Horizon Blue Cross Blue Shield of New Jersey is pleased to present you with an updated Horizon PPO Network Office Manual. It is designed to help you understand basic benefits, and our reimbursement and administrative procedures and policies. It also includes a brief overview of Horizon BCBSNJ products. Specific sections focus on topics such as Identification, Claims and Coordination of Benefits (COB).

This manual is designed to make it as easy as possible for you to answer day-to-day questions and provide services to patients enrolled in our products. If you are unable to find what you need in this manual, service numbers and information about our online capabilities are provided for your convenience.

The policies and procedures in this manual should be followed. Your failure to comply with any policies, rules and procedures may constitute a breach of your Horizon Blue Cross Blue Shield of New Jersey Agreement with Participating Physicians and Healthcare Professionals.

Updates to the information contained within this manual will be provided periodically in Blue Review, our online newsletter for participating physicians and other health care professionals and their office staff.

Current and past issues of Blue Review are available online. Registered users of NaviNet™ may follow the steps below to access Blue Review online:

- Select Horizon BCBSNJ within the Plan Central dropdown menu.
- Click References and Resources.
- Click Provider Reference Materials.
- Under News and Events, click Blue Review Newsletters.

If you are not registered for NaviNet, visit www.NaviNet.net and click Sign up.

We hope you find this manual helpful. We value our relationship with your office and look forward to building and maintaining our relationship with you.
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Horizon PPO Network Office Manual – 2010-2011
Definition of Terms

This section is designed to assist you with some of the terminology you may encounter in this manual, at our seminars, when speaking to one of our telephone representatives or when reading our newsletters.

Agreement
The Agreement is the general name of the signed contract (including any amendments) between Horizon BCBSNJ and our participating independent primary and specialty care physicians, health care professionals, facilities and other ancillary providers.

authorization/certification
Certain services or procedures must be reviewed for medical necessity and approved for coverage before they are provided or performed. This process, and the resulting approval, is called authorization. Authorization ensures that the member receives medically necessary services at the appropriate level of care in the right setting, at the right time, by the right physician or health care professional.

Authorization provides the requester with confirmation that the proposed services or procedures are considered by the Plan to be medically necessary based on the information provided with the request and that the service or procedure will be covered.

The member may be penalized if an authorization is required and not obtained prior to services being provided.

coinsurance
A type of cost sharing whereby the member assumes a portion or percentage of the costs of covered services.

Consumer-Directed Healthcare (CDH)
Consumer-Directed Healthcare, or CDH, is the trend toward increasing the participation of the consumer in the realm of health care decision-making and finance. CDH plans, which include Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs) and Flexible Spending Accounts (FSAs), generally pair a high-deductible health insurance plan with a tax-advantaged savings/spending account.

copayment
A type of cost sharing whereby the member, at the time of service, pays a specified flat amount per visit, unit of service or unit of time (e.g., $25 per office visit, $100 per Emergency Room visit).

deductible
The amount of eligible expenses that must be incurred by the member before Horizon BCBSNJ assumes any liability for all or part of the remaining cost of covered services.

dependent
A person (child, spouse or legal domestic partner) who is eligible for health care benefits because of his or her relationship to the subscriber.

HCAPPA
The New Jersey state law known as the Health Claims Authorization, Processing and Payment Act (HCAPPA), was effective on July 11, 2006. This law affects all New Jersey health insurers, including Horizon BCBSNJ. HCAPPA has broad implications on the way we conduct business. It affects only insured products offered by Horizon BCBSNJ and its subsidiaries and Horizon BCBSNJ’s managed Medicaid plan administered by Horizon NJ Health. The law does not apply to Administrative Services Only (ASO) plans, the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP), and federal programs, including Federal Employee Health Benefit Plan (FEHBP) and Medicare.

health care fraud and abuse
Health care fraud and abuse can take many forms and is defined by various state and federal laws and/or statutes including the Insurance Fraud Prevention Act, N.J.S.A. 17:53A-1 et seq.
Horizon Direct Access
A product in which members receive health benefits through participating physicians and health care professionals without a referral from a Primary Care Physician (PCP). Members have two levels of benefits: in-network and out of network. To receive the highest level of benefits, or in-network benefits, members must access care through participating managed care physicians and other health care professionals. When members do not, out-of-network benefits apply. Members are encouraged to select a PCP to help coordinate care, but it is not required.

Horizon MyWay
Horizon MyWay℠ is the name for our family of Consumer-Directed Healthcare (CDH) products. Horizon MyWay plans generally consist of three main components:

• A comprehensive, high-deductible health plan, such as Horizon Direct Access or Horizon PPO.
• An easy-to-use Health Reimbursement Arrangement, Health Savings Account or Flexible Spending Account.
• State-of-the-art tools, education and support to help members make informed decisions about health care and related spending.

in-network benefits
In-network benefits are the highest level of benefits available to members and are accessed by using a physician, other health care professional, clinical laboratory, outpatient or inpatient facility, etc., that is in the Horizon PPO Network.

medical emergency
A medical emergency is a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such 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:

• Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
• Serious impairment to bodily functions.
• Serious dysfunction of a bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency exists where:

• There is inadequate time to effect a safe transfer to another hospital before delivery.
• The transfer may pose a threat to the health or safety of the woman or unborn child.

When you refer a member to the Emergency Room (ER), you must contact us within 48 hours. Members who use the ER for routine care may be responsible for all charges except the medical emergency screening exam.

If emergency care is obtained with the assumption that the member’s health is in serious danger, but it is later determined that it was not an emergency, the medical emergency screening exam would still be covered.

Please see page 81 for the definition of medical emergency as it pertains to Medicare members.

medical necessity/medically necessary
HCAPPA established definitions of medical necessity and medically necessary, which describe a number of factors used to determine medical necessity, including the prudent clinical judgment as exercised by a health care professional for the purpose of evaluating, diagnosing or treating an illness, injury or disease; and that the service “is in accordance with generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person’s illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the
Horizon BCBSNJ’s Utilization Management (UM) program functions under the HCAPPA definition in the same way as it has previously. Our Medical Policies and UM criteria, used to help us reach decisions about medical necessity for coverage purposes, have been revised for compliance with the HCAPPA definition standard. This may not apply to Administrative Services Only (ASO) plans, the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP), the Federal Employees Health Benefit Plan (FEHBP) and Medicare.

**member or patient**
A person eligible for health care benefits under a PPO or Indemnity program. This individual is either a subscriber or a dependent of the subscriber.

**National Committee for Quality Assurance (NCQA)**
The National Committee for Quality Assurance (NCQA) is a nonprofit organization that primarily accredits health plans like Horizon BCBSNJ.

**National Provider Identifier**
The National Provider Identifier (NPI) is a 10-digit numeric identifier supplied by the Centers for Medicare & Medicaid Services (CMS) as a part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of NPI is to uniquely identify a health care provider in standard transactions, such as health care claims. HIPAA requires that covered entities (i.e., health plans, health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

**out-of-network benefits**
A reduced level of benefits that occurs when a member chooses to use a physician, other health care professional, clinical laboratory, outpatient or inpatient facility, etc., that is not in the Horizon PPO Network.

**participating health care professional**
A non-MD or non-DO licensed health care professional or any other health care services professional who has entered into an agreement with Horizon BCBSNJ to be in the Horizon PPO Network.

**participating physician**
A physician or physician group who has entered into an agreement with Horizon BCBSNJ to be in the Horizon PPO Network.

**Point of Service (POS)**
A product that uses the Horizon Managed Care Network but incorporates cost sharing and an option for members to access out-of-network care from any physician without first seeing the PCP. Our point of service program is called Horizon POS.

**predetermination**
A predetermination is a decision in response to a written request submitted by a member or by a physician or health care professional on behalf of the member, prior to receiving or rendering services, to determine if the service is medically necessary and eligible for coverage under the member’s contract for the specific CPT/HCPCS code submitted. Predeterminations are based solely on the information provided.

Predetermination decisions are never contractually required but are provided as a service to the member (or physician or health care professional) making the request.

**primary physician**
A duly licensed family practitioner, general practitioner, internist or pediatrician who has entered into an agreement with us to be in the Horizon PPO Network who treats Horizon BCBSNJ PPO or Indemnity members as his or her first contact for an undiagnosed health concern as well as continuing care of varied medical conditions.
Definition of Terms

referral
A recommendation by a physician and/or health plan for a member to receive care from a Horizon BCBSNJ participating specialist physician, other health care professional or facility.

subscriber
A person eligible for health care benefits under an insurance plan of Horizon BCBSNJ or its subsidiaries or affiliates. Subscribers may be eligible because they are employees of an organization that contracts with Horizon BCBSNJ to offer an insurance program to its employees, or because that person contracts directly for health care benefits.

urgent care
Urgent care, except as to the Medicare Program and except where otherwise provided by a health benefit plan that is not an insured plan issued or delivered in the state of New Jersey, means a non-life threatening condition that requires care by a physician or other health care professional within 24 hours.

Please see page 81 for the definition of urgent care as it pertains to Medicare members.
Horizon BCBSNJ is committed to providing our members access to a wide range of quality acute care facilities located conveniently throughout the region. A list of our network acute care facilities appears below and on the following page.

Periodically, hospitals may be added or removed from the network. *Blue Review* and special mailings will advise you of these changes. Participating physicians and other health care professionals should use the Horizon Hospital Network so that members receive the maximum level of benefits available under their benefit plans.

Please note that this listing is accurate at time of printing. Please visit our Provider Directory on [www.HorizonBlue.com](http://www.HorizonBlue.com) for the most current information.

**ATLANTIC COUNTY**
- AtlantiCare Regional Medical Center (Atlantic City, Pomona, *Hammonton*)
- Shore Memorial Hospital

**BERGEN COUNTY**
- Englewood Hospital and Medical Center
- Hackensack University Medical Center
- Holy Name Hospital
- The Valley Hospital

**BURLINGTON COUNTY**
- Deborah Heart & Lung Center
- Lourdes Medical Center of Burlington
- Virtua-Memorial Hospital of Burlington County
- Virtua-West Jersey Health System (Marlton)

**CAMDEN COUNTY**
- Cooper University Hospital
- Kennedy Memorial Hospitals – University Medical Center (Cherry Hill, Stratford)
- Our Lady of Lourdes Medical Center
- Virtua-West Jersey Health System (Berlin, *Camden, Voorhees*)

**CAPE MAY COUNTY**
- Cape Regional Medical Center

**CUMBERLAND COUNTY**
- South Jersey Healthcare Regional Medical Center
- *South Jersey Healthcare – Bridgeton Hospital*

**ESSEX COUNTY**
- St. Michael's Medical Center
- *St. Michael’s Medical Center – Columbus Campus*
- *St. Michael’s Medical Center – St. James Campus*
- Clara Maass Medical Center
- East Orange General Hospital
- The Mountainside Hospital
- Newark Beth Israel Medical Center
- Saint Barnabas Medical Center
- UMDNJ – University Hospital

**GLOUCESTER COUNTY**
- Kennedy Memorial Hospitals – University Medical Center (Washington Township)
- Underwood-Memorial Hospital

**HUDSON COUNTY**
- Christ Hospital
- Jersey City Medical Center
- Meadowlands Hospital Medical Center
- Hoboken University Medical Center
- *Clara Maass Medical Center, West Hudson Division*

**HUNTERDON COUNTY**
- Hunterdon Medical Center

**MERCER COUNTY**
- Capital Health System – Fuld Campus
- Capital Health System – Mercer Campus
- University Medical Center at Princeton
- Robert Wood Johnson University Hospital at Hamilton
- Saint Francis Medical Center

**MIDDLESEX COUNTY**
- JFK Medical Center
- Raritan Bay Medical Center (Old Bridge, Perth Amboy)
- Robert Wood Johnson University Hospital
- Saint Peter’s University Hospital

**MONMOUTH COUNTY**
- Bayshore Community Hospital
- CentraState Medical Center
- Jersey Shore University Medical Center
- Monmouth Medical Center
- Riverview Medical Center
Horizon Hospital Network

MORRIS COUNTY
Chilton Memorial Hospital
Morristown Memorial Hospital
Saint Clare’s Hospital (Denville, Dover)

OCEAN COUNTY
Community Medical Center
Kimball Medical Center
Ocean Medical Center (Brick, *Point Pleasant)
Southern Ocean County Hospital

PASSAIC COUNTY
St. Joseph’s Hospital & Medical Center
St. Joseph’s Wayne Hospital
St. Mary’s Hospital

SALEM COUNTY
The Memorial Hospital of Salem County, Inc.
South Jersey Healthcare – Elmer

SOMERSET COUNTY
Somerset Medical Center

SUSSEX COUNTY
St. Clare’s Hospital/Sussex

UNION COUNTY
*JFK Medical Center – Muhlenberg Campus
Overlook Hospital (Summit, *Union)
Trinitas Regional Medical Center

WARREN COUNTY
Hackettstown Regional Medical Center
Warren Hospital

DELAWARE
A.I. duPont Hospital for Children

NEW YORK
Bon Secours Community Hospital
St. Anthony Community Hospital

PENNSYLVANIA
Children’s Hospital of Philadelphia
Hahnemann University Hospital
Hospital of the University of Pennsylvania
Pennsylvania Hospital
St. Christopher’s Hospital for Children
Temple University Hospital
Thomas Jefferson University Hospital
(Main Campus and Methodist Campus)
University of Pennsylvania Medical Center – Presbyterian

* No inpatient services/limited outpatient services available.
Your Responsibilities

As a physician or other health care professional who participates with Horizon BCBSNJ, you have specific responsibilities and obligations. The following information is for your reference.

License, Certification or Registration

To maintain your contracting status with us, you are required to maintain a current, unrestricted, valid license, certification or registration to practice as a health care professional in New Jersey, or a contiguous state when your practice is outside the state of New Jersey.

Medical Records

You agree that Horizon BCBSNJ and their affiliates and designees have the right, subject to reasonable advance notice, to review any and all documents, books and records, including but not limited to medical records, maintained by you in connection with services provided under your Agreement.

According to your Agreement, upon Horizon BCBSNJ's request, you agree to provide copies of these materials, in the manner and within the timeframe set forth in that request.

Out-of-State BCBS Plans

Responsibilities and obligations under your Agreement are also applicable to customers and individuals who have health insurance underwritten or administered by out-of-state Blue Cross and/or Blue Shield Plans licensed by the Blue Cross and Blue Shield Association.

Cultural Competency

Horizon BCBSNJ's membership represents many cultural, ethnic, linguistic and racial backgrounds. To meet the needs of our members, you are required to ensure that all services, clinical and nonclinical, are accessible to all members in a manner compatible with their cultural health beliefs and practices, including those with limited English proficiency or reading skills.

Notifications

You must notify us in writing if:

- Your license, certification or registration to practice is restricted, suspended actively or stayed, or revoked for any reason.
- Your certification(s) to prescribe medication is suspended actively or stayed, or revoked for any reason.
- Your medical staff privileges at any hospital are voluntarily or involuntarily withdrawn, restricted temporarily or permanently, or suspended actively or stayed, or revoked for any reason.
- You change your name or the name of your group practice.
- Your tax ID number or address changes or you join or leave a group practice.
- You fail to maintain required medical malpractice insurance.
- You take a leave of absence or resign from the medical staff of any hospital.
- You are indicted, convicted of, or plead guilty to a criminal offense regardless of the nature of the offense.
- You are subjected to any disciplinary action (including, but not limited to voluntarily or involuntarily being subject to censure, reprimand, nonroutine supervision or monitoring or remedial education or training) by any government program, licensing, professional registration or certification authority, or hospital privileging authority.

Please mail notifications to:

Horizon BCBSNJ
PO Box 420, PP-14V
Newark, NJ 07101-0420
Horizon PPO members have the following rights and responsibilities:

**Access to Information**

Members have the right to:

- Receive information about Horizon BCBSNJ and its services, policies and procedures, products, physicians and other health care professionals, appeals procedures, coverage limitations and other information about the organization and the care provided.

- Be provided with the information needed to understand their benefits and obtain care through the Horizon PPO Network.

- Obtain a current directory of credentialed, board-certified participating physicians and other health care professionals in our network, upon request. The directory includes addresses, telephone numbers and information about fluency in languages other than English.

- Receive prompt notification of termination or changes in benefits or services within 30 days prior to the date of any change or termination, as appropriate.

- Obtain information about whether a referring physician or other health care professional has a financial interest in the facility or services to which a referral is being made.

- Know Horizon BCBSNJ’s payment method for physicians, in order to know if there are financial incentives or disincentives tied to medical decisions.

- Receive from their physician or other health care professional, in terms they understand, an explanation of their complete medical condition such as information regarding their health status, medical care or treatment options including alternative treatments that may be self-administered, recommended treatment, risk(s) of the treatment, expected results of the treatment and reasonable medical alternatives, whether or not these are covered benefits.

The member also has the right to be provided the opportunity to decide among all relevant treatment options. If the member is not capable of understanding the information, the explanation shall be provided to the next of kin or guardian and documented in the medical record.

- Have full, candid discussions about the risks, benefits and consequences regarding appropriate or medically necessary diagnostic and treatment or nontreatment options with participating physicians and other health care professionals, regardless of cost or benefit coverage.

- To refuse treatment and to express preferences about future treatment decisions.

- Know their rights and responsibilities as a Horizon BCBSNJ member.

**Services of Physicians**

Members have the right to:

- Choose and change a physician within the limits of benefits and the physician’s availability.

- Have access to a physician and accessible services when medically necessary. This includes the availability of care 24 hours a day, seven days a week, 365 days a year for urgent or emergency conditions.

**Medical Emergency Care**

Members have the right to:

- Call the 911 emergency response system or an appropriate local emergency number in a potentially life-threatening situation without prior approval.

- Have their Horizon BCBSNJ plan provide coverage for a medical emergency screening exam in an emergency facility to determine whether a medical emergency condition exists.

- Go to an Emergency Room without prior approval when it appears that serious harm could result from not obtaining immediate treatment.
Member Rights and Responsibilities

Specialty and Hospital Care
Members have the right to:

• Be afforded a choice of specialists from the network following an authorized referral (if needed), subject to the specialist’s availability to accept new patients.

• Obtain assistance and referrals (if needed) to participating physicians and other health care professionals with experience in the treatment of patients who have chronic disabilities.

Approval of Care
Members have the right to:

• An explanation why approval for payment of benefits for specific services requested by them or their physician or other health care professional was denied or limited under the Horizon BCBSNJ plan.

• Have a Horizon BCBSNJ physician determine to deny or limit payment of benefits for admission, service, procedure or extension of stay. Our physician who made the decision must directly communicate with the member’s physician or supply that physician with his/her telephone number. Members also have the right to know that the person denying or limiting a covered service is a physician.

• Be free from balance billing by participating physicians and/or other health care professionals for medically necessary services that were authorized or covered by Horizon BCBSNJ (not including copayments, deductible, coinsurance amounts and/or other member responsibilities).

Voice a Concern
Members have the right to:

• Voice complaints or file internal and external appeals about the plan or the care provided.

• File a complaint or appeal with Horizon BCBSNJ or the New Jersey Department of Banking and Insurance (DOBI). Members have the right to receive an answer to their complaint or appeal within a reasonable period of time.

• Know that neither the member nor their physician can be penalized for voicing a complaint or appeal about their Horizon BCBSNJ plan or the care provided.

Personal Rights
Members have the right to:

• Participate with physicians and other health care professionals in decision-making regarding health care.

• Be treated with courtesy and consideration and with respect for their privacy and dignity.

• Formulate and have advance directives implemented.

• Make recommendations concerning the Horizon BCBSNJ Member Rights and Responsibilities Policy.
Member Rights and Responsibilities

Continuity of Care
Members have the right to:

• Receive prompt notification of termination or change in benefits and services and notice of termination of their primary physician from the network.

• Continue receiving covered services from a participating physician or other health care professional who has terminated from the network for up to four months beyond the effective date of termination (the end of the notice period). Additionally, members undergoing certain courses of treatment are granted longer periods of care as indicated below:
  – Pregnancy – up to the postpartum evaluation (up to six weeks after delivery).
  – Post-operative follow-up care (up to six months).
  – Oncological treatment (up to one year).
  – Psychiatric treatment (up to one year).

All benefits shall be subject to contract limits and Horizon BCBSNJ policies and procedures, including but not limited to prior authorization and utilization management requirements.

For information on terminating your Horizon Blue Cross Blue Shield of New Jersey Agreement with Participating Physicians and Healthcare Professionals, please see page 104.

Member Responsibilities
Members are responsible for:

• Supplying information (to the extent possible) that Horizon BCBSNJ and its practitioners and providers need in order to provide care.

• Understanding their health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible.

• Following plans and instructions for care that they have agreed upon with their practitioners.

Member Nondiscrimination
Horizon BCBSNJ does not discriminate in its delivery of health care services based on, race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, geographic location, disability, genetic information, or source of payment.

Practitioners must have policies to prevent discrimination in health care delivery and implement procedures to monitor to ensure it does not occur.
This section includes the phone numbers you may call for the information you need. It also contains important addresses and other information presented at our seminars. In addition, we’ve included information on how you can request in-office training on Horizon BCBSNJ administrative policies and procedures, and the products and members you serve.

Interactive Voice Response (IVR) System

Your satisfaction is important to us. We understand that as a physician or other health care professional, you may have questions or need information about patients’ health care plans outside of our regular business hours. We strive to have systems and processes in place that allow you to contact us in ways that are efficient, flexible and compatible with your practice.

The Interactive Voice Response (IVR) system, expands your options for contacting us, allowing you to obtain the information you need in a more convenient manner.

Through IVR natural speech recognition, you can access information 24 hours a day, generally including weekends and holidays, and get instant answers to many questions previously handled by our service representatives.

Not only is the system available when you are, it’s also user-friendly. Our natural speech recognition technology gives you the option of speaking your request in a natural manner, much like you would when speaking with a service representative.

We encourage you to access the easy-to-use IVR system by calling 1-800-624-1110 and explore all the information and services that it has to offer.

IVR improvements

You have the ability to skip past disclaimers at the start of each call and spend less time confirming what you’ve said.

Use either your natural voice or the touchtone keypad to enter information or navigate through the call, whichever is right for the environment you’re in.

Here are some tips to help you navigate our IVR system:

• Speak clearly in your natural tone.
• Try using touchtone when there is excessive background noise.
• Say numbers one digit at a time.
• When speaking numbers, please say Zero rather than O.
• Say Main Menu from wherever you are to get back to the beginning.
• If you need help, just say Agent or Operator.
• You don’t have to listen to all the options. Go directly to the option you want by using the following voice prompts.

Just say ...

Enrollment to verify that a patient is enrolled under a Horizon BCBSNJ plan.

Claims to check claim status or payment.

Authorization to request an authorization, check the status of an authorization or find out if an authorization is required.

Referral to refer a patient for a treatment or check the status of an existing referral (if needed).

Duplicate Vouchers to request a copy of a voucher by date or by patient.

DME to get more information about ordering durable medical equipment.

Physician Services Representatives are available to help you and provide information that you may not be able to access through our IVR system. Call 1-800-624-1110, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time (ET).
At Your Service

Our medical and non-medical professional staff are dedicated to helping you and your patients. They are trained to communicate with patients, employers and the medical community and are available to answer your questions.

<table>
<thead>
<tr>
<th>Prefix or Area</th>
<th>Service #</th>
<th>Claims Address</th>
<th>Claim Appeals</th>
<th>Inquiry Address*</th>
</tr>
</thead>
<tbody>
<tr>
<td>YHC, YHI, YHJ, YHK, YHS, YHU, JGA, JGD, JGG</td>
<td>1-800-624-1110**</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>R, 8-digits and PPO logo Federal Employee Program (including behavioral health claims)</td>
<td>1-800-624-5078</td>
<td>PO Box 656 Newark, NJ 07101-0656</td>
<td>PO Box 656 Newark, NJ 07101-0656</td>
<td>PO Box 656 Newark, NJ 07101-0656</td>
</tr>
<tr>
<td>FMA, FMR, NCH, YHF, YHN, HIF, HSG, HWA, HWW and other National Accounts***</td>
<td>1-800-624-4758</td>
<td>PO Box 247 Newark, NJ 07101-0247</td>
<td>PO Box 247 Newark, NJ 07101-0247</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>AHK, AWW, BBB, DNB, IRA, NVP, NVF, PFZ, WYE and other National Accounts***</td>
<td>1-800-624-1110**</td>
<td>PO Box 1219 Newark, NJ 07101-1219</td>
<td>Addresses vary. Please review your patient’s ID card</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>MKV, MKY, MWK, MWJ, MWK</td>
<td>1-877-663-7258</td>
<td>PO Box 18 Newark, NJ 07101-0018</td>
<td>PO Box 317 Newark, NJ 07101-0317</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>HSE, NFW, YHD, YHG, YHM, YHP, YHT, YHV and all other Point of Service members</td>
<td>1-800-624-1110**</td>
<td>PO Box 820 Newark, NJ 07101-0820</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>JGE, JGB, JGH, YHQ, YHX, YKP Horizon Direct Access members</td>
<td>1-800-624-1110**</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>YHA NJ State Health Benefits Program (SHBP and SEHBP)</td>
<td>1-800-624-1110**</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>NJX, NJP NJ State Health Benefits Program (SHBP and SEHBP)</td>
<td>1-800-624-1110**</td>
<td>PO Box 820 Newark, NJ 07101-0820</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>YHR, YHW Medigap</td>
<td>1-800-624-1110**</td>
<td>PO Box 1184 Newark, NJ 07101-1184</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
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<tr>
<td>DEH, DMM, DTP, NGM General Motors/Delphi Auto</td>
<td>1-800-452-9336</td>
<td>PO Box 839 Newark, NJ 07101-0639</td>
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<tr>
<td>BlueCard® (out-of-state) claims BlueCard Service Team</td>
<td>1-888-435-4383</td>
<td>BlueCard Claims PO Box 1301 Neptune, NJ 07754-1301</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Magellan Behavioral Health™</td>
<td>1-800-626-2212</td>
<td>Addresses vary according to product. Please review the behavioral health information on your patient’s ID card.</td>
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<tr>
<td>For questions about the Horizon Health and Wellness Education Program (chronic care management programs)</td>
<td>1-888-333-9617</td>
<td>3 Penn Plaza East, PP-13X Newark, NJ 07105-2200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-existing Medical Documentation</td>
<td></td>
<td>PO Box 1740 Newark, NJ 07101-1740</td>
<td></td>
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<tr>
<td>Claim Policy Clinical Appeals</td>
<td></td>
<td>PO Box 220 Newark, NJ 07101-9020</td>
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</tr>
<tr>
<td>Claim Policy Code Edit Inquiries</td>
<td></td>
<td>PO Box 681 Newark, NJ 07101-0681</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Policy Clinical Predetermination for PPO and Indemnity Products</td>
<td></td>
<td>PO Box 220 Newark, NJ 07101-9020</td>
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</tbody>
</table>
Please do not send medical documentation with your claim if it has not been requested.

* Corrected claim submissions must be accompanied by a completed Physician/Health Care Professional Inquiry Request/Response Form (5548).

** 1-800-624-1110 can also be used to access our Interactive Voice Response (IVR) system to create referrals and for service information.

*** Check your patient’s ID card to confirm the contact and mailing information for prefixes that are not listed on the previous page.

Other Service Areas

Horizon BCBSNJ has a number of more specialized service areas that provide more specific information and assistance with authorizations and pre-certification. For these specialized service areas to perform their functions efficiently and effectively, it’s important that their time is not spent responding to basic benefits, enrollment and eligibility inquiries.

Please seek basic benefits, enrollment and eligibility information prior to contacting our Precertification Call Center for an authorization request. If you require documentation that a service does not require precertification, a Physician Services Representative can provide both the information you need and a service reference number that documents the information you were provided.

- BlueCard/Out-of-state authorizations
  Phone: 1-888-621-5894

- BlueCard/Out-of-state members (eligibility and benefits)
  Phone: 1-800-676-BLUE (2585)

- CareCore National, LLC (CareCore) (prior authorization/medical necessity determinations)
  Phone: 1-866-496-6200
  Fax: 1-888-785-2480 (for cardiology services)

- Dental inquiries
  Phone: 1-800-4-DENTAL (455-6825)

- e-Service Desk – e-Business
  (Online capabilities inquiries and help)
  Provider_Portal@HorizonBlue.com
  Phone: 1-888-777-5075
  Fax: 1-975-274-4555

- e-Service Desk – Electronic Data Interchange (EDI) (data feed issues)
  HorizonEDI@HorizonBlue.com
  Phone: 1-888-554-9242
  Fax: 1-975-274-4555

- Home care and/or Home IV infusion
  Fax: 1-800-492-2580

- Infertility services
  Fax: 1-975-274-4410

- National Provider Identifier (NPI) submission
  Fax: 1-975-274-4416

- NaviNet
  www.NaviNet.net
  Phone: 1-888-482-8057

- Notices of admission for out-of-state and non-network facilities
  Phone: 1-888-621-5894

- Physician profile changes
  Provider_Portal@HorizonBlue.com
  Fax: 1-975-274-4225 (for northern NJ)
  Fax: 1-975-274-4502 (for southern NJ)

- Physical Therapy Unit
  Phone: 1-888-789-3457

- Prior-authorization requests
  Phone: 1-800-664-BLUE (2585)
  Fax: 1-877-798-5905
Utilization Management
Contact Information
If you need to obtain prior authorization for a Horizon BCBSNJ member, please call 1-800-664-BLUE (2585).
To access our Utilization Management Department after business hours and on weekends, physicians and other health care professionals should call our after-hours emergent clinical issues number at 1-888-223-3072.
Please see page 36 for additional information.

Behavioral Health and Substance Abuse Care
Please check your patient’s ID card for the name and phone number of the behavioral health and substance abuse care administrator that administers benefits for your patient. Whether it is an emergency or a request for inpatient or outpatient services, either you or the member should call the appropriate behavioral health care administrator.
With few exceptions, we contract with Magellan Behavioral Health to administer our members’ behavioral health and substance abuse benefits. Call 1-800-626-2212 to speak with a Magellan Behavioral Health case manager who can inform you of your patient’s treatment plan and progress. This service is available 24 hours a day, seven days a week.
You may call Magellan Behavioral Health to refer most patients for behavioral health or substance abuse care.
If Magellan Behavioral Health does not administer your patient’s behavioral health and substance abuse benefits, please contact the behavioral health and substance abuse administrator listed on the back of your patient’s ID card.

Health Care Fraud and Abuse Investigation
Health care fraud, waste and abuse is a national problem that affects us all. According to figures compiled by the National Health Care Anti-Fraud Association, more than $68 billion is lost to fraud each year.
Horizon BCBSNJ takes health care fraud, waste and abuse seriously. Each day, our Special Investigations Unit works to uncover fraudulent activities and recover monies paid as a result of these activities.
Health care fraud, waste and abuse can take many forms:
• Billing for services that were not rendered.
• Upcoding – charging for a more complex service than what was actually provided.
• Patients misrepresenting themselves by using a member ID card that is not theirs.
• Providing less than the fully prescribed medication quantity to a member, but billing for the fully prescribed amount.
If you suspect that a member, health care professional or employee of a health care facility is committing fraud, please call our Special Investigations Unit’s Anti-Fraud Hotline at 1-800-624-2048.
As a Medicare Advantage and Medicare Part D plan sponsor, we also work closely with the CMS to investigate and prosecute all instances of fraud, waste and abuse involving those lines of business. The dedicated Medicare Advantage and Medicare Part D Fraud, Waste and Abuse Hotline number is 1-888-889-2251.
You may also send documents and/or inquiries to:
Horizon BCBSNJ
Investigations
Riverfront Plaza
PO Box 200145
Newark, NJ 07102-0505
All information is strictly confidential.
Fax Inquiries

If you have five or more inquiries for any of our Horizon BCBSNJ members, you may fax your inquiries to us at 1-973-274-4159.

You may download fax inquiry forms from the Downloadable Forms section of our website <www.HorizonBlue.com/Providers>. To receive a supply of fax inquiry forms, please call 1-800-624-1110.

Copies of Agreements

As a participating physician or other health care professional, you may request a copy of your Horizon Blue Cross Blue Shield of New Jersey Agreement with Participating Physicians and Healthcare Professionals by faxing a request to the Network Operations Department at 1-973-466-8125 or by mailing a request to:

Horizon BCBSNJ
Three Penn Plaza East, PP-14V
Newark, NJ  07105-2200

Professional Relations Representatives

Professional Relations Representatives are dedicated to providing service to you and your office staff. Your Professional Relations Representative is available to educate your staff on Horizon BCBSNJ’s administrative policies and procedures.

In 2010, our Physician Services (Phone) Representatives became your primary point-of-contact for claim and service inquiries. This change was put in place to resolve your claim and service inquiries more effectively, and to help us proactively identify trends and root causes. This change also allows our Professional Relations Representatives to focus their time and attention on their primary responsibility of providing effective communication and education to your office staff on our products, policies and procedures.

Call 1-800-624-1110 to obtain your Professional Relations Representative’s direct telephone number.

If your office is located in northern New Jersey (Bergen, Essex, Hudson, Hunterdon, Morris, Passaic, Sussex, Union or Warren county) or New York, please direct Professional Relations Representative correspondence to:

Horizon BCBSNJ
Network Management
Three Penn Plaza East, PP-14V
Newark, NJ  07105-2200

If your office is located in southern New Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Ocean, Salem or Somerset county), Pennsylvania or Delaware, please direct Professional Relations Representative correspondence to:

Horizon BCBSNJ
Network Management
250 Century Parkway, MT-03N
Mount Laurel, NJ  08054-1121
Online Education Resources

We now offer an online educational resource where information, job aids and training materials are available to you anytime.

Webpage

We have created an easy-to-use training and education page that will be your starting point to access a variety of information you need to know to conduct business with us. This webpage includes:

• Horizon BCBSNJ new physician orientation.
• A collection of online demos and webinars.
• Horizon BCBSNJ product knowledge courses and assessments.
• Online user guides including physician office manuals, and information on the BlueCard program.
• A section for quick and concise updates and highlights on new features.
• A section for frequently asked questions and answers.
• Central, organized and easily accessed locations for:
  – Newsletters and other communication.
  – Horizon BCBSNJ downloadable forms.
  – Policies and agreements.

To access this page:

• Visit www.NaviNet.net and sign in by entering your User Name and Password.
• Select Horizon BCBSNJ within the Plan Central dropdown menu.
• Mouse over References and Resources and click Provider Reference Materials.

Physician Training Webinars

Our Professional Relations Representatives will host online training webinars to introduce new products, reinforce existing product knowledge, highlight our self-service features and more. Visit the webpage to learn more.

Interactive Online Classes

Online courses have been developed to provide valuable information about Horizon BCBSNJ products, initiatives and other topics. Courses are available to all participating physicians, other health care professionals, their office managers and staff. Courses include assessments to help validate and reinforce understanding of the material presented. We use the assessment data to help us improve the course content and direct other training and education efforts.

In the future, we will also implement:

• Communications via e-mail that will enable us to provide and track important and time-sensitive information quickly and efficiently, right to your inbox.
• A capability to allow you to provide feedback about our new webpage and features to ensure that we are meeting your needs.

If you have questions, please contact your Professional Relations Representative.
www.HorizonBlue.com

Horizon BCBSNJ’s website, www.HorizonBlue.com, contains basic marketing information, product information, plan history and answers to frequently asked questions. Our site also provides access to several tools and resources including patient support information, downloadable forms, pharmacy services and electronic features.

The website also includes our online Provider Directory.

www.NaviNet.net

In 2010, the information you previously accessed through Horizon BCBSNJ’s Online Services moved to NaviNet.

Through NaviNet Insurer Connect®, a multi-payer web portal, your office has access to all the important Horizon BCBSNJ information that you previously accessed directly through our website. Through NaviNet you can:

• Check patient eligibility and benefits.
• Check claim status, review payment information and Explanation of Payments (EOPs). You may also submit attachments providing additional information when requested by Horizon BCBSNJ.
• View eligibility and claims for members in out-of-state Blue Cross and/or Blue Shield Plans.
• View your PCP panel and capitation reports (if applicable).
• View authorization/referral information.
• Submit referrals online.
• Submit fee schedule inquiries and view our injectable medication fee schedule.
• Submit CMS 1500 claims.
• View Horizon BCBSNJ’s medical policies and clinical guidelines.

• Review your demographic information to help avoid delays due to incomplete or inaccurate information.
• Keep up-to-date with what’s happening at Horizon BCBSNJ by viewing copies of Blue Review newsletters, this office manual and more.

New features and improvements made to our Online Services options accessed through NaviNet will be communicated in Blue Review.

We urge you to join the other offices already using NaviNet Insurer Connect. Through NaviNet, your office will also have access to the online information of many other health plans. You’ll save time and money accessing online information for more than 95 percent of the commercially insured members in the state.

To register for NaviNet, visit www.NaviNet.net and click Sign up.

To view all the transactions and insurers available to you through NaviNet, visit <www.NaviNet.net/NJ>.

Online Demo
Learn about NaviNet by viewing their tutorial:

• Mouse over Forms and Vouchers and click Provider Reference Materials.
• Click NaviNet.
• Click NaviNet Information Demo.

This online demo is also available on NaviNet’s website.

• Visit www.NaviNet.net and sign in by entering your User Name and Password.
• Select Horizon BCBSNJ within the Plan Central dropdown menu.
• Click NaviNet.
• Click NaviNet Information Demo.
Electronic Data Interchange (EDI)

Our e-Service Desk supports all of the most common Electronic Data Interchange (EDI) transactions. All of our transactions are based on the nationally accepted ANSI (American National Standard Institute) format. Some of the transactions are set as a real-time process, providing responses within seconds, while others run in a batch format.

Transactions We Handle
- Physician, Hospital and Dental Claims (837).
- Eligibility Inquiry and Response (270/271).
- Services Review (Referral/Authorization) and Response (278).
- Claim Status and Response (276/277).
- Benefit Enrollment and Maintenance (854).
- Claim Payment Advice (855).
- Premium Payment (820).

Benefits of EDI
- Faster exchange of information.
- Improved accuracy.
- Reduced postage cost.
- Reduced administrative cost.
- Elimination of paper documents.
- Timely postings.
- Reduced handling.
- Reduced payment cycle.
- Tracking capabilities.
- More efficient means of conducting business.
- Minimize possibility of lost or misrouted documents.

If you have questions about EDI transactions, or for more information, contact the e-Service Desk’s EDI team toll-free at 1-888-534-9242, via e-mail at HorizonEDI@HorizonBlue.com or by fax at 1-973-274-4553.

Standards for Electronic Transactions

On January 16, 2009, the Department of Health and Human Services (HHS) announced two final rules to adopt updated HIPAA (Health Insurance Portability and Accountability Act of 1996) standards. All HIPAA covered entities (health plans, health care clearinghouses, physicians, other health care professionals and facilities) must use the new standards when they electronically conduct administrative transactions, such as submitting claims, remittance advice, eligibility verification, claims status requests and responses and others.

Version 5010
According to the HHS final rule, the current Version (4010A1) of the nine current standard transactions for Electronic Data Interchange will be replaced with Version 5010. Version 5010 standards reflect industry changes that have occurred since the transactions were adopted and provide a framework for future business needs.

Effective January 1, 2012, you must be ready to submit electronic transactions using Version 5010 standards.

Horizon BCBSNJ has already begun work to implement Version 5010 and expects to be fully compliant with Version 5010 on schedule. Throughout our implementation, you will be notified about our Version 5010 requirements (i.e., companion documents, testing schedules, etc.) to help ensure a smooth transition to the new standards.

For information about our progress toward implementing Version 5010, please visit www.HorizonBlue.com/Providers and:

- Mouse over Forms and Vouchers and click Provider Reference Materials.
- Click HIPAA.
- Click HIPAA 5010.

If you have questions, please e-mail HIPAA@HorizonBlue.com.
ICD-10
In a separate final rule, HHS announced that they are adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS) for inpatient hospital procedure coding.

The implementation date for ICD-10-CM and ICD-10-PCS is October 1, 2013 for all covered entities.

Developed almost 30 years ago, ICD-9 is outdated. It lacks the precision, specificity and detail needed to document new technology, preventive services and a number of other emerging uses. ICD-10 code sets contain more than 155,000 codes (compared with the 17,000 codes contained within ICD-9) and can accommodate many new diagnoses and procedures. The implementation of ICD-10 code sets will result in:

• Improved ability to measure health care services.
• Increased sensitivity when refining grouping and reimbursement methodologies.
• Enhanced ability to conduct public health surveillance.
• Decreased need to include supporting documentation with claims.

The implementation of ICD-10 will require early planning for extensive system changes, training and adoption. Horizon BCBSNJ has begun planning for this effort and will continue to educate and assist participating physicians and other health care professionals throughout the ICD-10 adoption process.

For More Information
The U.S. Government Printing Office and the Office of the Federal Register makes the text of these two final rules available online.


To view the fact sheet, "HHS MODIFIES HIPAA CODE SETS (ICD-10) AND ELECTRONIC TRANSACTIONS STANDARDS," dated January 15, 2009, please visit the CMS website, www.cms.gov, and:

• Click Newsroom.
• Under the Media Releases heading, click Fact Sheets.
• Search by title or date.
Provider Directory

Information on participating physicians and other health care professionals, their office locations, specialty information, office telephone numbers and hospital affiliations appears on <www.HorizonBlue.com>.

In addition, the online Provider Directory also provides the ETIN number for participating specialists, which is useful when submitting referrals online and via the IVR system.

We also provide a value-added feature offering street maps and detailed directions to physician offices.

You should check your details on our website to ensure it accurately reflects current information. If it is incorrect, please notify your Professional Relations Representative.

Cost and Quality information

As a result of the consumer-directed health care movement, members and employer groups are looking to their health insurance carriers for physician performance information to help them make more informed choices when they select a physician for themselves or for their family members. In 2010, we will make network physician information available to our members through our online Provider Directory.

In preparation for making this valuable information available to our members, we asked participating physicians in certain specialties to access and review our online Cost and Quality tool and the data included within the tool, and provide us with comments, questions and feedback.

The feedback we received was used to improve the quality of our data source and enhance our clinical quality metrics. This enhanced data was used in our most recent Horizon Physician Recognition Program and is the information we will make available to our members.

Accessing the Cost and Quality Tool

You may access the Cost and Quality tool and review your information online (and provide us with feedback) at any time.

This tool also provides the details behind the measures that better align Horizon BCBSNJ with the principles of transparency.

To access our online Cost and Quality tool, please visit <www.NaviNet.net>.
Demographic/File Changes

It’s important that we have your most current information to help ensure that claims are processed correctly, that information and reimbursement is sent to the correct address and that the information members see when they access our online Provider Directory on www.HorizonBlue.com and the Blue National Doctor and Hospital Finder at www.BCBS.com/healthtravel/finder.html is accurate.

If you haven’t updated your office information recently, please do so as soon as possible.

Visit www.HorizonBlue.com, click Forms and Vouchers and print the Provider File Change Request Form (9093). Complete the form and fax it to one of the following numbers.

• If your office is located in northern New Jersey (Bergen, Essex, Hudson, Hunterdon, Morris, Passaic, Sussex, Union or Warren county) or New York, please fax a completed Provider File Change Request Form to 1-973-274-4225.

• If your office is located in southern New Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Ocean, Salem or Somerset county), Pennsylvania or Delaware, please fax a completed Provider File Change Request Form to 1-973-274-4502.

Registered NaviNet users may also initiate demographic changes online.

Required Information

The following information is required for any file changes:

• Physician name(s) and signature(s).
• Effective date of change.
• Tax ID/NPI and Social Security Number.
• W-9.
• Practice/billing locations and phone numbers.

Thirty-days advance notice is required for file changes.

Fee Information

Online Fee Schedule

Horizon BCBSNJ is pleased to make fee information (for most specialties) available to you online immediately. Registered NaviNet users may access online fee schedule information by following the steps below:

• Visit www.NaviNet.net and sign in by entering your User Name and Password.
• Select Horizon BCBSNJ within the Plan Central dropdown menu.
• Mouse over Claim Management and click Fee Request Inquiry.
• On the Fee Requests page, select your Billing (Tax) ID number and your county.
• Then, based on the information you’re seeking, you may either:
  – Select your specialty to view our fees for the most common CPT codes for that specialty, or
  – Enter specific CPT codes to view our allowances for those specific services.

Online Fee Inquiry Form

Fee information for the following services/specialties is not yet available in this immediate electronic format:

• Anesthesia services.
• Services provided by:
  – Nurse practitioners.
  – Physician assistants.
  – Certified nurse specialists.
  – Registered nurse first assistants.
  – Behavioral health specialties.

Please follow the steps below to obtain fee information using our online Fee Inquiry Form:

• Visit www.NaviNet.net and sign in by entering your User Name and Password.
• Select Horizon BCBSNJ within the Plan Central dropdown menu.
• Mouse over References and Resources and click Provider Reference Materials.

• Click Additional Information.

• Click Fee Request, and then click Fee Inquiry Form.

• Complete the required fields and click Submit Request.

The fee schedule information will be e-mailed to you within 15 days.

**Online Injectable Medication Allowances**

You may also access many of our injectable medication allowances online.

Click the appropriate Injectable Medication Fee Schedule also within the Additional Information section.

**Federal Form W-9 Online**

You can quickly provide us with your Federal Form W-9 information through our website. When you complete our online form, your new or updated tax information will be electronically forwarded to our Tax Department.

When you use this option, you will no longer need to prepare and submit paper copies of your Federal Form W-9 and we will be able to quickly update or correct your tax information, including your Federal Form 1099.

You may also download a blank, printable W-9 form via our website and submit it by mail or fax, if you prefer.

Accessing the online W-9 form is easy:

• Visit <www.HorizonBlue.com/Providers>.

• Mouse over Forms and Vouchers and click W-9 Tax Form.

**Deductible Information**

Physician Service Representatives and Professional Relations Representatives are unable to provide information on the amount of deductible a specific patient has satisfied. Since money applied to the deductible can vary with each claim processed, an amount shown today may be different than the amount when your claim is processed.

Please collect only applicable office visit copayments at the time of service. Other than copayments, you may not collect any other monies in advance.

After a claim is processed, you will receive an Explanation of Payment (EOP) that will include deductible and coinsurance information. An Explanation of Benefits (EOB) including similar information will also be sent to the patient explaining their liability to you.
As a participating physician or other health care professional, you are required to:

- Send claims to us before billing your Horizon BCBSNJ patients.
- Collect only applicable office visit copayments at the time of service. Other than copayments, you may not collect any other monies in advance.
- Accept our allowance for eligible services as payment in full.

We will process your claims and send you payment for all eligible services. A payment summary will be sent to you outlining patient liability. In some cases, we may pay our full allowance; however, some services or products may require a copayment, or be subject to a deductible or coinsurance.

Horizon BCBSNJ will pay the lesser of your billed charge or our fee schedule amount, less applicable copayment, coinsurance or deductible amounts. For more information on your responsibilities and obligations, please see the Policies, Procedures and General Guidelines section beginning on page 94.

If your patient asks for a copy of their bill, please explain that you will file the claim with Horizon BCBSNJ. We hope to discourage patients from sending claims that you have already submitted. This will help us avoid processing the same claim twice and generating two notifications, confusing your office and the member.

Some managed care products may allow members to self-refer to you. In such situations, you will be paid at the participating allowance. The patient is only responsible for the applicable copayments, deductibles and coinsurance and may not be balance billed. Please be aware that these members must use the Horizon Hospital Network, when necessary.

National Provider Identifier (NPI)

In accordance with CMS regulations, physicians and other health care professionals who conduct electronic transactions or submit claims to us through a third-party vendor have been required to use a National Provider Identifier (NPI) since May 25, 2008. To avoid claim rejection, please include NPI information on your standard transactions.

Apply for NPI

If you have not yet applied for a NPI, please visit the CMS website, www.cms.gov/NationalProvIdentStand/, and click How to Apply.

Registering your NPI

To reimburse you correctly, your NPI(s) must be registered with Horizon BCBSNJ. Registration ensures that our internal systems accurately reflect your NPI information and prevents reimbursement delays. If you’ve not yet registered your NPI information with us, please do so immediately.

To register by fax:

- Visit our website <www.HorizonBlue.com/Providers>.
- Mouse over Forms and Vouchers and click Downloadable Forms.
- Under HIPAA, select the appropriate form:
  - National Provider Identifier (NPI) Collection Form for Individual Practitioner/Physician (19418).
  - National Provider Identifier (NPI) Collection Form for Facility/Group/Practice (19419).
- Complete the form and fax it to 1-973-274-4416.

If you would like paper copies of the NPI collection forms sent to your office, please contact your Professional Relations Representative.
Claims Submissions and Reimbursement

NPI and Group Tax ID Number Affiliation
Ensure that your NPI is linked/associated with your group Tax ID number (TIN) and correctly registered in our files. A group NPI that is incorrectly associated to an individual practitioner’s TIN or Social Security Number may cause claims to be incorrectly processed.

If your group practice NPI is incorrectly associated with an individual practitioner, please contact CMS through their website, www.cms.gov/NationalProvIdentStand/ to request a correction to the NPI. Once CMS has corrected their records, please fax the updated information to us at 1-973-274-4416.

For more information, please visit <www.HorizonBlue.com/NPI>.

Claims Submissions
Claims are a vital link between your office and Horizon BCBSNJ. Please submit them in a timely manner. Helpful Hints are provided in this section for your reference.

Electronic Submissions
Electronic claims submissions help speed our payment to you. We encourage all physicians and other health care professionals to submit claims to us electronically.

Our e-Service Desk’s EDI team is available to discuss:
• Your electronic claim submission options.
• Enhancing your current practice management system with specifications for electronic submission to us.

For more information on submitting your claims electronically, contact the e-Service Desk’s EDI team toll-free at 1-888-554-9242, via e-mail at HorizonEDI@HorizonBlue.com or by fax at 1-973-274-4553.

Paper Claims Submissions
We require that all paper claim submissions are printed on an original, government-approved CMS 1500 claim form. Claim submissions that we receive on photocopies of the CMS 1500 claim form, on other carrier’s claim submission forms or on superbills will not be processed.

Always fill out CMS 1500 forms completely and accurately. Disregard group-specific claim forms a patient may present. Pay close attention to required fields to minimize processing delays.

Behavioral Health Care and Substance Abuse Care Claims
When providing behavioral health and substance abuse care, please check the patient’s ID card for information on the behavioral health and substance abuse care administrator and the specific claim submission address.
Helpful Hints for Claim Submissions

For fast, accurate processing of your claims:

- Ensure the billing physician’s name and address are complete and accurate.
- Ask for the patient’s ID card at each visit to have the most current enrollment information available. Always photocopy both sides of the ID card for your files.
- Don’t confuse the subscriber with your patient. The patient is always the person who you treat. Complete the patient information on your claims as it relates to the person being treated.
- Use the subscriber’s and/or patient’s full name. Avoid nicknames or initials.
- Complete the date of birth for the patient.
- Claims must include the entire ID number. Always use the prefixes or suffixes that surround the ID number. The only exceptions are the Federal Employee Program (FEP) products; disregard any characters after the eighth numeric character following the R prefix.
- Include the group number when it appears on the ID card.
- When you treat a patient due to an injury, include the date the injury occurred.
- When appropriate, include the date of onset for the illness you are treating.
- When submitting claims under your NPI, please remember that your tax ID number is also required.
- Clearly itemize your charges and date(s) of service.
- Use accurate and specific ICD-9-CM diagnosis codes for each condition you are treating. List the primary diagnosis first. To report multiple ICD-9 codes (our systems can handle up to four), list each one with the corresponding procedure by number 1, 2, 3 or 4.
- Always use accurate, current and compliant five-digit CPT-4 codes or HCPCS codes for the date(s) on which services were rendered.
- When applicable, use valid CMS-accepted modifier codes.
- When treating a BlueCard patient from any other Blue Cross and/or Blue Shield Plan, unless you participate directly with that Plan, please submit your claim(s) to us.
- If the patient has any other insurance, include the patient’s Coordination of Benefits (COB) information on the claim form. If another carrier is primary and we receive incomplete information, it will delay our payment to you.
- When the patient’s primary insurance is Medicare, claims are sent to Horizon BCBSNJ from Xact or Empire Medicare Services only after the Medicare Payment Floor (14 days) has been reached regardless of when you receive a remittance advice from Medicare Xact or Medicare Empire Services. If you do not receive a payment summary from us or your claim was not paid by Xact or Empire Medicare Services, submit the claim along with a copy of the Medicare Provider Summary to us.

Helpful Hints for Paper Claim Submissions

If you submit paper claims, your claim submissions may be processed through Optical Character Recognition (OCR). Our enhanced OCR processing provides faster and more efficient adjudication and payment than the traditional methods of manually processing paper claims. The efficiency of processing paper claims through OCR depends on your legible, compliant and complete claim submission. Claims showing insufficiencies in these areas may be delayed.
To maximize the benefits of OCR, we recommend the following when submitting your CMS 1500 form:

- Use an original redlined form instead of a black and white photocopy.
- Use dark ink (black ink is recommended).
- All characters on the CMS 1500 form need to be intact. We use Optical Character Recognition (OCR) equipment that recognizes full characters only. If the characters are missing tops or bottoms of the letters, the OCR equipment will not function properly, causing claims processing delays. Use a laser printer for best results.
- Center characters in each box on the CMS 1500 form.
- Use a standard Sans Serif font and select a font size that fits comfortably within the boxes.
- Do not apply extraneous stamps or verbiage to the forms.
- Do not circle or highlight information, as it may cover other data and cause it to become illegible.
- For information omitted from computer prepared forms, use typewritten instead of handwritten data.
- When submitting a claim for secondary carrier payment, please ensure the primary carrier's corresponding Explanation of Benefits (EOB) is included with the CMS 1500 claim form (patient name, procedures and dates of service must coincide).
- Do not staple any submitted documents.
- To assist in tracking referrals, please complete Box 17 on the CMS 1500 form with the referring PCP's name (as applicable).
- Complete Box 23 on the CMS 1500 form with the prior authorization or referral number. In situations where you have both a referral number and a prior authorization number, please enter the prior authorization number in Box 23.

**EDI Transaction Investigation**

From time to time, you might experience Electronic Data Interchange (EDI) transaction rejections. Different from a claim denial, an EDI transaction rejection is not forwarded to our claim processing systems for adjudication. The following information will help to expedite any transaction rejection investigations you may need to conduct with the e-Service Desk's EDI team.

**Information Required for EDI Investigation**

If you need help with EDI rejection messages for any of the transactions listed below, please have the Horizon EDI Gateway Receipt Number or Carrier Reference Receipt Number available to provide to the e-Service Desk Representative.

- Professional claims.
- Eligibility status.
- Claim status.

**Remittance Advice**

If you need help with a Remittance Advice/835 investigation, please also have the following information available:

- Provider NPI or Tax ID.
- Check date.
- Check amount.
- Check number.

You may reach the e-Service Desk's EDI team toll-free at 1-888-554-9242, via e-mail at HorizonEDI@HorizonBlue.com or by fax at 1-973-274-4353.
Corrected Claims and Inquiries

Use our Physician/Health Care Professional Inquiry Request/Response Form (5348) to help us provide quicker and more accurate responses to your claim inquiries and corrected claim submissions. Below are some tips and information to help ensure that your claim inquiries and corrected claim submissions include the information we need to investigate your claims.

• Ensure that your completed 5348 is legible (either printed or typed).

• Be as specific as possible when describing what it is that you’re asking us to do. For example, if you send in a corrected claim form, please clearly indicate how the current claim information differs from the original claim submission (codes, units, charges added, etc.).

• Ensure that all necessary supporting documentation accompanies the completed 5348 (e.g., the corrected CMS 1500 claim form, a Medicare or other carrier Explanation of Benefits, etc.).

If our claim investigation results in a change in the claim payment amount, Horizon BCBSNJ will send an Explanation of Payment (EOP) to the billing address we have on file. If the claim investigation does not result in a change in the claim payment amount, we will complete the response section of your submitted 5348 and return it to the person/address noted on the form.

To download the Physician/Health Care Professional Inquiry Request/Response Form (5348), visit www.HorizonBlue.com/Providers and:

• Mouse over Forms and Vouchers and click Downloadable Forms.

• Click Physician/Health Care Professional Inquiry Request (5348) under the Inquiry Requests heading.

If you would like paper copies mailed to your office, please contact your Professional Relations Representative.

Claims rejected due to missing or incorrect billing information are not entered into our claim adjudication systems. Claims that have not been entered into our claims adjudication systems may be submitted (either electronically or hard copy) without the need for an accompanying 5348.
Chiropractic Claims

Please use the Chiropractic Manipulative Treatment (CMT) codes listed below when submitting chiropractic claims to us.

98940    CMT; spinal, one or two regions.
98941    CMT; spinal, three or four regions.
98942    CMT; spinal, five regions.
98943    CMT; extraspinal, one or more regions.

E&M Services and PT Modalities

In 2010, Horizon BCBSNJ revised our policy regarding consideration of Evaluation and Management (E&M) services and physical therapy (PT) modalities for reimbursement separate from the reimbursement of CMT codes.

Our policy revision is in compliance with New Jersey Department of Banking and Insurance (DOBI) Order A09-115 and impacts all participating and nonparticipating New Jersey chiropractors.

Chiropractic Order Number A09-115 does not apply to Federal Employee Program (FEP) members, Horizon Medicare Advantage members or Medigap members.

Evaluation of E&M services and PT modalities may require the submission of medical records to support the appropriateness of the services being billed.

The eligible CPT-4 codes are listed below, however, reimbursement of codes is subject to Horizon BCBSNJ policies and the member’s benefits.

• Evaluation and Management Codes
  For initial patient – 99201 through 99205.
  For established patient – 99211 through 99215.

• Physical Therapy Modality Codes
  97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97035, 97034, 97055, 97056, 97059, 97110, 97112, 97115, 97116, 97124, 97159, 97140, 97550, 97750, G0283.

• Chiropractic Manipulative Therapy Codes
  98940 through 98945.

Benefit Maximums

A common standard benefit is to cover a maximum of 50 visits per benefit year. However, some groups have other benefit maximums or elect not to cover chiropractic services.

Depending on the member’s contract, maximums may also apply to physical therapy modalities.

Please call the service number on your patient’s ID card to verify chiropractic and physical therapy modality benefits.

Physical Therapy Claims

Horizon BCBSNJ transitioned to a maximum per-visit reimbursement for physical therapy and occupational therapy services. This applies to the Horizon Managed Care Network and the Horizon PPO Network, and impacts CPT codes 97001 to 97799.

The per-visit reimbursement covers all medically necessary treatment you provide to a patient in that visit. We also recognize physical therapy and occupational therapy evaluations as part of the per-visit payment.

Helpful Hints for Physical Therapy Claims

• Standard benefit is to cover a maximum of 50 visits per benefit year. However, some large groups can elect other benefit maximums. Call the service phone number on the patient’s ID card to verify his or her physical therapy benefits.

• Submit all claims using current CPT-4 codes that accurately reflect your services.

• Certain groups may require services to be reviewed for medical necessity at specific intervals.

• Medical records may be requested to confirm the medical necessity for care.

Please note that reimbursement may vary by county.
Clinical Laboratory Claims

Horizon BCBSNJ members should use participating laboratories to be covered at the highest level of benefits and incur the lowest out-of-pocket expense.

Participating PPO laboratories can be viewed on our online Provider Directory at <www.HorizonBlue.com>.

Electronic Funds Transfer

Horizon BCBSNJ strongly encourages all participating physicians and other health care professionals to register for electronic funds transfer (EFT). The benefits of EFT include:

- Elimination of paper checks to track and deposit.
- Reduction in paperwork and administrative costs.
- Reduction in the opportunity for error/theft.
- Quicker reimbursement into one or more designated bank accounts.
- Improved cash flow by eliminating mail time and check float.
- Elimination of bank fees for check deposits.

Enrolling in EFT requires that you receive online Explanation of Payments (EOPs) in place of paper statements.

To sign up for EFT, registered users of NaviNet may:

- Select Horizon BCBSNJ within the Plan Central dropdown menu.
- Click Claim Management.
- Click EFT Registration.

We will perform two test deposits into the bank account you indicate. Once you confirm that the tests were successful, it takes only two to four business days before EFTs begin.

If you have questions about EFT or EFT registration, please call our e-Service Helpdesk at 1-888-777-5075. You can also e-mail questions to the e-Service Helpdesk at Provider_Portal@HorizonBlue.com.

If you are not registered with NaviNet, visit www.NaviNet.net and click Sign up.

If you have questions about NaviNet registration, please call NaviNet Customer Care at 1-888-482-8057.

Please note that payments generated from our dental claim processing system will still be made via paper check, even for those who sign up for EFT.

We will keep you apprised of our progress toward generating EFTs from our dental claim processing system in our Blue Review newsletter.
Prompt Pay

The New Jersey statute known as Prompt Pay became effective for all claims received on or after December 28, 1999, and replaces previous prompt pay laws. One Prompt Pay requirement is that all New Jersey insurance companies, health, hospital, medical and dental services corporations, HMOs and Dental Provider Organizations and their agents for payment (all known as payers) process claims in a timely manner.

Prompt Pay requires that carriers pay clean claims within 30 calendar days for electronic claims and 40 calendar days for paper claims. Claims that are not paid must be denied or disputed within the same 30- or 40-day timeframes.

In addition, the Health Claims Authorization, Processing and Payment Act (HCAPPA), where it applies, requires any claim eligible for Prompt Pay interest be paid at the rate of 12 percent per annum as of July 11, 2006, rather than the previous interest rate of 10 percent per annum beginning on the 31st day for electronic claims and the 41st day for paper claims (when applicable).

Prompt Pay applies to all insured New Jersey group and individual business. Prompt Pay requirements do not apply to certain lines of business, such as self-funded business, including Administrative Services Only (ASO) accounts such as the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHB). If you have questions about identifying the members to whom Prompt Pay applies, please call 1-800-624-1110.

Additional Interest Payments

In June 2010, Horizon BCBSNJ began issuing additional interest payments on claims (for certain lines of business) to MDs and DOs. These interest payments are a result of (and are specified in) the settlement agreement of the class action lawsuit, Love, et al. v. Blue Cross Blue Shield Association, et al.

These interest payments do not supersede any interest payment required by New Jersey law.

Interest will be paid at a rate of 8 percent per annum on balances due from the 20th calendar day after Horizon BCBSNJ receives a complete, electronically submitted claim to the earlier of the date that:

1. Horizon BCBSNJ directs issuance of payment, or
2. Interest becomes payable under New Jersey law.

These additional interest payments will be noted on your Explanation of Payment (EOP), which will separately identify interest payments required by New Jersey law and interest payments resulting from the settlement.

Claims eligible for this additional interest are limited to certain lines of business and exclude, for example, claims of members enrolled in the Federal Employee Program (FEP), certain national account groups managed outside of New Jersey and Medicare or Medicaid programs. Other limitations include:

- Duplicate claims submitted within 30 days of the original claim submission.
- Claims that include a defect or error that prevents it from being systemically processed.
- Claims of a physician who balance bills a Horizon BCBSNJ member in violation of their network participation agreement.
- Claims paid to a member.
- Claims payable during a major disruption in services for which claims processing is excused or delayed as a result of that event.

Please note that, in accordance with the settlement agreement entered into under Love, et al. v. Blue Cross Blue Shield Association, et al., all additional interest payments will cease for payments made on, or after, May 30, 2011 (not including interest payments that Horizon BCBSNJ is required to make under New Jersey law).
Reimbursement Requests for Under- and Overpayments

The New Jersey state law, known as the Health Claims Authorization, Processing and Payment Act (HCAPPA), effective July 11, 2006, affects physicians, other health care professionals and facilities. This law applies to all insured New Jersey group and individual business. HCAPPA requirements do not apply to certain lines of business, such as self-funded business, including Administrative Services Only (ASO) accounts such as the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP).

Overpayment

Health insurers may only seek reimbursement for overpayment of a claim from a physician or health care professional within “18 months after the date the first payment on the claim was made.” There can only be one reimbursement sought for overpayment of a particular claim. All claims paid on or after July 11, 2006 are subject to this requirement. However, recapture of an overpayment, beyond the 18-month period, is permitted if there is evidence of fraud, a physician or health care professional with a “pattern” of inappropriate billing submits the claim, or if the claim is subject to COB.

Recapture of overpayments by a health insurer may be offset against a physician’s future claims if a notice of account receivable is provided at least 45 calendar days in advance of the recapture, and all appeal rights under HCAPPA are exhausted. An offset will be stayed pending an internal appeal and state-sponsored binding arbitration. However, with prior written consent, Horizon BCBSNJ will honor requests for the recapture prior to the expiration of the 45-day period. If a physician or health care professional prefers to make payment directly to Horizon BCBSNJ rather than permit an offset against future claims, the 45-day notice letter will include an address to remit payment.

Underpayment

Horizon BCBSNJ may extend the notice period up to 90 days. The decision to offer an extended notice period will be made on a case-by-case basis.

Please note that Horizon BCBSNJ will not recapture an overpayment until the expiration of the notice period (except with a physician’s or health care professional’s prior written consent, or if a physician or health care professional remits payment directly to Horizon BCBSNJ). Both the paper voucher and the electronic (HIPAA standard 835 transaction) version of the voucher, if applicable, will reflect the adjustment as soon as it is recorded.

In the event that Horizon BCBSNJ has determined that an overpayment is the result of fraud and has reported the matter to the Office of the Insurance Fraud Prosecutor, HCAPPA allows a recapture of that overpayment to occur without the 45-day notice period.

Underpayment

Under HCAPPA, no physician or other health care professional may seek reimbursement from a member/patient or health insurer for underpayment of a claim submitted later than 18 months from the date the first payment on the claim was made, except if the claim is the subject of an HCAPPA appeal submitted or the claim is subject to continual claims submission.

No physician or other health care professional may seek more than one reimbursement for underpayment of a particular claim.
Advanced Imaging Services and Cardiology Imaging Programs

CareCore National, LLC (CareCore) works with Horizon BCBSNJ to help coordinate members’ Advanced Imaging Services (AIS) and members’ cardiology imaging services by providing prior authorization/medical necessity determination.

CareCore:
- Helps ensure that appropriate radiology/imaging services are provided to members.
- Provides clinical consultation to participating physicians and other health care professionals.
- Assists in the scheduling of radiology/imaging services.

Prior Authorization/Medical Necessity Determination

Prior authorization (PA) or Medical Necessity Determination (MND) is required for some Horizon BCBSNJ products (i.e., Horizon POS, NJ DIRECT, NJ PLUS, Horizon Direct Access, insured Horizon PPO and Medicare Advantage plans) for the services listed below.

An ordering physician must request a PA/MND for the following AIS:
- CT and CTA scans.
- MRIs.
- MRAs.
- PET scans.
- Nuclear medicine studies (including nuclear cardiology).

An ordering physician must request a PA/MND for the following cardiology imaging services:
- Echo Stress.
- Diagnostic Left Heart Catheterization.
- Echocardiograms.

Please note that this listing is accurate at time of printing. Visit www.HorizonBlue.com and click Radiology/Imaging for the most current information.

Echocardiograms

An initial echocardiogram requires prior notification, not prior approval. Prior notification ensures that the service is the member’s first echocardiogram and that it will be properly reimbursed. PA/MND is required for any subsequent echocardiograms requested on a patient who had an initial echocardiogram performed on or after July 1, 2008.

Pediatric cardiologists are not required to provide clinical information to CareCore, but they are required to contact CareCore to notify of each echocardiogram to be performed. This notification will ensure that claims are processed correctly.

Verifying the Need for a PA/MND

CareCore can advise which Horizon BCBSNJ patients require PA/MND for the AIS and cardiology imaging services that are provided in a physician’s office, freestanding radiology site or in an outpatient setting.

Visit www.carecorenational.com to verify a member’s participation in this program.

You may also call CareCore, toll-free, at 1-866-496-6200, Monday through Friday, between 7 a.m. and 7 p.m., Eastern Time (ET), and Saturday and Sunday, between 9 a.m. and 5 p.m., ET, to confirm a member’s participation in this program.

PA/MND Exceptions/Exclusions

PA/MND does not apply to radiology/imaging services that are:
- Ordered during Emergency Room visits.
- Performed while a member is an inpatient.

PA/MND requirements do not apply to:
- Members enrolled in self-insured Administrative Services Only (ASO) groups (unless the groups have opted-in to the program).
- Members enrolled in the New Jersey State Health Benefits Program’s Traditional Plan.
- Members enrolled in the Federal Employee Program (FEP).
• Members enrolled in Horizon NJ Health.
• Members enrolled in Traditional/Indemnity plans (but members may use CareCore’s Scheduling Line services as a convenience).
• Small Employer (Reform) and Individual policyholders. However, we recommend that cases be reviewed for medical necessity. This helps to ensure timely and accurate claim payment and protect the member from balance billing in the event that a claim payment is recaptured due to a retrospective determination that the service is not medically necessary.
• Members for whom Horizon BCBSNJ is the secondary insurance carrier.
• Medigap members.
• BlueCard members.

The PA/MND Process
To obtain a PA or a pre-service MND for a procedure, the participating physician who is requesting the service should contact CareCore and supply the relevant clinical information to support the need for the service.

1. The ordering physician’s office contacts CareCore to request a PA/MND by either:
   • Submitting a request online through www.carecorenational.com (available 24 hours a day, seven days a week).
   • Calling CareCore at 1-866-496-6200, Monday through Friday, between 7 a.m. and 7 p.m., ET, and Saturday and Sunday, between 9 a.m. and 5 p.m., ET.
   • By faxing a request to CareCore at:
     – 1-800-657-5204 for AIS.
     – 1-888-785-2480 for cardiology imaging services.

2. CareCore requires the following relevant clinical information and history:
   • Completed fax form (if faxing your request).
   • Clinical office notes.
   • Consultation reports.
   • Previous diagnostic reports (visit www.carecorenational.com/physicians.asp for more information).

3. CareCore will contact the member to schedule the procedure at a participating rendering location. When possible, CareCore will conduct a three-way call with the member, CareCore and the rendering location to facilitate the scheduling process.

   Members may also call CareCore directly at 1-866-969-1254 to schedule the approved procedure. Members will receive a letter from CareCore confirming the scheduled appointment.

   If you call to initiate a case on Saturday or Sunday, you will be advised to have the member call CareCore at 1-866-969-1254 on Monday to schedule the procedure.

4. Once the appointment is scheduled, CareCore will fax a notice to your office. The notice will include the PA/MND confirmation and the location where the imaging services will be performed.

   A PA/MND request may be made up to two weeks prior to the planned date of service. Determinations are made as soon as possible, not to exceed two business days from the receipt of all required clinical information.

   Provided that all necessary clinical information is made available, physicians who call CareCore will generally receive the PA/MND number by the end of the call.
Medically Urgent Requests
CareCore accommodates medically urgent requests (non-life-threatening requests that can wait up to three hours) for PA/MND. Urgent cases are handled as soon as possible, with no more than a three-hour turnaround. Please make urgent requests to CareCore by telephone at 1-866-496-6200.

Emergent cases should be directed to the nearest ER; PA/MND is not required.

PA/MND Numbers
• The format of the cardiology imaging services PA/MND number follows the same format as numbers for advanced imaging services:
  One alpha character, followed by nine numbers, followed by the CPT code. For example: A123456789-799999.
• PA/MND numbers are good for up to 45 calendar days from the date of the initial request.
• To verify a PA/MND number, visit www.carecorenational.com, or call CareCore at 1-866-496-6200 Monday through Friday, between 7 a.m. and 7 p.m., ET, and Saturday and Sunday, between 9 a.m. and 5 p.m., ET.

CareCore’s Scheduling Line
Radiology/Imaging scheduling services are available to all Horizon BCBSNJ members regardless of the product in which they are enrolled.

Physicians and patients may call the toll-free Scheduling Line at 1-866-969-1254, Monday through Friday, between 7 a.m. and 7 p.m., ET.

Physicians who use the Scheduling Line do not need to create a referral for their managed care patients.

Members may use the Scheduling Line to schedule appointments for AIS procedures that have been authorized, as well as for other radiology/imaging procedures that are prescribed for them.

Prescription Pads and Fax Forms
Your office should have received radiology/imaging prescription pads and fax forms. If you did not receive these, please call CareCore at 1-866-496-6200. Fax forms are available on www.HorizonBlue.com within the Downloadable Forms section.

Services Provided Outside of New Jersey
If the rendering facility participates with Horizon BCBSNJ directly (including those facilities within the contiguous counties of Delaware, Pennsylvania and New York) the physician will need to obtain PA/MND from CareCore.

If the rendering facility does not participate with Horizon BCBSNJ, no PA/MND is needed. These claims process against the member’s out-of-network benefits (if applicable) or through the BlueCard program.

Roles and Responsibilities
• The referring physician is responsible for obtaining PA or MND from CareCore. Physicians can obtain a PA/MND by either:
  – Submitting a request online through www.carecorenational.com (available 24 hours a day, seven days a week).
  – Calling CareCore at 1-866-496-6200, Monday through Friday, between 7 a.m. and 7 p.m., ET, and Saturday and Sunday, between 9 a.m. and 5 p.m., ET.
  – By faxing a request to CareCore at:
    • 1-800-657-5204 for AIS.
    • 1-888-785-2480 for cardiology imaging services.
• The rendering physician/site, prior to rendering services, is responsible for verifying that a PA/MND has been obtained.

Rendering physicians/sites can validate that a PA/MND has been obtained online at www.carecorenational.com or by calling CareCore at 1-866-496-6200.

Services provided without a PA/MND in place may result in non-payment of services.
• The rendering physician/site, after rendering services, must notify CareCore within two days if the service provided differs from the service indicated on the PA/MND.

CareCore will not accept a request for prior authorization or medical necessity determination from a radiology facility. However, CareCore will accept requests for upgrading or downgrading of an approved AIS procedure from a radiology facility.

• The rendering site must ensure that CareCore’s PA/MND number is included on all claim submissions (including claims for professional component) for AIS services provided to those members whose contracts require PA/MND.

Diagnostic Radiology Quality Standards

Horizon BCBSNJ has compiled a set of diagnostic radiology quality standards to help ensure that all our members consistently receive high levels of care in imaging throughout our network. Our quality standards were reviewed and approved by a Radiology Advisory Committee comprised of participating physicians from a variety of specialties.

We request that all participating physicians, other health care professionals and facilities that perform any radiology or imaging procedures, visit www.HorizonBlue.com to review our quality standards and initiate any necessary corrective actions to come into compliance with our standards.

Please pay special attention to the approved accreditation agencies that apply to your office and to the equipment/modality requirements. The approved accreditation agencies will specify personnel educational requirements for the covered modalities.

To review our diagnostic radiology quality standards online, visit www.HorizonBlue.com/Providers and:

• Mouse over Forms and Vouchers and click Provider Reference Materials.

• Click Utilization Management.

• Click the link under Medical Policies and Guidelines.

• Read the Medical Policy disclaimer and click the statement: If you have read and agree with the previous statement, you may access Horizon BCBSNJ’s Medical Policies by clicking HERE.

• Within the Medical Policy Manual, click Section and then click Radiology.

• Click Standards for Diagnostic Radiology/Imaging Facilities/Freestanding-Office including Surgi-Centers and Diagnostic Dental Radiographic Imaging.

If you have questions, or would like to have these standards mailed to you, please contact your Professional Relations Representative.
Radiation Therapy Utilization Management Program

CareCore works with Horizon BCBSNJ to help coordinate radiation therapy services that are provided to Horizon BCBSNJ members who have been diagnosed with cancer. CareCore works with the treating radiation oncologist to make use of his or her treatment plan to provide information used to determine the appropriate level of care for radiation therapy services.

This program offers clinicians the necessary flexibility to render appropriate quality care in a timely manner and it ensures safety by requiring technologies used in radiation therapy to conform to appropriate standards established by a national board of recognized radiation oncologists.

If a pre-service MND is not obtained, reimbursement may be delayed pending a post-service medical necessity review to determine medical necessity. This post-service medical necessity review will be conducted by CareCore applying the same medical policies as used during a pre-service MND.

The time limit for initiating a post-service MND is 18 months from the date of service. If a request does not demonstrate medical necessity, you will be notified in writing. This notice will provide detailed instructions to submit clinical appeals.

Plans That Require MND

MND applies to radiation therapy services provided in all participating and nonparticipating office and outpatient settings to members enrolled in the following plans:

- Horizon HMO.
- Horizon HMO Access.
- Horizon Point of Service (POS).
- Horizon Direct Access.
- Indemnity and PPO.
- Horizon Medicare Advantage plans.
- Small group plans.

Services that Require MND

MND is required for the following radiation therapy services:

- Bone Metastases.
- Brain Metastases.
- Breast Cancer.
- Cervical Cancer.
- Endometrial Cancer.
- Gastric Cancer.
- Head/Neck Cancer.
- Non-Small Cell Lung Cancer.
- Pancreatic Cancer.
- Primary Central Nervous System Lymphoma.
- Primary Central Nervous System Neoplasms.
- Prostate Cancer.
- Rectal Cancer.
- Small Cell Lung Cancer.

Please note that chemotherapy drugs are not included in this program.

MND Exclusions

MND does not apply to and is not required for:

- Members enrolled in self-funded groups.
- Members enrolled in Horizon NJ Health.
- Members enrolled in any New Jersey State Health Benefits Program (SHBP) or School Employees’ Health Benefits Program (SEHBP) plan.
- Members enrolled in the Federal Employee Program (FEP).
- Members enrolled in Medigap plans.
- Members whose Horizon BCBSNJ coverage is secondary to another insurance plan.
- BlueCard members.
- Services rendered during an Emergency Room visit or inpatient stay.
Requesting a MND
The Radiation Oncologist who has determined the type of Radiation Therapy treatment the patient will receive is responsible for obtaining the MND.

There are two ways to request a radiation therapy MND from CareCore:

• Submit an online request, along with the necessary information, through <www.carecorenational.com>.

• Call CareCore, toll-free, at 1-866-242-5749, Monday through Friday, between 7 a.m. and 7 p.m., ET, and Saturday and Sunday, between 9 a.m. and 5 p.m., ET.

A radiation therapy MND request may be made up to two weeks prior to the planned administration of the treatment plan.

MND Timeframes
Provided that all necessary clinical information is provided and meets clinical criteria, physicians who:

• Submit an online request can obtain a MND online in real time.

• Telephone CareCore can receive a MND number by the end of the call.

Determinations will be made as soon as possible, but no later than three business days from the receipt of all required clinical information.

Medically Urgent Requests
CareCore accommodates medically urgent requests (non-life-threatening requests that can wait up to three hours) for MND. Urgent cases are handled as soon as possible, with no more than a three-hour turnaround. Please make urgent radiation therapy requests to CareCore by telephone at 1-866 242-5749.

Necessary Information
CareCore makes worksheets specific to each cancer type available on their website, <www.carecorenational.com>. The worksheets assist the physician ordering the radiation therapy treatment by outlining the clinical and treatment plan information that is required when submitting a request for a MND, including:

• The cancer type being treated with radiation therapy.

• Patient information.

• Ordering physician information.

• Rendering site information.

• Patient history.
  – Recent test results.
  – Work up information.
  – Current clinical condition.

• Treatment plan specifics (which may include):
  – Immobilization techniques.
  – Treatment plan.
  – Treatment technique.
  – Fields.
  – Fractions.
  – Boost.

MND Numbers

• The format of a radiation therapy MND number follows the same format as numbers for advanced imaging services:

  One alpha character, followed by nine numbers, followed by the CPT code.

  For example: A123456789-79999.

• One MND number is assigned per treatment plan.

• To verify and review authorizations and their expiration dates, visit www.carecorenational.com, or call CareCore at 1-866-496-6200 Monday through Friday, between 7 a.m. and 7 p.m., ET, and Saturday and Sunday, between 9 a.m. and 5 p.m., ET.
Claim Denials
Claims may be denied for a variety of reasons. Please review denial reason code and description on the Explanation of Payments you receive to help determine your next steps.

If your claim is denied due to a:

- Lack of a MND, submit a MND request right away. If your request does not demonstrate medical necessity, you will be notified in writing. This notice will provide detailed instructions for submitting clinical appeals.
- Pre-existing condition, eligibility, provider/site participation or another benefit-related issue, please call Horizon BCBSNJ’s Physician Services at 1-800-624-1110.

If you are having other issues with radiation therapy claims not paying, please call CareCore Customer Service at 1-866-242-5749.

Episodes of Care
A MND is valid for the treatment plan that has been requested by the physician (an episode of care). A new MND must be established to provide the member with another episode of care.

Modifying an Approved Treatment Plan
Call 1-866-242-5749 and speak to a CareCore Medical Director if, during a course of treatment, you wish to modify an approved treatment plan.

The treatment plan modifications that are determined to be medically necessary will be communicated during the call.

If a member changes physicians/facilities in the middle of a treatment plan, a new MND must be created.

Partial Approval Notice
This document will inform the provider of approved and nonapproved services for the requested treatment plan. It will also contain clinical appeal information.

If you received a partial approval you will need to submit additional clinical information to CareCore for the remainder of the treatment plan.

Peer-to-Peer Consultations
Physicians who do not agree with CareCore’s determination may discuss the case in detail with a CareCore Medical Director by calling 1-866-242-5749.

Appealing Clinical Decisions
Physicians may appeal a clinical decision in writing to:

   CareCore National
   Attn: Clinical Appeals, Mail Stop 600
   400 Buckwalter Place Blvd.
   Bluffton, SC  29910

Clinical appeals may also be faxed to 1-866-699-8128.

CareCore Resources
For access to a number of CareCore tools and resources, visit www.carecorenational.com and click Provider Resources.

From this page, you can:

- Click Provider Tools to display CareCore process tutorials, fax forms, worksheets and more.
- Click Criteria to review CareCore’s criteria for referring physicians.
Coordination of Benefits

Coordination of Benefits (COB) applies when expenses for covered services are eligible under more than one insurance program. Usually, one health insurance company has primary responsibility and there is at least one other health insurance company with responsibility for any remaining patient liability. On occasion, an automobile insurance or workers’ compensation insurance carrier will be involved.

Regardless of which insurance carriers are responsible, the combined payments are never greater than the actual charges of services and generally are not more than the primary carrier’s contract rate. This portion of the manual offers some guidelines to help in COB situations.

Please remember to ask your patient if they have other health insurance coverage.

Obligations of Physician to Obtain COB Information and to Bill Primary First

Claims should be submitted to the primary carrier first. You must assist with processing forms required to pursue COB with other health care plans and coverages (including, without limitation, workers’ compensation, duplicate coverage and personal injury liability). You are required to make diligent efforts to identify and collect information concerning such other health care plans and coverages at the time of service and, where Horizon BCBSNJ is or appears to be secondary to another plan or coverage, you must first seek payment from such other plans or coverage, according to the applicable rules for COB.

HCAPPA Revised COB Rules

The New Jersey state law known as the Health Claims Authorization, Processing and Payment Act (HCAPPA), states that no health insurer can deny a claim while seeking COB information unless “good cause” exists for the health insurer’s belief that other coverage is available (when applicable). For example, if the health insurer’s records indicate that other insurance coverage exists. Horizon BCBSNJ will continue to gather information from members regarding other benefits in an effort to maintain accurate records and have the appropriate health insurer be financially responsible.

Patient who has Two or More Insurance Plans (other than Medicare, Motor Vehicle Accidents or Workers’ Compensation)

Claim is for the covered spouse of a Horizon BCBSNJ subscriber who also has his/her own health plan:

• The spouse’s health plan is always primary UNLESS all of the following are true: the spouse is retired; the spouse is also eligible for Medicare; our subscriber is covered as an active employee and Medicare is not primary under the Medicare Secondary Payer rules described beginning on page 47.

In this event, the Horizon BCBSNJ coverage is primary, Medicare is secondary and the spouse’s health plan is tertiary.

Claim is for a Horizon BCBSNJ subscriber who also has coverage as a subscriber with another health plan. If the subscriber is:

• An active employee of one group and a retired employee of another, the plan from the group where the employee is active is primary.

• A retired employee of two groups, the plan in effect the longest is primary.

• An active employee of two groups, the plan in effect the longest is primary.
Coordination of Benefits

Claim is for a dependent child, whose parents are not separated or divorced:

- If the parents both have health insurance, determine from their benefit plans whether the Birthday Rule or the Gender Rule will apply. In most cases, the Birthday Rule will apply.

Claim is for a dependent child whose parents are separated or divorced:

- The plan of the parent with the financial responsibility for health care expenses (as determined by the court) is the primary plan, regardless of who has custody of the child.
- In claims for a dependent child whose parents are separated or divorced, but a court has not stipulated financial responsibility, the unmarried parent with custody is primary. The other parent is secondary.
- Any coverage through a stepparent married to the custodial parent would be next, and the noncustodial parent’s coverage last.

Birthday Rule

To determine the primary carrier, you need the month and day of the parents’ birth dates; the year is never considered. The parent whose birthday falls earlier in the year has the primary plan for the dependent child. If both parents have the exact same birthday (month and day), the plan in effect the longest is primary. The Birthday Rule will only apply if both carriers use the Birthday Rule.

Gender Rule

The father’s plan is primary for the dependent child. If one parent’s contract uses the Birthday Rule and the other contract uses the Gender Rule, then the Gender Rule determines the father’s plan as primary.

Motor Vehicle Accidents

If the primary carrier is:

- The auto insurance, you must submit your claim to them. Once you receive an Explanation of Payment (EOP), send it to us along with a completed copy of the automobile declaration sheet, a claim form and an itemized bill. Electronic claims cannot be accepted because of the additional information required to process the claim.
- Horizon BCBSNJ, we need a copy of the automobile declaration sheet where the subscriber has indicated the health insurance as primary. Be sure to attach an itemized bill and completed claim form.

Automobile insurance is not primary for motorcycle accidents.

Workers’ Compensation

Workers’ compensation covers any injury which is the result of a work-related accident. Employers purchase insurance which covers work-related illnesses or injuries.

Horizon BCBSNJ does not provide payment for services rendered to treat work-related illnesses or injuries or for services or supplies which could have been covered by workers’ compensation.

Always bill the workers’ compensation carrier directly for work-related illnesses or injuries. If Horizon Casualty Services, Inc. is the workers’ compensation carrier, please mail medical bills to:

Horizon Casualty Services
55 Washington Street, 11th floor
Newark, NJ 07102-5194


**Regulations on New Jersey Insured Group Policy**

Special rules apply for COB where the Horizon BCBSNJ policy is an insured group policy issued by Horizon BCBSNJ. N.J.A.C. 11:4-28.7, as amended effective January 1, 2003, provides for different COB rules (as to insured group policies issued in New Jersey) depending on what basis the primary and secondary plans pay and whether the physician is or is not in the network of either or both plans.

If Horizon BCBSNJ is the primary payer, these rules do not apply. If the Horizon BCBSNJ insured group policy is secondary and the physician or other health care professional is in Horizon BCBSNJ's network, these rules apply:

- Where both the primary and secondary plans pay on the basis of a contractual fee schedule and the physician is in the network of both plans, Horizon BCBSNJ pays the cost sharing of the covered person under the primary plan up to the amount Horizon BCBSNJ would have paid if primary, provided that the total amount paid to the physicians from the primary plan, Horizon BCBSNJ, and the covered person does not exceed the contractual fee of the primary plan and provided that the covered person is not responsible for more than the cost sharing under our plan. (N.J.A.C. 11:4-28.7(e)1.)

- Where the primary plan pays on the basis of UCR and Horizon BCBSNJ pays on the basis of a contractual fee schedule, the primary plan pays its benefits without regard to the other coverage and Horizon BCBSNJ pays the difference between billed charges and the benefits paid by the primary plan up to the amount we would have paid if primary. Our payment is first applied to the covered person's cost sharing under the primary plan. The covered person is only liable for cost sharing under our plan if he/she has no liability for cost sharing under the primary plan and the total payments of the primary and our plan are less than billed charges. The covered person is not responsible for billed charges in excess of the amounts paid by the primary and secondary plans and cost sharing under either plan. The covered person can never be responsible for more than the cost sharing under the secondary plan. (N.J.A.C. 11:4-28.7(e)2.)

- Where the primary plan pays on the basis of a contractual fee schedule but the secondary pays on the basis of UCR, and the physician or other health care professional is in the network of the primary plan, the secondary plan pays any cost sharing of the covered person under the primary plan up to the amount the secondary would have paid if primary. (N.J.A.C. 11:4-28.7(e)3.)

- Where the primary plan is an HMO plan but the physician or other health care professional is out of network and services are not covered by the primary plan, Horizon BCBSNJ pays as if it were primary. (N.J.A.C. 11:4-28.7(e)4.)

- Where the primary plan pays capitation and Horizon BCBSNJ's plan is an HMO plan that pays on a contractual fee schedule and the physician or other health care professional is in the network of both plans, Horizon BCBSNJ pays the cost sharing of the covered person under the primary plan up to the amount Horizon BCBSNJ would have paid if primary. (N.J.A.C. 11:4-28.7(e)5.)

- Where the primary plan pays capitation, contractual fee schedule or UCR, and Horizon BCBSNJ's plan pays on a capitated basis, Horizon BCBSNJ pays its capitation and the covered person has no responsibility for payment of any amount for eligible services. (N.J.A.C. 11:4-28.7(e)6.)

- Where the primary and Horizon BCBSNJ's plan are both HMO plans and the physician or other health care professional is not in the primary plan's network, and the primary has no liability, Horizon BCBSNJ pays as if primary. (N.J.A.C. 11:4-28.7(e)7.)
**Medicare Eligibility**

There may be instances when an individual who has coverage with us may also be entitled to Medicare coverage. This section will help you to determine which plan will pay as primary.

COB when Medicare is involved is usually called Medicare Secondary Payer (MSP). MSP does not apply to members who have individual contracts. Medicare is always primary for individual contract holders.

There are three ways a person can become eligible for Medicare:

- **Attaining age 65.**
- **Becoming disabled.**
- **Having end-stage renal disease (ESRD).**

**Attaining Age 65**

When individuals attain age 65 and have contributed enough “working quarters” into the Social Security system, they are entitled to Medicare Part A benefits at no cost. To receive Medicare Part B benefits, they must pay premiums through monthly deductions from their Social Security checks.

For individuals who have not contributed enough quarters in the Social Security system, there are two ways they may receive Medicare Part A benefits:

- **Through a spouse who has contributed enough quarters to the Social Security system.** This is identified by the letter B following the spouse’s Medicare claim number on his or her Medicare ID card.
- **Purchase Medicare Part A benefits.** This is identified by the letter M following the Medicare claim number on his or her Medicare ID card.

**Becoming Disabled**

Disabled individuals under age 65 are entitled to Medicare under the disability provisions of the Social Security Act. They must be unable to work and must have been receiving Social Security disability payments for 24 months. Beginning with the first day of the 25th month of receiving Social Security payments, they are entitled to Medicare Part A benefits at no cost. Medicare Part B benefits may be purchased.

**Having End-Stage Renal Disease (ESRD)**

A person becomes eligible for Medicare under the ESRD provisions after beginning a regular course of renal dialysis. He/She is entitled to Medicare benefits after completing a three-month waiting period beginning the first day of the month after the start of a regular course of renal dialysis. The waiting period continues until the first day of the fourth month following the initiation of renal dialysis. On the first day of the fourth month, such a person is entitled to Medicare Part A at no cost. Medicare Part B benefits may be purchased.

The three-month eligibility waiting period for ESRD Medicare benefits may not apply when the Medicare-eligible individual:

- **Receives a kidney transplant.** In this circumstance, the individual is entitled to Medicare the first day of the month in which the transplant occurred.
- **Initiates a course of self-dialysis training during the three-month waiting period.** In this circumstance, the individual becomes entitled to Medicare the first day of the month of his or her eligibility.
Medicare Secondary Payer

There are three ways a Medicare-eligible person may be primary with us under an employer group health program:

• Working-aged.
• Disabled.
• End-stage renal disease (ESRD).

Working-Aged

When a person becomes entitled to Medicare at age 65, there is the possibility that he or she has health insurance through an employer group health account. It is important to know whether the policyholder (subscriber) is retired or actively working.

To determine the primary carrier, three questions need to be asked of the Medicare beneficiary who has a group health policy through Horizon BCBSNJ:

1. Are you or your spouse actively employed?
2. Are there 20 or more employees (regardless if full-time or part-time employees) where you or your spouse work?
3. Are you covered under that insurance policy?

If the answers to all three questions are YES, then the Horizon BCBSNJ group health policy is primary to Medicare for the Medicare-eligible person.

Examples:

• Patient is 67 years old and is entitled to Medicare. She is actively working for a company that employs 25 full-time and part-time employees and receives health coverage through her employer. The health coverage through her employer would be primary since she is actively working and Medicare would be secondary.

• Patient is 76 years old, retired and is entitled to Medicare. He is covered under his wife’s group health coverage. His wife is actively working for a group of more than 20 employees. She is not yet entitled to Medicare. For this patient, his wife’s coverage would be primary and Medicare secondary since he is covered by his wife’s group health coverage. Even if the wife were Medicare-entitled, they would both be primary with the group insurance because the wife is actively working.

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<td>• Beyond 30 months of Medicare entitlement</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>• Medicare already paying primary due to attaining age 65 or disability and then ESRD</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Please note that with Medicare disability, a group may be a multi-employer, such as the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP) or a local union. Be sure to identify the larger group before determining the number of employees.
Coordinating Benefits

- Husband is 70 years old, actively working for a group of more than 20 employees and also entitled to Medicare. Additionally, his wife is actively working and has health coverage through her employer. In this situation, the husband’s coverage would be primary for him, his wife’s health coverage would be secondary and Medicare would be tertiary.

- Patient is over age 65, entitled to Medicare and actively employed. His employer only has 10 employees, so Medicare would be primary and his group health care coverage secondary. In this case, the patient should enroll in both Medicare Part A and Part B. Since the MSP provisions do not apply, Medicare is primary and Horizon BCBSNJ will never pay more than we would have had the patient purchased Medicare Part B.

Special Enrollment Period for Medicare Part B Benefits

A Medicare-eligible person may choose not to purchase Medicare Part B since it may not be necessary if the group is primary. When Medicare becomes primary, the subscriber may sign up for Medicare Part B benefits, with no increase in premiums. Coverage begins the first day of the month following the month the primary coverage ends. They must sign up immediately upon becoming eligible once Medicare is primary, since the Medicare Part B benefits will only begin the first of the month that they sign up. This is called the Special Enrollment Period (SEP).

If an individual is entitled to Medicare because of age and is covered under the MSP provisions, they have the right to select Medicare as primary. If they do so, they must be dropped from their employer’s group health benefits with the exception of prescription drug and dental coverage. The employer may not subsidize a supplemental Medicare plan under these circumstances.

If Medicare is primary and the subscriber chooses not to purchase Medicare Part B benefits, we will never pay more than we would have if that individual had Medicare Part B benefits. In addition, this person would not be eligible for the Special Enrollment Period (SEP) and would face increased premiums and be restricted when they may sign up for Medicare Part B benefits.

Medicare Exceptions

Medigap

MSP regulations only apply when the insurance coverage is through an employer. A Medicare supplemental policy may be offered by an employer (if there are less than 20 employees or if the employee is not actively working) or purchased on an individual basis; however, a Medicare supplemental policy will never be primary over Medicare.

Medicare Part A

If there are no Medicare Part A benefits, MSP regulations do not apply. Medicare Part A services are billed to the group health plan.

These individuals are identified with an M at the end of the Medicare claim number on their Medicare ID card.

Disabled

Individuals entitled to Medicare due to disability must be under the age of 65, otherwise the working-aged provisions apply. You should ask the following questions to determine primacy:

- Are you, your spouse or a family member actively employed?
- Are there 100 or more employees (regardless if full-time or part-time) where you, your spouse or family member works?
- Are you covered by that insurance policy?

The two important differences between the MSP working-aged and the disability provisions are:

- Who the active employee is; and
- The number of employees in the group.

Unlike the working-aged provisions, under the MSP disability provision, the Medicare-eligible individual may be covered by a family member other than their spouse. This typically occurs when a parent or legal guardian covers a disabled dependent – either child or adult.
Coordination of Benefits

Under the disability provisions, the employer must employ 100 or more employees. It is important to verify the number of employees because the patient may be part of a subgroup within a group, such as the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP). There may be local municipalities with fewer than 100 employees, but the larger group has greater than 100 employees. The number of employees in the entire employer group is considered when making the determination of eligibility for Medicare due to disability.

Examples:
- The patient is entitled to Medicare due to disability. He is not actively working, but his wife is and she has family health coverage through her employer, who has more than 100 employees. The patient would be primary under his wife’s group health policy since she is actively employed by an employer of 100 or more employees and her group health insurance covers him.
- A patient is entitled to Medicare due to disability and is covered under his mother’s insurance. She is actively employed and has family group health coverage through the employer who employs more than 100 individuals. In this case, the son’s primary insurance is the mother’s group health insurance plan.
- The patient is Medicare-eligible due to disability and is actively employed by a municipality that provides group health coverage. While she is no longer collecting Social Security disability payments, she still continues under the Medicare program. The municipality has only 55 employees but their health coverage is through the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP), and the state employs more than 100 individuals. The group health insurance would be primary for the patient and Medicare would be secondary.
- A local union that may appear to employ fewer than 100 employees, however, the patient’s coverage is through the Health and Welfare Fund for all union members. If just one of the Locals that belong to that Health and Welfare Fund has 100 or more employees, then any local covered by that group health plan would be covered by the MSP regulations.

End-Stage Renal Disease (ESRD)
A person becomes Medicare-eligible due to ESRD when he or she began a regular course of renal dialysis. As stated earlier, there is a three-month waiting period to receive Medicare Part A and Part B benefits (unless an exception applies). When a person is entitled to Medicare due to ESRD, the MSP regulations will apply when:
- The patient has group health coverage of their own or through a family member (including spouse).
- That group health coverage is through a current or former employer.

When the Medicare beneficiary meets the above conditions, he/she is primary under the group health coverage for a specific period of time known as the Coordination of Benefit (COB) period. The COB period always begins on the first date of entitlement, and all medical services are covered by the group health coverage – not just renal services. If the individual became entitled to Medicare due to ESRD on or after March 1, 1996, they have a 30-month COB period, beginning with the first date of entitlement.

Examples:
- The patient is not working but his wife works. She has family group health coverage through her employer who has 25 employees. The patient began a regular course of renal dialysis on February 20, 2005, and became entitled to Medicare due to ESRD on May 1, 2005. The patient has a 30-month COB period beginning with his first date of entitlement and the COB period will end on October 31, 2007.
Coordination of Benefits

- The patient had a kidney transplant in August 2004. He had not yet begun a regular course of renal dialysis but since he had a kidney transplant, he became entitled to Medicare on August 1, 2004. The patient is a covered dependent under his mother's family health coverage through her employer. In this case, the dependent son would be primary with the group health coverage under a COB period of 50 months ending on December 31, 2007.

- The patient began a regular course of renal dialysis on October 10, 2005. She has group health coverage through a former employer. The following month, she initiated a course of self-dialysis training so her entitlement begins the first day of the month she began a regular course of renal dialysis, October 1, 2005. The three-month waiting period would be waived and her COB period would end on March 51, 2008.

Extending Health Coverage through COBRA

An individual who is Medicare-eligible due to ESRD may extend his or her health coverage through the COBRA provisions. Typically, when a person becomes Medicare entitled, the COBRA provisions no longer apply and that individual may be dropped from the group health coverage. This is not automatic and may vary depending on the employer.

Some may allow the Medicare beneficiaries to continue their coverage while other employers do not. It is up to the individual employer to make that decision.

If a patient has extended their employer health benefits through COBRA, those benefits will be primary over Medicare for the COB period or the duration of COBRA coverage.

Dual Entitlement

Prior to August 10, 1995, an individual who was entitled to Medicare because of ESRD and disability, or ESRD and attaining age 65, automatically became primary to Medicare upon the date of their dual entitlement. On August 10, 1995, the law changed to require the individual to remain primary to the group health plan for the applicable COB period under ESRD, if the group health plan had already been paying as primary.

To determine who is the primary payer, it will be necessary to apply the following rules:

The group health plan is primary when:
- The group was already paying as primary because the individual was not Medicare-eligible.
- The Medicare-eligible individual was covered under the Working-Aged or Disability rules of the MSP provisions.

Medicare is primary when:
- Medicare was already paying primary for a Medicare-eligible individual due to attaining age 65 or disability because they did not fall under either the Working-Aged or Disability provisions.
Horizon BCBSNJ’s goal is to provide prompt administrative responses to our participating physicians and health care professionals’ inquiries and timely resolution of complaints brought to Horizon BCBSNJ’s attention. To assist you with such issues, you are encouraged to use our Interactive Voice Response (IVR) system by calling 1-800-624-1110.

A service representative will be happy to respond to your inquiries or complaints. Our service staff is often able to immediately resolve your questions at the point of contact. The service telephone lines are staffed during regular business hours, Monday through Friday, from 8 a.m. to 6 p.m., ET. You may also submit your inquiries or complaints in writing to:

Horizon BCBSNJ
Physician Services
PO Box 199
Newark, NJ 07101-0199

Provider Inquiries

An inquiry is a verbal or written request for administrative action or information, or an expression of opinion or comment regarding any aspect of Horizon BCBSNJ’s (or its subsidiaries’ or affiliates’) health care plans, or those of its Administrative Services Only (ASO) accounts*. Inquiries are often addressed or resolved by the Horizon BCBSNJ service representative at the point of contact. Examples of inquiries include, but are not limited to, questions regarding eligibility of members, benefits or a particular claim’s status.

* Certain ASO accounts handle inquiries and complaints related to their self-insured plans. In such cases, Horizon BCBSNJ will refer you to the proper person or office for you to pursue your inquiry or complaint.

Provider Complaints

A complaint is a verbal or written expression of dissatisfaction made by a physician or other health care professional, on his/her own behalf, regarding any aspect of Horizon BCBSNJ’s (or one of its subsidiaries’ or affiliates’) health care plans, or the plans of its ASO accounts, including Horizon BCBSNJ’s administration of those plans generally or with respect to a specific action or decision made or taken by Horizon BCBSNJ in connection with any of those health care plans.

Examples of complaints include, but are not limited to:

• Claims issues.
• Credentialing.
• Administrative difficulties.
• Communication problems.

Complaints relating to claims may typically involve:

• Contract benefit issues.
• CPT-4 code inconsistencies.
• Re bundling of charges.
• Incorrect coding.
• Payment disagreements.

Complaints do not include complaints relating to specific utilization management determinations. The process for challenging utilization management determinations is described later in this section.

No physician or other health care professional who exercises the right to file a complaint shall be subject to any sanction, disaffiliation and termination or otherwise penalized solely due to such action.
Inquiries, Complaints and Appeals

Time Limits for Inquiry or Complaint Filing

You may submit a written or verbal complaint within 18 months from the date of the Horizon BCBSNJ decision or action with which you are dissatisfied.

There is no time limit for physicians or other health care professionals to make an inquiry, with the exception that an inquiry related to a specific claim cannot be made beyond the longer of the timely claims filing time period requirement within your contract or the relevant member or covered person’s underlying benefits contract.

There is also no limit applicable for the filing of a complaint relating to matters in general with which you are dissatisfied that do not involve a specific decision or action taken by Horizon BCBSNJ.

Resolving Your Inquiries and Complaints

Horizon BCBSNJ will attempt to address your inquiries and complaints immediately, whenever possible.

Inquiries and complaints will typically be responded to no later than 30 days from Horizon BCBSNJ’s receipt. If an inquiry or complaint involves urgent or emergent care issues, responses are expedited consistent with the circumstances and patient need involved. Our final response will describe what further rights you may have concerning the matter in question.

Those who remain dissatisfied with the outcome of their inquiries and complaints at the conclusion of the internal inquiry and complaint process have the right to contact the following state agency:

Department of Banking and Insurance
Division of Enforcement and Consumer Protection
PO Box 529
Trenton, NJ 08625-0529

1-609-292-5516
Provider Claim Payment Appeal Process

The Health Claims Authorization, Processing and Payment Act (HCAPPA) modified the claim payment determination appeal process under the Prompt Pay law and regulations making it available to participating and nonparticipating physicians, hospitals and other health care professionals for services rendered on, or after, July 11, 2006.

This law affects only insured products offered by Horizon BCBSNJ and its subsidiaries. The law does not apply to Administrative Services Only (ASO) plans, the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP), and federal programs, including Federal Employee Health Benefit Plan (FEHBP) and Medicare. As such, claims for physician and other professional health care services provided to individuals covered under such plans are unaffected by HCAPPA.

If your complaint involves a specific Claim Payment Determination that relates to your treatment of an insured member, written appeals must be initiated on the New Jersey Department of Banking and Insurance (DOBI) required form on or before 90 calendar days following receipt of the health insurer’s claim determination.

The DOBI’s form, the Application for Independent Health Care Appeals Program may be found within the Downloadable Forms section of www.HorizonBlue.com/Providers. This form may also be found on the DOBI’s website, at <www.state.nj.us/dobi>.

Physicians and other health care professionals should include all pertinent information and documents necessary to understand your position on why you dispute the health insurer’s determination of the claim.

Claim appeals for medical services* should be mailed to:

Horizon BCBSNJ
Appeals Department
PO Box 10129
Newark, NJ 07101-5129

* Appeals cannot be of a medical necessity determination. Medical necessity disputes should be appealed through the Independent Health Care Appeals Program (IHCAP).

Health insurers are required by law to make a determination (either favorable or unfavorable) and notify the physician or other health care professional of its decision on or before 30 calendar days following its receipt of the appeal form.

- If a favorable determination is made for the physician or other health care professional, the health insurer must make payment within 30 calendar days of notification of the appeal determination together with any applicable prompt pay interest, which shall accrue from the date the appeal was received.

- If an unfavorable determination is made for the physician or other health care professional, the health insurer must provide the physician or other health care professional instructions for referral to external arbitration.

- If the physician or other health care professional is not timely notified of the determination, or disagrees with the final decision, the physician or other health care professional may refer the dispute to external arbitration.
What is an HCAPPA Claim Appeal?

A Claim Appeal is a written request made by a participating physician or other health care professional asking for a formal review by Horizon BCBSNJ of a dispute relating to the payment of claims. This includes, but is not limited to, a request for a formal review of a Horizon BCBSNJ Claim Payment Determination as described as follows.

What is an HCAPPA Claim Payment Determination?

A Claim Payment Determination is Horizon BCBSNJ’s decision on a submitted claim or a claims-related inquiry or complaint. Claim Payment Determinations may involve recurring payments, such as a base monthly capitation payment, made to a participating physician or other health care professional pursuant to the terms of the contract.

A claim dispute that concerns a utilization management determination, where the services in question are reviewed against specific guidelines for medical necessity or appropriateness to determine coverage under the benefits plan, may not be appealed under this process. These decisions are considered adverse utilization management determinations and follow a different process. Please see page 58 for more information.

HCAPPA External Appeals Arbitration

The New Jersey Department of Banking and Insurance (DOBI) awarded the independent arbitration organization contract to MAXIMUS, Inc.

As of July 2007, parties with claims eligible for arbitration may complete an application and submit it, together with required review and arbitration fees, directly to MAXIMUS, Inc. External appeals are not submitted through Horizon BCBSNJ.

Visit www.njpicpa.maximus.com for additional information and applications.

Physicians and other health care professionals must initiate a request for an external appeal of their claim within 90 calendar days of their receipt of the health insurer’s internal appeal decision.

However, to be eligible for this second level arbitration appeals process, disputes must be in the amount of $1,000 or more. Physicians and other health care professionals may aggregate claims (by carrier and covered person or by carrier and CPT code) to reach the $1,000 minimum.

The independent arbitrator’s decision must be issued on or before 50 calendar days following receipt of the required documentation.

The decision of the independent arbitrator is binding.

Payment must be issued within 10 business days of the arbitrator’s decision.

Provider Claim Payment Appeal Process: Third Party Representation

Participating and nonparticipating physicians and other health care professionals may wish to use the services of a third party organization or service to file a Claim Appeal on their behalf. If so, Horizon BCBSNJ has specific requirements that must be met to safeguard the patient health information entrusted to us by our members or covered persons.

Please call Physician Services at 1-800-624-1110 for more details on these requirements.
Inquiries, Complaints and Appeals on Behalf of Members

In addition to the rights you have as a physician or other health care professional, Horizon BCBSNJ offers complaint and appeal processes for members/covered persons.

These member-based processes relate to our utilization management decision-making as well as all other nonutilization management issues. As with our physician-based processes, these processes are designed to handle our members’ or covered persons’ concerns in a timely manner.

From time to time, our members or covered persons may seek their physicians’ or other health care professionals’ assistance in pursuing an inquiry, complaint or appeal on their behalf. Physicians and other health care professionals may only pursue these avenues on behalf of their patients if the consent of the patient is obtained.

Non-Utilization Management Member Inquiries and Complaints

Horizon BCBSNJ’s process for handling member inquiries and complaints is similar to the manner in which Horizon BCBSNJ handles physician-based issues. However, our member inquiries and complaints are handled through our Member Services Department, which members may reach by calling 1-800-355-BLUE (2583).

A Member Services Representative will be happy to respond to member inquiries or complaints, or those made by a physician or other health care professional on behalf of a member with their consent. Our service staff is often able to immediately resolve questions at the point of contact. Member Services telephone lines are staffed during regular business hours, Monday through Wednesday and Friday, from 8 a.m. to 6 p.m., and Thursday, from 9 a.m. to 6 p.m., ET.

Inquiries or complaints may also be submitted in writing to:

Horizon BCBSNJ
Member Services
PO Box 820
Newark, NJ 07101-0820

Physicians and other health care professionals are reminded that to pursue an inquiry or complaint on behalf of a member through Member Services, physicians and other health care professionals must have the consent of the member.

The timeframe for submission and response to member inquiries is similar to those under the physician-based process. Member inquiries and complaints are typically responded to within 15 days from receipt when they involve any claims for a benefit that requires Horizon BCBSNJ’s approval in advance prior to receipt of services (a pre-service determination), and 30 days from receipt in all other instances (a post-service claim).

If a member inquiry or complaint involves urgent or emergent care issues, responses are expedited consistent with the circumstances and patient need involved. Our final response will describe what further rights the member may have concerning the matter in question.
Filing an Appeal on Behalf of a Member

Prior to receiving services, a covered person or a person designated by the covered person may sign a consent form authorizing a physician or other health care professional acting on the covered person’s behalf to appeal a determination by the carrier to deny, reduce or terminate benefits. The consent is valid for all stages of the carrier’s informal and formal appeals process and the Independent Health Care Appeals Program. The covered person shall retain the right to revoke his/her consent at any time.

When appealing on behalf of the member, HCAPPA requires that the physician or health care professional provide the member with notice of the appeal whenever an appeal is initiated and again at each time the appeal is continued to the next stage, including any appeal to the Independent Utilization Review Organization (IURO).

Non-Utilization Management Determination Appeals

Member Appeals – Requesting an Appeal*

Following the receipt of the complaint determination, in appropriate instances, the member/covered person, or a physician or other health care professional on behalf of, and with the consent of the member or covered person, may request an appeal either orally, in-person or by telephone, or in writing as instructed by Horizon BCBSNJ in its complaint determination.

Horizon BCBSNJ’s written complaint determinations will detail the member’s appeal rights. Members are directed to send their appeal requests, whether by phone or in writing, to the appeals unit at the address and telephone number supplied.

An Appeals Coordinator investigates the case and collects the information necessary to forward the case to the Appeals Committee.

Within five calendar days of receiving the appeal request, the Appeals Coordinator sends the member/covered person a letter acknowledging the request for appeal, describing the Appeal Committee process and advising of the actual hearing date.

* Members/covered persons enrolled in certain plans, such as ASO and self-insured accounts, may not have the appeal rights described here.
Resolving the Member’s Appeal

Cases are scheduled within five days of receiving the request for an appeal related to a pre-service determination and within 10 days for an appeal related to a post-service claim. Appeals that involve requests for urgent or emergent care may be expedited.

The member/covered person is given the option of attending the hearing in person or via telephone conference. The Appeals Coordinator makes the appropriate arrangements.

Members/covered persons, or physicians and other health care professionals on behalf of and with the consent of members or covered persons, who participate in the hearing are notified of the Committee’s decision verbally, on the day of the hearing, whenever possible. Written confirmation of the decision is sent to the member/covered person and/or the physician or other health care professional who pursued the appeal on their behalf, within two business days of the decision.

Appeals are decided within 15 days of receipt for pre-service determinations and 30 days of receipt for post-service claims. Letters of decision advise members what other remedies may be available to them if they remain dissatisfied with the resolution reached through the internal complaint system.

Expedited Complaints and Appeals

Member complaints and appeals may be expedited if the complaint or appeal involves a request for urgent or emergent care. Horizon BCBSNJ reserves the right to decide if the complaint or appeals process should be expedited in instances where the member/covered person or their representative is not a physician.

Expedited complaint review determinations are made as soon as possible, in accordance with the medical urgency of the case, which in no event shall exceed 72 hours.

In cases where an expedited appeal is required, the Chairperson of the Appeals Committee will convene an expedited Appeals Subcommittee, which will review the case and render a determination to the appellant as soon as possible in accordance with the seriousness of the medical circumstances of the case, which in no event shall exceed 72 hours.

The member/covered person, or the physician or other health care professional acting on behalf of and with the consent of the member/covered person, will be notified of the outcome of the expedited complaint or appeal within 72 hours of receipt of the complaint or appeal.
Inquiries, Complaints and Appeals

Utilization Management or Medical Appeals

Medical Appeals
Members and physicians and other health care professionals, on behalf of the member and with the member's written consent, generally have the right to pursue an appeal of any adverse utilization management decision made by Horizon BCBSNJ.

An adverse utilization management decision is a decision to deny or limit an admission, service, procedure or extension of stay based on Horizon BCBSNJ's clinical and medical necessity criteria. Adverse utilization management decisions may usually be appealed up to three times. Some ASO/self-insured plans only allow one level of appeal.*

* Members/covered persons in some plans do not have the appeal rights described here. Medicare Advantage members follow a different appeal policy, and members/covered persons of certain plans, such as ASO accounts and self-insured accounts, may not have the appeal rights described here.

First Level Medical Appeals
You will be advised how to initiate a first level medical appeal at the time the adverse utilization management decision is made.

First level medical appeals are reviewed by our Medical Director or Medical Director's designee. First level urgent and emergent medical appeals are reviewed within 24 hours. Non-emergent appeals are reviewed within five business days.

If the denial is upheld, members and physicians or other health care professionals, on behalf of the member and with the member's written consent, may submit a second level medical appeal.

Second Level Medical Appeals
If a second level medical appeal is received, it is submitted to the Appeals Committee, which is made up of Horizon BCBSNJ Medical Directors and staff, physicians from the community and consumer advocates. The member/covered person is given the option of attending the hearing in person, or via telephone conference, and the Appeals Coordinator makes the appropriate arrangements. Appeals that involve requests for urgent or emergent care may be expedited.

Members/covered persons, or physicians and other health care professionals on behalf of and with the written consent of members/covered persons, who participate in the hearing are notified of the Committee's decision verbally by telephone on the day of the hearing whenever possible. Written confirmation of the decision is sent to the member/covered person, and/or the physician or other health care professional who pursued the appeal on their behalf, within five business days of the decision. Members/covered persons who choose not to appear are also notified of the Committee's decision in writing within two business days of the decision.

Expedited second level medical appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from our receipt of the first level medical appeal request whenever possible. Standard second level medical appeals involving requests for services, supplies or benefits which require our prior authorization or approval in advance to receive coverage under the Plan are reviewed and decided within 15 calendar days of our receipt. All other second level medical appeals are decided within 20 business days of our receipt. Second level medical appeals should be mailed to the address provided in the first level medical appeal determination letter or can be verbally requested by calling the telephone number listed on the first level medical appeal determination letter.
Inquiries, Complaints and Appeals

Third Level Medical Appeals
If the Appeals Committee upholds the second level medical appeal, the member or the member’s physician or other health care professional, acting on behalf of the member and with the member’s written consent, may request a third level medical appeal with the Independent Health Care Appeals Program (IHCAP). The case will be reviewed by a medical expert under contract with an Independent Health Utilization Review Organization (IURO). The IURO only considers appeals on denials based on medical necessity. Denials based on contract issues are not reviewed by the IURO.

Instructions on how to file with the IURO are included with the denial letter from the second level medical appeal, where applicable. Third level medical appeals must be filed within 60 days from the receipt of the notice of determination of the second level medical appeal. The IURO will review the appeal and respond to the member or facility, physician or other health care professional within 50 business days.

The IURO decision is binding. Members of certain plans such as self-funded plans and some Medicare plans may not appeal to the IURO. Some employers may offer an additional level of appeal.

Appeals Relating to Medicare Members
Medicare Advantage members follow a different appeal policy. Please see page 82 for more information or visit <www.HorizonBlue.com/Medicare>.

Speaking with a Medical Director
Our Utilization Management (UM) policy is to always allow the treating or attending physician the opportunity to discuss any UM denial determination with the Horizon BCBSNJ reviewing physician who issued the adverse utilization management decision.

Each UM denial determination includes the reviewing physician’s name and telephone number. Participating physicians can also be connected to that Horizon BCBSNJ reviewing physician by calling 1-800-664-BLUE (2585).

UM Protocols and Criteria Available
Horizon BCBSNJ makes available to you our individual protocols and criteria that we use to make specific UM decisions.

To view this information online, visit www.HorizonBlue.com/Providers and:

- Mouse over Forms and Vouchers and click Provider Reference Materials.
- Click Utilization Management.
- Click the link under the Medical Policies and Guidelines heading.
- Review the Medical Policy disclaimer statement and click the link: If you have read and agree with the previous statement, you may access Horizon BCBSNJ’s Medical Policies by clicking HERE.

If you do not have access to the Internet or would prefer a paper copy of this information contact your Professional Relations Representative.

Health Care Reform and Appeals
The Affordable Care Act, signed into law on March 23, 2010, puts into place comprehensive health care reforms that will result in changes in our appeals processes and procedures. Changes will be phased in beginning October 2010 and continuing through 2012.

Details about these changes and how they affect you and your patients will be published in Blue Review. Changes will also be included in subsequent editions of this office manual.
The member’s identification (ID) number is the most important link between you, your patient and Horizon BCBSNJ. It is critical that you include all alpha and numeric characters when submitting claims to us. For your reference, charts showing prefixes, the type of product and general information for different accounts appear on the following pages of this manual.

The ID card is an important tool in determining the product in which your patient is enrolled. Most cards include general coverage and copayment information, as well as important telephone numbers.

Both the front and back of the ID card contain important information. We recommend that you make a photocopy of both sides for your records.
## Identification

### Prefix Information

The table below contains basic information on product types and your participation status. Use the alpha prefix that appears on the patient’s ID card for ease in locating information in this table.

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Product Type</th>
<th>Comments</th>
<th>You are considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHP</td>
<td>PPO</td>
<td>This is the prefix for Wyeth.</td>
<td>In network.</td>
</tr>
<tr>
<td>FMA</td>
<td>Indemnity</td>
<td>This is the prefix for Ford Motor Company active employees. Members have basic hospital, medical-surgical and major medical type benefits.</td>
<td>In network.</td>
</tr>
<tr>
<td>FMR</td>
<td>Indemnity</td>
<td>This is the prefix for Ford Motor Company retired employees. Members have basic hospital, medical-surgical and major medical type benefits.</td>
<td>In network.</td>
</tr>
<tr>
<td>JGB</td>
<td>Direct Access</td>
<td>This is the prefix for the Horizon MyWay Direct Access Plan. Please see page 65 for more information.</td>
<td>Out of network, unless you are also in the Horizon Managed Care Network.*</td>
</tr>
<tr>
<td>JGE</td>
<td>Direct Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JGH</td>
<td>Direct Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JGA</td>
<td>PPO (Horizon MyWay)</td>
<td>This is the prefix for the Horizon MyWay PPO Plan. Please see page 65 for more information.</td>
<td>In network.</td>
</tr>
<tr>
<td>JGD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JGG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCH</td>
<td>Indemnity</td>
<td>This is the prefix for the Chrysler Corporation. Members have basic hospital, medical-surgical and major medical type benefits.</td>
<td>In network.</td>
</tr>
<tr>
<td>NGM</td>
<td>Indemnity</td>
<td>This is the prefix for the General Motors (GM) account. Members have basic hospital, medical-surgical and major medical type benefits.</td>
<td>In network.</td>
</tr>
<tr>
<td>NHL</td>
<td>Indemnity</td>
<td>This is the prefix for the Hoffmann-LaRoche/Roche group account. Members have basic hospital, medical-surgical and major medical type benefits. Call 1-800-624-4758 for benefits.</td>
<td>In network.</td>
</tr>
<tr>
<td>NJX</td>
<td>Direct Access</td>
<td>This is the prefix for the NJDIRECT 10 and NJDIRECT 15 plans. These plans are available to employees and retirees participating in the New Jersey State Health Benefits Program.</td>
<td>Out of network, unless you are also in the Horizon Managed Care Network.*</td>
</tr>
<tr>
<td>R</td>
<td>PPO</td>
<td>This is the prefix for the Federal Employee Program (a.k.a., FEP or the Federal Employee Health Benefits Program). There are two programs: Basic Option and Standard Option.</td>
<td>In network.</td>
</tr>
<tr>
<td>YHC</td>
<td>PPO or Indemnity</td>
<td>This is the prefix assigned to large businesses with 51 or more employees. In some cases, patients will have PPO benefits while other patients who have this prefix will have indemnity coverage with us. Call Physician Services for patient-specific benefits.</td>
<td>In network.</td>
</tr>
<tr>
<td>YHD</td>
<td>POS</td>
<td>This prefix is for our Point of Service (POS) product. To maximize benefits, members should use contracting facilities and Horizon Managed Care Network physicians.</td>
<td>Out of network, unless you are also in the Horizon Managed Care Network.*</td>
</tr>
<tr>
<td>YHF</td>
<td>PPO</td>
<td>This prefix is for our Preferred Provider Organization (PPO) with the BlueCard enhancement that benefits the patient when receiving medical services outside of New Jersey. When in New Jersey, members are encouraged to use contracting facilities and participating physicians and other health care professionals.</td>
<td>In network.</td>
</tr>
<tr>
<td>YHI</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>YHJ</td>
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<td></td>
</tr>
<tr>
<td>YHK</td>
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</tbody>
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*Note: Benefits may vary based on the specific product and plan details.

---

Horizon PPO Network Office Manual – 2010-2011

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## Prefix Information

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Product Type</th>
<th>Comments</th>
<th>You are considered</th>
</tr>
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<tbody>
<tr>
<td>YHG</td>
<td>POS</td>
<td>See YHD for information on the basic product design.</td>
<td>Out of network, unless you are also in the Horizon Managed Care Network.*</td>
</tr>
<tr>
<td>YHM</td>
<td>HMO</td>
<td>This is the prefix for our Health Maintenance Organization (HMO) product that requires members to use a Primary Care Physician (PCP) for treatment or to access medical care. They are also required to use contracting facilities and physicians participating in our Horizon Managed Care Network. Self-referred care is not covered except in emergency situations.</td>
<td>Out of network, unless you are also in the Horizon Managed Care Network.*</td>
</tr>
<tr>
<td>YHN</td>
<td>Indemnity</td>
<td>This prefix is used for large businesses headquartered in New Jersey with employees residing in other states or large businesses headquartered outside of New Jersey with employees residing in the state. Product design varies. Please call 1-800-624-4758 for patient-specific information.</td>
<td>In network.</td>
</tr>
<tr>
<td>YHP</td>
<td>POS</td>
<td>See YHD for information on the basic product design.</td>
<td>Out of network, unless you are also in the Horizon Managed Care Network.*</td>
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<tr>
<td>YHQ</td>
<td>Direct Access</td>
<td>To maximize benefits, Horizon POS members should use contracting facilities and Horizon Managed Care Network physicians and other health care professionals.</td>
<td>Out of network, unless you are also in the Horizon Managed Care Network.*</td>
</tr>
<tr>
<td>YHS</td>
<td>Indemnity</td>
<td>This prefix is used for small group customers (employers of two to 50). Members could be enrolled in a variety of products (e.g., Medallion, Fixed Fee, Horizon Comprehensive Health Plan B, etc.). Check the ID card for a product name or call 1-800-624-1110 for patient-specific information.</td>
<td>In network.</td>
</tr>
<tr>
<td>YHU</td>
<td>Indemnity</td>
<td>This prefix is used for nongroup (direct pay) customers who are generally under age 65. Members could be enrolled in a variety of products (e.g., Medallion, Fixed Fee, Horizon Traditional Plan B, etc.). Check the ID card for a product name or call 1-800-624-1110 for patient-specific information.</td>
<td>In network.</td>
</tr>
<tr>
<td>YHX</td>
<td>Direct Access</td>
<td>See YHQ for information on the basic product design.</td>
<td>Out of network, unless you are also in the Horizon Managed Care Network.*</td>
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<tr>
<td>YKP</td>
<td></td>
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</tr>
<tr>
<td>YHT**</td>
<td>Medicare Advantage</td>
<td>Horizon Medicare Blue Value and Horizon Medicare Blue Access are our managed Medicare options for Medicare beneficiaries. These managed Medicare programs replace Medicare Part A and Part B, as well as Medigap coverage.</td>
<td>In network.</td>
</tr>
<tr>
<td>YHV**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YKN**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YHR</td>
<td>Medigap</td>
<td>This is our Medicare supplement products. In some cases, these subscribers will have hard, plastic ID cards with ID numbers that include these suffixes. Other Medigap customers have soft, flexible ID cards. There will not be any suffix; however, the soft ID card will have the word Medigap printed in the upper right corner.</td>
<td></td>
</tr>
<tr>
<td>YHW</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* To receive in-network reimbursement, the requirements stated in our Managed Care Network Office Manual must be followed. According to the terms of your PPO Agreement, if you are not in the Horizon Managed Care Network, you will be reimbursed directly for eligible services and you can’t bill members for amounts in excess of our reimbursement (excluding copayments, coinsurance and/or deductibles as indicated on the Explanation of Payment you receive).

** If you are not in the Horizon Managed Care Network, you will receive PPO reimbursement rates for eligible services, except if you opt out or are excluded from Medicare, in which case you are not eligible for payment for services rendered to a Medicare Advantage member.
Identification

Sample ID Cards

Horizon BCBSNJ ID cards have been redesigned in recent years to comply with Blue Cross and Blue Shield Association (BCBSA) branding regulations and New Jersey Department of Banking and Insurance (DOBI) regulations.

Our redesigned ID cards contain the important information you need in a uniform and consistent layout so that Horizon BCBSNJ ID cards – and all other Blue Plan ID cards – are easy to read and use. All members will receive new ID cards by January 1, 2011.

The images that follow are not actual ID cards. They are for educational purposes only.

1. Member name.
2. Member ID number.
3. Coverage verification data.
4. The name of the product.
5. Copayment information, including inpatient hospital copayment. This information will vary based on the plan.
6. PPO in a suitcase logo indicates BlueCard PPO coverage, if applicable.
7. The Primary Care Physician’s (PCP) name (if a PCP is required under the plan).
8. Claim filing information. This information will vary based on the plan.
9. Logo indicating prescription drug coverage, if the member has CVS Caremark prescription drug coverage through Horizon BCBSNJ.
10. Website address.
11. Service telephone numbers. This information may vary based on the plan.
12. Indication of whether the plan is insured or self-funded. A self-funded ID card will state, “Horizon BCBSNJ provides administrative services only and does not assume any financial risk for claims.”
Identification

Sample ID Cards

1. Member name.
2. Member ID number.
3. Coverage verification data.
4. The name of the plan.
5. Copayment information, including inpatient hospital copayment. This information will vary based on the plan.
6. PPO in a suitcase logo indicates BlueCard PPO coverage, if applicable.
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11. Indication of whether the plan is insured or self-funded. A self-funded ID card will state, “Horizon BCBSNJ provides administrative services only and does not assume any financial risk for claims.”

Sample National ID Card

- **Member Name:** JOHN DOE
- **Member ID Number:** IDC3HZN99999999
- **Group Number:** 75999-0000
- **Plan Type:** FAMILY
- **Plan Codes:** 280/780

**BlueCross BlueShield**

<table>
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<th>Benefit Type</th>
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<tr>
<td>PRIMARY CARE</td>
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<tr>
<td>SPECIALIST</td>
<td>$30</td>
</tr>
<tr>
<td>EMERGENCY ROOM</td>
<td>$125</td>
</tr>
<tr>
<td>INPATIENT HOSP COPAY</td>
<td>$150</td>
</tr>
<tr>
<td>DENTAL DEDUCTIBLE</td>
<td>$80</td>
</tr>
<tr>
<td>DENTAL MAXIMUM</td>
<td>$2500</td>
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</table>

**RXBIN:** 004336
**RXPCN:** HZRX
**ISSUER:** 80640
**RXGRP:** 0759990000
**PPO BlueCard**

Hospitals or Providers: File Claims with local Blue Cross and/or Blue Shield Plan.

Members: See your Benefit Booklet for covered services. Possession of this card does not guarantee eligibility for benefits.

Horizon Blue Cross Blue Shield of New Jersey is an independent licensee of the Blue Cross and Blue Shield Association. Insured by Horizon BCBSNJ.

A network administrator outside of the Horizon service area.

**DENTEMAX**

**www.horizonblue.com/nationalaccounts**

- **For Member Use Only**
  - Member Services: 1-800-355-2583
  - Behavioral Health Services: 1-800-626-2212
  - Provider Locator: 1-800-810-2583
  - 24/7 Nurse Line: 1-888-624-3096
  - Dental Customer Line: 1-888-624-6825

- **For Provider Use**
  - Utilization Management: 1-800-664-2283
  - Provider Services: 1-800-624-1110
  - Pharmacists: 1-800-364-6331

**MEMBER CLAIM FILING**

- Horizon BCBSNJ
- PO BOX 1609
- NEWARK, N.J. 07105-1609

*Medicare members submit claims to Medicare first.

**AN INDEPENDENT COMPANY ADMINISTERING PHARMACY BENEFITS.**
Horizon BCBSNJ offers innovative Consumer-Directed Healthcare (CDH) products called Horizon MyWay – one plan is based on a Horizon Direct Access plan and another is based on a Horizon PPO plan. These products incorporate a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA) with a high-deductible medical plan. In addition, Horizon BCBSNJ provides a wide variety of tools and resources to help your patients make their health care decisions. These products offer in-network and out-of-network benefits.

Horizon MyWay Direct Access plans use the Horizon Managed Care Network and the Horizon MyWay PPO plans use the Horizon PPO Network.

**Key Features of Horizon MyWay**

- **Copayments**
  Physicians, other health care professionals and facilities should collect copayments during visits, if applicable. Copayment information will appear on the member’s ID card. You should wait until you receive an Explanation of Payment (EOP) from Horizon BCBSNJ before billing patients for coinsurance and deductible.

- **No referrals for specialists**
  This reduces the administrative process for physicians and members.

- **Individual spending accounts**
  Horizon MyWay plans are combined with individual spending accounts, such as HSAs, HRAs and Flexible Spending Accounts (FSAs). Members can draw from these accounts to pay for medical expenses not covered by their health plan, including deductible and coinsurance.

  The member’s ID card will indicate whether a member has HRA or HSA.

- **Preventive care**
  Generally, to promote wellness, routine preventive care services that are coded as such are covered at 100 percent. This includes childhood immunizations.

  The following services are examples of preventive care:
  - Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
  - Routine prenatal and well-child care.
  - Child and adult immunizations.
  - Tobacco cessation programs.
  - Obesity/weight-loss programs.
  - Age-specific screenings.
Consumer-Directed Healthcare Products

**Horizon MyWay – PPO Plan Design**

The Horizon MyWay PPO product combines a high-deductible PPO plan with a medical account. This health plan offers in- and out-of-network benefits and covers preventive care at 100 percent in network. Members can maximize benefits by using participating PPO physicians, health care professionals and participating facilities.

<table>
<thead>
<tr>
<th>Horizon MyWay HRA/HSA PPO Prefixes</th>
<th>JGA</th>
<th>JGD</th>
<th>JGG</th>
</tr>
</thead>
</table>

**Billing Horizon MyWay patients**

**Horizon MyWay Visa/Debit cards**

The Understanding your Horizon MyWay HRA information on the following page outlines the Horizon MyWay claim process. You should wait until you receive an Explanation of Payment (EOP) from Horizon BCBSNJ before billing patients for coinsurance and deductible, since you may not know the correct amount to collect at the point of service. Your contract prohibits you from balance billing members.

**Special Payment Options**

To simplify payment to you, Horizon MyWay members with an HSA, HRA or FSA may have a personalized checkbook and Horizon BCBSNJ Visa/debit card to pay for medical expenses not covered under their health plan. These will process like regular checks and debit cards. Members can use the Visa/debit card or checkbook to pay copayments, coinsurance and other eligible medical expenses.
Consumer-Directed Healthcare Products

Understanding your Horizon MyWay HRA

Your Horizon MyWay HRA health plan combines a high-deductible health plan with a Health Reimbursement Arrangement (HRA). The HRA is a funding arrangement, in which your employer reimburses a portion of incurred claims for covered services.

Obtaining care with your Horizon MyWay HRA health plan is simple:

**Step 1:** Visit your physician or other health care professional and present your Horizon Blue Cross Blue Shield of New Jersey ID card.
- In-network physicians or other health care professionals will submit your claim directly to Horizon BCBSNJ.
- Out-of-network physicians or other health care professionals may require payment up front and may require you to submit claims directly to Horizon BCBSNJ.

**Please note:** An Explanation of Benefits (EOB) will be mailed to you and your physician or other health care professional, detailing your liability and any payment made by Horizon BCBSNJ.

**Step 2:** If you have not met your deductible and there is a member liability, Horizon BCBSNJ will automatically access your HRA account and apply available funds towards that liability. Depending on your employer’s funding arrangement, payments will be made either to an in-network physician or other health care professional, or directly to you.
- An Account Summary will also be sent to you and the physician or other health care professional showing the detailed HRA payments, account balance and member liability.

**Step 3:** If you have depleted your HRA funds, the Account Summary mailed to you and your physician or other health care professional will detail any remaining member liability.
Your physician or other health care professional will bill you for any outstanding balances like copayments, deductibles and coinsurance amounts.

Visit www.HorizonBlue.com to view your HRA funds:

On the Member’s tab:
- Log in via the Member’s Sign on. (You will need to be registered with Member Online Services before you can log on.)
- Under Additional Services, click MyWay Balance.
- Click Horizon MyWay HRA, then View Personal Account Balance.
You may receive an additional explanation of payment for Horizon MyWay HRA patients. This is in addition to the initial Horizon BCBSNJ explanation of payment advising you of available funds in the member’s HRA. This additional explanation may include payment from that account and an explanation of the final member liability. Please see the following pages for a sample HRA Explanation of Payment (EOP).

An online user guide has been created to provide a detailed overview of the voucher. Visit www.HorizonBlue.com to access this guide.

Please review the following information to help you understand this statement.

**Description of Fields found on page 2 of the EOP:**

A: **Horizon Allowed**
   The amount that Horizon BCBSNJ originally allowed on the medical explanation of payment.

B: **Horizon Medical Payment**
   The amount that Horizon BCBSNJ originally paid on the medical explanation of payment.

C: **Customer Liability**
   The amount of customer liability that Horizon BCBSNJ originally indicated on the medical explanation of payment.

D: **Approved Amount**
   The amount that will be drawn out of the member's HRA account.

E: **This Payment**
   The amount that will be factored into the total HRA check amount paid to the practice.

F: **Patient Responsibility**
   The remaining customer liability after any payments from the member’s HRA.
EXPLANATION OF HORIZON MY WAY HRA PAYMENT

ACME PHYSICIAN GROUP
123 MAIN STREET
ANYTOWN, NJ 01234

PAYMENT SUMMARY:  GROSS CLAIM AMOUNT:  200.00
AR's APPLIED  0.00
CHECK AMOUNT:  200.00

IF YOU SUSPECT HEALTH CARE FRAUD, PLEASE CALL OUR SPECIAL INVESTIGATIONS HOTLINE - 1-800-624-2048.

An independent licensee of the Blue Cross Blue Shield Association.

.provider services
1-800-624-1110
MONDAY-FRIDAY 8AM-6PM
WWW.HORIZONBLUE.COM

Check No: 12345678
Payee Id: 221234657
Tax Id: 221234657
Date: 7/20/10
Page 1 of 3

PO BOX 420
NEWARK, NJ 07101-0420
## Consumer-Directed Healthcare Products

### Explanation of Horizon MyWay HRA Payment—Cont.

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<th>Date: 7/20/2010</th>
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#### Patient Details

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<th>CLAIM NO.</th>
<th>PATIENT ACCT.</th>
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</tr>
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<tbody>
<tr>
<td>BILL WILLIAMS</td>
<td>YH7123456789</td>
<td>NA-12345678910113 11</td>
<td>1067056432</td>
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#### Horizons MyWay HRA - Provider Services: (800)-824-1110

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<tr>
<th>BILL WILLIAMS</th>
<th>MEDICAL PAYMENT</th>
<th>LIABILITY</th>
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| 2 PENDING FUTURE MEMBER CONTRIBUTION

#### MARY JONES

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<td>NA-1516189202222 23</td>
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<td>TOTAL</td>
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#### JOHN JONES

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<td></td>
</tr>
</tbody>
</table>

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*This is the final payment determination. Net patient responsibility is noted above. If you have already collected a payment prior to this explanation, please refund the patient.*

*If you are an out-of-state provider, you may have already received payment from your local BCBS plan. The additional reimbursement enclosed is funded from the patient's HRA account and should be applied to any outstanding patient responsibility.*

---
Consumer-Directed Healthcare Products
Certain nationally located or large New Jersey-based accounts design special benefit programs for their employees. We refer to such accounts as major accounts.

Major accounts consist of several different types of contracts. You may identify these accounts by a group number consisting of three letters followed by three digits (such as NHL280).

In some cases, Horizon BCBSNJ is the Control Plan. This means that Horizon BCBSNJ contracted with the employer group. In these cases, the ID number starts with an N followed by two other letters. As an example, Hoffmann-La Roche (NHL) employees have coverage under a contract issued by Horizon BCBSNJ. We are the Control Plan for this account.

When a Blue Cross and/or Blue Shield Plan in another state issues the contract, Horizon BCBSNJ is considered a Par Plan. For example, General Motors employees have coverage under a contract issued by BCBS of Michigan. BCBS of Michigan is the Control Plan and Horizon BCBSNJ is a Par Plan for New Jersey employees of General Motors.

Deductibles, copayments and/or coinsurance amounts are part of these contracts. Some groups incorporate cost containment and utilization review programs. For patient-specific information, we recommend reading the patient's ID card for special benefit messages and telephone numbers of dedicated service teams.

Major accounts have unique benefits. Call the appropriate Physician Services area for patient-specific information.
This section provides an overview of the features of many of the products we offer. Additional product information is available online.

- Visit [www.NaviNet.net](http://www.NaviNet.net) and sign in by entering your User Name and Password.
- Select Horizon BCBSNJ within the Plan Central dropdown menu.
- Mouse over References and Resources and click Provider Reference Materials.
- Click Products.

**Horizon PPO**

Horizon PPO plans provide members a choice of physicians and hospitals without having to choose a Primary Care Physician (PCP).

Members incur lower out-of-pocket costs and higher plan benefits, and do not need to file claims when they receive care from Horizon PPO Network physicians, other health care professionals or facilities.

Members may also choose to use their out-of-network benefits, which offer care from any physician or hospital outside the network in exchange for higher out-of-pocket costs.

Nationwide and worldwide access to medical care is available through the BlueCard PPO program. Members have access to the largest health care network in the nation – more than 760,000 physicians, specialists and subspecialists and more than 6,500 participating hospitals.

**Horizon Indemnity Plans**

These products combine hospital, medical/surgical and major medical-type benefits into one product. After a deductible, we will pay a percentage of our applicable allowance for eligible services. There are no office visit copayments; however, the patient is responsible to pay the deductible, coinsurance and any amount charged for ineligible services.

The following pages include brief benefit descriptions of:

- Horizon Comprehensive Health Plans A, B, C, D, E.
- Horizon Traditional Plans B, C, D.
- Basic Blue℠ Plan A.
- BlueCare®.
- Comprehensive Health Plan (CHP).
- Comprehensive Major Medical (CMM).
- Horizon Basic Health Plan A/50.
- Network Comprehensive Major Medical.
Horizon Comprehensive Health Plans A, B, C, D, E

These plans are available to employee groups of two to 50 employees under the Small Employer Insurance Reform Act.

Brief benefit description:
- Deductible Ranges from $150 to $1,000.
- Coinsurance Varies 90/10%, 80/20%, 70/50%, 60/40%, 50/50%.
- Office Visits/ Medical Care Covered after deductible.
- Well Child Care/ Adult Physicals Covered.
- Lab and X-ray Varies with contract.

Horizon Traditional Plans B, C, D

These plans are available to individuals under the Individual Health Insurance Reform Act.

Brief benefit description:
- Deductible Ranges from $1,000 to $2,500 (Individual); $2,000 to $5,000 (Family).
- Coinsurance Varies 80/20%, 70/50%, 60/40%.
- Office Visits/ Medical Care Covered after deductible.
- Well Child Care/ Adult Physicals $500 annually per covered person (except newborns). $500 maximum for newborns up to age one. Not subject to deductible or coinsurance.
- Lab and X-ray Covered after deductible.
- Maternity Requires subscribers and/or physicians and other health care professionals to notify us within 12 weeks of medical confirmation of pregnancy. If we are not notified, payment of maternity claims will be reduced by 50 percent.

Basic Blue Plan A

Basic Blue Plan A is no longer sold by Horizon BCBSNJ; however, we continue to service those customers currently enrolled.

This limited hospitalization plan covers 30 days of inpatient care and some professional services. The plan does not provide benefits for behavioral health and substance abuse care services.

Brief benefit description:
- Deductible $100/individual, $500/family.
- Coinsurance 50/50%
- Office Visits/ Medical Care Covered after deductible.
- Well Child Care/ Adult Physicals Covered.
- Lab and X-ray Covered after deductible.

BlueCare

BlueCare is no longer sold by Horizon BCBSNJ; however, we continue to service those customers currently enrolled.

Brief benefit description:
- Deductible $500; two deductibles per family.
- Coinsurance 80/20%
- Office Visits/ Medical Care Covered after deductible.
- Well Child Care/ Adult Physicals Not covered.
- Lab and X-ray Covered after deductible.
Comprehensive Health Plan (CHP)
This plan is no longer sold by Horizon BCBSNJ; however, we continue to service those customers currently enrolled.

Brief benefit description:
• Deductible Ranges from $100 to $1,000.
• Coinsurance 80/20%
• Office Visits/ Medical Care Covered after deductible.
• Well Child Care/ Adult Physicals Not covered.
• Lab and X-ray Covered after deductible.

Comprehensive Major Medical (CMM)

Brief benefit description:
• Deductible Ranges from $100 to $1,000.
• Coinsurance Varies 80/20%, 70/50%.
• Office Visits/ Medical Care Covered after deductible.
• Well Child Care/ Adult Physicals Call Physician Services for patient benefits if no indication appears on ID card.
• Lab and X-ray Covered after deductible.

Horizon Basic Plan A/50
This plan is available to individual, nongroup customers.

Brief benefit description:
• Deductible $1,000, $2,500, $5,000 or $10,000 (Individual); $2,000, $5,000, $10,000 or $20,000 (Family).
• Coinsurance 50/50%
• Office Visits/ Medical Care Covered after deductible.
• Well Child Care/ Adult Physicals Covered.
• Lab and X-ray Covered after deductible.

Network Comprehensive Major Medical (Network CMM)

Brief benefit description:
• Deductible Ranges from $100 to $1,000.
• Coinsurance Varies 80/20%, 70/50%.
• Office Visits/ Medical Care Covered after deductible.
• Well Child Care/ Adult Physicals Call Physician Services for patient benefits if no indication appears on ID card.
• Lab and X-ray Covered after deductible.
Fixed Fee Contracts

Series 14/20
Student Program

These programs cover medical and surgical services performed at a hospital and in a physician’s office. Major medical types of service are not covered unless the patient has separate major medical coverage. The term Fixed Fee Contracts accurately describes these products because payment for an eligible service is fixed.

Service Benefits are paid-in-full benefits extended to certain individuals covered under a Fixed Fee Contract. Payments are not considered payment in full unless the subscriber meets specified income limits, which vary depending on whether the contract is for single or family coverage and the subscriber’s marital status.

Service Benefits Requirements

The patient must advise you within 120 days of the last day of rendering an eligible service that they qualify for Service Benefits. You may request proof of income by asking for a copy of the Federal Tax Form 1040 for the calendar year preceding the date of service. The subscriber must furnish proof within 45 days of your request.

Service Benefits Income Limits

<table>
<thead>
<tr>
<th>Income Limits for</th>
<th>Single, Unmarried</th>
<th>Single, Married</th>
<th>Parent and Child</th>
<th>Husband and Wife</th>
<th>Family</th>
<th>Student</th>
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<tbody>
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<td>14/20 Series</td>
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<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
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</tr>
</tbody>
</table>

If you are not notified of Service Benefits eligibility within 120 days of the last date of service, or proof of income is not furnished within 45 days of your request, the customer is disqualified from receiving Service Benefits. The Service Benefits feature described on this page is not related to, or part of, the BCBS Service Benefit Plan (a.k.a., FEP or the Federal Employee Program). Income is defined as the gross annual income from all sources for the calendar year prior to the year services were rendered. The income limits are listed in the chart below.

Service Benefit Payments

If your covered patient is enrolled under a fee schedule contract, you must accept our payment for eligible services as payment in full if the subscriber’s income makes him or her eligible for paid-in-full Service Benefits.

If the patient is not eligible for Service Benefits, the combined payment from us, from the patient or from any other source, shall equal your usual or reasonable fee for the procedure performed. You will not submit a fee to us that is higher than the fee usually accepted by you as payment in full for services performed.
Student Program
This product is no longer sold; however, we continue to service those customers currently enrolled. The Student Program covers full-time students between ages 19 and 30. It provides basic hospital and medical/surgical benefits only. Enrollment in this program is for the student only. The benefits are identical to those shown on the previous page except maternity-related services are not covered.

Brief benefit description:

- Deductible  None.
- Coinsurance None.
- Office Visits/ One consultation per Medical Care hospital admission. Medical care covered in hospital only. Office visits are only covered if the patient also has Major Medical.
- Well Child Care/ Not covered. Adult Physical
- Lab and X-ray Covered with annual dollar benefit maximums.
Medicare Supplemental (Medigap)

We offer a variety of Medicare Supplemental Products to our members who have traditional Medicare as their primary insurance coverage. These products supplement or “fill the gaps” of eligible services paid by Medicare and have also been referred to as “Complementary” coverage in the past.

As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), beginning June 1, 2010, we offer a new set of standardized Medigap plans. The new plans, to distinguish them from the previously offered Medigap plans (which we will continue to service – but no longer sell – beginning June 1, 2010), will be identified by a YHW prefix on their ID card and will be referred to as Horizon Contemporary Medigap Plans.

We offer the following Horizon Contemporary Medigap Plans:

- Plan A.
- Plan C – ages 50 to 64.
- Plan F.
- Plan K.
- Plan C – under age 50.
- Plan C – age 65+.
- Plan G.
- Plan N.

For more information about Horizon Contemporary Medigap Plans, please visit <www.HorizonBlue.com/Contemporary>.

Horizon Contemporary Medigap Plans will be the only Medigap plans we will offer for sale effective June 1, 2010.

For members enrolled in one of our existing Medigap plans (see below), there will be no change in benefits. However, members may choose to enroll in one of the new Horizon Contemporary Medigap Plans, as long as they meet the requirements for that new plan.

- BCBSNJ 65.
- BCBSNJ 65 Select.
- Horizon Medigap Plans A, C, F, I.
- Super 65.

Members enrolled in the above Medigap plans will be identified by a YHR prefix on their ID card.

Medicare Part D

We also offer Medicare Part D coverage to our members who have traditional Medicare as their primary insurance coverage.
Horizon HMO Access
Horizon HMO Access plans provide members with direct access to Horizon Managed Care Network specialists without a referral. Members enjoy both the benefits of working with a selected Primary Care Physician (PCP) and the freedom to coordinate their needs without a referral. Members may not self-refer to PCP-type providers; they must use their selected PCP.

Split Copayments
Horizon HMO Access plans include split copayments for physician services. A lower office visit copayment applies to visits to preselected PCPs. A higher office visit copayment applies to office visits to non-preselected PCPs, all other participating PCP-type physicians and other health care professionals and to participating specialist office visits.

Other Copayments
Horizon HMO Access includes various inpatient and outpatient facility copayments as well as for other professional health care services and durable medical equipment.

Coinsurance
Some Horizon HMO members are required to pay a coinsurance payment for most services not performed in an office setting.

Referrals
Horizon HMO Access members may visit participating specialists without a referral. Preapproval is required for some services.

Out-of-Network Benefits
Horizon HMO Access members have no out-of-network benefits.

Prescriptions
Member charges for prescription drug services do not accumulate to the maximum out of pocket (MOOP).

Well Care
Well care such as routine adult physicals, annual Ob/Gyn exams, well child care and immunizations are covered and billable. Coverage limitations exist and vary per contract.

Annual Vision Exam
Some Horizon HMO Access members are eligible for an annual vision exam or vision hardware reimbursement. Since this program does not use referral forms, they are not needed. Coverage limitations exist and vary per contract.

Products
Horizon Medicare Advantage 
Products

We are an approved Medicare Advantage (MA) Organization and offer two products for our Medicare beneficiaries. Members may choose Horizon Medicare Blue Value or Horizon Medicare Blue Access in place of Medicare Parts A and B. These products all use our extensive Horizon Managed Care Network and are offered to individuals and group account members.

Horizon Medicare Blue Value (HMO)
This HMO plan requires members to choose a Primary Care Physician (PCP). Members receive benefits at an in-network level only. Referrals are needed for additional services. Members enrolled in this plan use the Horizon Managed Care Network.

Members can select one of the following to convert Medicare Advantage to Medicare Advantage with Prescription Drug coverage:
- Horizon Medicare Blue Value w/Rx Standard (HMO).
- Horizon Medicare Blue Value w/Rx Enhanced (HMO).

Horizon Medicare Blue Access (HMO-POS)
This Point of Service plan gives members the option of selecting a PCP. However, if a PCP is not selected, the member incurs higher copayments. Members can receive benefits at in- and out-of-network levels. No referrals are needed for additional services. Members enrolled in this plan use the Horizon Managed Care Network. Members can select one of the following to convert Medicare Advantage to Medicare Advantage with Prescription Drug coverage:
- Horizon Medicare Blue Access w/Rx Standard (HMO-POS).
- Horizon Medicare Blue Access w/Rx Enhanced (HMO-POS).

Well Care
Our Medicare Advantage products cover services coded as preventive, such as prostate screening and gynecological exams (subject to plan limitations). These services can be obtained without a referral from the PCP when provided by participating physicians and other health care professionals.

Chiropractic Care
Our Medicare Advantage members may go directly to participating chiropractors for manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray. This means they do not require a referral from their PCP to visit a participating chiropractor. Members are also eligible for an unlimited amount of chiropractic visits per year. X-rays ordered by chiropractors are not covered.

Case Management
New members are asked to complete and return a health assessment questionnaire within one month of enrolling in any of the Medicare Advantage product plans. Members identified as high risk are assigned a case manager to help you coordinate the member’s care.

Copayments and Coinsurance
Our Medicare Advantage members may have various office visit copayments. In other healthcare settings, coinsurance may be required. Copayment amounts and coinsurance percentages, if applicable, are printed on the ID card.

Dual Eligibles
The CMS has issued new requirements for Dual Eligibles (members who are enrolled in both a Horizon BCBSNJ Medicare Advantage (MA) program and in the state’s Medicaid program as a full-benefit dual eligible or qualified Medicare beneficiary (QMB)) and to all dual eligible categories for which the state provides coverage and chooses to protect beneficiaries from the cost sharing for Medicare Part A and Part B services.
Effective January 1, 2010, Horizon BCBSNJ participating physicians and other health care professionals may not seek to collect copayments or other cost sharing from Dual Eligible enrollees who are enrolled in Horizon BCBSNJ's Medicare Advantage plans when the state is responsible for paying those amounts. Participating physicians and other health care professionals may bill the appropriate state source for those amounts.

**Emergency and Urgent Care Definitions**

In respect to our Medicare Advantage products, a medical emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child,

(b) Serious impairment of bodily functions, or

(c) Serious dysfunction of any bodily organ or part.

Emergency services include a medical screening examination and inpatient and outpatient services that are needed to stabilize an emergency medical condition.

In respect to our Medicare Advantage products, urgently needed services are those services required to prevent a serious deterioration of a covered person’s health that results from an unforeseen illness, injury or condition that requires care within 24 hours.

**Medical Record Retention**

Physicians and other health care professionals are required to maintain medical records for a minimum of 10 years for all Medicare Advantage members.

**Medical Necessity Determinations**

The medical necessity review and determination process for Horizon Medicare Advantage products is different than that of other managed care products. Occasionally, you may encounter situations when a service has not been authorized by Horizon BCBSNJ. We have up to 14 days to determine whether an initial request for a service is medically appropriate and covered.

If additional clinical information is required, we may have up to an additional 14 days to make a final determination.

In some cases, the standard review process could endanger the life or health of the member. As a participating physician or other health care professional, you may request an expedited 72-hour determination for your Medicare Advantage patient if, in your opinion, the health or the ability of the patient to function could be harmed by waiting for a medical necessity determination.

Expedited determinations may be requested by calling 1-800-664-BLUE (2585).

Non-expedited determinations may be requested in writing to:

Horizon Medicare Advantage
Utilization Management Department
Appeals Coordinator
Three Penn Plaza East, PP-14J
Newark, NJ 07105-2200
Fax: 1-877-798-5905
Horizon Medicare Advantage
Member Appeals
Members have the right to appeal any decision regarding payment by us or our denial of coverage based on medical necessity. Normally, we have 60 days to process an appeal pertaining to post-service denial of claim payment (appeal for payment) and 30 days to process an appeal pertaining to denial of a requested service (pre-service appeal for service). Members may also request an expedited appeal verbally or in writing. Based on the medical circumstances of the case, a Horizon BCBSNJ physician reviewer will determine if your request qualifies as an expedited appeal. For an expedited appeal, the member may file a request by calling Member Services at 1-800-365-2223.

To request an appeal in writing, members should write to or fax:

Horizon Medicare Advantage
Appeals Coordinator
Three Penn Plaza East, PP-10C
Newark, NJ 07105-2200

Fax expedited (72-hours) or standard (50 day) pre-service appeal requests to: 1-856-658-5145.

Fax 60-day post-service appeals (appeals for payment) to: 1-975-466-4090.

Physicians may appeal on behalf of a member with the member’s written consent and request an expedited appeal. Medical records and your professional opinion should be included to support the appeal. We process expedited appeals within 72 hours.

If coverage of services is denied, you must inform your Medicare Advantage patient of their appeal rights. At each patient encounter with a Medicare Advantage enrollee, you must notify the enrollee of their right to receive, upon request, a detailed written notice from the Medicare Advantage organization regarding the enrollee’s benefits.

You may issue the appeal rights directly to the member in your office at the time of the denial, or contact Member Services and we will issue the appeal rights to the member.

Advance Directives
Advance directives allow patients to make sure their wishes are clearly known regarding the type of care a member would like to receive. They also allow the patient to appoint someone to make medical decisions for them if they are unable to speak for themselves.

Advance Directives are legally recognized documents and are an important part of a member's medical record. During an audit, Horizon BCBSNJ representatives look for documentation that the physician asked their patient if they either have an Advance Directive or would like to create one.

When treating your Medicare Advantage patients, ask them if they have completed their advance directives.

• If the patient responds that he or she has an advance directive, that documentation (along with an actual copy of the advance directive document itself) should be included as a prominent part of the medical record. Please also advise your patients who have advance directives already in place that they should make their designated health care proxy and their family members aware of the advance directive.
• If the patient responds that he or she has no desire to create an advance directive, that documentation should also be included as a prominent part of the medical record.

There are three options available when patients are making an advance directives choice:

• **Proxy Directive**
  Proxy Directives, or durable power of attorney for health care, are used to designate a health care representative or health care proxy who is authorized to make medical decisions on the patient’s behalf, in the event he or she is unable to do so.

• **Combined Directive**
  A Combined Directive is a single document in which the patient names a proxy and documents specific treatment instructions used to guide treatment decisions.
• **Instruction Directive**

  Instruction Directives, also known as living wills, specifically express in writing the patient’s desires or instructions for treatment and indicate treatments the patient is not willing to accept.

  The state of New Jersey has Advance Directive forms available online, however, no particular form is required. For an Advance Directive to be legally recognized, it must be documented in writing, signed by the patient in front of two adult (age 18 or older) witnesses or by a Notary Public.

  In addition, the patient should be encouraged to make his or her desires known, not only to his or her health care proxy and physician, but also to his or her family members.

  For more information on advance directives, review the brochure *Advance Directives for Health Care*, published by the State of New Jersey Commission of Legal and Ethical Problems in the Delivery of Health Care. This brochure is available at [www.state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf](http://www.state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf).

  **Nine-Digit Zip Codes Required**

  CMS requires the use of nine-digit ZIP codes on all Medicare Advantage claim submissions in certain locations where a five-digit ZIP code spans more than one pricing area.

  The New Jersey and Pennsylvania towns that require the use of nine-digit ZIP codes are listed below.

  **New Jersey**
  08512 – Cranbury
  08525 – Hopewell
  07755 – Keyport
  08530 – Lambertville
  07747 – Matawan
  08540 – Princeton
  08558 – Skillman
  08560 – Titusville

  **Pennsylvania**
  18042 – Easton
  18055 – Hellertown
  18951 – Quakertown
  18077 – Riegelsville
  19087 – Wayne

  To avoid delays in claim processing, we recommend that physicians and other health care professionals within these areas bill with the complete nine-digit ZIP code for all patients. If you’re unsure of your nine-digit ZIP code, visit the United States Postal Service’s online *Zip Code Lookup* at [www.usps.com/zip4](http://www.usps.com/zip4).
Horizon POS

Horizon POS is a point of service program providing the advantages of an HMO, but incorporating patient cost sharing and an option for members to access care from any physician without a referral from their PCP at a lower level of benefits.

Horizon POS has two levels of benefits: in network and out of network. To receive the highest level of benefits, members must access care through their PCP (and obtain referrals as appropriate). When members’ care is not coordinated through their PCP, the lower, or out-of-network, benefits apply. Members are given the choice to seek services either in network or out of network at each point of service.

Members are responsible for sharing the cost of their health care. For in-network care, this can amount to a basic office copayment, a deductible and/or coinsurance. Patients who go out of network or see a specialist without a PCP referral pay a higher share of the costs, including higher deductibles, coinsurance and copayment amounts. Employers or association groups select the level of cost sharing for their employees. Horizon POS is designed to encourage members to maximize their benefits by using their PCP.

When Horizon POS members who have not selected you as their PCP come to you without a referral form, you should bill us first. We will provide you with an Explanation of Payment (EOP) advising you of our payment and the amount you can collect from your patient.

Well Care

Well care, such as routine adult physicals and well child care, is covered under capitation. If you are a fee-for-service PCP, well care is also covered and billable. Immunizations are billable for capitated and fee-for-service PCPs (subject to plan limitations).

Obstetrical/Gynecological Care

Female Horizon POS members may go directly to participating Ob/Gyns for obstetrical and gynecological-related care. They do not require a referral from their PCP.

Most members do not need a referral from their PCP or Ob/Gyn for routine mammography services. However, please give these members a prescription to present to the radiologist.

Annual Vision Exam

Some Horizon POS members are eligible for an annual vision exam or vision hardware reimbursement. This service does not require a referral form. If the services are not covered, the member is responsible for these charges.

Certain Horizon POS members are eligible for annual exams only when the PCP issues a referral form. You can identify these members by the YHG alpha prefix on their ID card. These groups cover annual eye exams (with a referral form) for dependents 17 years or younger only.

Most members who have diabetes may go directly to a participating eye care physician or professional for a dilated retinal exam without a referral from their PCP.

Chiropractic Coverage

Most Horizon POS members are eligible for chiropractic care. Some members may require a referral from their PCP to visit a participating chiropractor. Please call to verify chiropractic benefits since some accounts have varying limitations.
Pre-Existing Condition
Some Horizon POS programs have a pre-existing condition clause. Under this clause, fee-for-service* bills, for certain members, are subject to review.

A pre-existing condition is an illness or injury, whether physical or mental, which manifests itself in the six months before a covered person’s enrollment date, and for which medical advice, diagnosis, care or treatment would have been recommended or received in the six months before his/her enrollment date. The restriction could remain on the member’s policy, based upon the plan, up to 12 months after enrollment, unless a Certificate of Creditable Coverage (COCC) is provided.

A COCC, or a letter from a previous carrier on that carriers’ letterhead indicating the effective and terminating dates of coverage, will nullify or reduce the pre-existing wait period.

Based on the member’s pre-existing limitation clause under their benefit plan, a request for prior authorization and/or claim payment is automatically subject to a screening process based upon the member’s qualifying pre-existing time period and the specific clinical situation.

The pre-existing condition limitation does not affect benefits for other unrelated conditions, or birth defects in a covered dependent child. Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to that information.

If a pre-existing condition exists, the member will be responsible for payment of services rendered.

*Treatment provided under capitation is not subject to pre-existing condition review.

NJ DIRECT
Horizon BCBSNJ administers two plans on behalf of the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP). The plan options are Direct Access plans, called NJ DIRECT10 and NJ DIRECT15 (NJ DIRECT for general reference).

Members have out-of-network benefits; however, members will maximize their benefits and minimize their out-of-pocket expenses by using physicians and facilities in the Horizon Managed Care Network.

Copayments
The 10 or 15 in the plan option name refers to the office visit copayment amounts. The appropriate copayment amounts are indicated on the member’s ID card.

NJ DIRECT Network
NJ DIRECT uses the Horizon Managed Care Network and it offers some special features. With NJ DIRECT:

• Members access physicians within the Horizon Managed Care Network, without having to select a Primary Care Physician (PCP).

• Members do not need to obtain referrals to see specialists.

• Authorizations are required for some services.

• Members and their dependents have access to in-network benefits through the BlueCard PPO network outside of New Jersey.
Horizon Direct Access

Our Horizon Direct Access product allows members to visit participating specialists without a referral from a PCP. Horizon Direct Access is similar to a POS product by offering two levels of benefits: in network and out of network.

Members are encouraged to select a PCP to help them access the appropriate medical care, however, it is not necessary. PCPs are encouraged to refer members to participating physicians and other health care professionals.

Members are responsible for sharing the cost of their health care. For in-network care, this can amount to a basic office copayment, a deductible or coinsurance. Patients who receive care out of network pay a higher share of the costs, sometimes including higher deductibles, coinsurance and/or copayment amounts.

No Referrals

This product does not require referrals for in-network professional services. PCPs do not need to complete referrals for the member to receive care from a specialist or facility.

Prior Authorization

Please obtain prior authorization when referring a Horizon Direct Access member to an in-network or out-of-network facility for inpatient and outpatient care.

By obtaining the authorization, your patient may incur lower out-of-pocket expenses.

In-Network Benefits

To receive the highest level of benefits, members must access care from a participating physician, other health care professional or facility in the Horizon Managed Care Network. When a Horizon Direct Access member receives care from a participating physician, other health care professional or network facility, they are covered at the in-network level of benefits and incur lower out-of-pocket costs.

Out-of-Network Benefits

Out-of-network benefits apply when members do not use a Horizon Managed Care Network physician, health care professional or facility. Members pay a higher share of the costs for out-of-network care, usually including deductible and/or coinsurance amounts.

Help your Horizon Direct Access members save money by encouraging them to receive all medical care and services from our large and comprehensive network of participating physicians and other health care professionals. This can significantly reduce their out-of-pocket costs and paperwork submissions and may also increase their satisfaction with your services.

We recognize that there may be instances in which a service is not available in network. If a member’s care is coordinated by their PCP and the proper authorization is obtained, eligible and medically necessary out-of-network services may be covered at the in-network level of benefits.

Please see our Out-of-Network Consent Policy on page 100.

Horizon Direct Access and BlueCard

Horizon Direct Access is a managed care product. These ID cards display the PPO in the suitcase logo indicating that these members have access to PPO physicians and health care professionals when receiving services outside of New Jersey.

Well Care

Well care, such as routine adult physicals, annual Ob/Gyn exams, well child care and immunizations, is covered and billable. Coverage limitations exist and vary per plan.

Annual Vision Exam

Some Horizon Direct Access members are eligible for an annual vision exam or vision hardware reimbursement. Since this plan does not use referral forms, they are not needed. Coverage limitations exist and vary per benefit plan.
Products

Chiropractic Coverage
Horizon Direct Access members are eligible for chiropractic care from a participating chiropractor. Referral forms are not needed. Coverage limitations exist and vary per benefit plan.

Claim Address
Mail Horizon Direct Access claims to:

Horizon Direct Access
PO Box 1609
Newark, NJ 07101-1609
Identifying BlueCard Members

Identifying BlueCard members is critical to timely and accurate claim processing and it's easy once you know what to look for.

The key to identifying BlueCard members is their ID cards. There are three ID card elements you should look for to identify a BlueCard member:

**Blue Plan Logo**
The presence of another Blue Cross and/or Blue Shield's Plan logo on the member's ID card is the first visual indicator that a member may be eligible for BlueCard benefits.

**Alpha Prefix**
The alpha prefix on the member's ID card is the key element used to identify the Blue Plan to which the member belongs and to correctly route claims. It is critical to confirm membership, eligibility and coverage. Ask to see the member's ID card at each visit and share this information with your billing staff.

If there is no prefix on a member's ID card, that member is not eligible for benefits through the BlueCard Program. Review these ID cards for the telephone number of the member's Blue Plan or for other instructions.

**Suitcase Logo**
The suitcase logos shown here and on the following page are unique identifiers for BlueCard members.

- Members whose ID cards display the PPO in the suitcase logo are enrolled in PPO (Preferred Provider Organization) products. Benefits are delivered through the BlueCard Program. Members traveling or living outside their Plan's service area receive PPO-level benefits when they need services from participating physicians and other health care professionals.

Identifying BlueCard members is critical to timely and accurate claim processing and it's easy once you know what to look for.

The program allows you to submit almost all types of claims for out-of-state members directly to us, your local Blue Plan. We process your reimbursement and provide you with an Explanation of Payment (EOP).

Please treat BlueCard members the same as you would a local Horizon BCBSNJ member. Doing so will increase your patients' satisfaction and improve their overall BlueCard experience.

In addition, here are a few BlueCard guidelines:

- When BlueCard-eligible members receive services, the only up-front billing that is permissible is the collection of the applicable copayment as indicated on the member's ID card. This information may be verified by calling BlueCard Eligibility at 1-800-676-BLUE (2583).

- Up-front billing at the time of service, for any amount that exceeds the copayment, is not permitted.

- Billing charges in excess of the allowance is also not permitted.

*The exception to this is if your office participates directly with the plan in which a BlueCard member is enrolled. If you participate with the other Blue Plan, please submit claims directly to that other Blue Plan for processing.*
• Members whose ID cards display the blank suitcase logo are enrolled in a product other than PPO. These members are also eligible for BlueCard processing.

Members whose ID cards do not display a suitcase logo are excluded from receiving benefits through the BlueCard Program. Be sure to review the member’s ID card for telephone numbers and claim filing addresses.

BlueCard ID Cards

All Blue Cross and/or Blue Shield Plans are independent licensees of the Blue Cross and Blue Shield Association (BCBSA) and are required to follow specific ID card standards. ID cards must contain the following elements on the front of the card:

- Subscriber’s name.
- ID number.
- Group number, if applicable.
- Blue Cross and/or Blue Shield Plan code, a numeric value identifying each Blue Plan. In New Jersey, our codes are 280 and 780.
- Blue Cross and/or Blue Shield symbols. Some Plans are only a Blue Cross or a Blue Shield Plan. Their ID cards may only show one symbol rather than both the Cross and Shield. The BCBSA has licensed them in a state or given geographic area to offer only certain products or services under the Blue Cross or Blue Shield brand name and symbol.
- Blue Cross and/or Blue Shield Plan name, which may be a Plan’s legal name or it may be a trade name. Our ID cards are issued with the Horizon BCBSNJ name.

Participating Physician Information

To obtain information about participating physicians and other health care professionals in another BCBS Plan’s service area, members may call BlueCard Access at 1-800-810-BLUE (2585).

BlueCard Eligibility and Benefits

There are two fast and easy ways to obtain eligibility and benefits information for your BlueCard patients – by telephone or electronically. Remember to have the member’s ID card information handy – that’s your key to getting the information you need.

Obtaining Information by Telephone

There’s no need to call all over the country for the information you need, just call BlueCard Eligibility at 1-800-676-BLUE (2583). After providing the alpha prefix from the member’s ID card, you’ll be connected to the Customer Service team at the member’s Blue Plan. If the member’s ID card does not include an alpha prefix, please call the telephone number on the ID card.

Obtaining Information Electronically

You may also submit a HIPAA 270 transaction to Horizon BCBSNJ to request the information you need. Most BlueCard electronic inquiries received Monday through Friday, during regular business hours, are answered within 48 hours.
BlueCard Members and Prior Authorization

Your patients who are enrolled through other Blue Cross and/or Blue Shield Plans and who have BlueCard benefits, are responsible for obtaining prior authorization and preauthorization for services as defined by their benefit plan. In some cases, mandatory second surgical opinions may be required or prior authorization of inpatient hospital admissions may be needed.

You may choose to contact the Blue Cross and/or Blue Shield Plan where your patient is enrolled to obtain the prior authorization or preauthorization. To do so, refer to your patient’s ID card for telephone number information or call 1-800-676-BLUE (2585).

Please note that the responsibilities and obligations outlined in this manual are applicable to out-of-state Blue Cross and/or Blue Shield members.

For More Information

Specific information on the BlueCard Program is available at <www.bluecares.com>.

Submitting BlueCard Claims

Submit BlueCard claims electronically with other Horizon BCBSNJ claims or send paper claims to:

Horizon BCBSNJ
BlueCard Claims
PO Box 1501
Neptune, NJ 07754-1501

Be sure to include the member’s complete ID number when you submit the claim. Claims with incorrect or missing alpha prefixes and member ID numbers delay claims processing.

If the patient’s ID card does not include an alpha prefix, check for a phone number on the card. Call the appropriate Blue Cross and/or Blue Shield Plan for claim submission instruction.

Please do not send duplicate claims. Check a claim’s status through our IVR system, NaviNet or through an electronic transaction before you resubmit a claim.

BlueCard Claims Processing

Upon receipt, we will electronically route the claim information to the other Blue Cross and/or Blue Shield Plan, who will process the claim and approve payment. They will transmit the approval to us and we will issue payment and an EOB to you.

Behavioral Health and Substance Abuse Claims and Inquiries

Effective January 1, 2009, all behavioral health and substance abuse claim submissions and inquiries for your BlueCard patients (those enrolled in another state’s Blue Cross and/or Blue Shield Plan) must be handled through the BlueCard program.

Claim Submissions

Mail claims for your BlueCard patients to:

BlueCard Claims
PO Box 1501
Neptune, NJ 07754-1501

Be sure to include the member’s complete ID number when you submit claims. Incorrect or missing alpha prefixes and member ID numbers delay claims processing. If your office participates directly with another Blue Cross and/or Blue Shield Plan, please send claims for those enrolled patients directly to that Plan.

Claim Inquiries

Call Horizon BCBSNJ’s Dedicated BlueCard Unit at 1-888-455-4585 or visit <www.NaviNet.net>.

Eligibility/Enrollment Inquiries

Call BlueCard Eligibility at 1-800-676-BLUE (2585) or visit <www.NaviNet.net>.

Please note that the changes outlined here pertain only to your patients enrolled through an out-of-state Blue Cross and/or Blue Shield Plan. There is no change to how inquiries and claims should be handled for your patients enrolled through Horizon BCBSNJ.
**BlueCard**

### BlueCard Claims Submissions

**Helpful Hints**

- Regardless of the method you use to submit claims, be sure to include the alpha prefix and the complete ID number. Incorrect or incomplete information may delay claims processing or cause the claim to deny since we will be unable to identify the member.
- Always indicate the state where services were rendered in box 32 or 33 on the CMS 1500 form.
- Always include appropriate ICD-9 and CPT-4 codes.
- Ensure that section 1A of the CMS 1500 form is completed by entering either the requested information or the word “Same,” as appropriate, in boxes 4 and 7 for all BlueCard paper claim submissions.

### BlueCard Exclusions

BlueCard applies to most claims; however, the following types of claims currently are excluded from the program.

- Coordination of Benefits situations when BCBS is not the primary carrier.
- Workers’ compensation situations.
- Stand-alone dental coverage.
- Stand-alone prescription drug coverage.
- Vision care services.
- Hearing care services.

### Avoid BlueCard Claim Rejections

Horizon BCBSNJ strives to process your BlueCard claims quickly and accurately, but claim rejections do occur.

The items below reflect the most frequent BlueCard claim rejection messages and offer suggestions for what you can do to avoid having your BlueCard claims rejected.

- **No Record of Membership**
  Validate the BlueCard member’s ID card at each visit to ensure that you have the member’s most current information.

- **Claim Submitted with an Incorrect ID Number**
  Be sure to include the member’s complete ID number when you submit the claim. Claims with incorrect or missing alpha prefixes and member ID numbers delay claims processing.
  If the patient’s ID card does not include an alpha prefix, call the member’s Blue Cross and/or Blue Shield Plan for claim submission instructions.

- **Care After Coverage Termination Date**
  Verify the member’s BlueCard eligibility and coverage by telephone or electronically.

  **By Telephone:**
  Call BlueCard Eligibility at 1-800-676-BLUE (2583). Follow the prompts and the automated system will ask you for the alpha prefix on the member’s ID card. You will be connected to the Customer Service team at the member’s Blue Plan. If you are unable to locate an alpha prefix on the member’s ID card, review the ID card for the telephone number of the member’s Blue Plan and call them directly for information.

  **Electronically:**
  Submit a HIPAA 270 transaction to Horizon BCBSNJ. Most BlueCard electronic inquiries received Monday through Friday, during regular business hours, are answered within 48 hours.
Physician Contracts with Two Plans
If your office participates directly with Horizon BCBSNJ and with the plan through which the member is enrolled, submit claims directly to that other plan for processing.

If services are rendered in New Jersey and your office does not participate with the plan through which the member is enrolled, submit claims to Horizon BCBSNJ.

Avoid Duplicate Claim Denials
Based on a recent review of BlueCard claim denials, we found that the number one reason for BlueCard claim denials is that the claim in question is a “duplicate of a previously processed claim.” Here are some of the duplicate claim trends we uncovered as part of this review:

• Claim resubmissions received within a week or two of the original claim.
• Claim submissions received for patients who have Medicare as their primary insurance.
• Claim resubmissions received where the original claim was finalized without generating a payment.

Please review the guidelines below to help decrease the trends identified above. Following these guidelines will help reduce or eliminate the number of duplicate claim denials you receive.

Check Claim Status First
BlueCard claims generally take 14 to 21 business days to finalize once they are routed to the patient’s plan. Before resubmitting a claim, please check the status of your claim online at www.NaviNet.net or by calling our Dedicated BlueCard Unit at 1-888-455-4583.

Wait for MEOBs
If Medicare is your patient’s primary insurance, submit your claim to Medicare first. The Medicare Explanation of Benefits (MEOB) you receive will indicate if the claim was automatically routed to the patient’s secondary insurance carrier. If the MEOB indicates that the claim was sent to the secondary carrier, please do not resubmit it. If the MEOB doesn’t indicate that the claim was sent to the secondary carrier, submit it with the MEOB, to:

BlueCard
PO Box 1501
Neptune, NJ 07754-1501

Submit Corrected Claims with a 5348 Form
Ensure that corrected claim submissions are accompanied by a completed copy of our Physician/Health Care Professional Inquiry Request/Response Form (5348). Be sure to specify the changes made relative to the original claim submission (revenue codes, late charges added, etc.) and include all required supporting documentation (CMS 1500 form, other carrier/MEOBs, etc.).

A 5348 form may be accessed on our website. Visit www.HorizonBlue.com/Providers and:

• Mouse over Forms and Vouchers and click Downloadable Forms.
• Click Physician/Health Care Professional Inquiry Request/Response Form (5348) under the Inquiry Requests heading.
BlueCard Claim Appeals

In 2010, we implemented a new BlueCard claim appeal process to improve our response/resolution times. Our goal is to resolve BlueCard claim appeals within 30 to 45 days of their receipt.

As part of our BlueCard claim appeal process, we have developed a BlueCard Claim Appeal Form (5373). This form is available on our website. To download this form, visit www.HorizonBlue.com and:

- Mouse over Forms and Vouchers and click Downloadable Forms.
- Under Miscellaneous Forms, click BlueCard Claim Appeal Form (5373).

The process and form only support BlueCard-related claim appeals from physicians or other health care professionals or from physicians or other health care professionals on behalf of their patient. Use of this form is NOT intended for non-BlueCard claim appeals or for routine BlueCard claim inquiries.

A BlueCard claim appeal is a formal request for reconsideration of a previously adjudicated BlueCard claim that may or may not include additional information. BlueCard claim appeals may involve, but are not limited to, inquiries about:

- Payer allowance.
- Medical policy/medical necessity determinations (e.g., cosmetic or investigational services).
- Incorrect payment or coding rules applied.

The following are NOT considered a claim appeal and should not be submitted on the new form:

- Corrected claim submissions.
- General claim inquiries or questions.
- Claim denial requiring additional information.

Completed forms, along with necessary supporting documentation, may be mailed to:

Horizon BCBSNJ
BlueCard Claim Appeals
PO Box 1501
Neptune, NJ 07754-1501

If you have questions about the BlueCard claim appeal process, please call our Dedicated BlueCard Unit at 1-888-455-4585.

To avoid delays, please ensure that claim appeals submitted on behalf of your patient are accompanied by a completed Consent to Representation in Appeals form (also available on our website under Miscellaneous Forms).
This section contains information about our policies and procedures. In addition, we have required forms for subjects contained in this section, as well as other subjects.

Please note that your failure to comply with any policies, rules and procedures may constitute a breach of your Horizon Blue Cross Blue Shield of New Jersey Agreement with Participating Physicians and Healthcare Professionals.

In-office Radiology Services

As a participating physician, you will only be reimbursed for performing certain diagnostic-related radiology/imaging tests in your office.

Participating primary physicians, specialists and other health care professionals will be reimbursed for only those exams that they are privileged to perform in an office setting.

A complete list of the radiology/imaging procedures that may be performed by certain specialties in an office setting is available on our website. To access this list, visit www.HorizonBlue.com/Providers and:

• Click Radiology/Imaging.
• Click Diagnostic Imaging Privileging Policy.

For all other radiology services, please refer your Horizon BCBSNJ patients to a participating radiologist. You can find the names and locations of all participating radiologists through our online Provider Directory, or in the Directory of Participating Physicians and Other Health Care Professionals.

For advanced imaging services, you must call CareCore at 1-866-496-6200.

For more information, please see page 36.

Pharmacy Services

As a participating physician or other health care professional, you should write prescriptions for drugs listed as Preferred on the Horizon Prescription Drug Guide for those Horizon BCBSNJ members with prescription drug coverage, unless it would not be medically appropriate to do so.

The Horizon Prescription Drug Guide lists at least one Preferred prescription drug within each drug category. The guide was developed by the Pharmacy and Therapeutics Committee, which is comprised of New Jersey independent physicians and clinical pharmacists. The Horizon Prescription Drug Guide was developed through careful analysis of the medical literature on clinical effectiveness and secondarily based on cost effectiveness.

To review the Horizon Prescription Drug Guide, please visit www.HorizonBlue.com and click Pharmacy Services.

Pharmacy Prior Authorization

Pharmacy Prior Authorization (PA) ensures appropriate utilization of certain drugs, promotes treatment or step-therapy protocols, actively manages prescription drugs with serious side effects and positively influences the process of managing prescription drug costs.

Prescription drugs that have medical utility for only a select group of patients require PA before coverage is approved. Specific guidelines, developed and approved by physicians and pharmacists, have to be met for certain drugs to be approved and covered under our prescription drug benefit plans. The Horizon Pharmacy and Therapeutics Committee establishes PA criteria after evaluating medical literature, physician opinion, and Food and Drug Administration (FDA)-approved labeling information.
To view the current list of prescription drugs requiring PA, visit www.HorizonBlue.com, and:

- Mouse over Pharmacy Services and click Tools and Resources.
- Click Rx Utilization Management Programs.
- Click Prior Authorization.

**Prior Authorization Program Expansion**
In 2010, we expanded our prescription drug prior authorization (PA) program to help us to better ensure that generic drugs are prescribed rather than brand name drugs when medically appropriate.

You can expect to receive a request for PA (for certain prescriptions written for those Horizon BCBSNJ members whose benefit plans require PA for prescription drugs) when you prescribe:

- A name brand drug when a direct generic equivalent is available.
- A non-Preferred brand.

To minimize the number of PA requests you receive, please ensure that, whenever medically appropriate, your Horizon BCBSNJ patients are prescribed generic or Preferred brand drugs.

**Prescription Drug Dispensing Limitations**
Certain prescription drugs have specific dispensing limitations for quantity, age, gender and maximum dose. To arrive at these quantity or safety limits, Horizon BCBSNJ follows recommendations by the FDA, coupled with our analysis of prescription drug dispensing trends and standard clinical guidelines. These dispensing limitations are drug-specific and are designed to provide a safe and effective amount of prescription drug to the patient.

**Medication Therapy Management Program**
As part of our commitment to provide physicians with important information to support appropriate drug therapy, we offer our Medication Therapy Management (MTM) program.

Through the MTM program, we identify those enrolled in our Medicare Advantage with Prescription Drug and Medicare Part D plans who may be at risk for medical or drug adverse events. We then work with you and your patient to reduce that risk.

The MTM program encourages these members to use prescription drugs according to national clinical guidelines and to take their prescription drugs appropriately and in accordance with their physicians’ instructions.

**MTM participant identification**
Members are identified for participation in the MTM program from prescription claims history as outlined by CMS. Eligible members who meet all three of the following criteria are automatically enrolled* in the program:

- Must have two or more chronic diseases.
- Must take five or more covered Medicare Part D drugs per month.
- Must incur at least $5,000 annually or at least $750 per quarter in covered Medicare Part D drug expenses.

The MTM program includes regular communications to members and physicians.

* Members may opt-out of the program at any time by calling the Member Services number on the back of their ID card.
MTM program activities

• Horizon Healthcare of New Jersey, Inc. pharmacists conduct routine medication profile reviews. When a medication concern is identified (e.g., the use of multiple drugs to treat the same condition; excessive dosing of medications; drug-to-drug interactions), the pharmacist will contact your office. Depending on the medication concern identified, the pharmacist may also contact the member to address the issue.

• Each participant in the MTM program will be offered an annual Comprehensive Medical Review (CMR) by a pharmacist via mail and/or telephone. The CMR assesses medication therapies and helps to optimize patient outcomes by reviewing all medications being taken by the member, including prescription drugs, over-the-counter medications, herbal therapies and dietary supplements. A written summary of the CMR discussion will be provided to the member and may be sent to his/her physician(s) for review as needed.

• All Medicare Advantage with Prescription Drug and Medicare Part D members enrolled with us will also receive a quarterly newsletter, Good Medicine. This newsletter provides information and resources to help members maximize their health. It includes updates on the latest prescription drug treatments, reminders about the importance of taking prescription drugs appropriately and lifestyle tips to help individuals with certain medical conditions better manage their health.

The success of the MTM program is measured through the acceptance of the recommended interventions, as well as by clinical outcomes such as reductions in hospitalization or Emergency Room visits, or reduced number of physician encounters. The MTM program complements and coordinates with the Horizon Health and Wellness Education Program in which your patients may already be enrolled.

For additional information about the MTM Program, call your Professional Relations Representative.

Specialty Pharmacy

For the latest information regarding Horizon BCBSNJ’s Specialty Pharmacy program, please visit our website, <www.HorizonBlue.com>.

To access information about the Specialty Pharmacy Program for office-based therapies:

• Within the Pharmacy Services menu option, click Specialty Rx Program.

To access information about the Members Specialty Pharmacy Program:

• Click Pharmacy Services.

• Within the Tools and Resources menu option, click Specialty Rx Program.

Medical Necessity Determinations for Injectable Medication

To help ensure that our members receive the appropriate and medically necessary care regarding the use of Darbepoetin alfa and Epoetin alfa, Horizon BCBSNJ performed a focused review of the use of those medications and compared utilization to nationally recognized clinical guidelines established by the American Society of Clinical Oncology (ASCO) and National Comprehensive Cancer Network (NCCN).

In light of medical literature concerning the safety of these injectable medications, and based on the analysis of data collected from our physician network, we instituted a Medical Necessity Determination (MND) program with CareCore for participating physicians who administer certain injectable medications in their offices.

Physicians must obtain a MND prior to administering certain injectable medications to avoid a delay or denial of claims pending receipt of information needed to determine medical necessity. As a participating physician, you may not balance bill the member for denied or pended claims that result from your noncompliance with our MND program.
The program covers the following injectable medications for the indicated HCPCS Codes:

- **J0881** Darbepoetin alfa, non-ESRD, 1 mcg.
- **J0882** Darbepoetin alfa, ESRD, 1 mcg.
- **J0885** Epoetin alfa, non-ESRD, 1000 units.
- **J0886** Epoetin alfa, ESRD, 1000 units.
- **Q4081** Epoetin alfa, ESRD, 100 units.

(One MND allows for four treatments over an eight-week period.)

To obtain a MND from CareCore:

- Submit a request online at <www.carecorenational.com>.
- Call 1-866-529-8348, Monday through Friday, between 7 a.m. and 7 p.m., ET, or Saturday and Sunday, between 9 a.m. and 5 p.m., ET.
- Fax a completed Medical Necessity Determination Request Form to 1-866-537-2058. To access forms online, click Downloadable Forms within the Forms and Vouchers section of <www.HorizonBlue.com>.

Call 1-866-529-8348 or contact your Professional Relations Representative with questions.

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**Behavioral Health and Substance Abuse Care**

Please check your patient’s ID card for the name and phone number of the behavioral health and substance abuse care administrator that administers benefits for your patient. Whether it is an emergency or a request for inpatient or outpatient services, either you or the member should call the appropriate behavioral health care administrator.

With few exceptions, we contract with Magellan Behavioral Health to administer our members’ behavioral health and substance abuse benefits. Call 1-800-626-2212 to speak with a Magellan Behavioral Health case manager who can inform you of your patient’s treatment plan and progress. This service is available 24 hours a day, seven days a week.

You may call Magellan Behavioral Health to refer most patients for behavioral health or substance abuse care.

If Magellan Behavioral Health does not administer your patient’s behavioral health and substance abuse benefits, please contact the behavioral health and substance abuse administrator listed on the back of your patient’s ID card.
Hospital and Other Inpatient Care

To maximize their benefits, members should use network hospitals or facilities (e.g., residential treatment centers or skilled nursing facilities). Inpatient care will be provided in semi-private accommodations.

When medically necessary, members may be referred to a nonparticipating or non-network facility if their need for medical treatment cannot be accommodated through our Horizon Hospital Network.

You must obtain authorization for all elective inpatient stays. An authorization number must be given to the member to present to the facility upon admission. Facility authorizations cover all inpatient services, including preadmission testing, anesthesia, laboratory, pharmacy and other specialty services related to the admission.

In emergency situations, you must notify us as soon as possible.

Inpatient Transfer from a Nonparticipating Hospital to a Participating Hospital

Members emergently admitted to a nonparticipating hospital will be transferred to a participating hospital as soon as they are medically stable. In the case of surgical admissions, burn unit patients, critically ill neonates or cases where child delivery has already taken place, no immediate transfer will be initiated.

If one of your patients is admitted to a nonparticipating hospital, please contact us immediately. One of our Concurrent Review Nurse Coordinators (CRNC) will assist in transferring the patient to a participating hospital.

The CRNC will contact the:
- Utilization review department of the nonparticipating hospital.
- Attending physician at the nonparticipating hospital.

• Member’s physician and encourage regular contact between the member’s physician and the attending physician.

If the member is ready for transfer, the CRNC will:
- Provide the member’s physician with a list of participating specialists at the receiving hospital.
- Contact the member and explain the reason for the transfer.
- Contact the nonparticipating hospital’s social worker.
- Arrange for ambulance transport to the receiving hospital.

The attending physician and member’s physician must maintain regular contact to determine the status of the patient and to follow the procedures for transfer, which include:
- Contacting the receiving hospital and arranging for admission.
- Arranging for an attending physician at the receiving hospital (if the member’s physician will not be the attending physician).

Please note that if the patient is not stable for transfer, the member’s physician and/or the attending physician must advise the CRNC of the medical necessity for the transfer not to occur.

Copayments and Allowed Amounts

Copayment amounts vary from plan to plan. It is possible that a member’s copayment may turn out to be greater than our allowance for the services provided.

You are permitted to collect the copayment indicated on the member’s ID card at the time of service, but if our allowed amount for the service you provided (indicated on the EOP you receive) is less than the copayment amount collected, you may need to refund the difference to the member.
Collection of Member Liability: Coinsurance and Deductible

At the time of service, you may collect copayment amounts as indicated on the member’s ID card. Additionally, you are expected to bill members for the appropriate member liability (coinsurance and/or deductible), as indicated on the EOP you receive. You must wait until you receive the EOP before billing the member for these amounts.

You are required to accept our allowance for eligible services as payment in full.

To protect our members, Horizon BCBSNJ forbids physicians and other health care professionals from adding a “collection” fee, interest or other amount to the member liability until the member has had a reasonable opportunity to pay (i.e., a minimum of 30 days).

We encourage you to inform members in advance of your billing practices for the collection of member liability and of any fees or interest that you charge when the member liability is not paid.

When Not to Collect Office Visit Copayments

As mandated by the Patient Protection and Affordable Care Act (PPACA), preventive care services must be covered with no member cost sharing or dollar maximums. Please do not collect preventive care copayments from your Horizon BCBSNJ patients.

Please note that PPACA allows group health plans offering custom benefits (plans in force on or before March 25, 2010 and continuing to be in force) to opt (for as long as that health plan continues to be in force) to retain a copayment for preventive care services.

Reimbursement for Assistants at Surgery Services

We reimburse for assistants at surgery in surgical procedures if use of an assistant at surgery is established as medically necessary and appropriate. To avoid any misunderstandings regarding reimbursement of assistants at surgery, we encourage you to check on reimbursable procedures in advance.

We encourage you to use Horizon PPO participating assistants at surgery (when medically necessary).

Confidentiality of Medical Records and Personal Information

Physicians and other health care professionals are responsible for complying with all applicable state and federal laws and regulations regarding confidentiality of medical records and individually identifiable health information, including, without limitation, the privacy requirements of HIPAA (the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-19, and any regulations promulgated thereunder) no later than the effective date of those state and federal laws.

Professional Responsibility

Physicians and other health care professionals should not recommend any treatment they feel is unacceptable. You have sole responsibility for the quality and type of health care service you provide to your patients. You should refer patients to other health care professionals as medically appropriate and medically indicated.

You are free to communicate openly with a member about all appropriate diagnostic testing and treatment options, including alternative medications, regardless of benefit coverage limitation.
Responsibility for the Use of Participating Tax ID Numbers

As a participating physician or other health care professional, you are responsible for the appropriate use of the tax ID number under which you bill.

Many participating physicians and other health care professionals direct us to pay their groups under the group’s tax ID number. Consequently, group tax ID numbers are loaded into our processing systems as participating. Claims submitted under these group tax ID numbers are paid at the participating allowance.

If a physician within a group practice (whom you have directed us to pay under a group tax ID number) resigns from our network, that physician may no longer bill under a tax ID number used by any participating physician, including group tax ID numbers. Likewise, if a nonparticipating physician joins the group which you have directed us to pay under a group tax ID number, you are responsible for contacting Horizon BCBSNJ’s Credentialing Department to consider him or her for credentialing. Until the nonparticipating physician becomes participating, that nonparticipating physician or other health care professional may not bill under a tax ID number used by you (including your group tax ID number).

Our billing policy prohibits the use of a participating tax ID number (including a group tax ID number) by a nonparticipating physician.

If a nonparticipating physician submits claims under a participating group tax ID number and claims are paid at the participating allowance, then Horizon BCBSNJ will consider you responsible for the difference between the participating and nonparticipating rates and for ensuring that the member is not balance billed.

Out-of-Network Services

When a member seeks care from nonparticipating physicians or other health care professionals, including facilities, DME providers, etc., or accesses benefits on an out-of-network basis, substantial copayments, coinsurance and/or deductibles may apply before the member’s coverage provides benefits.

Please keep this in mind when recommending that a member see nonparticipating physicians or other health care professionals, including facilities, DME providers, etc.

Out-of-Network Consent Policy and Procedure

Horizon BCBSNJ expanded the scope of our Out-of-Network Consent Policy to encourage our members to use participating physicians, other health care professionals and facilities, as well as to help ensure that our members fully understand the increased out-of-pocket expense they will incur for out-of-network care.

Our Out-of-Network Consent Policy applies to referrals made to any nonparticipating physician, other health care professional or facility (including clinical laboratories and ambulatory surgery centers). All physicians and other health care professionals who participate in our managed care and/or PPO networks are required to adhere to our Out-of-Network Consent Policy.

Horizon BCBSNJ expects participating physicians and other health care professionals to ensure that, whenever possible, their Horizon BCBSNJ patients are referred to participating physicians, other health care professionals or facilities unless the member wishes to use his or her out-of-network benefits and understands that higher out-of-pocket expenses will be incurred.
Participating physicians and other health care professionals should contact us for authorization if they believe that the necessary expertise does not exist within our network or that there is no available participating physician, other health care professional or facility to provide services to the member. If Horizon BCBSNJ agrees that a participating physician, other health care professional or facility is not available, the member's in-network coverage will apply to the out-of-network referral.

Prior to referring a Horizon BCBSNJ member for out-of-network services, participating physicians and other health care professionals are required to:

- Advise the member of the nonparticipating status of the physician, other health care professional or facility, the out-of-network benefit level that will apply to those services and the member's responsibility for increased out-of-pocket expenses (including deductible, coinsurance and any amount that exceeds the plan's allowance).

- Advise the member of a participating physician, other health care professional or facility that could provide the same services, unless one does not exist within our network.

- Advise of any financial interest in, or compensation made by, the nonparticipating physician, other health care professional or facility.

- Complete an Out-of-Network Consent Form (2180) (signed and dated by the member) and retain that document as part of the patient's medical record. In the event of an audit, this form must be provided within 10 business days.

Please note that you are still required to obtain the appropriate approval from Horizon BCBSNJ for those services that require prior authorization.

To access this administrative policy:
- Select Horizon BCBSNJ within the Plan Central dropdown menu.
- Mouse over References and Resources and click Provider Reference Materials.
- Click Additional Information.
- Click Out-of-Network Consent Policy.

To view, print or download a copy of the Out-of-Network Consent Form (2180), please visit www.HorizonBlue.com/Providers and:
- Mouse over Forms and Vouchers and click Downloadable Forms.
- Click Out-of-Network Consent Form (2180).

Please contact your Professional Relations Representative or Ancillary Account Executive if you have questions or would like copies of this information mailed to you.

When out-of-network ASC claims are received, the participating specialist who performed the service is contacted via letter and asked to provide us with a copy of the member's signed Out-of-Network Consent Form (2180).

Specialists are not to balance bill members for any administrative charges related to the Out-of-Network Consent Form (2180).

If a signed form is not provided within 10 business days or if a participating physician otherwise fails to abide by our policy, he or she may be subject to loss or restriction of network participation and/or termination.

Administrative charges imposed may be appealed. Appeals must be made in writing within 30 days from the notice of the assessment and sent to:

Horizon BCBSNJ
Network Management
5 Penn Plaza East, PP-14V
Newark, NJ 07105-2200

There is no second level appeal. A Horizon BCBSNJ Medical Director reviews the appeal and the determination is sent certified mail, return receipt requested, to the specialist.
Horizon BCBSNJ reserves the right to audit a participating specialist’s medical records pertaining to, but not limited to, the member’s signed Out-of-Network Consent Form (2180) as well as claims to out-of-network facilities. *The Out-of-Network Consent Policy does not apply to members enrolled in the Federal Employee Program.*

**Vision Care**

Most members are eligible for one routine eye examination per year with a participating optometrist or ophthalmologist. The routine vision examination covered for children through age 17 is a vision screening by a pediatrician only.

Coverage for refractive services (92015) varies from plan to plan. Please contact Physician Services to verify coverage.

**Medical Emergency**

A medical emergency is a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such 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:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of a bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency exists where:

- There is inadequate time to effect a safe transfer to another hospital before delivery.
- The transfer may pose a threat to the health or safety of the woman or unborn child.

When you refer a member to the Emergency Room (ER), you must contact us within 48 hours. Members who use the ER for routine care may be responsible for all charges except the medical emergency screening exam.

If emergency care is obtained with the assumption that the member's health is in serious danger, but it is later determined that it was not an emergency, the medical emergency screening exam would still be covered.

**Urgent Care**

In situations requiring urgent care, members are instructed to contact their physician, who can then assess the situation and coordinate the appropriate medical treatment.

If you recommend urgent treatment in your office and the member goes to a hospital ER instead, the resulting charges will be the member's responsibility.

**Treatment of Family Members**

Horizon BCBSNJ products typically exclude payment for services when the patient is a family member of the physician or other health care professional providing treatment.

Immediate relatives include:

- Self.
- Spouse or domestic partner.
- Children (natural, adopted or stepchildren).
- Parents (natural, stepparents or in-laws).
- Grandparents.
- Grandchildren.
- Siblings (natural, stepbrother, stepsister or in-laws).

This applies to individual physicians and other health care professionals, group practices and professional corporations. Treatment of a partner's or business associate’s immediate relative is also excluded for payment.

Please do not submit claims to us for services provided to any of the above-referenced individuals.
Asking a Member to Select Another Physician or Health Care Professional

The patient/physician relationship is essential to the delivery of quality, coordinated health care. In rare instances, this relationship can become seriously eroded if, for example, a member does not comply with treatment regimens, lacks compatibility with the managed care system or is abusive to you or your staff.

In such situations, you may initiate a discussion with your patient, asking him or her to choose another physician or health care professional.

If the member does not select a new physician or health care professional, please follow up with a letter to the member personally signed by you.

A copy of your letter to the member must also be sent to:

Horizon BCBSNJ
Three Penn Plaza East, PP-14G
Newark, NJ 07105-2200

Horizon BCBSNJ will provide the member with the necessary instructions and forms to transfer to another physician or health care professional.

Until the member selects a new physician or health care professional, you are required to continue to serve as his or her physician or health care professional.

Members without Proper ID Cards

If a member is unable to present an ID card at the time of service, there are several ways to verify eligibility:

• If you are a registered NaviNet user, you may check patient eligibility on <www.NaviNet.net>.
• You may verify the member's eligibility by calling 1-800-624-1110.
• You may verify the member's eligibility by asking the member for a copy of his or her signed application.
• Members may present a Coverage Letter obtained by visiting <www.HorizonBlue.com>.

If the member's status is still unclear after reasonable attempts to verify coverage, you have the option of billing the member for the visit. If the member is actively enrolled, we will ask that you reimburse the member.

Contractual Limits

All benefits are subject to contract limits and Horizon BCBSNJ's policies and procedures, including, but not limited to prior authorization and utilization management requirements.
Terminating Your Participation in the Network

There are certain policies and procedures you must follow when your Horizon Blue Cross Blue Shield of New Jersey Agreement with Participating Physicians and Healthcare Professionals is terminated. Following these policies and procedures will help to ensure that your PPO patients continue to receive care by a participating physician or other health care professional.

Termination Letters
If you decide to terminate your Agreement(s) with Horizon BCBSNJ, send a letter to us indicating your intention. The termination letter must be signed personally by the physician or other health care professional. Termination letters should be mailed to the attention of your Professional Relations Representative at the address indicated in the following section.

Your effective date of termination (unless another date is agreed upon by you and Horizon BCBSNJ) will be 30 days following the receipt of your termination letter from our Horizon PPO Network.

You are also required to notify us if you are retiring or moving your practice out of the area pursuant to the termination provisions under your Horizon Blue Cross Blue Shield of New Jersey Agreement with Participating Physicians and Healthcare Professionals.

Mailing Termination Letters
Physicians and other health care professionals located in northern New Jersey (Bergen, Essex, Hudson, Hunterdon, Morris, Passaic, Sussex, Union or Warren county) or New York should direct termination letters to the attention of their Professional Relations Representative at:

Horizon BCBSNJ
Network Management
Three Penn Plaza East, PP-14V
Newark, NJ 07105-2200

Participating physicians and other health care professionals located in southern New Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Ocean, Salem or Somerset county), Pennsylvania or Delaware should direct termination letters to the attention of their Professional Relations Representative at:

Horizon BCBSNJ
Network Management
250 Century Parkway, MT-03N
Mount Laurel, NJ 08054-1121

Rescinding a Request to Terminate
If you decide to rescind a recently submitted termination request, please contact your Professional Relations Representative in writing within 30 days of the original termination letter.

Patients Undergoing a Course of Treatment
You are required to notify us of any Horizon BCBSNJ members undergoing a course of treatment. Please prepare a list of members and send it to your Professional Relations Representative. We, in turn, notify those members who are receiving a course of treatment of your termination from the Horizon PPO Network prior to the effective date of your termination.
Continued Provision of Care
You must treat existing Horizon BCBSNJ PPO and Indemnity patients for up to four months beyond the effective date of termination. An existing patient is defined as one to whom you provided care within the 12-month period immediately preceding the effective date of termination of your Horizon Blue Cross Blue Shield of New Jersey Agreement with Participating Physicians and Healthcare Professionals.

Additionally, members undergoing certain courses of treatment are granted longer periods of care as indicated below:

- Oncological treatment (up to one year).
- Post-operative follow-up care (up to six months).
- Pregnancy – up to the postpartum evaluation (up to six weeks after delivery).
- Psychiatric treatment (up to one year).

You are required to accept our payment for services provided during these extended periods as payment in full, less any applicable copayments, coinsurance or deductible amounts. All benefits shall be subject to contract limits and Horizon BCBSNJ’s policies and procedures, including, but not limited to, payment at Horizon BCBSNJ’s fee schedule, prior authorization and utilization management requirements.

If you have questions, please contact your Professional Relations Representative.

DME and Prosthetic/Orthotic Networks
Horizon BCBSNJ’s Durable Medical Equipment (DME) and Prosthetic/Orthotic networks include standard and specialized centers throughout our service area. These centers are certified and recognized by national certification agencies.

If a Horizon BCBSNJ member requires DME or a prosthetic and/or orthotic device, direct him or her to a participating network provider. The DME and prosthetic and orthotic health care professionals in our network are contractually required to meet certain standards that nonparticipating health care professionals are not required to meet. This means that your patients get prompt, professional and accurate service.

Network DME and prosthetic/orthotic providers can be located through our online Provider Directory.

Follow the steps below to locate network DME or prosthetic/orthotic providers:

2. Click Hospital/Ancillary Search and then click Ancillary Search.
3. Choose Select an Ancillary and select the desired ancillary type from the drop-down menu.
4. Enter the ZIP code, county or state.
5. Click Search.
Credentialing and Recredentialing Obligations

Compliance with Horizon BCBSNJ’s credentialing and recredentialing standards is an ongoing contractual responsibility of all participating physicians and other health care professionals. Participating physicians and other health care professionals are also under a continuing contractual obligation to correct any previously provided credentialing information that is, or becomes, inaccurate.

Participating physicians and other health care professionals are also required to report any changes in their credentialing information, including, for example, any disciplinary action by the applicable licensing authority, any criminal conviction and the pendency of any investigation for matters related to their professional practice.

Physicians and other health care professionals who fail, at any time, to meet any of the standards, as determined by our Credentialing Committee, are subject to loss or restriction of network participation and termination of their Agreement.

Participating physicians and other health care professionals are subject to loss or restriction of network participation and termination of their contract if (among other circumstances):

- They are subject to disciplinary action, including, but not limited to, voluntarily and involuntarily submission to censure, reprimand, nonroutine supervision, nonroutine admissions review, monitoring or remedial education or training;
- Their license, accreditation or certification is restricted, conditioned, reclassified, suspended or revoked, whether active or stayed, and whether by the applicable authority, or any federal or state agency, or any hospital, managed care organization or similar entity;
- They are the subject of an investigation for matters related to their professional practice; or
- They are convicted of a criminal offense.

Recredentialing Process

As required by New Jersey state guidelines and accreditation bodies, all practitioners must be recredential ed every 56 months. Our recredentialing process begins approximately six months prior to the recredentialing date. Physicians and other health care professionals who fail to provide the necessary information in a timely manner are subject to termination of their Agreement.

We work with Medversant, a leader in technology solutions for the management of health care provider information, to help us carry out our recredentialing process, broadly outlined as follows:

- Six months prior to your recredentialing due date, Medversant begins the recredentialing process by searching for current information on the Council for Affordable Quality Healthcare’s (CAQH) online Universal Provider Datasource® (UPD). If your information is up to date on the UPD, the recredentialing process will continue.
- If information is either not on the UPD, or not updated on the UPD, Medversant will reach out to you by telephone, fax and mail to request that you provide updated and/or missing information.
- If Medversant does not receive a response, Horizon BCBSNJ will mail two requests to your office. Horizon BCBSNJ’s first letter will be mailed 60 days before the recredentialing cycle ends. The final request will be sent via certified mail, 30 days before the recredentialing cycle ends.
- If Medversant does not receive a response from these multiple attempts, you will be terminated from Horizon BCBSNJ’s networks at the end of that month. No additional requests will be sent and no information will be accepted after the first of that month.

If you have questions, please call Medversant at 1-800-508-5799.
Recredentialing Vehicles
There are two ways to carry out your recredentialing responsibilities with Horizon BCBSNJ.

Universal Provider Datasource
We encourage you to use the Universal Provider Datasource (UPD) to carry out your credentialing and recredentialing responsibilities with us.

Visit www.caqh.org and click Universal Provider Datasource to access this valuable resource.

If you’re already registered with CAQH:
• Review and/or update your information.
• Reattest that your information is true, accurate and complete.

If you’re not registered with CAQH:
• Contact your Professional Relations Representative and request a CAQH Registration Request Form.
• Complete the information on the CAQH Registration Request Form and return it to your Professional Relations Representative.
• Your Professional Relations Representative will provide you with a CAQH number that allows you to access and complete a CAQH online application.
• Visit www.caqh.org and click Logging in for the first time?
• Complete an online application (ensure that you select Horizon BCBSNJ so that we can access your information) and then attest that the information provided is true, accurate and complete.

New Jersey Universal Recredentialing Application Form
If you are unable to use the UPD, please complete a copy of the NJ Physician Recredentialing Application Form. This form is available on the New Jersey Department of Banking and Insurance website at www.state.nj.us/dobi/mccred.htm.

Hard copy recredentialing information and required source documents may also be submitted to Medversant at:

Medversant
555 S. Grand Ave, Suite 1700
Los Angeles, CA 90071

You may submit information to Medversant by fax at 1-877-503-4080 or by e-mail at HorizonApp@medversant.com.

Recredentialing Tips
To ensure that the recredentialing process runs smoothly for you, please confirm that:

• All questions are answered.
• All information and required source documents are current and included (for example, your proof of malpractice insurance – the item most frequently missing or expired, your Federal Drug Enforcement Agency [DEA] certificate, your Controlled Dangerous Substance [CDS] certificate, etc.).
• Information on the application matches the information on your source documents.
• Your Attestation has not expired.
Physician Access Standards

Below are our definitions and access standards for various types of care provided by primary care-type physicians (e.g., family practitioners, internists, pediatricians) and Ob/Gyns. These standards are approved by our Clinical Issues Committee, as well as our Quality Improvement Committee.

Please make sure your office schedules appointments with our members within these guidelines. The following standards and definitions apply to the first available appointment offered by your office.

The following standards may vary depending on the patient’s past medical history. In certain cases, your office may need to see a patient earlier than the timeframes listed below. Please make sure to see members within an appropriate timeframe for their medical needs.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Access Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Physical Exam</strong>, including annual health assessments, as well as routine gynecological physical exams for new and established patients.</td>
<td>Physician shall offer the member a scheduled appointment as soon as possible, but not to exceed four months of the request.</td>
</tr>
<tr>
<td><strong>Routine Care</strong>, including any condition or illness that does not require urgent attention or is not life-threatening, as well as routine gynecological care.</td>
<td>Physician shall offer the member a scheduled appointment as soon as possible, but not to exceed two weeks of the request.</td>
</tr>
<tr>
<td><strong>Urgent Care</strong>, including medically necessary care for an unexpected illness or injury.</td>
<td>Physician shall offer the member a scheduled appointment within 24 hours of the request.</td>
</tr>
<tr>
<td><strong>Emergent Care</strong>, including care for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain; psychiatric disturbances and/or symptoms of substance abuse such 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 placing the health of the individual (or, with the respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions or serious dysfunction of a bodily organ or part.</td>
<td>Physician shall respond to the member’s call immediately and advise as to the best course of action. This may include sending the member to an emergency facility.</td>
</tr>
<tr>
<td><strong>After-hours Care</strong></td>
<td>Physician shall have a mechanism to respond to the member’s call for urgent or emergent care that ensures calls in these circumstances are returned within 30 minutes.</td>
</tr>
<tr>
<td><strong>Office Waiting Time</strong></td>
<td>No member shall wait more than 30 minutes for a scheduled appointment. If the waiting time is expected to exceed the 30-minute standard, the office shall offer the member the choice of waiting or rescheduling the appointment.</td>
</tr>
</tbody>
</table>

Office Hour Requirements

You must maintain appropriate physician coverage for your practice to assure the availability of covered services 24 hours a day, seven days a week, and be available for office hours and provide appropriate coverage for office hours at least 28 hours per week.
Nonsolicitation of Our Customers

Horizon BCBSNJ provides information on our customers and health benefit plans (and administrative services arrangements) to enable physicians and other health care professionals to provide services to our members. This information is proprietary to Horizon BCBSNJ. The relationship with our customers, including groups and members, is Horizon BCBSNJ’s.

As a participating physician or other health care professional, you may not infringe on Horizon BCBSNJ’s relationship with any of our customers, including groups or members, by (directly or indirectly) soliciting any customer, member or group to enroll in any other health benefits plan (or administrative services arrangement).

Nor may you use any information as to Horizon BCBSNJ’s benefit plans (or administrative services arrangements) or customers for any competitive purpose or provide it to any person or entity for financial gain.

Specialty Medical Society Recommendations

Horizon BCBSNJ recognizes that from time to time, specialty societies will issue recommendations for new or updated technologies or treatments. To submit a new recommendation for consideration by Horizon BCBSNJ’s Medical Policy Department, please provide the following information:

- A detailed description of the technology or treatment and the recommendation on the specialty society’s letterhead.
- A list of the references and/or case studies used to determine the recommendation.
- The contact information for a representative of the specialty society who can respond to questions related to this recommendation.

This information should be submitted as soon as possible to:

Horizon BCBSNJ
Medical Policy Department
5 Penn Plaza East, PP-09P
Newark, NJ 07105-2200
Pre-existing Conditions

A pre-existing condition is an illness or injury, whether physical or mental, which manifests itself in the six months before a covered person’s enrollment date, and for which medical advice, diagnosis, care or treatment would have been recommended or received in the six months before his/her enrollment date.

A pre-existing condition limitation restriction could remain on the member’s policy, based upon the plan, up to 12 months after enrollment, unless a Certificate of Creditable Coverage (COCC) is provided.

A COCC, or a letter from the previous carrier on the prior carriers’ letterhead indicating the effective and terminating dates of coverage, will nullify or reduce the pre-existing wait period.

Based on the member’s pre-existing limitation clause under their benefit plan, a request for prior authorization and/or claim payment is automatically subject to a screening process based upon the member’s qualifying pre-existing time period and the specific clinical situation.

The pre-existing condition limitation does not affect benefits for other unrelated conditions, or birth defects in a covered dependent child.

Pre-existing Condition Medical Record Process

Based on feedback we received from participating offices, we implemented two major improvements to our pre-existing condition medical record process to decrease the need for medical documentation on many claims that are subject to a pre-existing condition review. We:

- Expanded the list of diagnosis codes that bypass the need for clinical pre-existing condition review, significantly reducing the number of requests for medical records.
- Implemented an Attestation Policy.

Beginning in 2010, to further streamline our pre-existing claim review process, we no longer require members to complete an attestation form.

When a claim for a newly diagnosed condition with total charges of less than $2,000 is received (for a patient enrolled in a policy that includes an active pre-existing condition waiting period), we generate an attestation form only to the submitting physician’s office. The completed attestation form from the submitting physician’s office is all we require to determine if claims are eligible for reimbursement.

Other improvements include:

- Implemented a toll-free fax number, 1-888-778-8891, dedicated to the transmission of medical record documentation requirements.
- Improved the COCC process to reduce the need for medical records.
- Reinforced training on pre-existing medical record requirements for Horizon BCBSNJ staff.
- Revised the Medical Request form to highlight appropriate return address.

Horizon BCBSNJ relies on the information provided by physicians to expedite claim adjudication. If claims are paid based on information we receive and it is subsequently determined that a patient’s condition was pre-existing, we reserve the right to recover payments made or offset them against other claim payments, subject to the Health Claims Authorization, Processing and Payment Act (HCAPPA) where applicable. If it’s determined that fraud is involved, we reserve the right to recover payments made with no time limit.
Utilization Management

Horizon BCBSNJ’s Utilization Management (UM) Program is based on the premise that quality medical care is the single most important element in delivering cost-effective care. Our UM Program is a coordinated and comprehensive program designed to achieve medically appropriate and cost-effective delivery of health care services to members within the parameters of the benefits available under each member’s benefit contract.

While there is recognition that there is a wide variation of appropriate medical practice, UM activities are intended to identify optimal modes of practice and, when possible, to help ensure physicians manage care in a medically appropriate and cost-effective manner. We know that underutilization of appropriate services can be as dangerous to our member’s health status and our medical costs as overutilization.

Horizon BCBSNJ adheres to the following principles in the conduct of our UM Program. Horizon BCBSNJ:

• Bases utilization management (UM) decisions on necessity and appropriateness of care and service within the parameters of the member’s benefit package.

• Does not compensate those responsible for making UM decisions in a manner that encourages them to deny coverage for medically necessary and appropriate covered services.

• Does not offer our employees or delegates performing UM reviews incentives to encourage denials of coverage or service and does not provide financial incentives to physicians and other health care professionals to withhold covered health care services that are medically necessary and appropriate.

• Emphasizes the provision of medically necessary and cost-effective delivery of health care services to members and encourages the reporting, investigation and elimination of underutilization.

Horizon BCBSNJ’s UM Program functions under the HCAPPA definition in much the same way as it has previously (when applicable). Our medical policies and UM criteria used to help us reach decisions about medical necessity for coverage purposes have been revised for compliance with HCAPPA’s definition standard.

As required by HCAPPA, policies and criteria, as well as information about the processing and payment of claims, is available at <www.HorizonBlue.com>.
Timeframes for Authorization/Additional Information Requests

Horizon BCBSNJ follows HCAPA mandated timeframes, where applicable, when responding to requests for authorization or when requesting additional information from a physician or other health care professional.*

HCAPA mandates that health insurers respond to requests for authorizations within 24 hours for current inpatient and emergency services and within 15 days for elective inpatient or outpatient services. However, Horizon BCBSNJ does not require authorization for emergency services and, therefore, our practices relating to emergency services have not changed as a result of HCAPA.

Generally, all nonemergent inpatient admissions and some outpatient services require an authorization. HCAPA requires that the hospital, physician or other health care professional respond to our request for additional information within 72 hours.

The law provides that if a hospital, physician or other health care professional does not respond within this timeframe, the original authorization request will be deemed withdrawn.

Conversely, if Horizon BCBSNJ fails to respond timely to an authorization request, it is deemed an approval of the request.

* Members/covered persons enrolled in certain plans are not affected by HCAPA and their authorization/additional information timeframes may vary from what is described here. For example, authorization/additional information timeframes for members/covered persons of certain plans such as ASO and self-insured accounts may vary from what is described here.

Honoring Other Carriers’ Authorization

Under HCAPA (where it applies), in the event a member is no longer eligible for coverage from Horizon BCBSNJ and Horizon BCBSNJ issued an authorization, the member's subsequent health insurer must honor the authorization.*

However, HCAPA also provides that the subsequent health insurer does not need to honor the authorization if the service is not covered under the member’s benefits contract with the subsequent health insurer.

In instances where Horizon BCBSNJ is the subsequent carrier, Horizon BCBSNJ will request adequate proof of the prior carrier’s authorization, and that it was obtained based on an accurate disclosure of the relevant medical facts and circumstances involved in the case. Upon validation, Horizon BCBSNJ will honor the prior carrier’s authorization. However, in accordance with industry standards, authorizations more than six months old will not be honored by Horizon BCBSNJ and will require a new review of the current clinical circumstance.

* Members/covered persons enrolled in certain plans, such as ASO and self-insured accounts, are not affected by HCAPA and their authorization information may not be honored by the subsequent carrier.
Medical Records Requests by Patients

We reprint, on the following pages, an excerpt of the actual regulation of the Board of Medical Examiners on the preparation and release of information if requested by the patient or an authorized representative.

From the State Board of Medical Examiners Statutes and Regulations

(13:55-6.5) Preparation of patient records, computerized records, access to or release of information; confidentiality, transfer or disposal of records

(a) The following terms shall have the following meanings unless the context in which they appear indicate otherwise:

“Authorized representative” means, but is not necessarily limited to, a person who has been designated by the patient or a court to exercise rights under this section. An authorized representative may be the patient’s attorney or an employee of an insurance carrier with whom the patient has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the patient is a minor, a parent or guardian who has custody (whether sole or joint) will be deemed to be an authorized representative, except where the condition being treated relates to pregnancy, sexually transmitted disease or substance abuse.

“Examinee” means a person who is the subject of professional examination where the purpose of that examination is unrelated to treatment and where a report of the examination is to be supplied to a third-party.

“Licensee” means any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners.

“Patient” means any person who is the recipient of a professional service rendered by a licensee for purposes of treatment or a consultation relating to treatment.

(b) Licensees shall prepare contemporaneous, permanent professional treatment records. Licensees shall also maintain records relating to billings made to patients and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered. Treatment records shall be maintained for a period of seven years from the date of the most recent entry.

1. To the extent applicable, professional treatment records shall reflect:
   i. The dates of all treatments;
   ii. The patient complaint;
   iii. The history;
   iv. Findings on appropriate examination;
   v. Progress notes;
   vi. Any orders for tests or consultations and the results thereof;
   vii. Diagnosis or medical impression;
   viii. Treatment ordered, including specific dosages, quantities and strengths of medications including refills if prescribed, administered or dispensed and recommended follow up;
   ix. The identity of the treatment provider if the service is rendered in a setting in which more than one provider practices;
   x. Documentation when, in the reasonable exercise of the physician’s judgment, the communication of test results is necessary and action thereon needs to be taken, but reasonable efforts made by the physician responsible for communication have been unsuccessful; and
xi. Documentation of the existence of any advance directive for health care for an adult or emancipated minor and associated pertinent information. Documented inquiry shall be made on the routine intake history form for a new patient who is a competent adult or emancipated minor. The treating doctor shall also make and document specific inquiry of or regarding a patient in appropriate circumstances, such as when providing treatment for a significant illness or where an emergency has occurred presenting imminent threat to life, or where surgery is anticipated with use of general anesthesia.

2. Corrections/additions to an existing record can be made, provided that each change is clearly identified as such, dated and initialed by the licensee.

5. A patient record may be prepared and maintained on a personal or other computer only when it meets the following criteria:
   i. The patient record shall contain at least two forms of identification, for example, name and record number or any other specific identifying information;
   ii. An entry in the patient record shall be made by the physician contemporaneously with the medical service and shall contain the date of service, date of entry and, full printed name of the treatment provider. The physician shall finalize or “sign” the entry by means of a confidential personal code (CPC) and include date of the “signing”;
   iii. Alternatively, the physician may dictate a dated entry for later transcription. The transcription shall be dated and identified as “preliminary” until reviewed, finalized and dated by the responsible physician as provided in (b)5ii above;
   iv. The system shall contain an internal permanently activated date and time recordation for all entries, and shall automatically prepare a back-up copy of the file;
   v. The system shall be designed in such a manner that, after “signing” by means of the CPC, the existing entry cannot be changed in any manner. Notwithstanding the permanent status of a prior entry, a new entry may be made at any time and may indicate correction to a prior entry;
   vi. Where more than one licensee is authorized to make entries into the computer file of any professional treatment record, the physician responsible for the medical practice shall assure that each such person obtains a CPC and uses the file program in the same manner;
   vii. A copy of each day's entry, identified as preliminary or final as applicable, shall be made available promptly:
      (1) To a physician responsible for the patient's care;
      (2) To a representative of the Board of Medical Examiners, the Attorney General or the Division of Consumer Affairs as soon as practicable and no later than 10 days after notice; and
      (3) To a patient as authorized by this rule within 30 days of request (or promptly in the event of emergency); and
viii. A licensee wishing to continue a system of computerized patient records, which system does not meet the requirements of (b)3i through vii above, shall promptly initiate arrangements for modification of the system which must be completed by October 19, 1995.

In the interim, the licensee shall assure that, on the date of the first treatment of each patient treated subsequent to October 19, 1992, the computer entry for that first visit shall be accompanied by a hard copy printout of the entire computer-recorded treatment record. The printout shall be dated and initialed by the attending licensee. Thereafter, a hard copy shall be prepared for each subsequent visit, continuing to the date of the changeover of computer program, with each page initialed by the treating licensee. The initial printout and the subsequent hard copies shall be retained as a permanent part of the patient record.

(c) Licensees shall provide access to professional treatment records to a patient or an authorized representative in accordance with the following:

1. No later than 30 days from receipt of a request from a patient or an authorized representative, the licensee shall provide a copy of the professional treatment record, and/or billing records as may be requested. The record shall include all pertinent objective data including test results and x-ray results, as applicable, and subjective information.

2. Unless otherwise required by law, a licensee may elect to provide a summary of the record in lieu of providing a photocopy of the actual record, so long as that summary adequately reflects the patient's history and treatment. A licensee may charge a reasonable fee for the preparation of a summary which has been provided in lieu of the actual record, which shall not exceed the cost allowed by (c)4 below for that specific record.

5. If, in the exercise of professional judgment, a licensee has reason to believe that the patient's mental or physical condition will be adversely affected upon being made aware of the subjective information contained in the professional treatment record or a summary thereof, with an accompanying notice setting forth the reasons for the original refusal, shall nevertheless be provided upon request and directly to:

   i. The patient's attorney;

   ii. Another licensed health care professional;

   iii. The patient's health insurance carrier through an employee thereof; or

   iv. A governmental reimbursement program or an agent thereof, with responsibility to review utilization and/or quality of care.

4. Licensees may require a record request to be in writing and may charge a fee for:

   i. The reproduction of records, which shall be no greater than $1.00 per page or $100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.) If the licensee is electing to provide a summary in lieu of the actual record, the charge for the summary shall not exceed the cost that would be charged for the actual record; and/or
Policies, Procedures and General Guidelines

ii. The reproduction of X-rays or any material within a patient record which cannot be routinely copied or duplicated on a commercial photocopy machine, which shall be no more than the actual cost of the duplication of the materials, or the fee charged to the licensee for duplication, plus an administrative fee of the lesser of $10.00 or 10 percent of the cost of reproduction to compensate for office personnel time spent retrieving or reproducing the materials and overhead costs.

5. Licensees shall not charge a patient for a copy of the patient’s record when:
   i. The licensee has affirmatively terminated a patient from practice in accordance with the requirements of N.J.A.C. 13:35-6.22;
   or
   ii. The licensee leaves a practice that he or she was formerly a member of, or associated with, and the patient requests that his or her medical care continue to be provided by that licensee.

6. If the patient or a subsequent treating health care professional is unable to read the treatment record, either because it is illegible or prepared in a language other than English, the licensee shall provide a transcription at no cost to the patient.

7. The licensee shall not refuse to provide a professional treatment record on the grounds that the patient owes the licensee an unpaid balance if the record is needed by another health care professional for the purpose of rendering care.

(d) Licensees shall maintain the confidentiality of professional treatment records, except that:

1. The licensee shall release patient records as directed by a subpoena issued by the Board of Medical Examiners or the Office of the Attorney General, or by a demand for statement in writing under oath, pursuant to N.J.S.A. 45:1-18. Such records shall be originals, unless otherwise specified, and shall be unedited, with full patient names. To the extent that the record is illegible, the licensee, upon request, shall provide a typed transcription of the record. If the record is in a language other than English, the licensee shall also provide a translation. All X-ray films and reports maintained by the licensee, including those prepared by other health care professionals, shall also be provided.

2. The licensee shall release information as required by law or regulation, such as the reporting of communicable diseases or gunshot wounds or suspected child abuse, etc., or when the patient’s treatment is the subject of peer review.

3. The licensee, in the exercise of professional judgment and in the best interests of the patient (even absent the patient’s request), may release pertinent information about the patient’s treatment to another licensed health care professional who is providing or has been asked to provide treatment to the patient, or whose expertise may assist the licensee in his or her rendition of professional services.

4. The licensee, in the exercise of professional judgment, who has had a good faith belief that the patient because of a mental or physical condition may pose an imminent danger to himself or herself or to others, may release pertinent information to a law enforcement agency or other health care professional in order to minimize the threat of danger. Nothing in this
paragraph, however, shall be construed to authorize the release of the content of a record containing identifying information about a person who has AIDS or an HIV infection, without patient consent, for any purpose other than those authorized by N.J.S.A. 26:5C-8. If a licensee, without the consent of the patient, seeks to release information contained in an AIDS/HIV record to a law enforcement agency or other health care professional in order to minimize the threat of danger to others, an application to the court shall be made pursuant to N.J.S.A. 26:5C-5 et seq.

(e) Where the patient has requested the release of a professional treatment record or a portion thereof to a specified individual or entity, in order to protect the confidentiality of the records, the licensee shall:

1. Secure and maintain a current written authorization, bearing the signature of the patient or an authorized representative;
2. Assure that the scope of the release is consistent with the request; and
3. Forward the records to the attention of the specific individual identified or mark the material “Confidential.”

(f) Where a third-party or entity has requested examination, or an evaluation of an examinee, the licensee rendering those services shall prepare appropriate records and maintain their confidentiality, except to the extent provided by this section. The licensee’s report to the third party relating to the examinee shall be made part of the record. The licensee shall:

1. Assure that the scope of the report is consistent with the request, to avoid the unnecessary disclosure of diagnoses or personal information which is not pertinent;
2. Forward the report to the individual entity making the request, in accordance with the terms of the examinee’s authorization; if no specific individual is identified, the report should be marked “Confidential”; and
3. Not provide the examinee with the report of an examination requested by a third party or entity unless the third party or entity consents to its release, except that should the examination disclose abnormalities or conditions not known to the examinee, the licensee shall advise the examinee to consult another health care professional for treatment.

(g) (Reserved)

(h) If a licensee ceases to engage in practice or it is anticipated that he or she will remain out of practice for more than three months, the licensee or designee shall:

1. Establish a procedure by which patients can obtain a copy of the treatment records or acquiesce in the transfer of those records to another licensee or health care professional who is assuming responsibilities of the practice. However, a licensee shall not charge a patient, pursuant to (c)4 above, for a copy of the records, when the records will be used for purposes of continuing treatment or care.
2. Publish a notice of the cessation and the established procedure for the retrieval of records in a newspaper of general circulation in the geographic location of the licensee’s practice, at least once each month for the first three months after the cessation; and
3. Make reasonable efforts to directly notify any patient treated during the six months preceding the cessation, providing information concerning the established procedure for retrieval of records.

Please note that the Medical Record fee does not apply to Horizon BCBSNJ’s request for medical records.
Clinical Practice Guidelines

Horizon BCBSNJ’s and Magellan Behavioral Health’s clinical practice guidelines (CPGs) are available to all participating physicians and other health care professionals.

Horizon BCBSNJ CPGs
Registered users of NaviNet can view, print or download our CPGs.
- Select Horizon BCBSNJ within the Plan Central dropdown menu.
- Click References and Resources.
- Click Provider Reference Materials.
- Under Additional Information, click Clinical Practice Guidelines.

If you are not registered for NaviNet, visit www.NaviNet.net and click Sign up.

Copies of our CPGs can also be mailed to you. E-mail your request to:

<QualityManagement_Coordinator@HorizonBlue.com>.

Mail your request to:

Horizon BCBSNJ Quality Management
Attn: Request for CPG
5 Penn Plaza East, PP-15X
Newark, NJ 07102-2200

If you have questions about Horizon BCBSNJ’s CPGs, please call 1-877-841-9629.

Magellan Behavioral Health CPGs
You may view, print or download Magellan Behavioral Health’s CPGs from their website, <www.MagellanHealth.com>.
- Click I’m A Provider.
- Under the Providing Care menu option, click Clinical Guidelines.
- Click Clinical Practice Guidelines.

If you have questions about Magellan Behavioral Health’s CPGs, or to request a copy be mailed to you, please call Magellan Behavioral Health at 1-800-626-2212.
Journey to Health® (JTH) is the name of our integrated health and wellness program. The collection of health and wellness services, tools and resources that comprise JTH, addresses various health-related situations that your patients may face, no matter where they are on the health care continuum. This program seeks to engage and educate patients and support them as they take a more active role in their health.

JTH features the following:

- **Horizon Health and Wellness Education Program**
  This is a comprehensive chronic care management program that focuses on helping members deal with chronic conditions.

- **Case Management**
  Our Case Management Program has specially trained case managers work with members and families facing complex medical situations and your office to provide members with a better understanding of available health care options and help coordinate health care services.

- **PRECIOUS ADDITIONS®**
  This prenatal program provides helpful information and resources to expectant and new mothers.

- **24/7 Nurse Line**
  This 24-hour-a-day hotline, staffed by caring and helpful registered nurses, provides immediate answers to members’ health questions.

- **Online tools and resources**
  We provide access to online resources and health-related web-based tools, such as *My Health Manager*, powered by *WebMD*® that provide information and education to participating members.

- **Health Assessment Tool**
  Our online health self-assessment helps members determine and monitor his or her individual health risks.

- **Horizon Wellness Discounts**
  This program provides our members with savings and discounts on popular health-related products and services.

- **Worksite Wellness**
  Worksite Wellness programs include health screenings, health fairs, kiosks, health education sessions and more.

*Availability of certain programs may require additional purchase by employer groups.*
The right preventive care and early detection of disease are critical to healthy living. At Horizon BCBSNJ, we offer the Horizon Health and Wellness Education Program to eligible members who have been diagnosed with one of the chronic conditions listed below.

The Horizon Health and Wellness Education Program is designed to reinforce the health goals established between you and your patient, by providing additional lifestyle and medication compliance education, through periodic educational mailings and telephonic support from registered nurses, registered dieticians and social workers.

The Horizon Health and Wellness Education Program, which is URAC-accredited, can provide health education focusing on the following conditions:

- Asthma.
- Chronic Kidney Disease (CKD, including members receiving dialysis).
- Chronic Obstructive Pulmonary Disease (COPD).
- Coronary Artery Disease (CAD).
- Diabetes.
- Heart Failure.
- Hepatitis C.
- Multiple Sclerosis.
- Weight Management.

To enroll eligible members using our online referral form, visit www.HorizonBlue.com and, from the Patient Health Support menu on the Physicians/Facilities tab, select Health and Wellness Education Program. You may also download the program referral form from this location.

To receive information on the programs for any of the conditions listed to the left, please call 1-888-535-9617. Please note that all programs may not be available for all products or lines of business.
The Quality Management Program consists of two major components: clinical and service. The range of the clinical activities is extensive, encompassing preventive, acute care, chronic care and care provided for special populations. It monitors credentialing and compliance, member education, screening, practice guidelines, delegation and medical record documentation. The service component of the program monitors accessibility of care, member satisfaction and member complaints and appeals. The complete range of quality management initiatives are not implemented in all product lines. The applicability of a specific program element is determined by contract, regulatory requirements and accreditation standards.

The Quality Management Program monitors the availability, accessibility, continuity and quality of care on an ongoing basis. Indicators of quality care for evaluating the health care services provided by all participating health care professionals include:

1. A mechanism for monitoring patient appointments and triage procedures, discharge planning services, linkage between all modes and levels of care and appropriateness of specific diagnostic and therapeutic procedures, as selected by the Quality Improvement Committee;

2. A mechanism for evaluating all providers of care; and

3. A system to monitor physician and member access to utilization management services.

More specific program goals include:

- Specifying standards of care, criteria and procedures for the assessment of the quality of services provided and the adequacy and appropriateness of health care resources used.

- Empowering members to actively participate in and take responsibility for their own health through the provision of education, counseling and access to quality health care professionals.

- Maximizing safety and quality of health care delivered to members through the continuous quality improvement process.

- Evaluating and maintaining a high-quality participating network through a formalized credentialing and recredentialing process.

- Establishing long-term collaborative relationships with individuals and organizations committed to continuously improving the quality of care and services that they provide.

- Maintaining effective communications systems with members and health care professionals to evaluate performance with respect to their needs and expectations.

- Monitoring the utilization of medical resources using utilization management processes as defined in the Utilization Management Program Description.

- Maintaining a structured, ongoing oversight process for quality improvement functions performed by independently contracted entities and/or delegates.

- Fulfilling the quality-related reporting requirements of applicable state and federal statutes and regulations, as well as standards developed by private outside review and accreditation agencies that Horizon BCBSNJ chooses to adhere to.

To receive a more detailed plan, please call the Quality Management Department at 1-877-841-9629.
Medical Records Standards

In accordance with the CMS, the National Committee for Quality Assurance (NCQA) and URAC guidelines on standards for medical record documentation, Horizon BCBSNJ requires participating physicians and other health care professionals to adhere to the following commonly accepted practices regarding medical record documentation. The items below are also used in our medical record audits:

- **Medical Record Organization**
  Medical records will be organized and maintained in a systematic and consistent manner that allows easy retrieval.

- **Medical Record Availability**
  The Practitioner has a process to make records available to covering practitioners and others, as needed. Practitioner communicates to staff guidelines relative to the dispersal/retrieval of confidential patient medical records within and/or outside the office, such as in the case of a covering practitioner requesting medical records.

- **Medical Record Confidentiality**
  Access to medical records is limited to appropriate office staff:
  - All medical records are stored out of reach and view of unauthorized persons.
  - All electronic medical records are maintained in a system that is secure and not accessible by unauthorized persons.
  - Staff receives periodic training in member information confidentiality.

- **Dated Entries**
  Entries and updates to a medical record are dated with the applicable month, day and year.

- **Author Identification**
  Entries are initialed or signed by the author. Author identification may be a handwritten signature, unique electronic identifier, initials or any other unique identifier system the Practitioner chooses.

- **Page Identification**
  Patient name or unique identifier is found on each page in the medical record.

- **Personal/Biographical Data**
  The medical record will contain patient personal/biographical information such as:
  - Patient’s insurer.
  - Patient’s home address.
  - Patient’s home, work and/or cell phone number.
  - Emergency contact name and telephone number.

- **Legible Entries**
  Entries and updates are legible to a reader other than the author.

- **Medication Allergies and/or Adverse Reactions**
  Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions) are prominently displayed in the medical record.

- **Prescribed Medications**
  Maintain a list of prescribed medications which include dosages and dates of initial or refill prescriptions.

- **Updated Problem List**
  A dated problem list summarizing a patient’s significant illnesses, as well as medical and psychological conditions, will be maintained.

- **Presenting Complaints/Physical Examinations**
  Presenting complaints, physical examinations, diagnoses, treatment plans and possible risk factors for the patient, relevant to the particular treatment, are noted.

- **Follow-up Care**
  Entries are recorded stipulating when the patient should return for follow-up care.

- **Laboratory Results**
  Laboratory results are reviewed and initialed by the Practitioner.
Tobacco, Alcohol and Substance Abuse
For patients age 14 and older, there are appropriate entries made concerning the use of cigarettes and alcohol, and substance abuse (including anticipatory guidance and health education).

Medical History
Past medical history, including serious accidents, operations and illnesses are prominently documented for patients who have had three or more visits.

Immunization Records
Childhood immunization records are present for children under the age of 14.

Growth Chart
Create and maintain a growth chart for pediatric patients.

Advance Directives
Information on Advance Directives is noted in the medical record for all Medicare Advantage members, including a completed copy of the directive or member’s decision not to execute.

Provider List
Physicians and other health care professionals involved in the patient’s care can be easily identified in the patient’s chart.

Preventive Services/Risk Screening
Each patient record includes documentation that age-appropriate preventive services were ordered and performed or that the physician discussed age-appropriate preventive services with the patient and the patient chose to defer or refuse them. Physicians should document that a patient sought preventive services from another physician (e.g., Ob/Gyn, cardiologist, etc.) and include results of such services as reported by the patient.

Medical Record Documentation Compliance Audits
The Quality Management staff conducts an annual Medical Record Documentation Compliance Audit to assess compliance with our medical record documentation standards and as an annual requirement for health plan accreditation by the NCQA.

We randomly select 20 physician offices (offices must be participating with us for at least two years) to participate. The medical records of five Horizon BCBSNJ members from each office, also selected at random, are reviewed for their compliance with our Medical Record Documentation Standards as appropriate for the member’s age and plan in which he or she is enrolled.

Actions are taken to improve medical record keeping practices of those offices that do not meet a performance threshold of 80 percent. Procedures to improve content, organization and completeness of member records may include on-site counseling, physician communications, best practice materials, etc.

Audit results identifiable to a particular practice are only released to that practice. Overall audit results (excluding any identifiable information regarding physicians or members) and specific strategies for medical record documentation improvement are communicated in Blue Review.

Please note that you may not charge Horizon BCBSNJ for medical records when they are requested for medical review, claim review or as part of a medical record audit for a site visit.

Medicare Advantage Medical Record Retention
Physicians and other health care professionals are required to maintain medical records for a minimum of 10 years for all Medicare Advantage members.
Medical Records for Quality-of-Care Complaints

Horizon BCBSNJ is required to investigate member complaints, including those that allege inadequate care was received from a participating physician, other health care professional or facility. Complaints that include potential medical quality-of-care issues will be referred to our Quality Case Review Subcommittee (which is comprised of Horizon BCBSNJ medical directors and participating physicians) for further review.

If we receive a member complaint that includes a potential medical quality-of-care issue, your office may be asked to provide medical records and documentation to help the Subcommittee investigate the complaint. You are required to respond to such requests under the terms and conditions of our participating agreements and your obligation to follow our policies and procedures.

- Failure to comply with a request for medical records and/or additional documentation required to investigate a medical quality-of-care complaint is a very serious issue and may result in termination for cause from Horizon BCBSNJ's networks.
- Physicians and other health care professionals who do not respond to such requests in a timely manner will have a notation placed in their credentialing file for consideration at the time of recredentialing.
- We will also advise impacted members of any failures to comply with requests for medical records and make these members aware of their right to issue a complaint to the New Jersey State Board of Medical Examiners.

We acknowledge and appreciate that the great majority of our medical record requests are responded to promptly and efficiently.

NCQA and HEDIS

The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral health care organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.

NCQA Health Plan Accreditation evaluates how well a health plan manages all parts of its delivery system – physicians, other health care professionals, hospitals, other providers and administrative services – to continuously improve the quality of care and services provided to its members.

HEDIS® (Healthcare Effectiveness Data and Information Set) is the measurement tool used by the nation’s health plans to evaluate their performance in terms of clinical quality and customer service. It is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare health care quality.

NCQA accreditation not only involves a rigorous review of a health plans’ consumer protection and quality improvement systems, but also requires health plans to submit audited data on key clinical and service measures (e.g., mammography screening rates, advising smokers to quit; consumer satisfaction, etc.).

As NCQA gathers data from health plans for its nationwide comparisons, health plans like Horizon BCBSNJ gather data from your medical offices. A physician’s diligence in ensuring his or her patients are appropriately treated (as in the beta blocker measure) or screened (as in the cervical cancer screening measure) will be reflected in the plan’s report card made available to the general public through the NCQA’s website, <www.NCQA.org>.

Horizon PPO Network Office Manual – 2010-2011
**PRECIOUS ADDITIONS Program**

**PRECIOUS ADDITIONS** is our free prenatal program for eligible Horizon BCBSNJ members. **PRECIOUS ADDITIONS** supplements your care by providing valuable educational materials to your pregnant patients. To receive the full benefits of this program, members need to enroll in **PRECIOUS ADDITIONS** early in the first trimester.

**Patient Self-Enrollment**

Encourage your eligible Horizon BCBSNJ pregnant patients to enroll in **PRECIOUS ADDITIONS**. Members can enroll:

- By calling Member Services at **1-800-555-BLUE (2583)**.

Once enrolled in the program, your patient will receive useful prenatal and postnatal information, including:

- A pregnancy journal.
- Information about proper prenatal care.
- Childhood immunization information.
- A children’s health and immunization journal.
- Newborn enrollment procedures.
- Information about reimbursement (up to $50) for the cost of completing one prenatal course.

Members may call Member Services at any time to disenroll.

**High Risk Maternity Program**

Your patients who are identified as high risk may be eligible to enroll in our Complex Case Management’s High Risk Maternity Program. Through this program, nurse care specialists address members’ concerns about their pregnancy and assist them in making informed decisions regarding facility and care options.

Your patients may call **1-888-621-5894**, option 2 to learn more about the High Risk Maternity Program.

**Postpartum Depression Preventive Health Program**

Understanding the importance of education and screening for postpartum depression (PPD), a serious condition that affects about 15 percent of women following the birth of a baby, Horizon BCBSNJ and Magellan Behavioral Health, offer a Postpartum Depression Preventive Health Program.

Expectant women who participate in Horizon BCBSNJ’s **PRECIOUS ADDITIONS** program will receive educational information on postpartum depression as well as the Edinburgh Postpartum Screening Scale, a standard screening tool for postpartum depression.

Members complete the Edinburgh Postpartum Screening Scale and return it to Magellan Behavioral Health where the results are processed. Members who are identified as at risk for PPD are contacted by Magellan Behavioral Health and provided with referrals to behavioral health professionals who can provide appropriate treatment to address their PPD.

Members may call **1-800-555-BLUE (2585)** to learn more about **PRECIOUS ADDITIONS** and the Postpartum Depression Preventive Health Program.
Most Horizon BCBSNJ members are eligible to take advantage of the 24/7 Nurse Line. Members can speak to experienced registered nurses who are specially trained to offer prompt general health information. Nurses are available 24 hours a day, seven days a week, at no cost to our members. The toll-free number for the 24/7 Nurse Line is displayed on each eligible member’s ID card.

Nurses do not diagnose or recommend treatment, but they can assist our members by:

- Providing general health information, which may help members determine when to seek medical attention.
- Being available after hours to answer general health questions and provide general health information.
- Encouraging preventive health services while supporting informed health decision making.
- Educating members on which questions to ask during an office visit to promote effective communication between you and your patient.

Our 24/7 Nurse Line also offers members access to an online chat feature where members can interact online in real-time with a nurse about various health and wellness issues.

During chats, nurses can display webpages and suggest other helpful resources related to the topic being discussed. Members can request a transcript of their conversation and webpages for future reference.

To access the 24/7 Nurse Line Chat feature, members can:

- Visit <www.HorizonBlue.com/Members>.
- Mouse over Health and Wellness and click 24/7 Nurse Line.
- Scroll down and click the appropriate link for the product in which they are enrolled.

The 24/7 Nurse Line is for informational purposes only. Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for a physician’s care.

The 24/7 Nurse Line services are not an insurance program and may be discontinued at any time.
Case Management

The Case Management Program, offered through the Horizon BCBSNJ Clinical Operations Department, is designed to help our members get the care and services they need. Our specially trained case managers are registered nurses who work with our members and your office to help members understand their health care options and coordinate their health care services.

Case managers:

• Provide information that can help empower members to make informed decisions about their health care.

• Coordinate health care services so they are received at the most appropriate level and setting to help maximize the member's benefits.

• Assist in securing any authorizations in advance of receiving services.

• Refer members to other valuable programs, including our Horizon Health and Wellness Education Program, our health care ethics counseling resource, or to a social worker or registered dietician.

• Provide information on community resources and health and wellness programs.

Case management is free to all eligible members. Participation is voluntary. Medical and personal information is kept confidential and shared only with those involved in the patient's care.

Case Management programs are available to help members with:

• High-risk maternity care.

• Oncology.

• Post-discharge telephonic follow-up.

• Supportive care.

• Transplants.

• Other general and pediatric conditions.

Case Management Program Eligibility

Members who have serious or complex medical conditions, which may be long-term, catastrophic or terminal, are eligible for case management.

Physicians refer most participants enrolled in the program, however, members may also request case management services. Others are asked to participate based on review of claims data and/or their utilization of services.

Case managers continue to work with members – and your office – for as long as the member is enrolled and meets our case management criteria.

For more information regarding Horizon BCBSNJ Case Management Programs, please visit www.HorizonBlue.com or call 1-888-621-5894, option 2.
Regional Programs of Quality

Horizon BCBSNJ provides our members with access to a large network of high-quality hospitals throughout the region and we encourage referring physicians to select hospitals that have demonstrated effectiveness in quantifiable performance measures.

Horizon BCBSNJ’s Regional Programs of Quality (RPQ) initiative makes it easier to find information on quality and performance measures to help you and your patients choose the participating hospital that best fits your patients’ specific health care needs.

Horizon BCBSNJ’s RPQ initiative compiles information from well-recognized independent quality sources and then summarizes this information into an easy to understand format.

Horizon BCBSNJ provides quality data for the following services:

- Coronary artery bypass graft (CABG) and angioplasty procedures.
- Specialty pediatric services.
- Comprehensive cancer services.

Please visit [www.HorizonBlue.com](http://www.HorizonBlue.com) for more information.

Blue Distinction Designation

In addition to our local participating centers providing quality care, certain Horizon BCBSNJ members have access to facilities that have received special recognition through the BCBSA’s Blue Distinction program.

This program works with independent Blue Cross and/or Blue Shield Plans to award designation to medical facilities that demonstrate expertise in delivering quality health care.

Designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians’ and medical organizations’ recommendations. The criteria used to select Blue Distinction Centers® are made available to the public, allowing all involved to understand what’s behind the quality designation.

The goals of Blue Distinction designation are to:

- Encourage health care professionals to improve the overall quality and delivery of health care, resulting in better overall outcomes for patients.
- Support consumers as they identify medical facilities that best meet their needs.

The Blue Distinction program includes the Blue Distinction Centers for Specialty Care®, facilities recognized for their distinguished clinical care and processes in the areas of:

- Bariatric Surgery.
- Cardiac Care.
- Complex and Rare Cancers.
- Knee and Hip Replacement.
- Spine Surgery.
- Transplants.

For more information, please visit <[www.bcbs.com/innovations/bluedistinction](http://www.bcbs.com/innovations/bluedistinction)>. 
Blue Distinction Centers for Transplants

The Blue Distinction Centers for Transplants® are a national comprehensive network of transplant centers for both solid organ and bone marrow transplants.

The Blue Distinction Centers for Transplants are designated facilities across the nation that meet stringent quality criteria established by national organizations and expert clinician panels. By meeting these requirements, the centers demonstrate better outcomes and consistency of care and provide greater value for many of our members. Blue Distinction Centers for Transplants are considered in network for all members with BlueCard access.

There are Blue Distinction Centers for Transplants for the following transplant types:
- Heart.
- Lung (deceased and living donor).
- Combination heart/bilateral lung.
- Liver (deceased and living donor).
- Simultaneous pancreas/kidney (SPK).
- Pancreas after kidney (PAK) and pancreas transplant alone (PTA).
- Combination liver/kidney.
- Bone marrow/stem cell (autologous and allogeneic).

Physicians referring a Horizon BCBSNJ member for a transplant, should call us for information about participating local and national transplant facilities.

Dedicated case management is available to assist you and your patient. For more information, please call 1-888-621-5894, extension 46404.

CMS requires that Medicare and Medicare Advantage members must receive transplant-related services only at Medicare-approved transplant facilities.

Visit www.cms.gov/ApprovedTransplantCenters for more information about CMS approved transplant facilities.

Physician Recognition Program

Horizon BCBSNJ recognizes the demonstrated commitment of participating physicians to provide quality health care to our members.

Horizon BCBSNJ’s Physician Recognition Program continues our commitment to quality health care by recognizing participating physician practices that have demonstrated high quality. This program is based upon quality criteria developed from input from participating physicians, health care consultants and national evidence-based resources.

Some participating physicians receive special recognition for the high-quality care they provide to Horizon BCBSNJ members.

Specialties that receive recognition include:
- Cardiology.
- Endocrinology.
- Family Practice.
- Gastroenterology.
- General Surgery.
- Internal Medicine.
- Multi-Specialty.
- Nephrology.
- Obstetrics/Gynecology.
- Orthopedics.
- Otolaryngology.
- Pediatrics.
- Urology.

Recognition for the above noted specialties will include financial recognition in the form of an increased reimbursement for certain procedures for the annual recognition cycle, as well as nonfinancial recognition.

If you have questions, please contact your Professional Relations Representative. We welcome feedback and invite interested physicians to collaborate with us and provide suggestions for this program.
Special Programs

Visit our website, www.HorizonBlue.com, for more information about the program and to view the current list of recognized physicians.

Only those physician groups that reach a threshold number of events on any particular measure will have scores presented. If no scores are present, your group did not achieve the requisite number of events for scoring.

In 2010, the Pulmonary Medicine specialty was removed from the Physician Recognition Program as the number of practices that could achieve the thresholds in a number of measures had become too small.

Our recognition programs are subject to change. You will be informed of changes at least 30 days in advance.

Enhanced Data
In 2009, we asked participating physicians in the specialties mentioned on the previous page to access our online Cost and Quality tool and review the data and provide us with comments, questions and feedback.

The feedback received was used to improve the quality of our data source and enhance our clinical quality metrics. This enhanced data was used for our most recent Horizon Physician Recognition Program and will also be used as we make network physician performance information available to our members through our website.

You may access the Cost and Quality tool to review your information online (and provide us with feedback) at any time. This tool also provides the details behind the measures that better align Horizon BCBSNJ with the principles of transparency.

To access our online Cost and Quality tool please visit <www.NaviNet.net>.

Physician Performance Reports
Our physician performance reports can assist participating practices in improving their performance and documenting those improvements through objective measures.

Selected specialists receive updated reports that include ranking information. Please review these reports in detail.

For more information, or to discuss your practice’s reports, please contact your Professional Relations Representative.

Horizon Hospital Recognition Program
The Horizon Hospital Recognition Program is designed to acknowledge participating hospitals in the areas of patient safety, clinical outcomes and patient satisfaction.

Hospitals with both high quality and safe patient outcomes may receive financial and public recognition from Horizon BCBSNJ.

Participating hospitals are required to report their data through the Leapfrog Hospital Survey™. LeapFrog Hospital Survey elements include:

• Computerized Physician Order Entry (CPOE).
• ICU Physician Staffing (IPS).
• Evidence-Based Hospital Referral (EBHR).
• Safe Practices Score (SPS).
• Common Acute Conditions (CAC).
• Managing Serious Errors: Never Events and Hospital-Acquired Conditions.

This program acknowledges hospitals for generating improved clinical performance and for sustaining superior performance.

Visit our website, www.HorizonBlue.com, for additional details about the program.
Horizon BCBSNJ (and its affiliated covered entities) is considered a “health plan” under federal law and a “covered entity” under the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191 (HIPAA). This means that Horizon BCBSNJ is subject to the “administrative simplifications” requirements of HIPAA, including its regulations on electronic standard transactions and code sets, privacy, security and National Provider Identifier (NPI) – just as you are, if you or your business associates on your behalf, engage in electronic health coverage transactions, such as for medical claims or encounter submissions.

Privacy and Security of Medical Records and Other Private Information

Hospitals, facilities, physicians and other health care professionals are responsible for complying with all applicable state and federal laws and regulations regarding the privacy and security of medical records and other individually identifiable (protected) health information, which Horizon BCBSNJ calls “Private Information.” In addition, for those hospitals, facilities, physicians and other health care professionals which are “covered entities” under HIPAA, that includes the obligation to comply with the privacy and security requirements of HIPAA, its NPI requirements and many of its other rules.

As you know, the federal rules generally allow you to use and disclose Private Information without an authorization from your patient for treatment, payment and health care operations (TPO), as well as for a number of other permissible purposes. This includes uses and disclosures made for the TPO purposes of other covered entities, like Horizon BCBSNJ (with limited exceptions).

If you have questions in reference to HIPAA, we suggest that you contact HIPAA consultants and/or attorneys.
NASCO Payment Summary

We use the NASCO® Processing System (NPS) to adjudicate claims for customers enrolled in Horizon POS, FEP, Medigap plans, large national accounts and claims for customers enrolled in an out-of-state Blue Cross and/or Blue Shield Plan.

Information about claims processed on the NPS is communicated to you on a NASCO Payment Summary.

For information about the NPS or the NASCO Payment Summary, please call the Physician Services number indicated on the patient’s ID card.

Universal Payment System Voucher

The Universal Payment System (UPS) voucher, our payment voucher, helps you obtain the information you need quickly and easily, in a simple-to-read format. The UPS voucher includes simpler summary sections, a message center and additional bolded information.

The UPS voucher includes:

- A cover page that includes payment summary information.
- Bolding of patient names to differentiate the patient from the subscriber.
- A layout that simplifies navigation of the voucher.
- Remark and reason code messages below the patient claim detail explaining any payments/non-payments.

Online User Guide Available

A Guide to Your Payment Voucher was created to help you better understand and navigate the UPS voucher. This guide is available online:

- Visit <www.HorizonBlue.com/Providers>.
- Mouse over Forms and Vouchers.
- Click Professional Payment Vouchers.

This guide provides a detailed overview of the UPS voucher and its features.

A sample voucher is included on the following pages.

If you have questions about the UPS voucher, please contact your Professional Relations Representative or call Physician Services at 1-800-624-1110.
Description of Fields

A: Payment Summary
This is a summary of the gross claim amount, late interest, account receivables (A/R) applied and the check amount.
The check amount is the actual payment after consideration of the late interest and A/Rs applied.

B: Claim Detail
This section lists all claims, sorted by product and patient. Claim detail includes remark and reason code messages directly below the patient claim detail providing further explanation.
In 2010, we began implementing variable messaging to provide specific detailed information regarding claims denials (where the message contains specific information about the claim or the member). The first of these enhanced messages provides specific details about claims processed against an authorization where one or more of the following have been exceeded:
• Days.
• Hours.
• Services.
• Units.
• Visits.
The message will contain both the quantity authorized and also the units of measure of that quantity, e.g., This claim is denied because the 30 authorized days have been used.

C: Account Receivable Summary
This section highlights all outstanding payments due to Horizon BCBSNJ. This section details the patient’s claim where the account receivable (A/R) was initiated, and indicates any monies deducted from your payment to satisfy the A/R.
Based on feedback received from you, we have limited the number of times a single Account Receivable (A/R) will appear in the Account Receivable Summary section of subsequent paper and online UPS vouchers.
An A/R will only appear in the Account Receivable Summary section of a UPS voucher when:
• The A/R is initiated.
• Monies are received from a physician and applied toward that A/R.
• The A/R is activated (45 days after an A/R is initiated if monies have not already been received to satisfy it).
• Claim payments are applied toward the active A/R.
• The A/R is completely satisfied.

D: Late Interest Summary
This area details claims that require Horizon BCBSNJ to pay a late interest payment. The late interest payment will be added to the claim payment on this voucher.
Payment Summaries and Vouchers

Sample Payment Voucher

PAYEE: YOUR EYE INSTITUTE
123 ANY STREET
ANY CITY, NJ 00000-1234

PAYMENT SUMMARY:
GROSS CLAIM AMOUNT: 1,171.50
LATE INTEREST: 101.10
A/P'S APPLIED: 171.50
CHECK AMOUNT: $1,101.10

IF YOU SUSPECT HEALTH CARE FRAUD, PLEASE CALL OUR SPECIAL INVESTIGATIONS UNIT HOTLINE - 1-800-624-2048.

An independent license of the Blue Cross and Blue Shield Association

Pay Exactly
ONE THOUSAND ONE HUNDRED ONE AND 10/100 DOLLARS

PP-15H 000011
YOUR EYE INSTITUTE
123 ANY STREET
ANY CITY, NJ 00000-1234
### Payment Summaries and Vouchers

**Jane Smith**

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>Subscriber</th>
<th>Sub ID</th>
<th>Claim No.</th>
<th>Patient Acct</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/06/10</td>
<td>24</td>
<td>27J904-RT</td>
<td>1234567890</td>
<td>1,200.00-</td>
<td>0.00</td>
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<td>0.00</td>
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</tbody>
</table>

**Mary Doe**

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>Subscriber</th>
<th>Sub ID</th>
<th>Claim No.</th>
<th>Patient Acct</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/10/10</td>
<td>27177</td>
<td>N14</td>
<td>1234567890</td>
<td>105.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>83.10</td>
</tr>
</tbody>
</table>

**Note:**
- **B151:** This cosmetic procedure/diagnosis is not eligible for benefits consideration under the subscriber's contract.
- **N14:** Payment is not allowed.
- **N15:** Separately billed services/estimates have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
- **N19:** Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
## Payment Summaries and Vouchers

### TOTAL REMAINING BALANCE OF ARs

<table>
<thead>
<tr>
<th>00319UCDSYO0010000005</th>
<th>0000001</th>
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</thead>
<tbody>
<tr>
<td>Date: 3/24/2010</td>
<td>Payee ID 1234567889</td>
</tr>
</tbody>
</table>

### ACCOUNT RECEIVABLE: STATUS: T - TO BE CLOSED

<table>
<thead>
<tr>
<th>ENTERED</th>
<th>ACTIVATED</th>
<th>PATIENT ACCOUNT</th>
<th>CLAIM NUMBER</th>
<th>SUBSCRIBER ID</th>
<th>PATIENT NAME</th>
<th>DOS</th>
<th>STARTING AMOUNT</th>
<th>REMAINING BALANCE</th>
<th>LAST ACTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/19/10</td>
<td>03/19/10</td>
<td>234567891</td>
<td>NA - 78001080000000</td>
<td>XXXXXXXXX</td>
<td>Daniel Jones</td>
<td>01/17/10</td>
<td>1,000.00</td>
<td>0.00</td>
<td>03/19/10</td>
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### ACCOUNT RECEIVABLE APPLIED TO:

<table>
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<tr>
<th>DATE TAKEN</th>
<th>PAYMENT NUMBER</th>
<th>BANK CODE</th>
<th>AMOUNT TAKEN</th>
<th>RUNNING BALANCE</th>
<th>SS - CLAIM</th>
<th>SUB ID</th>
<th>PATIENT NAME</th>
<th>DOS</th>
<th>PATIENT ACCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/19/10</td>
<td>0000538065 Z</td>
<td>Z</td>
<td>460.00</td>
<td>540.00</td>
<td>NA - 78001080030004</td>
<td>XXXXXXXXX</td>
<td>JANE SMITH</td>
<td>01/30/10</td>
<td>0</td>
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<tr>
<td>03/19/10</td>
<td>0000538065 Z</td>
<td>Z</td>
<td>360.00</td>
<td>180.00</td>
<td>NA - 78001080030003</td>
<td>XXXXXXXXX</td>
<td>JANE SMITH</td>
<td>01/30/10</td>
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<td>03/19/10</td>
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<td>Z</td>
<td>180.00</td>
<td>0.00</td>
<td>NA - 78001080030001</td>
<td>XXXXXXXXX</td>
<td>MARY DOE</td>
<td>12/01/09</td>
<td>3456789</td>
</tr>
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</table>

### LATE CLAIM PAYMENT - INTEREST PAID

<table>
<thead>
<tr>
<th>SS - CLAIM PAID LATE</th>
<th>RECEIPT DATE</th>
<th>RESET DATE</th>
<th>PAY DATE</th>
<th>IN SYS</th>
<th>LATE</th>
<th>I-RATE</th>
<th>AMOUNT</th>
<th>INTEREST</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC-12345678900000000</td>
<td>04/14/10</td>
<td>04/14/10</td>
<td>07/24/10</td>
<td>345</td>
<td>316</td>
<td>10.00</td>
<td>1,171.50</td>
<td>101.10</td>
</tr>
</tbody>
</table>

### Late Interest - Key

- RECEIPT DATE - The date used for claim receipt.
- RESET DATE - The date the last claim correction was made. Used when present, instead of receipt date to calculate the late interest payment.
- PAY DATE - This is the effective payment date for the the payment. Check or ACH.
- IN SYS - The number of days in the system. The difference between the Receipt Date and Pay Date.
- LATE - The number of days late. The days exceeding state max days to pay.
- I-RATE - Annualized interest rate.
- AMOUNT - The amount that is subject to late interest.
- INTEREST - Total late interest.
Downloadable Forms

Horizon BCBSNJ makes most of our forms available online.

To access our downloadable forms:

• Visit <www.HorizonBlue.com/Providers>.
• Mouse over Forms and Vouchers and click Downloadable Forms.

Our downloadable forms are organized into sections to help make locating the form you need fast and easy.

In this section, you can find:

• Pharmacy forms.
• Authorization forms.
• Claim forms.
• HIPAA forms
• Questionnaire forms
• EDI forms.
• Joint Replacement Recovery Program forms.
• Inquiry Requests.
• Miscellaneous forms.

If you do not have access to the Internet, please contact your Professional Relations Representative for copies of any of these forms.
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