPO <input type="checkbox"/> Federal Employee Program
The reason for this inquiry is: 1. <input type="checkbox"/> New Claim 2. <input type="checkbox"/> Corrected Claim 3. <input type="checkbox"/> Claim(s) Status <input type="checkbox"/> Blue eSM claim status has been reviewed 4. <input type="checkbox"/> Overpayment / Underpayment a. Patient's other coverage paid. \$ _____ b. Payment was made by: Name of company _____ Name of the group _____ Name of Insured _____ c. Possible underpayment of \$ _____ 5. <input type="checkbox"/> Medical Records - Reconsideration of a previously processed claim related to: a. <input type="checkbox"/> coding/bundling <input type="checkbox"/> Clear Claim Connection supporting documentation included b. <input type="checkbox"/> medical necessity c. <input type="checkbox"/> potentially cosmetic, experimental or investigational services d. <input type="checkbox"/> pricing e. <input type="checkbox"/> pre-existing 6. <input type="checkbox"/> Medical Records - Submission of solicited medical records for a pending claim related to: a. <input type="checkbox"/> medical necessity b. <input type="checkbox"/> pre-existing c. <input type="checkbox"/> pricing d. <input type="checkbox"/> potentially cosmetic, experimental or investigational services 7. <input type="checkbox"/> Medical Records submitted for other reasons: Explanation: _____ _____ _____		

G102, 6/10



Sample BCBSNC certification/prior review request form

BCBSNC Certification/Prior Review Request Form

Please complete every field on this form to prevent delays in processing. You will receive a response from BCBSNC no later than 2 business days after the date all necessary information is received.

Please print

Office contact: _____ Today's date: ____/____/____

Phone number: () _____ - _____ Fax Number: () _____ - _____

PART I

PATIENT NAME		BCBSNC ID NUMBER	DATE OF BIRTH ____/____/____
SEX: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		Is this a reconsideration? <input type="checkbox"/> YES <input type="checkbox"/> NO	
MEDICAL RECORDS INCLUDED: <input type="checkbox"/> Op Notes <input type="checkbox"/> H&P <input type="checkbox"/> Complete Records <input type="checkbox"/> Consultation <input type="checkbox"/> Photos <input type="checkbox"/> D/C Summary <input type="checkbox"/> Labs/X-rays/Diagnostics <input type="checkbox"/> Progress Notes			
TYPE OF PLAN: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> CMM			

PART II

PRIMARY CARE PHYSICIAN	PROVIDER #
ATTENDING PHYSICIAN	PROVIDER #
PRIMARY DIAGNOSIS	ICD-9 CODE
SECONDARY DIAGNOSIS	ICD-9 CODE

Treatment setting and date

<input type="checkbox"/> INPATIENT	<input type="checkbox"/> OUTPATIENT/OBSERVATION/OFFICE
ADMIT DATE ____/____/____	START DATE ____/____/____
FACILITY	FACILITY
OTHER	

PROCEDURES

CPT CODES

If you have questions about completing this form, please contact the BCBSNC Healthcare Management & Operations Department at 1-800-672-7897.

BCBSNC USE ONLY:	REVIEWER
	BCBSNC CERTIFICATION #



Sample BCBSNC certificate of medical necessity

BCBSNC Certificate of Medical Necessity

Please furnish the information requested below and submit with initial paper claim form.

Patient's name: _____ Subscriber ID: _____

Diagnosis: _____

Prognosis: _____

1. Describe equipment, special features and attachments prescribed: _____

A. Date physician examined patient: _____

B. Effective date of need: _____

C. Length of time needed: _____

D. Frequency used: _____

2. Patient status - please check items most appropriate for patient:

A. Bed confined 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 BCBSNC professional and institutional mailback – electronic

Professional and Institutional Mailback (Electronic Claims)

Please make the corrections in your database and refile the claim electronically.

Patient name: _____ Date(s) of service: _____	
Provider name: _____ Patient account number: _____	
Provider address: _____	Total Charge:
City: _____ State: _____ Zip: _____	
M001	Invalid member ID number. Resubmit member ID number as it appears on the ID card. Send copy of ID card.
M003	Provide dates of admission and discharge.
M004	Provide onset date of symptoms according to the medical record.
M008	Itemize charges, dates and include valid procedure/revenue codes for services rendered.
M009	Provide complete and specific diagnosis for each service rendered.
M010	Provide correct number of units or minutes in the units fields.
M014	Billed charges are inconsistent with the number of days filed. Please recompute bill.
M015	CPT 99070/E1399 is a generic supply code. Please provide HCPCS code or description of service/supply.
M017	Modifier 26 is inconsistent with the place of service.
M018	File PA charges with the appropriate modifier for surgical assistance with the surgeon's claim.
M019	Description of service is not consistent with the place of service.
M022	Provide the rendering physician's individual Blue Cross and Blue Shield of North Carolina provider number on each service line.
M024	Refile with Medicare. According to our records, Medicare is the primary insurance carrier.
M028	Accommodation rate is invalid for the date of service reported. Please correct and refile. Use Electronic Network Services, when possible.
M029	Verify if outpatient services were included in the inpatient charges for: _____
M030	Interim billing cannot be accepted. Please submit claim for member's complete admission.
M031	Provide the number of miles traveled for ambulance service.
M032	Provide most prevalent semi-private room rate for the patient.
M038	Please resubmit all lines from original claim on the corrected claim. If the correction is the omission of a service, please change the charge to \$0.00. Please do not mark through the line to be omitted. Please do not highlight anything on the claim.
M039	If this provider will be rendering total OB care, please submit total OB care claim at the time of delivery. If the patient has transferred to another physician, please resubmit the claim with supporting documentation verifying each date of service.
M040	Please resubmit with correct type of bill. No record of original claim on file.

Professional and Institutional Mailback • PO Box 35 • Durham, North Carolina 27702-0035 • 1-919-489-7431



Sample BCBSNC professional and institutional mailback – paper (page 1 of 2)

Professional and Institutional Mailback (Paper Claims)

Please make the necessary corrections on the claim form. DO NOT make changes to the mailback form and send to BCBSNC. Print a new red and white claim form and resubmit. File electronically whenever possible.

Patient name: _____ Date(s) of service: _____	
Provider name: _____ Patient account number: _____	
Provider address: _____	Total Charge:
City: _____ State: _____ Zip: _____	
M001	Invalid member ID number. Resubmit member ID number as it appears on the ID card. Send copy of ID card.
M002	Provide both the tax ID number and the Blue Cross and Blue Shield of North Carolina assigned provider number.
M003	Provide date of admission and discharge.
M004	Provide onset date of symptoms according to the medical record.
M005	If accident related, give onset date of injury.
M006	Provide specific dates for each service rendered.
M007	Verify patient information and give the missing data (patient name, sex, or month, day and year of birth).
M008	Itemize charges, dates and include valid procedure/revenue codes for services rendered.
M009	Provide complete and specific diagnosis for each service rendered.
M010	Provide correct number of units/minutes in the units field.
M011	Provide valid procedure/revenue code for each service.
M012	Error in total charge. Please recompute.
M013	Facility charges must be filed on a UB-04 claim form. Resubmit using the correct form. North Carolina providers should resubmit claims using Electronic Network Services, when possible.
M014	Billed charges are inconsistent with the number of days filed. Please recompute bill.
M015	CPT 99070/E1399 is a generic supply code. Please provide valid HCPCS code or description of service/supply.
M016	Provide drug name, quantity, and NDC number for code: _____
M017	Modifier 26 is inconsistent with the place of service.
M018	File PA charge with the appropriate modifier for surgical assistance with the surgeon's claims.
M019	Description of service is not consistent with the place of service.
M020	The claim includes charges for services not yet rendered. Please refile this claim once services have been performed.
M021	Provide name of supervising M.D. or PhD.
M022	Provide the rendering physician's individual Blue Cross and Blue Shield of North Carolina provider number on each service line.
M023	Professional charges must be filed on CMS-1500 claim form or the equivalent. Resubmit using the correct form.
M024	Refile with Medicare. According to our records, Medicare is the primary insurance carrier.
M025	Submit copy of Medicare EOB or indicate on the claim form if Medicare non-covered or exhausted.

This form is continued on the reverse side.



Sample BCBSNC professional and institutional mailback – paper (page 2 of 2)

M026	The member ID number is not valid or is no longer in effect for this patient. Verify member ID number with patient, then refile claim with the appropriate member ID number or health insurance carrier.
M027	File all prescription drug claims to Advance PCS: PO Box 853901, Richardson, TX 75085-3901.
M028	Accommodation rate is invalid for the date of service reported. Please correct and refile. Use Electronic Network Services, when possible.
M029	Verify if outpatient services were included in the inpatient charges for: _____
M030	Interim billing cannot be accepted. Please submit claim for member's complete admission.
M031	Provide the number of miles traveled for ambulance service.
M032	Provide most prevalent semi-private room rate for this patient.
M033	Other: _____
M034	Procedure code: _____ is inconsistent with the patient's diagnosis. Please correct and refile.
M035	Diagnosis/procedure code is inconsistent with the sex of the patient.
M036	_____ procedure code requires multiple dates of service.
M037	Provide principle procedure code (institutional claims only).
M038	Please resubmit all lines from original claim on the corrected claim. If the correction is the omission of a service, please change the charge to \$0.00. Please do not mark through the line to be omitted. Please do not highlight anything on the claim.
M039	If this provider will be rendering total OB care, please submit total OB claim at the time of delivery. If the patient has transferred to another physician, please resubmit the claim with supporting documentation.
M040	Please resubmit with correct type of bill. No record of original claim on file.

The following error(s) has (have) prevented your red and white claim from scanning into our system successfully.	
1	All dates must be eight digits in MMDDCCYY (month, day, century, and year) format. This includes birth date, dates of service and onset dates.
2	Your five-digit Blue Cross and Blue Shield of North Carolina assigned provider number must be in the lower right corner of field # 33b.
3	All scannable claims should be computer printed or typed. The ink should also be dark and easy to read.
4	Only six lines per CMS-1500 are acceptable. Do not list multiple lines in the same block.
5	Do not use a decimal point in the units field.
6	Other: _____

Professional and Institutional Mailback • PO Box 35 • Durham, North Carolina 27702-0035 • 1-919-489-7431

**Please send State claims to:
PO Box 30025
Durham, NC 27702-3025**



G291 Sample State Health Plan professional and institutional electronic mailback



PO Box 30025
 Durham, North Carolina 27702-3025
1-800-422-4658

Professional and Institutional Mailback			
Provider name:		Patient name:	
Provider address:		Date(s) of service:	
City:	State:	Zip:	Patient account number:
		Claim #:	Total charges:

Please make the necessary corrections to the claim and refile electronically.

M001	The member ID number is not valid for this patient. <input type="checkbox"/> Verify member ID number and health insurance carrier. <input type="checkbox"/> Send copy of ID card. <input type="checkbox"/> Alpha prefix missing or invalid. <input type="checkbox"/> Re-file claim with the complete member ID number as shown on the card to the appropriate carrier.
M003	The provider number is missing/invalid for this date of service. <input type="checkbox"/> Group <input type="checkbox"/> Individual NPI discrepancy. Claim cannot be processed until resolved. Please contact your BCBSNC Network Management Field Office. <input type="checkbox"/> Group <input type="checkbox"/> Individual
M004	Provide dates of admission and discharge.
M009	Itemize charges, dates and include valid procedure/revenue codes for services rendered.
M010	Provide complete and specific diagnosis for each service rendered.
M016	CPT 99070/E1399 is a generic supply code. Provide HCPCS code or description of service/supply.
M018	Modifier 26 is inconsistent with the place of service.
M019	File PA charges with the appropriate modifier for surgical assistance with the surgeon's claims.
M020	Description of service is not consistent with the place of service.
M023	Our records indicate the provider rendering the services is not associated with the group. Contact Network Management to update your records.
M025	Refile with Medicare. According to our records, Medicare is the primary insurance carrier.
M028	Accommodation rate is invalid for the date of service reported. Correct and refile.
M029	Verify if outpatient services were included in the inpatient charges for _____
M030	Interim billing cannot be accepted. Submit claim for member's complete admission.
M031	Provide the number of miles traveled for ambulance service.
M032	Provide most prevalent semi-private room rate for the facility.
M039	We have already considered a claim for _____ If this is a corrected claim, resubmit all lines from original claim with correct type of bill.
M040	If this provider will be rendering total OB care, submit total OB care claim at the time of delivery. If the patient has transferred to another physician, resubmit a claim with supporting documentation verifying each date of service.
M043	Services span fiscal/calendar year. Separate the charges using _____ as the end date and _____ as the start date.
M044	Provide appropriate modifier for anesthesia services.
M046	File the claim with the patient's pharmacy benefits manager.
M047	You are reminded that all claims must be filed no later than December 31st of the calendar year following the one in which the covered care or service was performed. In order for these returned bills to be reconsidered for benefits, all required information must be included and they must be received no later than the December 31st deadline for filing claims or 90 days from the date of this letter, whichever is later.
M049	Other:

Name:	Department:	Date:
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G291, 5/09



G292 Sample State Health Plan professional and institutional paper mailback (page 1 of 2)



PAPER Mailback
 PO Box 30025 • Durham, North Carolina 27702-3025
1-800-422-4658

Professional and Institutional Mailback			
Provider name:		Patient name:	
Provider address:		Date(s) of service:	
City:		Patient account number:	
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 number is not valid for this patient. <input type="checkbox"/> Verify member ID number and health insurance carrier. <input type="checkbox"/> Send copy of ID card. <input type="checkbox"/> Alpha prefix missing or invalid. <input type="checkbox"/> 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. <input type="checkbox"/> Group <input type="checkbox"/> Individual The NPI is not valid. Please confirm all NPI information and resubmit with correct NPI. The NPI has not been registered with BCBSNC. <input type="checkbox"/> Group <input type="checkbox"/> Individual Please contact your BCBSNC Network Management Field Office. NPI discrepancy. Claim cannot be processed until resolved. <input type="checkbox"/> Group <input type="checkbox"/> Individual Please contact your BCBSNC Network Management Field Office. 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 <input type="checkbox"/> units for _____ <input type="checkbox"/> 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.
M022	The claim includes charges for services not yet rendered. Refile this claim after services have been performed.
M023	Our records indicate the provider rendering the services is not associated with the group. Contact Network Management to update your records.
M024	Professional charges must be filed on 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, 5/09



G292 Sample State Health Plan professional and institutional paper mailback (page 2 of 2)

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 accommodation 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	<input type="checkbox"/> Procedure code _____ or <input type="checkbox"/> diagnosis code is inconsistent with patient's: <input type="checkbox"/> Age <input type="checkbox"/> Sex <input type="checkbox"/> 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	<input type="checkbox"/> Provide the ICD-9 procedure code and date for INPATIENT facility services. <input type="checkbox"/> Provide the HCPCS procedure code and date for OUTPATIENT facility services.
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: <input type="checkbox"/> Commercial & FEP Claims, PO Box 35, Durham, NC 27702 <input type="checkbox"/> State CMM / NCHC Claims, PO Box 30025, Durham, NC 27702 <input type="checkbox"/> 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.
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:
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G252 Sample refund of overpayment form

Provider Refund Return

Please complete this form when refunding overpayments to Blue Cross and Blue Shield of North Carolina. This will help us properly identify and credit the correct certificate and will prevent us from returning money back to your office. Thank you for your cooperation.

Subscriber: _____

Subscriber ID (prefix): _____

Check one:

- Blue Cross and Blue Shield of North Carolina Policy
- Blue Cross and Blue Shield Service Benefit Plan (Federal Employee Program)

Patient: _____ Date(s) of service: _____

Provider: _____ Provider number: _____

If out-of-state, give IRS number: _____ Amount of refund: _____

Please check reason(s) for refund:

- Duplicate payment (need both Blue Cross and Blue Shield of North Carolina vouchers)
- Worker's Compensation (Give date of onset: _____)
- Medicare payment is primary (need EOB)
- Medicare adjusted payment (need corrected claim)
- Other carrier paid primary (need EOB)
- Medicare adjusted payment (need EOB)
- Correct claim / billed in error (need copy of claim)
- Other carrier adjusted payment (need EOB)
- Filed under wrong patient (need copy of claim)
- Not our patient

Other comments: _____

Return To:

Cashiers Department
Blue Cross and Blue Shield of North Carolina
PO Box 30048
Durham, NC 27702-3048

Contact Person: _____

Phone Number: _____

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G293 Sample inter-plan programs par/host plan

Inter-Plan Programs Par/Host Plan

Please use this form as a checklist to insure that you are submitting the information necessary to support a returned claim payment (refund) for an out-of-area member's claim. Providing this information will allow BCBSNC to more effectively represent your interest when communicating with the patient's home plan.

<p>1. Break down of the refund per claim</p>	
<p>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:</p> <p><input type="checkbox"/> a. Provider's name _____</p> <p><input type="checkbox"/> b. Provider's BCBSNC ID number _____</p> <p><input type="checkbox"/> c. Policy holder's full name _____</p> <p><input type="checkbox"/> d. Policy holder's ID (include prefix and number) _____</p> <p><input type="checkbox"/> e. Patient's full name _____</p> <p><input type="checkbox"/> f. Patient's date of birth _____</p> <p><input type="checkbox"/> g. Date of service _____</p> <p><input type="checkbox"/> h. Amount of charge for the original claim _____</p> <p><input type="checkbox"/> i. Amount paid for the original claim _____</p> <p><input type="checkbox"/> j. Date of payment for the original claim _____</p> <p><input type="checkbox"/> k. Amount being returned against the original charge _____</p>	
<p>3. Specific reason for the refund</p> <p><input type="checkbox"/> a. Duplicate Payment (requires both BCBSNC vouchers)</p> <p><input type="checkbox"/> b. Worker's Compensation (provide the date of the onset) _____</p> <p><input type="checkbox"/> c. Medicare payment is primary (requires EOB)</p> <p><input type="checkbox"/> d. Other carrier paid primary (requires EOB)</p> <p><input type="checkbox"/> e. Corrected claim / billed in error (need a copy of the claim)</p> <p><input type="checkbox"/> f. Filed under wrong patient (requires a copy of the claim)</p> <p><input type="checkbox"/> g. Incorrect date of service (requires a corrected claim)</p> <p><input type="checkbox"/> h. Medicare adjusted payment (requires EOB)</p> <p><input type="checkbox"/> i. Other carrier adjusted payment (requires EOB)</p> <p><input type="checkbox"/> j. Not our patient</p>	<p>Please return the check and all attached information to:</p> <p>Blue Cross Blue Shield of North Carolina Attention: Cashiers Department PO Box 30048 Durham, NC 27702-3048</p>
<p>4. Provide corrected claim form (if necessary)</p>	
<p>5. If this is a rebuttal to a payment issue previously raised to BCBSNC, please attach a copy of the information described above, as well as a copy of the BCBSNC check voucher to the check.</p>	
<p>6. Provide the following support documentation (if available)</p> <p><input type="checkbox"/> a. Original claim number or copy of the original claim</p> <p><input type="checkbox"/> b. Original Notification of Payment (NOP)</p>	

Again as the Host Plan, BCBSNC requests that you submit one check per claim. Organizing this information in this manner will allow BCBSNC to affectively represent you the provider as we engage the home plan or national account to resolve payment contention issues for which they were originally held responsible for.

Thank you in advance for providing the necessary information and attaching it to the check to be sent to BCBSNC.



S115 Sample coordination of benefits questionnaire (inter-plan program) (page 1 of 2)

Coordination of Benefits Questionnaire



Your Blue Cross Blue Shield contract may contain a Coordination of Benefits (COB) provision. We depend upon your help in order for us to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact the policyholder's Blue Cross Blue Shield plan immediately.

Please send this completed form to the BCBS Plan that you are a member of.

You can call the customer service phone number on your membership ID card to get the address.

BCBS Policyholder Name	
BCBS Group Number	BCBS Member ID Number

Section A Other Insurance *If this does not apply, skip to Section B.*

Are you or any other member of this Blue Cross Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross Blue Shield policy or Medicare?

No If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply: Other Health Insurance Other Dental Insurance

What type of policy is this? Group Individual Policy Student Policy Medicare Supplemental

Other Insurance Carrier's Name

Address

City	State	Zip	Phone Number
------	-------	-----	--------------

Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name	Policyholder's Date of Birth	ID Number
Effective Date of Other Insurance	If Cancelled, Cancellation Date	

Is the policyholder: Actively working for the group Inactive
 Retired, retirement date: / / On COBRA, which began: / /

Policyholder's Employer

Address

City	State	Zip	Phone Number
------	-------	-----	--------------



S115 Sample coordination of benefits questionnaire (inter-plan program) (page 2 of 2)

Section B Medicare Information *If this does not apply, skip to Section C.*

Do the policyholder and/or dependent(s) have Medicare? Yes No

Name of person(s) with Medicare

Medicare Number, including alpha character(s)

Effective Date of Medicare Part A: ____ / ____ / ____ Effective date of Medicare Part B: ____ / ____ / ____

Medicare Entitlement: Age Disability* End Stage Renal Disease (ESRD)*

* If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability:

1st Date of Dialysis for ESRD:

Was ESRD started in a facility? Yes No

Was ESRD started as Self Dialysis or Home Dialysis: Yes No

Has a transplant been performed? Yes No

If yes, please provide the date of the transplant. ____ / ____ / ____

Section C Court Order Information *If this does not apply, skip to Section D.*

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

Yes No

List the name(s) of the dependent(s) that this applies to.

If yes, who is the person(s) listed to maintain health coverage?

What is the relation to the child(ren)?

Who has custody of the child(ren) more than 50% of the time?

Documentation of the court order may be requested from your Blue Cross Blue Shield plan.

Section D Name(s) of Dependent(s) on BCBS Policy

_____ Name	_____ Relationship	____ / ____ / ____ Date of Birth	_____ Sex	____ - ____ - ____ Social Security Number (Optional)
_____ Name	_____ Relationship	____ / ____ / ____ Date of Birth	_____ Sex	____ - ____ - ____ Social Security Number (Optional)
_____ Name	_____ Relationship	____ / ____ / ____ Date of Birth	_____ Sex	____ - ____ - ____ Social Security Number (Optional)

Policyholder Signature

Date



ENROLL1 Sample enrollment and change application with health questions (page 1 of 6)

Enrollment Application with Health Questions

Instructions:

- All employees complete Sections **A, B, C, D, F, H** and **I**.
- If your group has also elected USABLE Life products you must complete Section **G**.
For USABLE Life Only you must complete Sections **A, G, H, I**.
 If applying for Over the Guarantee Issue also complete Section **F**.

Completed by Group Administrator Only

Group Number (if applicable):
Life Class Designation (if applicable):

Please type or print in black or blue, NOT RED ink

A. Employee information						
First Name	Middle Initial	Last Name			Suffix	
Employee Birthdate mm dd yyyy	Employee Social Security Number			<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
Address	P.O. Box <i>(For Blue Options HSA you must also provide a street address.)</i>	Apt. No.	City	State	Zip Code	
Company Name	Occupation			Marital Status		
Work Location	Date of Full Time Employment mm dd yyyy	Language Preference <input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other _____				
Home Phone Number ()	Work Phone Number ()	E-Mail Address				
Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.) <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Choose not to report <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Other (specify) _____						
<input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> COBRA/STATE CONTINUATION						
COBRA/State Continuation Qualifying Event: <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Divorce <input type="checkbox"/> Over Age Dependent <input type="checkbox"/> Medicare Eligible						
What was the date of the Qualifying Event? mm dd yyyy		Date Continuation Started mm dd yyyy		Date Continuation Ends mm dd yyyy		
B. Benefits and coverage selection - complete for BCBSNC health and dental, if offered by employer						
MEDICAL PLAN: <input type="checkbox"/> No Medical Coverage <input type="checkbox"/> Blue Options HSA SM <input type="checkbox"/> Blue Options PPO <input type="checkbox"/> Blue Options 1-2-3 <input type="checkbox"/> High <input type="checkbox"/> Blue Care [®] (HMO) <input type="checkbox"/> Classic Blue [®] (CMM) <input type="checkbox"/> Low						
MEDICAL COVERAGE (if applicable): <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family						
DENTAL PLAN: <input type="checkbox"/> No Dental Coverage <input type="checkbox"/> Dental						
DENTAL COVERAGE (if applicable): <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family						

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ENROLL1 Sample enrollment and change application with health questions (page 2 of 6)

Employee Name:

C. Family information - complete for anyone taking medical and/or dental coverage*								
NAME First, Middle Initial, Last, Suffix	Social Security Number	Birthdate mm/dd/yyyy	Sex	H E I G H T	W E I G H T	H E A L T H	D E N T A L	Child Status (please check one)
Spouse	required		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***
Child 3****			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***
* Application does not guarantee enrollment. ** A request for coverage (form P24) is required if your child is 26 years or older and will be reviewed to determine eligibility. *** Consult your employer regarding dependent eligibility requirements. Supporting documentation may be required. **** If you have more than three children, complete Section D on another application.								<input type="checkbox"/> Additional dependent and/or custodial parent information attached.

D. Other health/dental insurance information	
Have you or your dependents had any other health or dental coverage within the last 12 months (other than BCBSNC coverage that you are applying for today)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list any health or dental coverage the employee and/or dependents has/had within the last 12 months (including BCBSNC coverage):	
Insurance Carrier	Policy Number
Policy Holder Name	Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
Effective Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)	
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents	
Additional Coverage that will be in-force when this policy becomes active:	
Insurance Carrier	Policy Number
Policy Holder Name	Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
Effective Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)	
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents	
Additional Coverage that will be in-force when this policy becomes active:	
Insurance Carrier	Policy Number
Policy Holder Name	Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
Effective Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)	
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents	

Application continued on next page → PAGE 2 of 6



ENROLL1 Sample enrollment and change application with health questions (page 3 of 6)

Employee Name:	
If anyone covered has Medicare Coverage please complete below:	
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents	
Medicare Claim Number:	Eligible Due To: <input type="checkbox"/> Renal Disease <input type="checkbox"/> First Day of Dialysis <input type="checkbox"/> Disability <input type="checkbox"/> Age
Part A Effective Date: <input type="text"/> <input type="text"/> <input type="text"/>	Part B Effective Date: <input type="text"/> <input type="text"/> <input type="text"/>
E. Legal notices	
Notice about your pre-existing condition limitations	
<p>This plan imposes a pre-existing condition exclusion for all employees and dependents age 19 and over whether they are timely or late enrollees. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or members under age 19. When applicable, this exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage".</p> <p>Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give Blue Cross and Blue Shield of North Carolina (BCBSNC) a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, BCBSNC will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact BCBSNC if you need help demonstrating creditable coverage. Throughout this notice, all references to "you" are meant to refer to both the employee and their dependents.</p> <p>For questions or to obtain more information, contact a BCBSNC Customer Service representative at: BCBSNC Customer Service Blue Cross and Blue Shield of North Carolina PO Box 2291, Durham, NC 27702 1-877-258-3334 (toll-free)</p>	
Notice of special enrollment	
<p>If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance (including Medicaid or Children's Health Insurance Program (CHIP)) or group health plan coverage, you may be able to enroll yourself and the dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.</p> <p>In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.</p> <p>For questions or to obtain more information, contact a BCBSNC Customer Service Representative at: BCBSNC Customer Service Blue Cross and Blue Shield of North Carolina PO Box 2291, Durham, NC 27702 1-877-258-3334 (toll-free)</p>	
Notice of Women's Health and Cancer Rights Act	
<p>If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:</p> <ul style="list-style-type: none"> • All stages of reconstruction of the breast on which the mastectomy was performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; • Prostheses; and • Treatment of physical complications of the mastectomy, including lymphedemas. <p>These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.</p> <p>For questions or to obtain more information, contact a BCBSNC Customer Service Representative at: BCBSNC Customer Service Blue Cross and Blue Shield of North Carolina PO Box 2291 • Durham, NC 27702 1-877-258-3334 (toll-free)</p>	
Application continued on next page → PAGE 3 of 6	



ENROLL1 Sample enrollment and change application with health questions (page 4 of 6)

Employee Name:

F. Health questions

All questions in this Section (Section G) MUST be answered in their entirety. Any questions left blank, or questions only partially answered will cause your application to be returned to you for the missing information. Please use "Month/Day/Year" where required.

PLEASE NOTE: "Section G2" information is required for all disorders with a "YES" answer.

Has any person applying for coverage sought medical attention and/or advice, been diagnosed with or been treated for any of the following diseases or disorders (this includes diseases or disorders past and present):

DISORDER	YES	NO	DISORDER	YES	NO
1. Heart attack, angina, angioplasty, stent placement, bypass surgery, coronary artery disease or congestive heart failure?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>
2. An irregular heart rhythm that requires treatment?	<input type="checkbox"/>	<input type="checkbox"/>	27. Epilepsy or seizure disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Hypertension or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	a. If yes, was the most recent seizure within the last 3 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
a. How many times a year do you contact or visit your doctor to get a prescription for your hypertension, either to renew your current prescription or get a different or additional prescription to treat your hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	28. Has anyone who is less than 12 years of age had more than 3 ear infections in the last year?	<input type="checkbox"/>	<input type="checkbox"/>
4. Emphysema, chronic bronchitis or chronic obstructive pulmonary disorder (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>	29. Has anyone ever had the following procedures or treatments performed:		
a. Any use of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	a. Spinal fusion?	<input type="checkbox"/>	<input type="checkbox"/>
b. Any inpatient treatment at a hospital for any of the above conditions?	<input type="checkbox"/>	<input type="checkbox"/>	b. Gastric bypass or gastric restrictive procedures, such as lap band?	<input type="checkbox"/>	<input type="checkbox"/>
5. Elevated cholesterol treated with medication within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	c. Heart valve replacement?	<input type="checkbox"/>	<input type="checkbox"/>
6. Inpatient or outpatient treatment at a hospital for asthma within the past 24 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	d. Currently in treatment/therapy for ligament or tendon repair of knee or shoulder?	<input type="checkbox"/>	<input type="checkbox"/>
7. a. Hepatitis A?	<input type="checkbox"/>	<input type="checkbox"/>	e. Cerebral shunt placement?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>	f. Permanent colostomy/ileostomy?	<input type="checkbox"/>	<input type="checkbox"/>
c. Hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>	g. Surgery related to gastro esophageal reflux disorder (GERD)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Hepatitis D?	<input type="checkbox"/>	<input type="checkbox"/>	h. Any internal organ transplant?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, Parkinson's disease, Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>	i. Kidney dialysis?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Chronic fatigue, chronic fibromyalgia, Epstein Barr and/or chronic lyme disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	j. Any past surgical procedure resulting in complications that still require treatment?	<input type="checkbox"/>	<input type="checkbox"/>
10. a. Depression?	<input type="checkbox"/>	<input type="checkbox"/>	30. Has anyone been advised or scheduled to have surgery within the next 6 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Anxiety/stress?.....	<input type="checkbox"/>	<input type="checkbox"/>	31. Within the last 12 months, has anyone seen an allergist or received an immuno-therapy injection?	<input type="checkbox"/>	<input type="checkbox"/>
c. Chemical imbalance?.....	<input type="checkbox"/>	<input type="checkbox"/>	32. Has anyone been treated within the last 2 years for an eating disorder? ..	<input type="checkbox"/>	<input type="checkbox"/>
d. Obsessive compulsive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	33. Has anyone seen a chiropractor or physical therapist more than 5 times in the last 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Bipolar disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	a. Primary - Date of your last visit: _____		
f. Suicidal thoughts?.....	<input type="checkbox"/>	<input type="checkbox"/>	b. Spouse - Date of your last visit: _____		
11. Brain damage, paralysis, stroke, Transient Ischemic Attack (TIA) or Hydrocephalus?	<input type="checkbox"/>	<input type="checkbox"/>	34. Has anyone had any treatment in the last year for disc disorder of back or neck including surgery or injection therapy other than chiropractic care or physical therapy?	<input type="checkbox"/>	<input type="checkbox"/>
12. Kidney stones or renal colic within the past 36 months?	<input type="checkbox"/>	<input type="checkbox"/>	35. More than 2 breast biopsies in the last 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have gall bladder disease or gall stones and STILL have your gallbladder?.....	<input type="checkbox"/>	<input type="checkbox"/>	36. Within the past 12 months, has anyone had any treatment for heavy, frequent, AND prolonged periods; uterine fibroids; or endometriosis; but have NOT had total abdominal hysterectomy (TAH)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	37. Have either of your last two pap smears been abnormal?	<input type="checkbox"/>	<input type="checkbox"/>
15. a. Colitis?	<input type="checkbox"/>	<input type="checkbox"/>	38. Does anyone exercise for at least 20 minutes per day 3 or more times per week?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>	39. Within the last 12 months, has anyone smoked cigarettes, marijuana, cigars, pipes or used chewing tobacco or snuff?	<input type="checkbox"/>	<input type="checkbox"/>
c. Irritable bowel syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	40. Has anyone applying for coverage on this application been prescribed or advised to use or taken any of the following categories of prescription medications within the last 12 months?		
d. Inflammatory bowel disease?	<input type="checkbox"/>	<input type="checkbox"/>	a. Anti-depressant?	<input type="checkbox"/>	<input type="checkbox"/>
e. Familial polyposis?.....	<input type="checkbox"/>	<input type="checkbox"/>	b. Anti-psychotic?	<input type="checkbox"/>	<input type="checkbox"/>
16. Osteoarthritis in the hips or knees?.....	<input type="checkbox"/>	<input type="checkbox"/>	c. Anti-anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
17. Joint replacement, or recommended joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>	d. Attention deficit (ADD) or attention deficit hyperactivity (ADHD) medication?	<input type="checkbox"/>	<input type="checkbox"/>
a. Primary - Date of surgery: _____			e. Antabuse or other medications used in the treatment of alcoholism? ..	<input type="checkbox"/>	<input type="checkbox"/>
b. Spouse - Date of surgery: _____			f. Migraine medication?	<input type="checkbox"/>	<input type="checkbox"/>
18. Arthritis, such as inflammatory arthritis, rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis?	<input type="checkbox"/>	<input type="checkbox"/>	g. Tracleer?.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Blood thinner/anti-coagulant medication?	<input type="checkbox"/>	<input type="checkbox"/>
a. Primary - Date of diagnosis: _____			i. Nitroglycerin, Digoxin or Lanoxin?	<input type="checkbox"/>	<input type="checkbox"/>
b. Spouse - Date of diagnosis: _____			j. Immunosuppressive medication, such as, Methotrexate, Imuran, Cytosan?	<input type="checkbox"/>	<input type="checkbox"/>
c. What is your most recent hemoglobin A1C (HGBA1C) reading taken by your doctor?			k. Oral steroids taken or prescribed for use every day all year, or oral steroids or steroid injections taken for an ongoing condition requiring usage at least 3 times a year?.....	<input type="checkbox"/>	<input type="checkbox"/>
Primary: _____ Spouse: _____			l. Plaquenil/Hydroxychloroquine?	<input type="checkbox"/>	<input type="checkbox"/>
20. Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?.....	<input type="checkbox"/>	<input type="checkbox"/>	m. Growth hormones such as: Humotrope, Genotropin, Nutropin, Norditropin? ..	<input type="checkbox"/>	<input type="checkbox"/>
21. Within the last 5 years has anyone been diagnosed with cancer or had cancer surgery, radiation therapy or chemotherapy for:			n. Gastrointestinal medication, such as Nexium?.....	<input type="checkbox"/>	<input type="checkbox"/>
a. Cancer/malignancy, including melanoma?	<input type="checkbox"/>	<input type="checkbox"/>	o. Injection medication for rheumatoid arthritis, psoriasis, inflammatory bowel disease, ulcerative colitis or Crohn's Disease such as Arava?....	<input type="checkbox"/>	<input type="checkbox"/>
b. Other forms of skin cancer?.....	<input type="checkbox"/>	<input type="checkbox"/>	p. Remicade?	<input type="checkbox"/>	<input type="checkbox"/>
22. Prostate disorders, including enlarged prostate, benign prostatic hypertrophy or elevated readings?.....	<input type="checkbox"/>	<input type="checkbox"/>	q. Enbrel?	<input type="checkbox"/>	<input type="checkbox"/>
23. Bleeding disorder, such as Hemophilia or Von Willebrand's?	<input type="checkbox"/>	<input type="checkbox"/>	r. Infertility medication?	<input type="checkbox"/>	<input type="checkbox"/>
24. Sickle cell anemia, aplastic anemia or thalassemia major?.....	<input type="checkbox"/>	<input type="checkbox"/>	s. Pancreatic enzymes used in the treatment of Cystic Fibrosis, such as, Creon, Pancrease, Ultrase, Lipram?.....	<input type="checkbox"/>	<input type="checkbox"/>
25. Moderate or severe psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	t. Synagis?	<input type="checkbox"/>	<input type="checkbox"/>



ENROLL1 Sample enrollment and change application with health questions (page 5 of 6)

Employee Name: _____

We need to know only about medications that are specified in Question 40. Please do not list any other medications.

41. Does anyone have a physical or mental impairment that substantially limits one or more major life activities: caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working?..... Yes No
Describe each such physical or mental impairment and identify the person with such physical or mental impairment:

Please describe how the physical or mental impairment substantially limits one or more of the major life activities stated previously:

If yes, is the physical or mental impairment temporary or correctable?..... Yes No
If yes, please explain how the physical or mental impairments are temporary or how the person plans to have it corrected:

F2. For each item checked "YES" in the previous Section, please provide condition or diagnosis for each person.

	Person #1 Name:	Person #2 Name:	Person #3 Name:
Condition or Diagnosis:			

If additional space is needed, please attach a separate sheet, with your signature and the date (mm/dd/yyyy).

G. Coverage selection for products underwritten by USABLE[®] Life Insurance Company, if offered by employer

USABLE Life is an independent life insurance company that does not provide BCBSNC products or services. USABLE Life is solely responsible for the life and disability insurance coverage below. Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for details. Employer is required to retain a copy of this form for beneficiary information.

Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No Weekly Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Supplemental Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No Benefits Selected <input type="checkbox"/> Applying for Over Guarantee Issue
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Supplemental Life/AD&D Amount: _____

Employee's Annual Salary (required if salary based plan) _____ Employee's Job Title _____

Primary Beneficiary Name (required)		Primary Beneficiary Address (required)	
Relationship	Date of Birth	Social Security Number	Percent ¹
	mm dd yyyy		
Second Primary Beneficiary Name (required)		Second Primary Beneficiary Address (required)	
Relationship	Date of Birth	Social Security Number	Percent ¹
	mm dd yyyy		
Contingent Beneficiary Name (required)		Contingent Beneficiary Address (required)	
Relationship	Date of Birth	Social Security Number	Percent ¹
	mm dd yyyy		
Second Contingent Beneficiary Name (required)		Second Contingent Beneficiary Address (required)	
Relationship	Date of Birth	Social Security Number	Percent ¹
	mm dd yyyy		

¹ NOTE: The primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I select any of the products listed above that I will be covered by USABLE Life at the discretion of the employer group (as indicated above).
- I understand that if I am not actively at work as defined in the policy(ies) (for the products selected above) on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

X Signature: _____ Date mm dd yyyy

Application continued on next page → PAGE 5 of 6



ENROLL1 Sample enrollment and change application with health questions (page 6 of 6)

Employee Name: _____

H. Statement of understanding - your signature is required

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina (BCBSNC) and/or the life insurance carrier (USABLE Life) contract (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that BCBSNC and/or the life insurance carrier may, within two years of the date of this application, rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. If fraudulent misstatements were made, BCBSNC may take legal action at any time.

I understand that if I am applying for Blue Options HSA and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with Blue Cross and Blue Shield of North Carolina (BCBSNC). BCBSNC is not responsible or liable for administration of the HSA.

Detailed information regarding my HSA will be provided by the designated HSA administrator. I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.

I understand that if my employer establishes an HSA, my employer or their designees will share certain personal information about me with these administrators to facilitate the administrator's establishment of the HSA account. By signing this application, I authorize my employer or their designees to share pertinent information with these selected administrators as applicable, which may include my name, address, social security number and my employer's name.

I understand that if issued a debit card in connection with my HSA, I agree that although BCBSNC's name and marks may be included on the face of the debit card for convenience, BCBSNC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.

HSA Only: If I am applying for Blue Options HSA, I understand that BCBSNC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my BCBSNC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.

X Signature: _____ Date

I. Statement of authorization for release of protected health information - your signature is required

I understand that if I refuse to sign this authorization that BCBSNC and/or USABLE Life may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC and/or USABLE Life.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

- (i) my past, present, or future physical or mental health or condition;
- (ii) the provision of health care to me; or
- (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to BCBSNC and/or USABLE Life.

I further authorize BCBSNC and/or USABLE Life to review any applications for health care coverage that I may have submitted to BCBSNC and/or USABLE Life in the past.

I authorize BCBSNC and/or USABLE Life to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that BCBSNC and/or USABLE Life will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that BCBSNC and/or USABLE Life will make every effort to safeguard my protected health information. I further understand that BCBSNC and/or USABLE Life will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require BCBSNC and/or USABLE Life to disclose my protected health information. I understand that BCBSNC and/or USABLE Life may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

Rating	USABLE Life
Blue Cross and Blue Shield of North Carolina	320 West Capital Avenue
P.O. Box 30013	Suite 700
Durham, NC 27702	Little Rock, Arkansas 72201

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

- (i) for information that BCBSNC and/or USABLE Life already used or disclosed, relying on this authorization or
- (ii) if the authorization was obtained as a condition of coverage in BCBSNC and/or USABLE Life and, by law, BCBSNC and/or USABLE Life has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below. After 120 days expire, BCBSNC and/or USABLE Life may no longer use this information.

Signature of Primary Applicant or Legal Personal Representative: _____ Date

Name of Legal Personal Representative and Relationship to Primary Applicant (please print): _____ Date



ENROLL2 Sample enrollment and change application (page 1 of 5)

Enrollment/Change Application

Instructions:

- All employees complete Sections A, C, D, E, G and H.
- For change requests, complete Sections A, B and all other applicable sections.
- If your group has elected USABLE Life products you must complete Section F.
For USABLE^{®1} Life Only you must complete Sections A, B, F, G and H.

Completed by Group Administrator Only

Group Number (if applicable):

Life Class Designation (if applicable):

Please type or print in black or blue, NOT RED ink

A. Employee information										
First Name			Middle Initial		Last Name			Suffix		
Employee Birthdate mm dd yyyy			Employee Social Security Number				<input type="checkbox"/> Male	Marital Status		<input type="checkbox"/> Female
Address		P.O. Box <i>(For Blue Options HSA you must also provide a street address.)</i>			Apt. No.	City		State	Zip Code	
Company Name					Occupation					
Work Location			Date of Full Time Employment mm dd yyyy		Language Preference <input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other _____					
Home Phone Number ()			Work Phone Number ()		E-Mail Address					
Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.) <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Choose not to report <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Other (specify) _____										
<input type="checkbox"/> ACTIVE EMPLOYEE	<input type="checkbox"/> COBRA/STATE CONTINUATION									
COBRA/State Continuation Qualifying Event:	<input type="checkbox"/> Termination of Employment	<input type="checkbox"/> Reduction in Hours	<input type="checkbox"/> Death of Subscriber	<input type="checkbox"/> Divorce	<input type="checkbox"/> Over Age Dependent	<input type="checkbox"/> Medicare Eligible				
What was the date of the Qualifying Event? mm dd yyyy			Date Continuation Started mm dd yyyy		Date Continuation Ends mm dd yyyy					
B. If making a change from previous enrollment										
Check All That Apply:			Add Dependent(s):			Reinstate Coverage:				
<input type="checkbox"/> Name			<input type="checkbox"/> Marriage			Reason: _____				
<input type="checkbox"/> Address			<input type="checkbox"/> Newborn			_____				
<input type="checkbox"/> Other Insurance Information			<input type="checkbox"/> Adoption			_____				
<input type="checkbox"/> Telephone			<input type="checkbox"/> Other _____			Cancel Coverage:				
<input type="checkbox"/> Replace ID Card			Remove Dependent(s):			<input type="checkbox"/> Not Eligible				
<input type="checkbox"/> Date of Birth Correction			<input type="checkbox"/> Divorce			Reason: _____				
<input type="checkbox"/> E-Mail Address			<input type="checkbox"/> Dependent Age			<input type="checkbox"/> Left Employment				
<input type="checkbox"/> Late Applicant			<input type="checkbox"/> Death			<input type="checkbox"/> Subscriber Request				
<input type="checkbox"/> Over the Guarantee Issue			<input type="checkbox"/> Other _____			<input type="checkbox"/> Other				
<input type="checkbox"/> Other _____						Reason: _____				

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ENROLL2 Sample enrollment and change application (page 2 of 5)

Employee Name:

C. Benefits and coverage selection - complete for BCBSNC health and dental, if offered by employer						
MEDICAL PLAN:	<input type="checkbox"/> No Medical Coverage	<input type="checkbox"/> Blue Options HSA SM	<input type="checkbox"/> Blue Options PPO	<input type="checkbox"/> Blue Options 1-2-3	<input type="checkbox"/> High	<input type="checkbox"/> Low
	<input type="checkbox"/> Blue Care [®] (HMO)	<input type="checkbox"/> Classic Blue [®] (CMM)	<input type="checkbox"/> Blue Options HRA SM			
MEDICAL COVERAGE (if applicable):	<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee/Child(ren)		<input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family	
DENTAL PLAN:	<input type="checkbox"/> No Dental Coverage		<input type="checkbox"/> Dental		<input type="checkbox"/> High <input type="checkbox"/> Low	
DENTAL COVERAGE (if applicable):	<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee/Child(ren)		<input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family	
D. Family information - complete for anyone taking medical and/or dental coverage*						
NAME First, Middle Initial, Last, Suffix	Social Security Number	Birthdate mm/dd/yyyy	Sex	H E A L T H	D E N T A L	Child Status (please check one)
Spouse	required		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***
Child 3****			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped** <input type="checkbox"/> Under the age of 26***
* Application does not guarantee enrollment. ** A request for coverage (form P24) is required if your child is 26 years or older and will be reviewed to determine eligibility. *** Consult your employer regarding dependent eligibility requirements. Supporting documentation may be required. **** If you have more than three children, complete Section D on another application.						<input type="checkbox"/> Additional dependent and/or custodial parent information attached.
E. Other health/dental insurance information						
Have you or your dependents had any other health or dental coverage within the last 12 months (other than BCBSNC coverage that you are applying for today)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
See important notices regarding pre-existing condition limitations and special enrollment information attached.						
Please list any health or dental coverage the employee and/or dependents has/had within the last 12 months (including BCBSNC coverage):						
Insurance Carrier				Policy Number		
Policy Holder Name					Date of Birth <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
Effective Date <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>		Termination Date or Expected Termination Date <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (If remaining active leave blank)				
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)						
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents						
Additional Coverage that will be in-force when this policy becomes active:						
Insurance Carrier				Policy Number		
Policy Holder Name					Date of Birth <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
Effective Date <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>		Termination Date or Expected Termination Date <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (If remaining active leave blank)				
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)						
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents						
Additional Coverage that will be in-force when this policy becomes active:						
Insurance Carrier				Policy Number		
Policy Holder Name					Date of Birth <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	

Application Continued on Next Page → PAGE 2 of 5



ENROLL2 Sample enrollment and change application (page 3 of 5)

Employee Name:	
Effective Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Termination Date or Expected Termination Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> (If remaining active leave blank)
What kind of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medical <input type="checkbox"/> Dental (Proof of dental coverage must be included with application for processing)	
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents	
If anyone covered has Medicare Coverage please complete below:	
Persons covered: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child1 <input type="checkbox"/> Child2 <input type="checkbox"/> Child3 <input type="checkbox"/> Additional Dependents	
Medicare Claim Number:	Eligible Due To: <input type="checkbox"/> Renal Disease <input type="checkbox"/> First Day of Dialysis <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/> <input type="checkbox"/> Disability <input type="checkbox"/> Age
Part A Effective Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>	Part B Effective Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
F. Coverage selection for products underwritten by USABLE Life, if offered by employer	
USABLE Life is an independent life insurance company that does not provide BCBSNC products or services. USABLE Life is solely responsible for the life and disability insurance coverage below. Your non-medical group insurance program may not include all the benefits listed below. These benefits will be written by USABLE Life. Ask your employer details. Employer is required to retain a copy of this form for beneficiary information.	
Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No Benefits Selected <input type="checkbox"/> Applying For Over Guarantee Issue
Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No	
Weekly Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	
Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supplemental Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No Supplemental Life/AD&D Amount: _____	
Employee's Annual Salary (Required If Salary Based Plan)	Employee's Job Title
Primary Beneficiary Name (required)	
Primary Beneficiary Address (required)	
Relationship	Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
Social Security Number	Percent ¹
Second Primary Beneficiary Name (required)	
Second Primary Beneficiary Address (required)	
Relationship	Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
Social Security Number	Percent ¹
Contingent Beneficiary Name (required)	
Contingent Beneficiary Address (required)	
Relationship	Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
Social Security Number	Percent ¹
Second Contingent Beneficiary Name (required)	
Second Contingent Beneficiary Address (required)	
Relationship	Date of Birth <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
Social Security Number	Percent ¹
¹ NOTE: The primary and contingent beneficiary's percentages must equal 100%.	
<ul style="list-style-type: none"> I understand that if I select any of the products listed above that I will be covered by USABLE Life at the discretion of the employer group (as indicated above). I understand that if I am not actively at work as defined in the policy(ies) (for the products selected above) on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required. I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries. 	
X Signature: _____	Date <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="yyyy"/>
Life insurability questionnaire - complete only if you are a late applicant or applying for coverage over the guarantee issue amount	
1. Employee Height:	2. Employee Weight:
3. Have you used any tobacco products in the past year?	Yes No <input type="checkbox"/> <input type="checkbox"/>
4. Do you have any condition for which consultation or treatment is contemplated or has been advised?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you been hospitalized for any reason during the past five (5) years?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you consulted a physician in the past one (1) year for any reason?	<input type="checkbox"/> <input type="checkbox"/>
Application Continued on Next Page → PAGE 3 of 5	



ENROLL2 Sample enrollment and change application (page 4 of 5)

Employee Name:				
7. Have you ever been diagnosed or treated by a member of the medical profession for:				
	Yes No			
a. Cancer, cancer related disease or benign tumor?	<input type="checkbox"/> <input type="checkbox"/>			
b. Disease of the heart or blood vessels, or had a stroke?	<input type="checkbox"/> <input type="checkbox"/>			
c. Kidney disease or diabetes?	<input type="checkbox"/> <input type="checkbox"/>			
d. Alcohol or drug abuse?	<input type="checkbox"/> <input type="checkbox"/>			
e. Lung, asthma, liver or blood disorder?	<input type="checkbox"/> <input type="checkbox"/>			
	Yes No			
f. Emotional, nervous system, eating disorder, or mental health problems?	<input type="checkbox"/> <input type="checkbox"/>			
g. Ulcer, stomach or digestive disorder?	<input type="checkbox"/> <input type="checkbox"/>			
h. Arthritis, back, bones or joint disorder?	<input type="checkbox"/> <input type="checkbox"/>			
i. Bladder, urinary system or reproductive organs disorder?	<input type="checkbox"/> <input type="checkbox"/>			
8. Have you ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")?	<input type="checkbox"/> <input type="checkbox"/>			
9. Have you ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? If yes, list name of person(s), medications taken, medication dosage, and last two blood pressure readings.	<input type="checkbox"/> <input type="checkbox"/>			
10. Are you currently taking medication(s)? If yes, list name of person, medications and dosage.	<input type="checkbox"/> <input type="checkbox"/>			
11. Have you ever had any impairments, diseases or illnesses not covered in questions 2-8?	<input type="checkbox"/> <input type="checkbox"/>			
12a. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	12b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?			
	<input type="checkbox"/> <input type="checkbox"/>			
13. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If no, give full details.	<input type="checkbox"/> <input type="checkbox"/>			
14. Names, addresses, and phone numbers of the personal physicians of all applicants:				
G. Statement of understanding - your signature is required				
<p>I understand the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina (BCBSNC) and/or the life insurance carrier (USABLE Life) contract (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that BCBSNC and/or the life insurance carrier may, within two years of the date of this application, rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. If fraudulent misstatements were made, BCBSNC may take legal action at any time.</p> <p>I understand that if I am applying for Blue Options HSA and my employer has established an HSA, the HSA will be provided to me directly by a separate administrator, unaffiliated with Blue Cross and Blue Shield of North Carolina (BCBSNC). BCBSNC is not responsible or liable for administration of the HSA.</p> <p>I understand that if I am applying for Blue Options HRA and my employer has established an HRA, the HRA may be administered by BCBSNC separately from my health insurance plan, or by a separate administrator.</p> <p>Detailed information regarding my HSA/HRA will be provided by the designated administrator. I also understand that due to bank regulations, if I provide a P.O. Box as my address I will receive a request for additional information regarding my mailing address. Failure to respond to requests for additional information will result in account closure and return of any funds posted to my account.</p> <p>I understand that if my employer establishes an HSA/HRA, my employer or their designees will share certain personal information about me with these administrators to facilitate the administrator's establishment of the HSA/HRA account. By signing this application, I authorize my employer or their designees to share pertinent information with these selected administrators as applicable, which may include my name, address, social security number and my employer's name.</p> <p>I understand that if issued a debit card in connection with my HSA/HRA, I agree that although BCBSNC's name and marks may be included on the face of the debit card for convenience, BCBSNC is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.</p> <p>HSA Only: If I am applying for Blue Options HSA, I understand that BCBSNC takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my BCBSNC plan with my employer. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the fund administrator.</p>				
I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.				
X Signature: _____	Date <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;">mm</td> <td style="width: 20px; height: 20px;">dd</td> <td style="width: 20px; height: 20px;">yyyy</td> </tr> </table>	mm	dd	yyyy
mm	dd	yyyy		



ENROLL2 Sample enrollment and change application (page 5 of 5)

Employee Name:

H. Statement of authorization for release of protected health information - your signature is required

I understand that if I refuse to sign this authorization that BCBSNC and/or USABLE Life may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC and/or USABLE Life.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

- (i) my past, present, or future physical or mental health or condition;
- (ii) the provision of health care to me; or
- (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to BCBSNC and/or USABLE Life.

I further authorize BCBSNC and/or USABLE Life to review any applications for health care coverage that I may have submitted to BCBSNC and/or USABLE Life in the past.

I authorize BCBSNC and/or USABLE Life to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that BCBSNC and/or USABLE Life will use my protected health information for the following purposes:

To determine my eligibility for enrollment and my premium rate.

I understand that BCBSNC and/or USABLE Life will make every effort to safeguard my protected health information. I further understand that BCBSNC and/or USABLE Life will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require BCBSNC and/or USABLE Life to disclose my protected health information. I understand that BCBSNC and/or USABLE Life may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

Rating
Blue Cross and Blue Shield of North Carolina
P.O. Box 30013
Durham, NC 27702

USABLE Life
320 West Capital Avenue
Suite 700
Little Rock, Arkansas 72201

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

- (i) for information that BCBSNC and/or USABLE Life already used or disclosed, relying on this authorization or
- (ii) if the authorization was obtained as a condition of coverage in BCBSNC and/or USABLE Life and, by law, BCBSNC and/or USABLE Life has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below. After 120 days expire, BCBSNC and/or USABLE Life may no longer use this information.

Signature of Primary Applicant or Legal Personal Representative: _____ Date

Name of Legal Personal Representative and Relationship to Primary Applicant (please print): _____ Date



ECR270 Sample EDI Services batch connectivity request

EDI Services Batch Connectivity Request

270/271 - Eligibility Inquiry / 276/277 - Claim Status Inquiry / 278 Authorization

Please complete the following information and fax the form to EDI Services at (919) 765-7101. A connectivity request form is required for each provider.

PROVIDER NAME		BCBSNC PROVIDER NUMBER	
CONTACT NAME		TITLE	
MAIL ADDRESS		CITY	STATE ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	

VENDOR / CLEARINGHOUSE NAME		CONTACT NAME		TITLE
MAIL ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS		

BILLING SERVICE NAME		CONTACT NAME		TITLE
MAIL ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS		

Are you changing vendor/clearinghouse or billing service? Yes No If so, effective date of change: ____ / ____ / ____

Type of Transaction (enter effective date and X12 version for each applicable transaction)		
Transaction Type	Effective Date	X12 Version
270/271 Eligibility Inquiry		
276/277 Claim Status Inquiry		
278 Authorization		

Type of Sender (select one): Provider Clearinghouse Billing Service

ISA05 Interchange Sender ID Qualifier*: _____ ISA06 Interchange Sender ID*: _____

*As a business practice, BCBSNC defines the Sender ID Qualifier to be "30" and the Sender ID to be the "Federal Tax ID"

Mode of Connectivity (select one) <input type="checkbox"/> Async (X, Y or Z Modem/Kermit) <input type="checkbox"/> Secure FTP (via Internet)	Complete for Asynchronous Connectivity Mode	
	BAUD RATE	PASSWORD (8 CHARACTERS)
	COMMUNICATION PROTOCOL	

X _____
 AUTHORIZED SIGNATURE OF PROVIDER PRINT NAME / TITLE OF AUTHORIZED SIGNER DATE OF AUTHORIZATION

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ECR835 Sample EDI Services batch connectivity request

EDI Services Batch Connectivity Request

835 – Payment/Remittance Advice

Blue Cross and Blue Shield of North Carolina (BCBSNC) Remittance Advice will be sent for payments on: New Blue, PCP, PPO, MedPoint, State Health Plan, FEP, NASCO, BlueCard® and Traditional Blue Cross and Blue Shield Plans.

Please complete the following information and fax the form to EDI Services, **(919) 765-7101**. A Connectivity Request form is required for each provider.

PROVIDER NAME		BCBSNC PROVIDER NUMBER	
CONTACT NAME		TITLE	
MAIL ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	

VENDOR / CLEARINGHOUSE NAME		CONTACT NAME		TITLE	
MAIL ADDRESS		CITY	STATE	ZIP CODE	
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS			

BILLING SERVICE NAME		CONTACT NAME		TITLE	
MAIL ADDRESS		CITY	STATE	ZIP CODE	
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS			

Are you changing vendor/clearinghouse or billing service? Yes No If so, effective date of change: _____ / _____ / _____

Type of Receiver (select one): <input type="checkbox"/> Provider <input type="checkbox"/> Clearinghouse <input type="checkbox"/> Billing Service		
ISA07 Interchange Receiver ID Qualifier*:	_____	ISA08 Interchange Receiver ID*:
*As a business practice, BCBSNC defines the Receiver ID Qualifier to be "30" and the Receiver ID to be the "Federal Tax ID"		

X12 Version:	_____
--------------	-------

Mode of Connectivity (select one):		
<input type="checkbox"/> Secure FTP (via internet)	<input type="checkbox"/> Async (X, Y, or Z modem/Kermit)	<input type="checkbox"/> RealMed

Complete for Connectivity Selected (not applicable for IBM Info Exchange or Other)	
BAUD RATE	
COMMUNICATION PROTOCOL	PASSWORD (8 CHARACTERS)

X	_____	_____	_____
AUTHORIZED SIGNATURE OF PROVIDER	PRINT NAME / TITLE OF AUTHORIZED SIGNER	DATE OF AUTHORIZATION	

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ECR837 Sample EDI Services batch connectivity request

EDI Services Batch Connectivity Request

837 – Claim/Encounter

Blue Cross and Blue Shield of North Carolina (BCBSNC) accepts the following claims electronically: New Blue, PCP, PPO, MedPoint, State Health Plan, FEP, BlueCard® and Traditional Blue Cross and Blue Shield plans.

Please complete the following information and fax the form to EDI Services, (919) 765-7101. A Connectivity Request form is required for each provider.

PROVIDER NAME		BCBSNC PROVIDER NUMBER	
CONTACT NAME		TITLE	
MAIL ADDRESS		CITY	STATE ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	
VENDOR / CLEARINGHOUSE NAME		CONTACT NAME TITLE	
MAIL ADDRESS		CITY	STATE ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	
BILLING SERVICE NAME		CONTACT NAME TITLE	
MAIL ADDRESS		CITY	STATE ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	

Are you changing vendor/clearinghouse or billing service? Yes No If so, effective date of change: _____ / _____ / _____

Type of Transaction (enter effective date and X12 version for each applicable claim type)		
Claim Type	Effective Date	X12 Version
837 Institutional		
837 Professional		

Type of Sender (select one): Provider Clearinghouse Billing Service

ISA05 Interchange Sender ID Qualifier*: _____ ISA06 Interchange Sender ID*: _____

**As a business practice, BCBSNC defines the Sender ID Qualifier to be "30" and the Sender ID to be the "Federal Tax ID"*

Mode of Connectivity (select one) <input type="checkbox"/> Async (X, Y or Z Modem/Kermit) <input type="checkbox"/> Secure FTP (via Internet)	Complete for Async Connectivity Mode	
	BAUD RATE	
	COMMUNICATION PROTOCOL	PASSWORD (8 CHARACTERS)

Claims Flow: from Provider site - directly to BCBSNC from Provider site - to Billing Service - to Clearinghouse - to BCBSNC
 from Provider site - to Billing Service - to BCBSNC
 from Provider site - to Clearinghouse - to BCBSNC Other (please specify): _____

Electronic Audit Reports should be sent to (select one): Provider Billing Service Clearinghouse

X

 AUTHORIZED SIGNATURE OF PROVIDER PRINT NAME / TITLE OF AUTHORIZED SIGNER DATE OF AUTHORIZATION

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Sample member appeal representation authorization form



BlueCross BlueShield of North Carolina

Date:
Name:
Address:
City/State/Zip Code:
Patient:
Date of Birth:
Date(s) of Service:
Provider:
Reference Inquiry:
Regarding:

I have given my permission for _____ to represent me, and act on my behalf regarding the above referenced denial for the following services: _____ .

I authorized Blue Cross and Blue Shield of North Carolina (BCBSNC) to release any of my Protected Health Information (PHI) to my representative named above for the purpose of resolving my appeal.

I understand that I may revoke this authorization at any time by mailing a written notice to BCBSNC at the address below. I understand that revoking this authorization will not affect my action that BCBSNC has taken prior to receiving my notice of revocation.

I further understand that BCBSNC will not condition the provision of my health plan benefits because of this authorization.

I further understand that the person(s) that I have given permission to receive my PHI may not be subject to receive my PHI may not be subject to federal health information privacy laws and that they may disclose my information and it may no longer be protected by federal health information privacy laws.

This authorization will expire upon resolution of this appeal.

Thank you,

Member Signature

Date

PO Box 30055 • Durham, NC 27702-3055 • 919-489-7431
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S133 Sample statement of accommodation charges (page 1 of 2)



**Blue Cross BlueShield
of North Carolina**
An Independent Licensee of the
Blue Cross and Blue Shield Association

STATEMENT OF ACCOMMODATION CHARGES

Name of Hospital _____

Blue Cross # _____

Medicare # _____

IRS # _____

Effective Date _____

Signature (Hospital CEO or CFO): _____

Date _____

Blue Cross
Signature: _____

Date: _____

NURSERY

ROUTINE CHARGE REV CODE

PREMATURE \$ \$

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Licensed Beds (excl. Bassinets)

Bassinets

GENERAL ACCOMMODATIONS

CLASSIFICATION # OF BEDS CHARGE REV CODE

SP \$ 0120

SP \$ 0120

SP \$ 0130

WARD \$ 0110

WARD \$ 0110

WARD \$ 0110

WARD \$ 0110

WARD \$ 0110

WARD \$ 0110

WARD \$ 0110

BOBSNC USE ONLY
MPSPO01 \$
AVSP002 \$

CLINICAL SPECIALTY

CLASSIFICATION # OF BEDS CHARGE REV CODE

ADULT SP \$ 0124

ADULT SP \$ 0114

ADULT SP \$

ADULT SP \$

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MPSPO12 \$
AVSP017 \$

MPSPO20 \$
AVSP022 \$

MPSPO21 \$
AVSP023 \$

MPSPO10 \$
AVSP015 \$

MPSPO11 \$
AVSP016 \$

CLASSIFICATION # OF BEDS CHARGE REV CODE

SP \$ 0127

SP \$ 0117

SP \$

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BOBSNC USE ONLY
MPSPO13 \$
AVSP018 \$

MPSPO24 \$
AVSP025 \$

MPSPO14 \$
AVSP019 \$

MPSPO \$
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Glossary of terms





Account - Includes any and all organized groups of individuals purchasing health insurance together, usually under employer sponsorship. Accounts are further defined as national, state, local and other.

Accreditation - The formal evaluation of an organization according to accepted criteria or standards. Accreditation may be rendered by a professional society, a non-governmental body or a government agency. National Committee for Quality Assurance (NCQA) accreditation is a nationally recognized evaluation that purchasers, regulators and consumers can use to assess HMO, POS and PPO plans.

Acute care - Treatment for a short-term or episodic illness or health problem.

Admission - When a member enters any facility that files UB-04 claim forms and is registered as an inpatient.

Admission certification - A procedure whereby the Plan determines, based on medically accepted criteria, whether an admission to a hospital as an inpatient is reasonable for the type of services to be received by a member. Non-maternity and non-emergency admissions must be certified prior to admission.

Administrative costs - The costs assumed by a health care plan for administrative services, such as claims processing, billing and overhead costs.

Administrative Services Only (ASO) - An account that assumes full claims liability (self-insured) for funding the health benefits contract with a third party (such as BCBSNC) providing all or a portion of the administrative services that would be available under a regular health plan. Because the service company assumes no liability for health coverage, claim reserves normally are not required.

Allowable charge/amount - The maximum amount to be reimbursed to a provider as negotiated.

Allowed amount - The charge that BCBSNC determines is reasonable for covered services provided to a member. This may be established in accordance with an agreement between the provider and BCBSNC. In the case of providers that have not entered into an agreement with BCBSNC, BCBSNC's methodology is determined based on several factors including BCBSNC's medical, payment and administrative guidelines.

Under the guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.

Alpha prefix - Three characters preceding the subscriber identification number on the Blue Plan ID cards. The alpha prefix identifies the member's Blue Plan or national account and is required for routing claims.

Alt Med BlueSM - A comprehensive, complementary and alternative medicine discount program. Offers discounts for alternative treatments and therapies such as acupuncture, stress management, massage therapy/somatic education, fitness centers and personal trainers, spas, and nutritional counseling.

Ambulatory care - Medical services that are provided on an outpatient (non-hospitalized) basis, including the office setting. Generally synonymous with outpatient; however, some outpatient services may be excluded.

Ambulatory surgery - See outpatient surgery.

Ambulatory surgical center - A non-hospital facility with an organized staff of doctors, which is licensed or certified in the state where located, and which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
- provides nursing services and treatment by or under the supervision of doctors whenever the patient is in the facility
- does not provide inpatient accommodations
- is not other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other provider

Ancillary providers - home health, home infusion, private duty nursing, dialysis facilities, hospice, durable medical equipment, skilled nursing facilities.

Ancillary services - Facility services exclusive of room and board, such as supplies and laboratory tests.

ASO pre-existing condition - A condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended during the six month period prior to the effective date of the member's coverage. Pregnancy variable is not considered a pre-existing condition.



Authorization - See certification.

Average Length of Stay (ALOS) - The number of inpatient days divided by the number of admissions for a given time period and a given population.

BCBSNC - Blue Cross and Blue Shield of North Carolina. BCBSNC may also be referred to as "we" or "us."

bcbs.com - Blue Cross and Blue Shield Association's Web site, 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.

Benefits package - Services an insurer, government agency or health plan offers to a group or individual under the terms of a contract. The components which make up a product's health benefit plan (e.g., deductible, out-of-pocket limit, lifetime maximum, etc.).

Benefit period - The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Billed charge - The amount a physician, institution, pharmacy, suppliers of medical equipment or other practitioner bills a patient for a particular medical service or procedure. This is referred to as actual charge or public charge.

Billing - (a) An itemized account of subscriber dues owed to the Plan by a group or subscriber; (b) an itemized account of services rendered by a physician, provider or supplier.

Birthday rule - A process under coordination of benefits clauses in a contract that determines which patient's coverage pays first when a dependent child has health insurance coverage through both parents. This rule states that the parent whose birthday falls first during the calendar year is primary (his or her coverage pays first).


BlueCard® - A collection of programs and policies that enable members to receive health care services while traveling or living in another Plan's service area.

BlueCard Access® - 1-800-810-BLUE - A toll-free 800 number for you and members to use to locate healthcare providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

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® doctor and hospital finder web site - <http://www.bcbs.com/healthtravel/finder.html>

A Web site you can use to locate healthcare providers in another Blue Plan's area <http://www.bcbs.com/healthtravel/finder.html>. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the Web site, please contact BCBSNC.

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 healthcare providers worldwide. The program also allows members of foreign Blue Cross and/or Blue Plans to access domestic (United States) Blue provider networks.

Blue Care® (HMO) - An open access HMO plan that allows the member to see any participating provider without a referral. There is no coverage for services received from a non-participating provider. Under Blue Care®, members are asked, but are not required, to select a primary care physician or provider.



Blue Cross and Blue Shield of North Carolina (BCBSNC) - A nonprofit hospital, medical and dental service corporation organized and operated under Chapters 55A and 58 of the North Carolina General Statutes. BCBSNC is an independent licensee of the Blue Cross and Blue Shield Association.

Blue Extras - Special program available to BCBSNC members as value-added services. These services are not covered benefits or otherwise a part of the member's health insurance contract.

Blue OptionsSM PPO - A Preferred Provider Organization (PPO) plan that allows members the freedom to choose in-network or out-of-network providers; however, when members receive services from an out-of-network provider, there is more out-of-pocket expense to the member.

Brand name - The proprietary name the manufacturer owning the patent places upon a drug product or on its container, label or wrapping at the time of packaging.

Bundling - The packaging of items or services containing defined elements grouped together in a global package.

Calendar year - The period of time beginning January 1 and ending December 31 of a given year.

Carrier - An insurance company, pre-paid health plan or a government agency that underwrites and/or administers a range of health benefits programs and any claims submitted by or for plan members.

Carryover - A provision in health plans that allows individuals to apply expenses incurred in the last quarter of that calendar year to the next year's deductible. This does not apply to most health benefit plans.

Case management - A program that is designed to assess the continuing needs of members with catastrophic or chronic health problems. Case managers assist physicians/providers in meeting an individual's health care needs through coordination of services and utilization of resources in order to promote high-quality, cost-effective outcomes.

CDW - Corporate Data Warehouse

Centers for Medicare and Medicaid Services (CMS) - A division of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.

Certification - Certification is the determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy our requirements for medically necessary services and supplies, appropriateness, health care setting, level of care and effectiveness.

Claim - A request for retrospective payment by a member or, on his/her behalf, by the provider for services or supplies rendered by an institution, provider or supplier of medical supplies and equipment. Each document or request for payment should be counted as one claim.

Classic Blue[®] (CMM) - An indemnity (Comprehensive Major Medical) plan. Unlike the other new Blue products, Classic Blue[®] members do not pay copayments for services provided in an office setting. Instead, all services are subject to a deductible and coinsurance. Members have the freedom to see any provider; however, when members receive services from a non-participating provider, payment is made to the member directly and they must reimburse the provider.

CMID - Common membership. Displays combined membership information from Legacy, State and New Blue products.

CMS-1500 claim form - Professional claim form which uses CPT codes and HCPCS codes to indicate procedures rendered for a member.

Coinsurance - 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.

Complimentary and alternative medicine -
See Alt Med BlueSM.

Comprehensive major medical - An indemnity policy characterized by a deductible amount, a coinsurance feature and maximum benefits.

Concurrent review - Healthcare management & operations 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 Healthcare/Health Plans (CDHC/CDHP) - Consumer Directed HealthCare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare 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.

Copayment - A specified charge that a member incurs for a specified service at the time the service is rendered.

Coordination of Benefits (COB) - Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Cost containment - A variety of activities directed at controlling the cost of medical care and reducing its rate of increase. Such activities include case management, concurrent review, etc.

Coverage - Benefits available to eligible members.

Covered service(s) - A service, drug, supply or equipment specified in this benefit booklet for which members are entitled to benefits in accordance with the terms and conditions of this health benefit plan.

Credentialing - The process of licensing, accrediting, and certifying health care providers to ensure quality standards are met. Managed care companies often verify providers' credentials prior to allowing them to participate in a provider network.

Credentialing application - The standardized credentialing application form developed by the North Carolina Department of Insurance.



Custodial care - Care comprised of services and supplies, including room and board and other facility services, which are provided to the patient, whether disabled or not, primarily to assist him or her in the activities of daily living. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services and supplies are custodial as determined by BCBSNC without regard to the provider prescribing or providing the services.

Deductible - 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 years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology.

All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice.

Durable medical equipment - Items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease and are appropriate for use in the patient's home.

Effective date - The date on which coverage for a member begins in the member's booklet.

Emergency - The sudden or unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of emergencies.

Emergency services - Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department.

Empty suitcase - An ID card logo that indicates away from home care coverage that is administered through the BlueCard® system.

Endorsement - Optional coverage purchased by the group. Examples of endorsements are prescription drugs, mental health, substance abuse, chiropractor services and dental.

Exclusions - Specific conditions or services listed in the health benefit plan for which benefits are not available.

Experimental - See investigational.



Explanation of Benefits (EOB) - A statement to the subscriber that explains the action taken on each claim.

Explanation of Payment (EOP) - A statement to the provider that explains the action taken on each claim.

Facility services - Covered services provided and billed by a hospital or non-hospital facility.

Family deductible - A deductible that is satisfied by either the combined expenses of all family members or a certain number of family members.

Fee schedule - Agreed upon reimbursement between a provider and BCBSNC.

FEP - The Federal Employee Program

Formulary - The list of outpatient prescription drugs and insulin that are available to members.

Generic - A non-brand name drug which has the same active ingredient, strength and dosage form, and which is determined by the FDA to be therapeutically equivalent to the drug product identified in the prescription.

Grievance - A written complaint submitted by a member about any of the following:

- Our decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.
- Claims payment or handling payment for services
- The contractual relationship between us and a member
- The outcome of an appeal of a non-certification under North Carolina General Statutes §58-50-61 or successor thereto.

Grievance and appeals process - The formal process described in this 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 - An employer or other entity that has entered into a contract for health care and/or administration of benefits for its eligible members.

Group administrator - A representative of the group designated to assist with member enrollment and provide information to subscribers and members concerning the health benefit plan.

Group contract - The agreement between BCBSNC and the group. It includes the master group contract, the benefit booklet(s) and any exhibits or endorsements, the group enrollment application and medical questionnaire when applicable.

Health benefit plan - The evidence of coverage issued to a group or individual by us or other Blue Cross and/or Blue Shield plans, that describes the scope of covered services and establishes the level of benefits payable, on an insured or administered basis, for such services rendered to members.

Health Maintenance Organization (HMO) - A plan which promises to deliver health services to an enrollee in exchange for the enrollee's prepayment of health care costs to the HMO. The enrollee has no liability to pay providers for health care services, other than copayments, coinsurance, and deductibles. The HMO enters into a direct contractual relationship with providers who promise to deliver all contractually promised health care services to the HMO's enrollees. See Blue Care®.

HIPAA - Health Insurance Portability and Accountability Act - Calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans and employer groups.

Hold harmless - A contract provision whereby providers agree not to charge members more than the allowable charges for covered services and not to charge members for non-covered services. The subscriber's only liability would be the deductible, coinsurance, and/or copayment.

Homebound - A member who cannot leave their home or temporary residence due to a medical condition and a member's ability to leave is restricted due to a medical condition which requires the aid of supportive devices, the use of special transportation or the assistance of another person. A member is not considered homebound solely because the assistance of another person is required to leave the home.



Home health/home care agency - A non-hospital facility which is primarily engaged in providing home health care services, and which:

- Provides skilled nursing and other services on a visiting basis in the member's home
- Is responsible for supervising the delivery of such services under a plan prescribed by a doctor
- Is accredited and licensed or certified in the state where located
- Is certified for participation in the Medicare program
- Is acceptable to BCBSNC

Home plan - The Blue Cross and/or Blue Shield Plan that carries the member's contract when the member receives services out-of-area.

Hospice - A non-hospital facility that provides medically-related services to persons who are terminally ill, and which:

- Is accredited, licensed or certified in the state where located
- Is certified for participation in the Medicare program
- Is acceptable to BCBSNC

Hospital - An accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located.

Hospital-based physician - A physician who is employed by or through a hospital or other facility and/or who provides services at the facility. Specialists which are designated hospital-based by BCBSNC are: emergency room physicians, pathologists, radiologists and anesthesiologists.

Host plan - A Blue Cross and/or Blue Shield Plan participating in the (inter-plan service) benefit bank that provides payment for medical care to a subscriber of another Blue Cross and/or Blue Shield Plan (home). BCBSNC serves as the host Plan in the BlueCard® program.

IBO (Individual) is a twelve month look back and does include pregnancy. **Pre-existing condition** - A condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended during the twelve month period prior to the effective date of the member's coverage. Pregnancy/maternity related diagnoses are considered a pre-existing condition.

Identification card (ID card) - The card issued to our members upon approval of the request for enrollment application and change form.

IGO (Insured Group) and MEWA pre-existing condition - A condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended during the six month period prior to the effective date of the member's coverage. Pregnancy, diabetes and genetic information is not considered as pre-existing conditions.

Incurred - The date on which a member receives the service, drug, equipment or supply for which a charge is made.

Indemnity (Comprehensive Major Medical) plan - Traditional fee-for-service health insurance in which a subscriber has free choice of physicians/providers. The coverage usually includes a deductible and co-insurance. See Classic Blue®.

Infertility - The inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.

In-network - Refers to participating providers.

In-network provider - A hospital, doctor, other medical practitioner or provider of medical services and supplies that has been designated as a Blue Care® provider by BCBSNC.

Inpatient - Pertaining to services received when a member is admitted to a hospital or non-hospital facility as a registered bed patient for whom a room and board charge is made.

Inpatient days - The number of days for which inpatient services are provided, including the day of admission and excluding the day of discharge.

Inquiry - A request for information, action or a document from a subscriber, provider, account, another plan or the general public. Inquiries may be received in any area within a plan office.



Medical policy - Medical policy consists of medical guidelines and payment guidelines. Medical guidelines detail when certain medical services are medically necessary, and whether or not they are investigational. (For more information concerning medical necessity and investigational criteria, please see these specific policies.) Our medical guidelines are written to cover a given condition for the majority of people. Each individual's unique, clinical circumstances may be considered in light of current scientific literature. Medical guidelines are based on constantly changing medical science, and we reserve the right to review and update our policies periodically. Payment guidelines provide (claims payment) editing logic for CPT, HCPCS and ICD-9-CM coding. Payment guidelines are developed by clinical staff, and include yearly coding updates, periodic reviews of specialty areas based on input from specialty societies and physician committees, and updated logic based on current coding conventions. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Therefore, medical policy is not an authorization, certification, explanation of benefits, or a contract. Benefits are determined by the group contract and the subscriber certificate that is in effect at the time services are rendered.

Medical review - The process of determining the appropriateness of care or treatment. Usually part of claims adjudication.

Medicare - The program of health care for the aged, disabled and individuals with end-stage renal disease established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Advantage - Medicare Advantage (MA) 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 Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-Of-Service (POS) and Private Fee-For-Service (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 BCBSNC.

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.

Mental illness - Mental disorders, psychiatric illnesses, mental illnesses, mental conditions and psychiatric conditions (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC.)

Most prevalent room rate - The charge made for the majority of the rooms in a particular category where a hospital or non-hospital facility has more than one level of charges for rooms in the same category.

National account - An employer group with employee and/or retiree locations in more than one 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 days or younger.

Non-hospital facility - An institution or entity other than a hospital which is accredited and licensed or certified in the state where located to render covered services and is acceptable to BCBSNC.



Non-participating provider - A provider that has not been designated as a Blue Care® provider by BCBSNC.

NPC segment - The segment contains any special prefix information that needs to be attached to a group. If the NPC segment is blank, a default prefix will be assigned unless a program specifies otherwise.

Office visit - Medical care, surgery, diagnostic services, short-term therapy services and medical supplies provided in a provider's office.

Open enrollment - (a) A period during which subscribers in a health benefit program have an opportunity to make changes in their health coverage (select an alternative program, for instance); or (b) a period when uninsured individuals can obtain coverage without presenting evidence of insurability (health statements).

Other Party Liability (OPL) - Cost containment programs that ensure that Blue Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.

Other professional provider - A person or entity other than a doctor who is accredited and licensed or certified in the state where located to render covered services and which is acceptable to BCBSNC.

Other provider - An institution or entity other than a doctor or hospital, which is accredited and licensed or certified in the state where located to render covered services and which is acceptable to BCBSNC.

Other therapies - The following services and supplies, both inpatient and outpatient, ordered by a doctor or other provider to promote recovery from an illness, disease or injury when provided by a doctor, other provider or professional employed by a provider licensed in the state of practice.

- **Chemotherapy** (including intravenous chemotherapy)
 - the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the Food and Drug Administration (FDA).

- **Dialysis treatments** - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- **Radiation therapy** - the treatment of disease by X-ray, radium, or radioactive isotopes.
- **Cardiac rehabilitation** - a multi-disciplinary approach to reconditioning of the cardiovascular system in order to help limit the physiologic and psychological effects of cardiac illness, reduce risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients. These programs may include exercise training, education, counseling, and cardiac risk factor modification.

Out-of-area benefits - Benefits that are available to individuals living or traveling outside a health plan's service area. Benefits may be somewhat less restrictive for enrollees living outside the service area.

Out-of-network services - Services performed by a provider who has not signed a contract with the member's health plan to be part of a provider network.

Outlier certification - The approval of reimbursement for inpatient days beyond the assigned length of stay threshold. Certification must be requested prior to the days of service.

Outlier cases - Services that are outside of the stated length of stay parameters or charge thresholds.

Outpatient - Pertaining to services received from a hospital or non-hospital facility by a member while not and inpatient.

Outpatient surgery - Surgery performed in a setting that does not require an inpatient admission. Sometimes called ambulatory surgery.

Partial hospitalization - A program that provides less than 24-hour care (usually during the day) for mental health care, rehabilitative care or other services, often for patients in transition from full-time inpatient care to outpatient care.

Participating provider - A hospital, doctor, other medical practitioner or provider of medical services and supplies that has been designated as a Blue Care® provider by BCBSNC.



Peer review - Evaluation by practicing physicians or other professionals on the effectiveness and efficiency of services ordered or performed by other members of the profession whose work is being reviewed (peers). Peer review is the all-inclusive term for medical review efforts. Medical practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review and claims review all are aspects of peer review.

Per diem rate - A prospective payment methodology for facility inpatient service in which the allowance for covered services is a negotiated daily rate.

Per visit rate - A prospective payment methodology for home infusion therapy services in which the allowance for covered services is a negotiated daily rate.

Plan profile - A tool that allows a plan to capture alpha prefix information. It defines the relationship between BCBS plans for the accounts BCBSNC serves.

Plan - Refers to any Blue Plan.

Practitioner - Any practitioner of health care services who is duly licensed to administer such services by the state in which covered services are performed, subject to any licensure or regulatory limitation as to location, manner or scope of practice.

Preferred Provider Organization (PPO) - A hybrid of HMOs and traditional insurance plans, that contract with various physicians, providers and hospitals. Enrollees are offered a financial incentive to use providers on a preferred list, but may use out-of-network providers as well. See Blue OptionsSM.

Prescription - An order for a prescription drug issued by a doctor duly licensed to make such a request in the ordinary course of professional practice.

Prescription drug - A drug that under federal law is required, prior to being dispensed or delivered, to be labeled, **Caution: Federal law prohibits dispensing without prescription**; or labeled in a similar manner, or injectable insulin, when ordered by a doctor as a prescription, and which is not entirely administered at the time and place where the prescription is dispensed.

Preventive care - Medical services provided by or upon the direction of a doctor or other provider related to the prevention of disease.

Prescription drug - A drug that under federal law is required, prior to being dispensed or delivered, to be labeled, **Caution: Federal law prohibits dispensing without prescription**; or labeled in a similar manner, or injectable insulin, when ordered by a doctor as a prescription, and which is not entirely administered at the time and place where the prescription is dispensed.

Preventive care - Medical services provided by or upon the direction of a doctor or other provider related to the prevention of disease.

Primary care provider - A participating provider from one of the following specialties: family practice/general practice, internal medicine, obstetrics and/or gynecology, physician's assistant, certified nurse practitioner, or pediatrics.

Primary payer - When a member is covered by more than one insurance carrier, the primary payer is the carrier responsible for providing benefits before any other insurer makes payment.

Prior plan approval - The approval of specific medical services and/or supplies for BCBSNC members. Procedures included in the prior plan approval list include high cost and/or potentially abused services. Services are evaluated against severity of illness and intensity of service requirements such as BCBSNC medical policy and M & R criteria for approval.

Prior review - Prior review is the consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of medical necessity of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in certification or non-certification of benefits.

Professional provider - A physician or other practitioner or group of practitioners who is licensed, certified or approved by the appropriate agency to render covered services/supplies in their state of practice.

Prosthetic appliances - Fixed or removable artificial limbs or other body parts, which replace absent natural ones.



Provider - A hospital, non-hospital facility, doctor, or other provider, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification.

Re-admission - A repeat admission for the same diagnosis or condition occurring shortly after the previous admission.

Referral - The recommendation by a primary care physician or provider for a member to receive care from a participating specialist or facility. This is not a formal process and does not require interacting with BCBSNC.

Registered Nurse (RN) - A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.

Resource Based Relative Value Scale (RBRVS) - A methodology introduced by Center for Medicare and Medicaid Services (CMS) and Medicaid Services to create the Medicare fee schedule. The methodology incorporates factors such as the amount of time and resources expended in treating patients, overhead costs and geographical differences.

Retrospective review - A manner of judging medical necessity and appropriate billing practices for services that have already been rendered.

Secondary payer - When a member is covered by more than one insurance carrier, the secondary payer is the carrier responsible for providing benefits after the primary payer has provided benefits.

Short-term therapy - Services and supplies both inpatient and outpatient, ordered by a doctor or other provider to promote the recovery of the member from an illness, disease or injury when provided by a doctor, other provider or professional employed by a provider licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

- Physical therapy
- Occupational therapy
- Speech therapy
- Respiratory therapy

Skilled nursing facility - A non-hospital facility licensed under state law that provides skilled nursing, rehabilitative and related care where professional medical services are administered by a registered or licensed practical nurse.

Specialist - A doctor who is recognized by BCBSNC as specializing in an area of medical practice other than family practice, general practice, internal medicine, pediatrician, obstetrician, gynecologist or obstetrician/gynecologist.

Sub-acute care - A level of care for patients requiring some support services but not requiring the intensity of services of a hospital.

Subrogation - The substitution of one person for another who has a legal claim or right.

Subscriber - The person who is eligible for coverage under this health benefit plan due to employment or association membership and who is enrolled for coverage.

Surgery - The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures.

- The correction of fractures and dislocations
- Usual and related pre-operative and post-operative care
- Other procedures as reasonable and approved by BCBSNC

Transplants - The surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive surgery are not considered to be transplants.

UB-04 claim form - Institutional claim form which uses revenue codes to indicate procedures rendered for a member.

Underwriting - The process by which an insurer determines if, and on what basis, an application for insurance will be accepted.



Urgent care - Services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Examples of urgent care include sprains, some lacerations and dizziness.

VRU - The VRU system is a voice response front end application that allows callers to access policy information and make selective changes to their policies (e.g., address, phone number, new ID cards and claim forms). Callers can also check eligibility, claims and payment status for their individual accounts.

Waiting period - See pre-existing condition.

We - BCBSNC will also be referred to as “we” or “us.”

Workers’ compensation - Insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured on the job, and to pay benefits to dependents of employees killed in the course of or in circumstances arising from their employment.

Class action settlement agreement (settlement)





24.1 Definitions applicable only to this chapter 24

24.1.1 Billing dispute reviewer

Billing dispute reviewer shall have the meaning assigned to that term in the settlement.

24.1.2 Billing dispute

Billing dispute shall have the meaning assigned to that term in the settlement.

24.1.3 Independent review organization

Independent review organization shall have the meaning assigned to that term in the settlement.

24.1.4 Physician

Physician shall have the meaning assigned to that term in the settlement.

24.1.5 Physician group

Physician group shall have the meaning assigned to that term in the settlement.

24.1.6 Physician organizations

Physician organizations shall have the meaning assigned to that term in the settlement.

24.1.7 Settlement

Settlement means *Love, et al. v. Blue Cross Blue Shield Association, et al.*, (formerly *Thomas et al. v. Blue Cross Blue Shield Association, et al.*), Civil Action No. CV-03-21296-MORENO/ SIMONTON in the United States District Court for the Southern District of Florida, Miami Division.

24.1.8 Termination date

Termination date shall have the meaning assigned to that term in the settlement.

24.1.9 Participating physician

Thomas settlement definition "1.79."

24.2 Applicability of this chapter 24

Unless otherwise specified, the provisions of this chapter twenty-four apply only to physicians, physician groups, and physician organizations, shall commence once a billing dispute reviewer has been selected, and shall expire upon the termination date.

24.2.1 Conflicts between this chapter 24 and other sections of this e-manual

In the event of a conflict between term(s) in this chapter twenty-four and any other chapter of this e-manual, the term(s) of this chapter twenty-four shall supersede such conflicting term(s) until the termination date.

24.3 Process for submitting a post-service level II provider appeal

The level II post-service provider appeal request should clearly identify the issue that is in dispute and rationale for the appeal. Demographic information including subscriber name, patient name, patient BCBSNC ID number, provider name, and provider ID number should also be included with any request for appeal. Level II post-service provider appeals require a filing fee to be submitted before the review can begin. Providers may reduce administrative cost associated with records submission by first verifying that the record document information is consistent with BCBSNC medical policy, payment policy and clinical edit clarification guidelines.

A physician, physician group, or physician organization may file a level II post-service provider appeal if an adverse determination was given on a level I post-service provider appeal billing dispute or medical necessity denial, as described below.

Level II post-service provider appeal for billing disputes:

The BCBSNC billing dispute resolution process is available to resolve disputes over the application of coding and payment rules and methodologies to specific patients.

Physicians, physician groups, or physician organizations must submit a written request for level II post-service provider billing dispute appeal within ninety (90) calendar days of the date of the level I post-service provider appeal denial letter.



Physicians, physician groups, or physician organizations must exhaust BCBSNC's level I post-service provider appeal process before submitting a level II post-service provider appeal. A physician, physician group, or physician organization is deemed to have exhausted BCBSNC's level I post-service provider appeal process if BCBSNC does not communicate a decision within thirty (30) calendar days of BCBSNC's receipt of all documentation reasonably needed to make a determination on the level I post-service provider appeal.

You may access BCBSNC's pricing and adjudication principles for professional providers at:

https://www.bcbsnc.com/services/medicalpolicy/pdf/pricing_and_adjudication_principles_for_professional_providers.pdf.

If a physician, physician group, or physician organization's level I post-service provider appeal was completed by BCBSNC prior to November 21, 2008, and level II post-service provider appeal rights are available, physicians, physician groups, and physician organizations will have 90 calendar days from November 21, 2008 to submit a Level II post-service provider appeal.

Requests for level II post-service provider appeals may relate to the following issues:

- Integral part of a primary service
- Mutually exclusive services
- Services not eligible for separate reimbursement
- Incidental procedures denials
- Surgical global period denials

Physicians, physician groups, or physician organizations should contact MES Solutions directly to submit a level II post-service provider appeal for a billing dispute.

Mailing address:

MES Solutions
BDRP Department
100 Morse Street
Norwood, MA 02062

Phone: **800-437-8583** • Fax: **888-868-2087**

www.mesgroup.com

The level II provider appeal requests for billing disputes administered by an independent review organization, will be reviewed based on the information previously submitted with the level I provider appeal. BCBSNC will supply all documentation from the level I provider appeal to the billing dispute reviewer. For additional questions, please contact MES Solutions directly.

Level II post-service provider appeal for medical necessity:

Level II post-service provider appeals are available to physicians, physician groups, and physician organizations to resolve disputes over the denial of investigational, experimental, cosmetic, and medical necessity determinations based on medical policy.

Physicians, physician groups, or physician organizations must submit a written request for a level II post-service provider medical necessity appeal within sixty (60) calendar days of the date of the level I post-service provider appeal denial letter. Physicians, physician groups, or physician organizations must exhaust BCBSNC level I post-service provider appeal process before submitting a level II post-service provider appeal.

You may access BCBSNC's medical policy at:

<http://www.bcbsnc.com/services/medical-policy>.

If a physician, physician group, or physician organization's level I post-service provider appeal was completed by BCBSNC prior to November 21, 2008, and level II post-service provider appeal rights are available, physicians, physician groups, and physician organizations will have 90 calendar days from November 21, 2008 to submit a level II post-service provider appeal.

Physicians, physician groups, or physician organizations should contact MES Solutions directly to submit a level II post-service provider appeal for medical necessity.

Mailing Address:

MES Solutions
Love Settlement Department
100 Morse Street
Norwood, MA 02062

Phone: **800-437-8583** • Fax: **888-868-2087**

www.mesgroup.com



24.4 Filing fee matrix

Billing dispute	
Amount of dispute	Filing fee calculation
\$1000 or less	Filing fee shall be equal to \$50
Greater than \$1000	Filing fee shall be equal to \$50 plus 5% of the amount by which the amount in dispute exceeds \$1000 but in no event shall the fee be greater than 50% of the cost of the review.

Medical necessity dispute	
Amount of dispute	Filing fee calculation
\$1000 or less	Filing fee shall be equal to \$50
Greater than \$1000	Filing fee shall be equal to \$250

Note: For level II post-service provider appeals related to billing disputes, the disputed amount must exceed \$500.00. In instances where the disputed amount is less than \$500, the physician, physician group, or physician organization may submit similar disputes to the independent review organization within one (1) year of the original submission date. If the physician, physician group, or physician organization intends to submit additional similar disputes during the year, the physician must contact the billing dispute reviewer to notify that additional similar submissions will be sent. If the 1 year lapses and the disputes submitted are not in excess of \$500 in the aggregate, the original dispute will be dismissed.

The filing fee will be refunded in the event that the physician, physician group, or physician organization prevails in the level II post-service appeal process.

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