Preparing for Health Care Reform:
WHAT YOU NEED TO KNOW ABOUT VERISK HEALTH MEDICAL RECORDS RETRIEVAL

In the May issue of Provider Bulletin, we explained the need for accurate coding and medical record documentation and how it relates to risk adjustment. As you know, we will be responsible to provide this information to the Department of Health and Human Services (HHS), as required under the federal Health Care Reform law.

Starting January 1, 2014, Blue Plans have enlisted the help of Verisk Health to retrieve medical records for out-of-area Blue members or from providers in other Plans’ service areas, to support HEDIS, risk adjustment and government-required programs related to Health Care Reform.

Effective medical record retrieval services play a fundamental role in quality reporting outcomes and ensuring appropriate risk scores. Verisk Health will provide an efficient centralized process to coordinate medical record requests from Blue Cross® and/or Blue Shield® companies across the country and help reduce multiple requests for patient data.

As outlined in your contract, you are required to respond to requests in support of risk adjustment, HEDIS and other government-required activities within the requested timeframe. This includes requests from Verisk Health on our behalf. We are working diligently to make this process as simple as possible for you.

FOR YOUR CONVENIENCE, YOUR MEDICAL RECORDS MAY BE SUBMITTED TO VERISK HEALTH IN THE FOLLOWING WAYS:

• Upload the record’s image to our secure portal at www.submitrecords.com; enter your secure password “bcbsa89” and select the files to be uploaded.

• Via secure fax to 1.888.231.9601.

• If the above options are not possible for your office, please contact Verisk Health directly at 1.877.489.8437 to discuss retrieval options.

HIPAA/PRIVACY

Verisk Health is contractually bound to preserve the confidentiality of health plan members’ protected health information (PHI) obtained from medical records, according to HIPAA regulations. Please note that patient-authorized information releases are not required in order for you to comply with these requests for medical records.

As per Federal Regulation, providers are permitted to disclose PHI to health plans without authorization from the patient when both the provider and health plan had a relationship with the patient and the information relates to the relationship [45 CFR 164.506(c)(4)]. For more information about privacy rule language, please visit the HHS website at: www.hhs.gov/ocr/privacy.

Blue Cross of Northeastern Pennsylvania provides medical record retrieval with administrative assistance from Verisk Health, part of the Verisk Analytics Family of Companies, an independent health care risk management company not affiliated with the Blue Cross and Blue Shield Association.

(Revenue Update 1510001)
Important Pharmacy Benefit Information to Help You

We would like to remind you that all prior authorization requests for any medications, including both self-administered and non-self-administered injections, should be directed to the Pharmacy Management department.

If you are prescribing an injectable medication or any other medication, please check the Utilization Management criteria online at www.bcnepa.com under “Rx Drug Benefits” to review any prior authorization coverage criteria.

To request prior authorization, please complete a Prior Authorization Form and fax it to 1.866.754.0370. You can also obtain this form online at www.bcnepa.com under the “Pharmacy Related Forms” link at the “Rx Drug Benefits” page, or by calling the Pharmacy Management department at the number noted below.

Once adequate documentation is received from the requesting provider, a decision is rendered within 48 hours and communicated to the provider.

FOR MORE INFORMATION:

• The Pharmacy Management department can be reached by phone weekdays, between 8 a.m. and 5 p.m., at 1.800.722.4062.

• Also, pharmacy benefit information, including the formulary, related instructions and formulary updates, can be found online at www.bcnepa.com under “Rx Drug Benefits.”

• Formulary updates are done quarterly throughout the year. In addition to our website, formulary updates can be found here in the Provider Bulletin or at Epocrates online at www.epocrates.com.

Administrative Practice Guideline Update

THE FOLLOWING ADMINISTRATIVE PRACTICE GUIDELINE WAS UPDATED, EFFECTIVE AUGUST 20, 2013, WITH THE STATED REVISIONS:

Cardiac Stress Testing (CST) and/or Holter Monitoring as Special Billable Procedures

THE CHANGES INCLUDE THE FOLLOWING SPECIFIC LANGUAGE:

The following are available in the office location at all times:

- Ambu bag
- Oral airways
  • Calibrated defibrillator or AED
  • Banyon kit or:
    - Nitroglycerin
    - 50% glucose
    - Lidocaine
    - Atropine
    - Epinephrine
    - Chewable aspirin, 325 mg
    - IV set-up
    - Oxygen and equipment
    - BP cuff and scope

The requirement for Lasix and Sodium Bicarbonate has been removed and chewable aspirin 325 mg added.

Administrative Practice Guidelines are available under the “Provider” tab at www.bcnepa.com or accessible via the web-based NaviNet system. Just click on the Provider Homepage then choose the “Quality Management” tab and click the “Quality Management Practice Guidelines” tab. If you are unable to access the web-based guidelines and would like to request a copy of the guidelines, please call Jennifer Reese at 570.200.4382, weekdays, between 8 a.m. and 5 p.m.

Save The Date!

For Upcoming Provider Webinar

On Wednesday, December 11, 2013, Blue Cross of Northeastern Pennsylvania (BCNEPA), Highmark Blue Shield (HBS), First Priority Life Insurance Company® (FPLIC) and First Priority Health® (FPH) will host an informational seminar from 10 a.m. until 12 p.m. Mark your calendar now and plan to join us for this interesting and informative session. The agenda will include:

• Health Plan Updates (BCNEPA, HBS, FPLIC and FPH)
• ICD-10 Updates
• Health Care Reform
• Medical Management
• Product Updates

A finalized agenda and a registration form will be included in the November issue of the Provider Bulletin. Please mark your calendar now and plan to join us on December 11th.
NEW MEDICARE ADVANTAGE MEDICAL POLICIES
This bulletin serves as formal notification to facility providers of 6 Highmark Blue Shield Medicare Advantage medical policies that will apply to them as of October 14, 2013.

BACKGROUND/OVERVIEW
Highmark Blue Shield will begin to apply the following Medicare Advantage medical policies to outpatient services provided by a facility to Freedom Blue PPO members on the policies’ October 14, 2013 issue date.

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Topic</th>
<th>Effective Date</th>
<th>Issue Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>R-13</td>
<td>Radiation Therapy Services (LCD L27515)</td>
<td>August 1, 2012</td>
<td>October 14, 2013</td>
</tr>
<tr>
<td>R-14</td>
<td>Stereotactic Body Radiation Therapy</td>
<td>November 28, 2012</td>
<td>October 14, 2013</td>
</tr>
<tr>
<td>R-15</td>
<td>PET and PET/CT Scans Used for Non-Oncologic Conditions (Article A47551)</td>
<td>October 1, 2011</td>
<td>October 14, 2013</td>
</tr>
<tr>
<td>R-16</td>
<td>PET and PET/CT Scans Used for Oncologic Conditions (Article A49325)</td>
<td>June 13, 2012</td>
<td>October 14, 2013</td>
</tr>
<tr>
<td>R-18</td>
<td>Proton Beam Therapy (LCD L30314)</td>
<td>October 1, 2011</td>
<td>October 14, 2013</td>
</tr>
<tr>
<td>R-21</td>
<td>Stereotactic Radiosurgery (LCD L32057)</td>
<td>October 27, 2011</td>
<td>October 14, 2013</td>
</tr>
</tbody>
</table>

Please review the April 10, 2013 bulletin, MAPROV-2013-002-C, for more information about Highmark Blue Shield’s application of its Medicare Advantage medical policies to facilities. The bulletin defines the policy effective date and issue date, and describes what happens if the medical necessity criteria of the Medicare Advantage medical policy are not met.

IMPACT/ACTION
Providers should familiarize themselves with the requirements of the applicable Highmark Blue Shield Medicare Advantage medical policies in the table. Please make whatever changes are necessary to comply with the specific medical policy guidelines.

HOW TO ACCESS MEDICARE ADVANTAGE MEDICAL POLICIES
To access a particular medical policy from NaviNet, click the “Medical & Claims Payment Guidelines” link from the Provider Resource Center, then click the “Medical Policy” link. Next, click the “Medicare Advantage Medical Policy” link, then click the Medicare Advantage Policy Search link. Begin your search using the appropriate search options.

TIMEFRAME
Highmark Blue Shield will apply the Medicare Advantage medical policies listed in this bulletin to facility providers on the October 14, 2013 issue date.

Questions?
Please contact the Highmark Blue Shield Provider Service Center (Freedom Blue PPO unit) at 1.866.588.6967 if you have questions about this bulletin.

Eligibility, benefits, claim status or authorizations
For inquiries about eligibility, benefits, claim status or authorizations, Highmark Blue Shield encourages providers to use the electronic resources available to them—NaviNet and the applicable HIPAA transactions—before calling the Provider Service Center.
ICD-10 Overview: What Does It Mean to You?

BCNEPA is planning for implementation of the HIPAA 5010 and ICD-10 regulations that take effect October 1, 2014. You should be aware of these regulations and the impact they will have on your claims submissions and electronic transactions with payers. We will continuously update you on our implementation plans as well as impacts, changes and timeframes essential for compliance with both HIPAA 5010 and ICD-10.

Centers for Medicare & Medicaid Services (CMS) Federal rule requires that ICD-10 diagnosis and procedure codes replace ICD-9 codes for services, starting October 1, 2014. Highlights of the ICD-10 regulation include:

- Number of diagnosis codes increases from 13,000 to 68,000; size increases to up to 7 alphanumeric characters. (ICD-10 diagnosis codes apply to professional & institutional claims.)
- Number of procedure codes increases from 3,000 to 87,000; size increases to 7 alphanumeric characters. (ICD-10 procedure codes used for institutional claims only.)
- HCPCS/CPT procedure codes are not impacted.

HOW DOES THIS AFFECT YOUR OFFICE?

This increase in codes could impact provider coding productivity, benefit-driven, present-on-admission and unspecified codes as well as date-span billing before or after the October 1, 2014 effective date.

We will explore these topics and others as we continue to update our ICD-10 website at www.bcnepa.com and Provider Bulletin newsletter regarding the status of HIPAA 5010 and ICD-10 implementation.

In addition, please work with your vendor/clearinghouse and share all pertinent HIPAA 5010 and ICD-10 information accordingly.

The October 1, 2014 ICD-10 compliance date is not far off. So if you haven’t done so already, contact your practice management system vendor to establish a comprehensive strategy to successfully transition to the October 1, 2014 ICD-10 compliance date.

PCP/Specialist Criteria for Initial and Continuing Participation Changes

The following changes were made to the FPH criteria for initial and continuing-participation primary care physician and specialist physician:

Section B Eligibility—These paragraphs were updated to accommodate the new criteria for board eligibility. The ABMS and AOA made changes to the eligibility requirements and we have adopted their changes. The last 3 pages of the updated full criteria define the changes.

These criteria changes are effective November 1, 2013. The full FPH criteria for initial and continuing-participation primary care physician and specialist physician are available upon request from your Provider Relations Consultant.
Beginning **January 1, 2014**, the following services will require prior authorization:

<table>
<thead>
<tr>
<th>Services</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uvulopalatopharyngoplasty (UPPP)</td>
<td>42145</td>
</tr>
<tr>
<td>CPAP Therapy</td>
<td>E0601</td>
</tr>
<tr>
<td>Reduction Mammaplasty <em>(If benefit is available)</em></td>
<td>19318</td>
</tr>
<tr>
<td>Proton Beam Radiation Therapy</td>
<td>77520, 77522, 77523, 77525</td>
</tr>
</tbody>
</table>

Beginning in the **spring of 2014**, the following services will require prior authorization:

<table>
<thead>
<tr>
<th>Services</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Fusion</td>
<td>20936, 20937, 20938, 22532, 22533, 22534, 22558, 22585, 22586, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 81.00, 81.01, 81.02, 81.03, 81.04, 81.05, 81.06, 81.07, 81.08, 81.62, 81.63, 81.64</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>27447</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>27130, 81.51</td>
</tr>
</tbody>
</table>

The prior authorization requirements will apply to all FPH and FPLIC products. Please check future editions of the *Provider Bulletin* for more details about new prior authorization requirements.

**Regionalization of Utilization Management Staff**

BCNEPA continually analyzes opportunities to enhance and improve services to our members and providers. In an effort to provide optimal service, the Utilization Management (UM) department will be adopting a regional model, in which teams of staff members will be assigned to the various regions that BCNEPA services. This will allow for our staff to better serve the specific needs of each region and assist in delivering the best possible care to our members.

**Consolidating FOCUS Pac/Prior Authorization Requirements Listings**

In an effort to streamline our Utilization Management documents and increase their ease of use for you, we have consolidated our FOCUS Pac/prior authorization requirement lists and authorization grids. You will notice now that there are only 3 documents: 1 for all FPH plans, 1 for all FPLIC plans and 1 for the Special Care plan.

You can view these lists on the Provider Resources & Tools website at [www.bcnepa.com](http://www.bcnepa.com), under the “Reference Materials” link. Please note that there are no changes to the requirements on these lists; only the formatting has changed. We will continue to update these listings as prior authorization requirements change.
Important Update:

Discharge Planning Process

As mentioned in previous editions of the Provider Bulletin, the Utilization Management department is partnering with our Case Management department to implement a member outreach program designed to assist select members with transition of care. This program is designed to ensure a safe and successful discharge plan and appropriate follow-up care for our members. This will also allow us to collaborate with you to improve overall patient outcomes and assist in reducing the number of patient readmissions.

The UM department will take an active role in managing the discharge planning process to help transition our members’ care and send referrals to Case Management/Disease Management, as needed. Beginning in January 2014, we will also be coordinating referring members, as appropriate, to behavioral health case management. It is our additional intent to further assist our hospital partners in reducing their readmission rates through this program.

In order to best support our members through transitions in care, we’d like to remind you it is very important that discharge information includes a copy of member discharge orders, medications, durable medical equipment, home health, follow-up appointments and/or other directives for the discharged patient.

We will be implementing this transitional care program potentially as early as fourth quarter, 2013. Please check future editions of the Provider Bulletin for more information regarding this initiative. If you should prefer, we would be happy to schedule a teleconference call to review this new program with you, by calling Jill Sikorski, administrative assistant for Medical Management, at 570.200.4376. Thank you for your continued cooperation with our efforts to provide high quality care to our members.

National Imaging Associates (NIA)'s Authorization Process for Expedited Urgent Requests

NIA has helped thousands of BCNEPA members receive clinically appropriate imaging studies, ensuring that they avoid unnecessary exposure to harmful radiation.

In order for NIA to properly recognize an urgent or emergent situation, we need to be aware of the member’s specific clinical situation and the indications described must meet the definition of an urgent or emergent condition. We encourage providers to contact us by phone to initiate an expedited prior authorization request:

- FPH HMO/CHIP 1.800.962.5353
- FPLIC Traditional 1.800.638.0505
- FPLIC PPO 1.866.262.5623
- FPLIC EPO 1.888.345.2360

When contacting NIA, please be prepared to provide clinical details that would justify an expedited review:

- Symptoms and their duration
- Physical exam findings
- Treatments or procedures already completed

EXPEDITED/URGENT REVIEW PROCESS

The expedited/urgent review process is intended for the evaluation of a condition that requires prompt medical intervention to prevent additional consequences to the health/wellbeing of the member. Conditions that demonstrate a requirement for prompt medical attention include, but are not limited to:

- Any condition that cannot be postponed for a period of time (24 hours) without risking progression to an emergent condition
- Any condition that cannot be postponed for a period of time (24 hours) without risking loss of life, limb or permanent disability
- Any condition that, in the opinion of a doctor 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 case

If you find that your office has training needs related to any aspect of the outpatient imaging management program for BCNEPA members, or if your office needs help with the authorization process, please feel free to contact your local NIA Provider Relations Manager, Lori A. Fink, at 410.953.2621 or at Lafink@magellanhealth.com.
Electronic Remittance Advices Reminder

Our Electronic Data Interchange (EDI) department has been receiving requests from clearinghouses to re-post Electronic Remittance Advices (ERAs). The majority of the requests are for ERAs with posting dates of, for example, May 1, June 1, July 1, August 1, etc. Payments with dates on the first of the month are most likely capitation checks. Capitation checks are always generated on the first of the month. ERAs are not generated for capitation payments.

The ERAs are distributed every Wednesday for FPH and FPLIC. On some occasions the ERAs can be issued on the first of the month if the first is on a Wednesday.

The HEDIS Homepage will add the following HEDIS measures in October:

**APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS (CWP)**

Measure Description:
The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents a better performance (i.e., appropriate testing).

**COLORECTAL CANCER SCREENING (COL)**

Measure Description:
Members with a diagnosis of colorectal cancer or total colectomy at any time in the member’s history.

Please refer to the HEDIS Homepage for these and other measures with documentation tips, best practices and information about the importance of these measures to your practice.

Electronic Remittance Advices Reminder

Our Electronic Data Interchange (EDI) department has been receiving requests from clearinghouses to re-post Electronic Remittance Advices (ERAs). The majority of the requests are for ERAs with posting dates of, for example, May 1, June 1, July 1, August 1, etc. Payments with dates on the first of the month are most likely capitation checks. Capitation checks are always generated on the first of the month. ERAs are not generated for capitation payments.

The ERAs are distributed every Wednesday for FPH and FPLIC. On some occasions the ERAs can be issued on the first of the month if the first is on a Wednesday.
Medical Policy Updates

Effective 10/01/13
(Policy Update 1510011)

**Electrical/Neuromuscular Stimulator**
(MPO-490-0018)

**Deep Brain Stimulation**

Policy language has been amended to include new investigational indications as follows:

- BCNEPA will not provide coverage for deep brain stimulation for the following indications, as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available, published, peer-reviewed literature:
  - Treatment of other psychiatric or neurologic disorders including, but not limited to, Tourette’s syndrome, depression, obsessive-compulsive disorders, anorexia nervosa, alcohol addiction, chronic pain and epilepsy.

**Surgically Implanted Hearing Devices**
(MPO-490-0031)

**Cochlear Implant**

Policy language has been updated as follows:

- Cochlear implantation as a treatment for patients with unilateral hearing loss, with or without tinnitus, is considered investigational.

**Genetic Testing**
(MPO-490-0083)

**Genetic Testing for Statin-Induced Myopathy**

Policy language has been added as follows:

- BCNEPA will not provide coverage for genetic testing for the presence of variants in the SLCO1B1 gene for the purpose of identifying patients at risk of statin-induced myopathy, as this is considered not medically necessary.

**Genetic Testing for the Diagnosis of Inherited Peripheral Neuropathies**

The following language has been added to the policy:

- BCNEPA will not provide coverage for genetic testing for the diagnosis of inherited peripheral neuropathies to confirm a clinical diagnosis, or for all other indications, as this is considered investigational.

**Genetic Cancer Susceptibility Panels Using Next-Generation Sequencing**

Language has been added to the policy as follows:

- BCNEPA will not provide coverage for genetic cancer susceptibility panels using next-generation sequencing (i.e., BreastNext, OvaNext, ColoNext and CancerNext) as these are considered investigational.

**Microarray-Based Gene Expression Profile Testing for Multiple Myeloma Risk Stratification**

The following new language has been added to the policy:

- BCNEPA will not provide coverage for microarray-based gene expression profile testing (i.e., MyPRS™/MyPRS Plus™ GEP70 test from Signal Genetics LLC, Little Rock, AR) for multiple myeloma, as it is considered investigational for all indications.

**Experimental/Investigative Services**

**Radiology**
(MPO-490-0137)

**Myocardial Sympathetic Innervation Imaging in Patients with Heart Failure**

Policy language has been added as follows:

- BCNEPA will not provide coverage for myocardial sympathetic innervation imaging with 123Iodine metaiodobenzylguanidine (MIBG), as this is considered investigational for patients with heart failure (i.e., AdreView™).

**Ablation Services**
(MPO-490-0165)

**Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate or Dermatologic Tumors**

The revised policy statements are as follows:

- BCNEPA will not provide coverage for cryosurgical ablation for the following indications, as they are considered investigational:
  1. As a treatment of renal cell carcinomas in patients who are surgical candidates
  2. As a treatment of benign or malignant tumors of the breast, lung, pancreas and other solid tumors or metastases outside the liver and prostate

(Policy Update 1510011)
2013–2014 Seasonal Flu Information

This Year’s Trivalent Influenza Vaccine (TIV) is a Combination of These 3 Viruses:

- A/California/7/2009 (H1N1)pdm09-like virus
- A(H3N2) virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011
- B/Massachusetts/2/2012-like virus

For the first time, a quadrivalent vaccine has been developed. Quadrivalent vaccines contain the same 3 viruses as the trivalent with an additional B virus strain. The 4-strain vaccines will be available under the names of Fluzone Quadrivalent, Fluarix Quadrivalent and FluLaval Quadrivalent. To see a complete list of FDA-approved vaccines, visit the CDC website at www.cdc.gov/flu/protect/vaccine/vaccines.htm.

The CDC and APP suggest immunizing as soon as the new vaccine is available, preferably around late summer or early fall, before the start of the flu season. However, immunization can be done throughout the flu season. Even end-of-season vaccination may be beneficial to traveling adults and children being vaccinated for the first time. To avoid missed opportunities, flu vaccines should be offered during routine health care visits or during hospitalizations.

The CDC recommends everyone 6 months and older, even healthy adults, be immunized against influenza annually. For children under the age of 6 months who cannot receive the vaccine, the best protection is vaccinating mothers, household members and caregivers. Nasal spray vaccine formulas are only recommended for healthy 2 to 49 year-olds.

Reminder: Intradermal vaccine is not covered for BCNEPA membership.

Vaccination Recommendations for Those with an Egg Allergy

Studies have shown people with egg allergies can receive the TIV without serious reactions. In 2012, the Advisory Committee on Immunization Practices (ACIP) recommended people who experienced only hives from consuming eggs can receive the TIV, intramuscularly, under the following conditions:

- They must be treated by a health care provider who is familiar with the potential manifestations of egg allergies and
- They must be observed by a health care professional for at least 30 minutes after receiving the dose

People with egg allergies have an alternative to the traditional flu vaccine. In January 2013, the FDA approved Flublok, a trivalent which is not produced using the influenza virus or eggs. This vaccine is approved for people 18–49 years of age. The drawback of this medication is the short shelf-life. The medication expires 16 weeks from the manufactured date. You should monitor the expiration date of this medication.

Sources:
www.cdc.gov/mmwr/preview/mmwrhtml/mm6223a5.htm?s_cid=mm6223a5_w
www.cdc.gov/mmwr/pdf/rr/rr6207.pdf

(Policy Update 1510012)
## Alpha Prefix List Updates

Below is an updated listing of the alpha prefixes used by BCNEPA, FPH and FPLIC. Prefixes that do not appear in this listing should be considered out-of-area.

### FPLIC PRODUCTS:

<table>
<thead>
<tr>
<th>Product</th>
<th>Alpha Prefix</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCare® PPO and BlueCare PPO Qualified High Deductible (QHD)</td>
<td>QFG</td>
</tr>
<tr>
<td>BlueCare PPO Individual Conversion (Terming 12/31/13)</td>
<td>QFC</td>
</tr>
<tr>
<td>BlueCare Direct</td>
<td></td>
</tr>
<tr>
<td>BlueCare Direct Advantage</td>
<td>QFD</td>
</tr>
<tr>
<td>BlueCare Direct Select</td>
<td></td>
</tr>
<tr>
<td>BlueCare Direct Essentials</td>
<td></td>
</tr>
<tr>
<td>BlueCare Traditional</td>
<td>QFT</td>
</tr>
<tr>
<td>BlueCare PPO Custom Groups</td>
<td>EBU, GSQ, LPO, NNU, NTJ, NTQ, SRI, WOH</td>
</tr>
<tr>
<td>BlueCare EPO: Name change to BlueCare Custom PPO in 2014</td>
<td>QFI or QFO</td>
</tr>
<tr>
<td>BlueCare QHD EPO: Name change to BlueCare QHD Custom PPO in 2014</td>
<td>QFI</td>
</tr>
<tr>
<td>AffordaBluesm (EPO 3-Tier)</td>
<td>QFZ</td>
</tr>
<tr>
<td>BlueCare Assure (Terming 12/31/13)</td>
<td>QEB</td>
</tr>
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### Additional Group Plans Offered in 2014

<table>
<thead>
<tr>
<th>Product</th>
<th>Alpha Prefix</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCare PPO (PPO plan purchased on the Federal Exchange)</td>
<td>QFR</td>
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</table>

### Additional Individual FPLIC Plans Offered in 2014

<table>
<thead>
<tr>
<th>Product</th>
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</tr>
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<tbody>
<tr>
<td>myBlue® Choice; myBlue Choice LP (QHDHP) (on Exchange)</td>
<td>QFL</td>
</tr>
<tr>
<td>myBlue Choice; myBlue Choice LP (QHDHP) (off Exchange)</td>
<td>QFF</td>
</tr>
<tr>
<td>myBlue Access; myBlue Access LP (QHDHP); myBlue Access Catastrophic (on Exchange)</td>
<td>QFN</td>
</tr>
<tr>
<td>myBlue Access; myBlue Access LP (QHDHP); myBlue Access Catastrophic (off Exchange)</td>
<td>QFH</td>
</tr>
<tr>
<td>myBlue Care (on Exchange)</td>
<td>QFA</td>
</tr>
<tr>
<td>myBlue Care (off Exchange)</td>
<td>QFB</td>
</tr>
<tr>
<td>myBlue Cross, a Multi-State Plan</td>
<td>QFJ</td>
</tr>
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</table>

### FPH PRODUCTS:

<table>
<thead>
<tr>
<th>Product</th>
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<tbody>
<tr>
<td>BlueCare HMO Direct (Terming 12/31/13)</td>
<td>YZH</td>
</tr>
<tr>
<td>BlueCare HMO Individual Conversion (Terming 12/31/13)</td>
<td>YZH</td>
</tr>
<tr>
<td>BlueCare HMO (base)</td>
<td>YZH</td>
</tr>
<tr>
<td>BlueCare HMO Plus (POS)</td>
<td>YZH</td>
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<td>CHIP</td>
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### BLUE CROSS® PRODUCTS:

<table>
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<tr>
<th>Product</th>
<th>Alpha Prefix</th>
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</thead>
<tbody>
<tr>
<td>BlueCare Cooperative (non-group) and Special Care (Terming 12/31/13)</td>
<td>YZR</td>
</tr>
<tr>
<td>BlueCare Senior; BlueCare Security</td>
<td>YZM</td>
</tr>
</tbody>
</table>

(Policy Update 1510013)
Qualified physicians who have received a waiver from the special registration requirements in the Controlled Substances Act (SAMHSA certified) may prescribe buprenorphine/naloxone and buprenorphine. Physicians who have obtained this waiver are issued a DATA 2000 (Drug Addiction Act of 2000) prescribing ID number. This number is identical to the previously issued DEA number except that an “X” will replace the first character.

To be compliant with Health Care Reform, FPH and FPLIC are ensuring that we provide coverage for our members to receive buprenorphine/naloxone and buprenorphine as well as the appropriate corresponding treatment for this mandated Essential Health Benefit. Please note, effective January 1, 2014, buprenorphine/naloxone (Suboxone) and buprenorphine (Subutex) will continue to be covered under the member’s pharmacy benefit; however, a prior authorization will be required. Also effective January 1, 2014, buprenorphine/naloxone treatment (e.g., med checks, visits, urine screens, etc.) will be covered under the member’s medical coverage.

Our contracted FPH/FPLIC network-participating providers who prescribe buprenorphine/naloxone and buprenorphine, and provide buprenorphine/naloxone and buprenorphine treatment, must bill their services (e.g., med checks, visits, etc.) directly to FPH/FPLIC and not to the member. This will also ensure that our FPH/FPLIC members are receiving the highest quality care by documenting the appropriate services.

As of January 1, 2014, coverage of buprenorphine/naloxone or buprenorphine for our members with pharmacy benefits will require a prior authorization by the prescribing doctor.

Please note: There is a special prior authorization form for coverage requests for these medications which will be available on our website at www.bcnepa.com before January 1, 2014. Just click on the Provider Homepage tab and select “Resources and Tools.” Choose the “Pharmacy Benefits” link and click on “Pharmacy Related Forms.”

The member will be an integral part of the prior authorization process; the member will be responsible for coordinating communication between his or her medication prescriber and his or her drug and alcohol counselor. When prior authorization criteria are met, an initial approval of 3 months will be given for coverage of buprenorphine/naloxone. Additional coverage in increments of 3 months will require a new prior authorization be submitted by the prescribing doctor, reviewed by the pharmacy management department and approved.

We are making you aware of this change in October so that you have adequate time to request continued coverage by completing the appropriate paperwork and so there is no lapse in therapy. If you have any questions or concerns about this article, please contact your Provider Relations Consultant.
How You Can Reach Us

FOR QUESTIONS ABOUT BENEFITS, ELIGIBILITY OR CLAIMS, PLEASE CALL, WEEKDAYS, BETWEEN 8 A.M. AND 5 P.M.:

• BlueCare HMO/HMO Plus—1.800.822.8752
• BlueCare PPO—1.866.262.5635
• BlueCare Traditional—1.888.827.7117
• BlueCare EPO—1.888.345.2353

VALUABLE HEALTH RESOURCES:

Refer your BlueCare patients to the following Blue Health Solutions™ health and wellness resources:

• Personalized health management and wellness programs, care management resources and much more—1.866.262.4764

• 24/7 Nurse Now health care information—1.866.442.BLUE and available online at www.bcnepa.com. Login to Self-Service, click on the “Health & Wellness” tab and then select “24/7 Nurse Now.”

REPORT FRAUD:

Call our Fraud Hotline at 1.800.352.9100, or email our Special Investigations Unit at siu@bcnepa.com.

IMPORTANT FAX NUMBERS:

BC Claims Department............. 570.200.6790
(For claims adjustments, BlueCare Senior, FEP)

BC Precertification Department...570.200.6788

BlueCard® ITS Claims................ 570.200.6790

FPH Claims Department.........570.200.6790
(For Maternity Precertification Forms, adjustments, Claims Research Request Forms, etc.)

Provider Relations...............570.200.6880

Provider Customer Service ......570.200.6868

FPH Complaint/Grievance Department..................570.200.6770

FPH Non-par Referral Requests...570.200.6840

FPH Pharmacy Department ........570.200.6870

FPH Precertification Department..................570.200.6799

Other Party Liability (OPL) ........570.200.6790

BCNEPA PROVIDER RELATIONS CONSULTANTS

Odette Ashby • 570.200.4658 Odette.Ashby@bcnepa.com

Cheryl Grimm • 570.200.4669 Cheryl.Grimm@bcnepa.com

Cheryl Hashagen • 570.200.4670 Cheryl.Hashagen@bcnepa.com

Louise LoPresto • 570.200.4674 Louise.Lopresto@bcnepa.com

Jean Wiernusz • 570.200.4682 Jean.Wiernusz@bcnepa.com

Tracie Wyandt • 570.200.4647 Tracie.Wyandt@bcnepa.com

SENIOR MANAGER, PROVIDER RELATIONS

Dave Levenoskie • 570.200.4673 Dave.Levenoskie@bcnepa.com

SENIOR MANAGER, PROVIDER SERVICES

Kevin Quagliano • 570.200.4676 Kevin.Quagliano@bcnepa.com

QUESTIONS?

CALL PROVIDER RELATIONS AT

1.800.451.4447