



Network News

A newsletter for contracting physicians, hospitals, pharmacies and other health care professionals

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www.bcbsok.com

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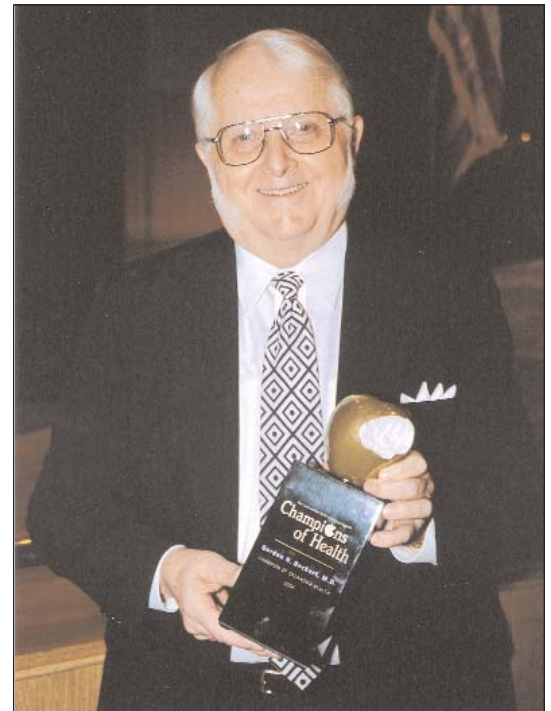
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Dr. Gordon Deckert chosen Oklahoma's Champion of Health

State Board of Health member Dr. Gordon H. Deckert was chosen as the Champion of Oklahoma Health, the highest recognition in the Champions Health Awards. Deckert was selected from more than 300 individuals and organizations nominated for their efforts to improve Oklahoma's health status.

Deckert was chosen for his visible, sustained leadership on state public health issues. He led the effort to create the Oklahoma State Department of Health's State of the State's Health Report, an annual health report card for the state. Produced since 1996, the report compiles statistics and other data about state health concerns, ranging from tobacco usage to obesity.

The Champions of Health awards are sponsored by Blue Cross and Blue Shield of Oklahoma, the Oklahoma State Department of Health, the Oklahoma Hospital Association, the Oklahoma



Dr. Gordon H. Deckert was chosen from more than 300 nominations as Champion of Oklahoma Health. He was recognized at the inaugural event Oct. 27.

Osteopathic Association, the Oklahoma State Medical Association and its Physicians' Campaign for a Healthier Oklahoma.



BlueCross BlueShield
of Oklahoma

A Member of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.

New ID cards set for 2005

All Blue Cross and Blue Shield of Oklahoma members will receive new ID cards - with a new ID number after Jan. 1, 2005.

The member number previously used was the member's social security number, with the addition of three letters at the beginning. The new ID cards will not include the member's social security number anywhere.

The change in ID numbers is being made to comply with a new Oklahoma law that prohibits certain uses of the social security number by an

employing entity. Since most health insurance policies are issued through employers to their employees, Blue Cross and Blue Shield of Oklahoma is changing the ID numbering system for all health plan members, including individual members with Health Check, Plan65 and similar plans.

The company will continue to collect social security numbers from members at enrollment for other business purposes.

Tier II medications can save members money at the pharmacy

We are committed to providing members with information that may lower prescription costs. To help with that effort, the Pharmacy and Therapeutics (P&T) Committee, made up of local physicians and pharmacists and Blue Cross and Blue Shield of Oklahoma medical personnel, has developed a three-tier formulary. Medicines on Tier II (preferred brand) of the formulary will have lower copayments than those on Tier III (brand).

The P&T Committee recently added Protonix® and Aciphex® (erosive gastroesophageal reflux disease medications) to Tier II of the formulary. Choosing these medications when writing prescriptions can help your patients save money at the pharmacy.

Other medicines in this class, such as Prevacid®, Prilosec® or Nexium®, are Tier III formulary medications and will have the highest copay-

ment. If your patient takes one of these medications, Protonix or Aciphex may be an alternative.

A coupon for your patient's first prescription of Protonix or Aciphex is available at www.bcbsok.com. Just click on the "Prescription Drug Information" link to download your coupon.

Also, beginning Oct. 1, 2004, members submitting claims for the Tier III erosive gastroesophageal reflux disease medicines will need prior authorization before the prescription may be filled, unless they have used the medication within the past 24 months. If you and your patient decide on a Tier III medication, please submit the request for authorization.

For more information on the three-tier formulary, visit www.bcbsok.com, or call the customer service phone number listed on the member's ID card.

To expedite processing, specify what has changed when submitting corrected claims

When submitting a corrected claim, mark the claim "corrected" and in black ink indicate exactly what information has changed.

When a corrected claim arrives at Blue Cross and Blue Shield of Oklahoma, if it is not clear

what has been corrected, the claims examiner may need to contact the provider to verify the information that has changed.

Including the information with the corrected claims can expedite processing and payment.

HIPAA News: National provider identifier (NPI) on the horizon

Beginning May 2005, the Centers for Medicare and Medicaid Services will begin issuing National Provider Identifiers (NPI) to several million health care providers.

The NPI will serve as the replacement for all other health care provider identifiers used in standard transactions that are regulated by the Health Insurance Portability and Accountability Act (HIPAA). The deadline for mandated NPI assignment and use is May 23, 2007.

The increasing "identity theft" crisis has raised awareness of the need to protect the providers' social security number and other

identifiers currently being used.

With the NPI, each provider who files claims electronically will be issued a unique identity. The NPI also will provide a consistent and permanent way to associate the health care provider with his or her identity. Providers may request an NPI beginning May 23, 2005.

After implementation of the NPI system, it will no longer be necessary for providers to use different identifiers for the various health plans they bill, which will simplify the billing process.

Visit <http://questions.cms.hhs.gov> for more information.

Business associate agreement necessary when doing business with collection agency

When a provider uses the services of a collection agency to contact Blue Cross and Blue Shield of Oklahoma on their behalf, Blue Cross and Blue Shield must have a copy of the collection agency's business associate agreement. This is required by the Health Insurance Portability and Accountability Act (HIPAA).

Due to HIPAA regulations, Blue Cross and

Blue Shield cannot provide information to a collection agency without the agreement, because the agency is considered a "third party."

The provider also may forward a letter, on business letterhead, stating the provider has a business associate agreement with the agency.

For more information, contact your provider relations consultant.

Blue Cross and Blue Shield to administer benefits for State Farm employees

Effective Jan. 1, 2005, Blue Cross and Blue Shield of Illinois will administer the State Farm Insurance Companies' group medical PPO plan. There are more than 2,500 State Farm employees in Oklahoma.

The group medical plan is only offered to State Farm associates (employees, agents and retirees) and not to the general public.

The administration of the State Farm group medical plan does NOT include medical policies sold as a line of business by State Farm agents.

The member ID card, issued by Blue Cross and Blue Shield of Illinois, will include the standard "PPO in a suitcase" logo and the alpha prefix "SFZ."

Please submit claims for these members to Blue Cross and Blue Shield of Oklahoma for processing through the BlueCard® program.

For more information, call the customer service phone number listed on the back of the member's ID card, or contact your provider relations consultant.

BlueLincs HMO affirms member rights and responsibilities

BlueLincs HMO is pleased to serve our members and provide the quality health care benefits our members need and deserve.

As with any health insurance plan, and particularly a Health Maintenance Organization, the member has certain rights and responsibilities.

The following information can also be found in the BlueLincs Member Handbook and is communicated to members in the member newsletter, *Member News*.

- ◆ The right to receive information about BlueLincs HMO, its services, its practitioners and providers, and members' rights and responsibilities.
- ◆ The right to receive or have arranged by the HMO or HMO Provider all medically necessary care covered under the member's benefit package.
- ◆ The right to considerate and courteous care with respect for personal privacy.
- ◆ The right to be informed in clear, understandable language about diagnosis, treatment options and prognosis.
- ◆ The right to be involved in decision making concerning treatment.
- ◆ The right to candid discussion of appropriate or medically necessary treatment options for conditions regardless of cost or benefit coverage.
- ◆ The right to confidentiality of information concerning treatment.
- ◆ The right to know the identity of all persons involved in care.
- ◆ The right to refuse treatment and to be told of the medical consequences.
- ◆ The right to be informed of research projects involving care and the right to refuse participation in them.
- ◆ The right to file a complaint or grievance and be given due process.
- ◆ The responsibility to work with the Primary Care Physician in maintaining a satisfactory physician-patient relationship.
- ◆ The responsibility to contact the Primary Care Physician for authorization of care when the member chooses to use HMO benefits.
- ◆ The responsibility to comply with the prescribed medical treatment.
- ◆ The responsibility to provide complete health status information for accurate diagnosis and appropriate treatment.
- ◆ The responsibility to keep appointments for care and give required cancellation notice.
- ◆ The responsibility to read and understand all materials concerning the health benefits.
- ◆ The responsibility to notify the employer and BlueLincs HMO of any other group coverage, and to cooperate with BlueLincs HMO in its coordination of benefits efforts.
- ◆ The responsibility to pay any required portion of the premium, as well as copayment amounts required under HMO benefits coverage.
- ◆ The responsibility to call BlueLincs HMO whenever the member is unsure of procedures or covered benefits (1-800-580-6202).

If you have any questions or need more information, please call the customer service phone number listed on the member ID card, visit www.bcbsok.com, or contact your health industry relations consultant.

URAC Core Standard 35

What you need to know about BlueCard claims filing

The BlueCard program makes filing claims easy

BlueCard is a national program that enables Blue Cross and Blue Shield Plan members to obtain health care services while traveling or living in another Blue Plan's service area.

The program links participating health care providers with all the Blue Plans across the nation through a single electronic network for claims processing and reimbursement.

Additionally, the program links providers in more than 200 countries and territories worldwide.

The program allows Oklahoma providers to conveniently submit claims for patients from other Blue Plans, either domestic or international, to the Oklahoma Blue Plan.

For the Oklahoma provider's convenience, the Oklahoma Blue Plan is the provider's single contact for all claims payments, customer service issues and adjustments — for BlueCard and out-of-area claims.

How to identify members

- ◆ BlueCard members have a three-character alpha prefix at the beginning of their member ID number. The alpha prefix is key to facilitating prompt payment
- ◆ The member ID number is a combination of alpha and numeric characters.

Important facts about the alpha prefix

- ◆ The alpha prefix on the member ID card is key to facilitating prompt payment and is always three alpha characters.
- ◆ It is used to identify and correctly route claims and confirm a patient's membership and coverage.
- ◆ It is critical for the electronic routing of specific Health Insurance Portability and

Accountability Act (HIPAA) transactions to the appropriate Blue Plan.

- ◆ It is important to not make up alpha prefixes or change any part of the member's ID number.

Helpful tips concerning member IDs

- ◆ Do not assume that the member's ID number is the Social Security number.
- ◆ Be sure that all your system upgrades accommodate the alpha prefix and all subsequent characters, up to 17 positions total.
- ◆ Some member ID numbers may include alphabetic characters in other positions following the alpha prefix, while others may be fewer than 17 positions.
- ◆ Do not add or delete characters or numbers within the member ID number.
- ◆ Do not change the sequence of the characters following the alpha prefix.
- ◆ Please make copies of the front and back of the ID card, and pass this information to your billing staff.

It's easy to file claims for BlueCard members

- ◆ Ask for the current member ID card.
- ◆ Check benefits and eligibility by calling 1-800-676-BLUE (2583) and provide the alpha prefix, or use electronic capabilities.
- ◆ Submit the claim to Blue Cross and Blue Shield of Oklahoma. For faster processing, please submit your claims electronically.

Please do not request full payment from the member upfront. To check claim status, call Blue Cross and Blue Shield of Oklahoma. For more information, contact your health industry relations provider consultant.

Health plans to cover ADD/ADHD drugs for children and teens

Effective Jan. 1, 2005, all Blue Cross and Blue Shield of Oklahoma and BlueLincs health plans will cover medications for the treatment of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (ADD/ADHD) for members 19 years of age and younger.

Blue Cross and Blue Shield of Oklahoma and BlueLincs also will cover routine office visits for the prescribing physician. The member's copayment will apply.

Prescribing generic medications helps minimize out-of-pocket prescription drug costs for members. When a generic is not available, physicians can help members save by choosing pre-

ferred brand name drugs, including Adderall XR, Concerta or Ritalin LA.

Prescriptions for non-preferred brand-name drugs may be covered if the member has received previous treatment (30-day minimum) within the past 24 months with a preferred ADD/ADHD drug or if the member's physician provides records documenting medical necessity (based upon the health plans' approved criteria).

Benefit plans vary by contract. For more information on specific benefits, please call the customer service phone number listed on the member's ID card.

Retired physicians re-entering practice must go through credentialing process

When a retired physician re-enters medicine, the physician must go through a review process of the applicant's current ability to practice medicine. To ascertain current clinical competency, the Credentialing Committee reviews recent medical education activities.

If a physician has not practiced for a signifi-

cant amount of time, he or she may wish to consider a preceptor-like or residency-like program to refresh clinical skills and become acquainted with recent pharmacotherapies.

For more information, contact Dr. Robert McCullough, at (918) 631-6670 or by e-mail at rmccullough@bcbsok.com.

Paper claims change effective Jan. 1, 2005

Blue Cross and Blue Shield of Oklahoma often receives claims that are illegible and require a significant amount of manual intervention.

If you are currently submitting paper claims and your claims have been received with light print or with information that is difficult to interpret, you have probably received a courtesy notification from your provider relations representative.

We are unable to continue manually inputting these claims that cannot be interpreted and scanned by our systems for processing.

Effective Jan. 1, 2005 claims that are illegible will be returned to providers for resubmission. If this occurs, please resubmit the claim on the original "red" claim form with dark, easy to read print. If you have questions, please contact your provider relations representative.

Compound medications not a covered benefit for members

Blue Cross and Blue Shield of Oklahoma does not cover compound medications for fully-insured members, effective Jan. 1, 2004.

Compound medications are those that are made by mixing or reconstituting substances in a manner not approved by the Food and Drug Administration (FDA).

Blue Cross and Blue Shield of Oklahoma covers most medications that are approved by the FDA. Compound medications do not go through the FDA approval process, therefore are not FDA-approved. *There are some self-funded groups administered by Custom Group Services that may provide benefits for compound medications.*

Physician ID required when filing claims

Many employer groups are asking for additional information on pharmacy expenses.

To accommodate groups, Blue Cross and Blue Shield is asking pharmacists to complete the doctor identification field when submitting claims.

The doctor identification number is the same as the Oklahoma Medicaid number for BlueLincs members. For Blue Cross and Blue Shield members, the Oklahoma Medicaid or physicians' DEA number will be accepted.

Prescription quantity limits apply to most plans

Most Blue Cross and Blue Shield of Oklahoma plans with prescription benefits have limits placed on the days supplied or quantity dispensed. For one copayment, most plans have a 30-34 day supply limit or 100-102 quantity

dispensed dose limit.

For maintenance prescriptions, there is a 90-102 day limit or a 300-306 quantity dispensed limit. If a claim is rejected due to quantity limits, resubmit the claim with a lower supply.

Drug Formulary Update

The prescription drug formulary is updated quarterly and applies to members with prescription drug cards with copayments.

Removed from Tier 2

Alphagan
Atrovent — all strengths except the inhaler
Cyclessa
Declomycin
Fem HRT
Glucotrol XL
Lotensin

Macrobid
Mircette
Ortho-tricyclen
Purinethol
Terazol 3
Voltaren
Voltaren XR
Zaroxolyn
Added to Tier 2
Activella
Caduet
Avodart
Requip

Added to Tier 3

Namenda
Synthroid
Accupril
Diflucan
Oxycontin 80 mg ext release
Accuretic
Miralex
Golytely
Ciloxan solution
Metrocream
Ocuflox
Uniphyl

Hospital News

Blue Cross and Blue Shield encourages hospitals to complete the Leapfrog survey

The Blue Cross and Blue Shield Association and Blue Cross and Blue Shield of Oklahoma are encouraging Oklahoma hospitals to participate in the Leapfrog patient safety initiatives and complete and return the Leapfrog survey the hospital received.

A leading group of Fortune 500 companies and other large health care purchasers founded "The Leapfrog Group" by creating and committing to a common set of principles to drive leaps in patient safety.

The group's goal is to initiate improvements in safety and overall value of health care to American consumers.

Hospitals already are taking important steps to ensure patients' safety. Based on scientific evidence, Leapfrog Group focuses on three practices with the potential to save lives by reducing preventable mistakes in hospitals. The three practices include:

- ◆ Computerized prescriptions in hospitals
- ◆ For certain elective procedures and treatments, guiding patients to hospitals and clinical teams that are more likely to produce better outcomes
- ◆ Hospital ICU care managed or co-managed by a physician certified in critical care medicine.

For more information about The Leapfrog Group, visit www.leapfroggroup.org.

Dr. Gordon H. Deckert chosen as Oklahoma's Champion of Health

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