Reminder: Ultrasound Accreditation Requirement

We remind physicians and other health care professionals who perform certain ultrasound procedures that they are required to obtain American Institute of Ultrasound in Medicine (AIUM) accreditation.

Target: BP™ Can Help Increase Blood Pressure Control Rates

The American Heart Association (AHA) and American Medical Association (AMA) have collaborated to establish Target: BP – a free clinical hypertension management initiative.

Is Your Directory Listing Up to Date?

It's critical that provider file information is accurate and up to date as this information is used to populate our Online Doctor & Hospital Finder on HorizonBlue.com/doctorfinder.

The Importance of Our Members’ Oral Health

Horizon Blue Cross Blue Shield of New Jersey has implemented an outreach program directed towards members with diabetes who demonstrate gaps in dental care.

Are You Using the Prior Authorization Procedure Search Tool?

Using Horizon BCBSNJ’s online search tool helps make it easier for you to determine if services require prior authorization for your fully-insured Horizon BCBSNJ patients.
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Mark Your Calendars: 2017 Hospital Forums

Horizon Blue Cross Blue Shield of New Jersey is pleased to announce dates for this year’s Hospital Forums:

- **Tuesday, November 7, 2017**
- **Wednesday, November 8, 2017**

The sessions, hosted by the Network Hospital Relations staff, will highlight program improvements, new policies and collaborative opportunities and will include information from our provider services, BlueCard®, utilization management and patient-centered programs departments. Guest speakers from network facilities will also share their best practices.

At our 2017 sessions, we’ll also be hosting a Solution Center that will provide you with an opportunity to discuss your specific claims, inquiries and questions with an onsite Horizon BCBSNJ representative for real-time research and issue resolution.

Invitations with details and locations will be sent out electronically later this year to personnel within network hospital patient accounts, patient access and utilization management departments/areas.

If you have questions, please contact your Network Hospital Specialist.

Access Our FAQs

When you have questions, access our FAQs on NaviNet®. There you can quickly find information regarding these topics and more:

- Claims and payments
- Eligibility and benefits
- Office and provider management
- Provider resources
- Referrals and authorizations

To get started, log on to NaviNet.net, select Help and then select Horizon BCBSNJ.
Incentives for Completed In-Home Health Assessments

Horizon BCBSNJ is committed to partnering with physicians and other health care professionals to support our members in leading a healthy lifestyle.

As part of this commitment, we are offering members enrolled in the following plans a $40 CVS Pharmacy® gift card for completing a comprehensive health assessment in the comfort of their own home:

- Commercial (Individual plan or Small Group Employer plan)
- Dual Eligible Special Need Plans
- Medicare Advantage; and
- Medicare Advantage NJ DIRECT (PPO) Plans

*Note: Gift cards are not offered if members receive a physical or health assessment from their physician.*

Horizon BCBSNJ works with Matrix Medical Network and EMSI Health to provide our members with a fully-licensed and qualified nurse practitioner to evaluate their health.

Results of the assessment are shared with the member, his or her primary physician and Horizon BCBSNJ to help ensure our member receives the best care possible and stays on top of any health conditions.

This assessment is part of the member’s current coverage and is provided at no additional cost. It does not replace the care of or appointments with the member’s physician and is strictly voluntary.

**What’s Included**

During the assessment, the health care professional will:

- Go over the member’s health history
- Listen to the member’s health concerns
- Answer the member’s health-related questions
- Review any medicines the member takes
- Suggest screenings or other tests

The assessment is strictly voluntary, is offered at no cost to the member and will not impact the member’s benefits or premium. No medicines, treatments or tests are ordered during the assessment.
Additional Medications to be Added to Our Medical Injectables Program

As of May 1, 2017, additional injectable medications are included as part of our Medical Injectables Program (MIP) administered by Magellan Rx ManagementSM.

Beginning with services to be provided on and after May 1, 2017, Magellan Rx Management will conduct medical necessity and appropriateness reviews (MNARs) for additional injectable medications that are administered in a freestanding or hospital-based dialysis center, an outpatient facility, a patient’s home or a physician’s office.¹

Review the list of additional injectable medications and the complete list of injectable medications that currently require MNAR at HorizonBlue.com/mip.

If you have questions, contact your Network Specialist.

Work Smarter with Magellan Rx Management

Follow these best practices to save time when working with Magellan Rx Management:

• Avoid delays in claim processing and reimbursement by always obtaining pre-service MNAR of injectable medications for your patients.

• Avoid time spent waiting on the phone by submitting and managing your MNAR requests through Magellan Rx Management’s secure website, MagellanRx.com.

If you don’t already have a Magellan Rx Management username and password, we encourage you to request them today.

• Visit MagellanRx.com.

• Click the Providers and Physicians icon.

• Click New User Request Access (within the yellow Sign In section).

• Click Contact Us.

• Complete the required fields and then click Send.

Magellan will respond with a username, password and quick start guide within two business days.

¹ Medical necessity and appropriateness review is not required for injectable medications that are administered during an inpatient stay, or in an Emergency Room setting or observation room setting. For medical injectable services rendered in the patient’s home, call 1-855-243-3321 for participating Horizon Care@Home providers to obtain pre-service determination.
Reminder: Ultrasound Accreditation Requirement

We remind physicians and other health care professionals who perform certain ultrasound procedures that they are required to obtain American Institute of Ultrasound in Medicine (AIUM) accreditation as documented in our Diagnostic Imaging Privileging by Participating Provider Practice Specialty policy.

All physicians and other health care professionals must have earned appropriate AIUM accreditation to perform the ultrasound services noted in the table below.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Procedure Codes</th>
<th>AIUM Accreditation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrinologists</td>
<td>76536, 76942</td>
<td>Dedicated Thyroid/Parathyroid</td>
</tr>
<tr>
<td>Head and Neck Surgeons (ENTs, Otolaryngologists)</td>
<td>76536, 76942</td>
<td>Head and Neck</td>
</tr>
<tr>
<td>Sports Medicine, Physical Medicine &amp; Rehabilitation Rheumatologists</td>
<td>76881, 76882, 76942</td>
<td>Musculoskeletal (Ultrasound-Guided Interventional Procedures)</td>
</tr>
<tr>
<td>Urologists</td>
<td>76775, 76857, 76870, 76872, 76873, 76942, 76965</td>
<td>Urologic</td>
</tr>
</tbody>
</table>

Visit the AIUM.org and click the Accreditation tab to learn more and to access their Application Instructions.

If you have any questions, please call your Network Specialist.

Information about this and other radiology requirements within the Diagnostic Imaging Privileging Policy documents may be reviewed by visiting HorizonBlue.com/evicore and selecting Radiology/Imaging Services.

Our Standards for Diagnostic Radiology/Imaging policy may be reviewed by visiting HorizonBlue.com/medicalpolicy.
Communicating Electronically

Electronic communications are an efficient and effective way to convey important information.

We will convey most information to you in an electronic format, including news and legal notices, material adverse change announcements, newsletters, office manuals and more.

Electronic communications about material adverse changes to our policies, procedures, fee schedules, and/or capitation rates, which may adversely impact your practice, will be posted online at least 90 days prior to the implementation date of the proposed change.

Make sure you are getting our messages

We encourage all providers to regularly check for Horizon BCBSNJ News and Legal Notices online using one of the following ways:

• Visit HorizonBlue.com/providers, or
• Log in to NaviNet.net and select Horizon BCBSNJ from the My Health Plans menu. Then mouse over References and Resources and click Provider Reference Materials.

If you have any questions, please contact your Network Specialist.

All physicians and other health care professionals in our managed care and PPO networks agree that we may communicate with them by electronic means per the participating Agreement(s). Please see section 9.11 of the HORIZON HEALTHCARE OF NEW JERSEY, INC. AGREEMENT WITH PARTICIPATING PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS (Horizon Managed Care Network Agreement) and/or section 12 of the HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY AGREEMENT WITH PARTICIPATING PHYSICIANS AND HEALTHCARE PROFESSIONALS Horizon PPO Network Agreement).

Benefits-at-a-Glance Available Online

Horizon BCBSNJ is pleased to announce that updated versions of our popular job aids, Managed Care Benefits-at-a-Glance and PPO Benefits-at-a-Glance, are available online.

To access this information, registered NaviNet® users affiliated with participating providers may log in to NaviNet.net, select Horizon BCBSNJ from the My Health Plans menu and:

• Mouse over References and Resources and click Provider Reference Materials
• Mouse over Resources and click Manuals & User Guides

These job aids do not provide comprehensive benefits or address all benefit categories. For complete benefit information, please visit NaviNet.net or call 1-800-624-1110 to use our Interactive Voice Response system, available 24 hours a day, seven days a week, generally including weekends and holidays.
Is Your Directory Listing Up to Date?

We recently posted a revised administrative policy that changes the way we address situations in which we are unable to validate whether information included in our provider files is current and accurate.

Our Provider Directory Management administrative policy outlines the process Horizon BCBSNJ staff and business partners acting on our behalf will take as they work to ensure that the information within our provider files is correct. This revised policy also outlines actions that will be taken in regard to provider directory inclusion and continued participation of practice location(s) and/or practitioners whose information we are unable to validate.

It’s critical that provider file information is accurate and up to date as this information is used to populate our Online Doctor & Hospital Finder on HorizonBlue.com/doctorfinder. Inaccurate or outdated information may result in a misrepresentation of your practice to patients and referring physicians or other health care professionals searching our Online Doctor & Hospital Finder.

Our Policy Online

We encourage you to review our Provider Directory Management administrative policy online.

To access this information, registered NaviNet users may sign in to NaviNet.net, select Horizon BCBSNJ from the My Health Plans menu and:

- Mouse over References and Resources and click Provider Reference Materials
- Mouse over Policies & Procedures and click Policies
- Click Administrative Policies
- Click Provider Directory Management

If you have questions, please contact your Network Specialist.

Provider Directory Management Practitioner Validation Process

1. Horizon BCBSNJ validates practitioner information every 90 days through outreach efforts conducted by our business partners, CAQH and Atlas Systems. These outreach efforts seek to validate that the information we have on file is accurate.

Our business partners will pursue their outreach for a period of 90 days.

2. If the initial outreach efforts of our business partner(s) are not successful, Horizon BCBSNJ staff will conduct a secondary 90-day outreach effort to validate that the information we have on file is accurate.

While this secondary outreach is conducted, the information pertaining to practitioners in question will be suppressed from appearing within our Online Doctor & Hospital Finder.

3. If, at the end of this second 90-day period, we are unable to validate that the information we have on file is accurate, the practice location(s) and/or practitioner in question will be terminated from all Horizon BCBSNJ networks.
Is Your Directory Listing Up to Date? (continued)

**Use CAQH ProView™**

Horizon BCBSNJ strongly encourages all participating practitioners to use CAQH ProView™ to maintain their Horizon BCBSNJ provider file information.

- Practitioners should access CAQH ProView as soon as demographic/practice information changes to make updates as appropriate, and then re-attest that information is current, accurate and complete.

- Practices should ensure that practice roster information is up to date.

- Horizon BCBSNJ captures all CAQH updates on a weekly basis and incorporates this information into our provider files.

If you do not want Horizon BCBSNJ to access your CAQH information, please remove Horizon BCBSNJ from your CAQH profile.

**If you’re not registered with CAQH, please:**

- Visit [ProView.caqh.org/pr](https://proview.caqh.org/pr) to self-register with CAQH. Upon completion of the self-registration process, you will receive a CAQH welcome email with your unique CAQH Provider ID number.

- Visit [caqh.org](https://caqh.org), mouse over CAQH ProView and select Log In.

- Complete an online application (ensure that you select Horizon BCBSNJ so that we can access your information) and then attest that the information is accurate and complete.

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Choosing to Prescribe Generic Medications

Prescription medications are an important part of the health care system, as some patients rely on medicines to help them get well or keep them healthy. In recent years, medication innovations have increased the number and quality of treatment options for many diseases. However, this has also been connected to an increase in overall pharmacy cost, which indirectly limits access and burdens the health care system. In addition, prescription medications were recently ranked as the largest single expense of consumer premium dollars by America’s Health Insurance Plans (AHIP) at 22 percent.¹

Horizon BCBSNJ strives to provide meaningful solutions to improve access to affordable options, which helps decrease members’ overall prescription cost burden.

**How to Make a Difference**

It can be difficult for a prescriber to determine which medications may be more expensive than other alternatives without access to cost information. Although the exact cost of a medication can vary based on the dosage, form, quantity prescribed and a patient’s benefit design, there may be alternative lower-cost options.

We encourage you to consider prescribing generic medications to help reduce out-of-pocket costs which are generally less costly than branded alternatives, thereby increasing patient satisfaction and medication adherence.

**Source**

Pharmacy Corner: Formulary Changes Announced

Changes to our commercial formulary were determined at the Pharmacy and Therapeutics (P&T) Committee meeting in February 2017. The most up-to-date commercial formulary is available on HorizonBlue.com/formulary, or for Federal Employee Program® (FEP®) members, by visiting fepblue.org/en/formulary.

<table>
<thead>
<tr>
<th>Moved from Non-Preferred to Preferred Status</th>
<th>Brand</th>
<th>Generic</th>
<th>Prior Authorization (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Xiidra</td>
<td>lifiterast</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moved from Preferred to Non-Preferred Status</th>
<th>Brand</th>
<th>Generic</th>
<th>Prior Authorization (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lacrisert</td>
<td>hydroxypropyl cellulose</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Drugs Reviewed and Remain in Non-Preferred Status</th>
<th>Brand</th>
<th>Generic</th>
<th>Prior Authorization (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Zinbryta</td>
<td>daclizumab</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Jentadueto XR</td>
<td>linagliptin and metformin</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Byvalson</td>
<td>nebivolol and valsartan</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>Relistor tablet</td>
<td>methylnaltrexone</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Viekira XR</td>
<td>dasabuvir, ombitasvir, paritaprevir and ritonavir</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Doryx MPC</td>
<td>doxycycline</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Otovel</td>
<td>ciprofloxacin and fluocinolone</td>
<td>N</td>
</tr>
</tbody>
</table>

Recent changes to our Medicare formulary are listed in the table below. The most up-to-date Medicare formulary is available on HorizonBlue.com/medicare/formulary.

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Formulary Status</th>
<th>Prior Authorization (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubraca</td>
<td>rucaparib</td>
<td>Added</td>
<td>Y</td>
</tr>
<tr>
<td>Invokamet XR</td>
<td>canagliflozin and metformin</td>
<td>Added</td>
<td>N</td>
</tr>
<tr>
<td>Basaglar</td>
<td>insulin glargine</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Adlyxin</td>
<td>lixisenatide</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Soliqua</td>
<td>insulin glargine and lixisenatide</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Xultophy</td>
<td>insulin degludec and liraglutide</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Zurampic</td>
<td>lesinurad</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Rayaldee</td>
<td>calcifediol</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>GoNitro</td>
<td>nitroglycerin</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Lomaira</td>
<td>phentermine hydrochloride</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Belviq XR</td>
<td>lorcaserin</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Yosprala</td>
<td>aspirin/omeprazole</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Bromsite</td>
<td>bromfenac</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Ameluz</td>
<td>aminolevulinic acid</td>
<td>Not Covered</td>
<td>-</td>
</tr>
<tr>
<td>Taytulla</td>
<td>norethindrone/ethinyl estradiol iron</td>
<td>Not Covered</td>
<td>-</td>
</tr>
</tbody>
</table>
FEP® Pharmacy Program and Formulary Information

Blue Cross and Blue Shield Service Benefit Plan members with Basic or Standard Option can get the prescription medicines they need through Preferred in-network pharmacies.

Information about the pharmacy program and its procedures can be found in the 2017 Blue Cross and Blue Shield Service Benefit Plan brochure and in the 2017 Pharmacy Benefit Summary Book online. For more information, visit [fepblue.org/pharmacy](http://fepblue.org/pharmacy) or call the Pharmacy Program at 1-800-624-5060.

FEP Explanation of Payments (EOPs)

Effective May 8, 2017, EOP statements for claims processed beginning May 8, 2017 for Federal Employee Program® (FEP) members (ID numbers beginning with R) will be available on NaviNet.

Accessing Pharmacy Benefits Under Medicare Part B

Horizon Medicare Advantage NJ DIRECT (PPO) plan members have a Medicare Part B benefit that covers medically necessary services and supplies they may need to help with an illness or condition. Common medical supplies are covered under the Part B portion of their Horizon Medicare Advantage NJ DIRECT (PPO) plan rather than under the Part D prescription coverage with Express Scripts®.

Common covered Part B drugs and supplies include:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic supplies</td>
<td>Test strips, lancets</td>
</tr>
<tr>
<td>Immunosuppressant drugs</td>
<td>Drugs used for transplant patients</td>
</tr>
<tr>
<td>Oral anti-cancer drugs</td>
<td>Drugs used for cancer treatment</td>
</tr>
<tr>
<td>Oral anti-emetic drugs</td>
<td>Drugs used within 48 hours of chemotherapy</td>
</tr>
<tr>
<td>Erythropoietin</td>
<td>Treatment for anemia for people undergoing dialysis</td>
</tr>
<tr>
<td>Vaccines</td>
<td>Influenza, Pneumococcal and Hepatitis B</td>
</tr>
<tr>
<td>Parenteral nutrition</td>
<td>If permanent dysfunction of digestive tract</td>
</tr>
</tbody>
</table>

How It Works

The pharmacy will bill Horizon BCBSNJ and the member will be responsible for their cost share, if applicable, beginning in July. The pharmacist must be provided with Rx Bin (016499) and PCN (Part B) to submit Part B claims.

If you have questions, please call Physician Services at 1-800-624-1110.
Refer Your Members to In-Network Providers

Our participating physicians and health care professionals must ensure that whenever possible, their Horizon BCBSNJ patients are referred to participating physicians, health care professionals, ancillary providers (including clinical laboratories) or facilities (including ambulatory surgery centers) unless the member has and wishes to use his or her out-of-network benefits and understands that higher out-of-pocket expenses will be incurred.

All participating physicians and other health care professionals are required to follow our Out-of-Network Referral Policy¹ to help ensure that members fully understand the increased out-of-pocket expense they will incur for out-of-network care. 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, ancillary provider 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.

• Advise the member of a participating physician, other health care professional, ancillary provider or facility that could provide the same services unless one does not exist within our network.

Participating physicians and other health care professionals should call us at 1-800-664-BLUE (2583) for authorization if they believe that the necessary expertise does not exist within our network or there is no available participating physician, other health care professional, ancillary provider or facility to provide services to the member. If Horizon BCBSNJ agrees that a participating physician, other health care professional, ancillary provider or facility is not available, the member’s in-network coverage will apply to the out-of-network referral.

• Advise the member of any financial interest in, or compensation made by, the nonparticipating physician, other health care professional, ancillary provider 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.

You are still required to obtain the appropriate approval from Horizon BCBSNJ for those services that require prior authorization.

To review our Out-of-Network Referral Policy, please log in to NaviNet.net, select Horizon BCBSNJ from the My Health Plans menu and:

• Mouse over References and Resources and click Provider Reference Materials

• Mouse over Policies and Procedures and click Policies

• Click Administrative Policies

• Click Out-of-Network Referral Policy

The Out-of-Network Consent Form is available at HorizonBlue.com/consent.

• Select Consent Form – Out-of-Network (2180) or

• Select Consent Form – Out-of-Network (Spanish) (2180S)

Contact your Network Specialist if you have questions.

¹ Our Out-of-Network Referral Policy does not apply to members enrolled in Horizon BCBSNJ plans that have no out-of-network benefits (e.g., Horizon HMO plans, Horizon EPO plans, OMNIA Health Plans, Medicare Advantage HMO plans, etc.).
The Importance of Our Members’ Oral Health

Horizon BCBSNJ recognizes the importance that oral and dental care has to a patient’s overall health, especially in those who manage diabetes. That’s why Horizon BCBSNJ has implemented an outreach program directed toward members with diabetes who demonstrate gaps in dental care. Identified members are reminded monthly of the importance of maintaining regular dental checkups.

People with poorly-controlled diabetes are at greater risk for dental problems because diabetes can reduce the blood supply to the gums, increasing the risk for infections of the gums and to the bones that hold their teeth in place. With good blood sugar control and dental care such as regular cleanings, your patients can avoid these problems. As well, appropriate oral health habits help people with diabetes to better prevent or manage periodontal and gum disease.

Please remind your patients the importance of maintaining their oral health, especially if they manage a chronic disease such as diabetes. If your patients have questions, they should call our Care Management Program at 1-888-334-9006.

Source: WebMD®

Transitioning Teens from Child to Adult Care

According to the American Academy of Pediatrics, the transition to adult-oriented health care should begin between the ages of 18 and 21 years old. If you are a pediatrician providing services to members over age 18 years, Horizon BCBSNJ requests that you assist them and their parents in transitioning care to an adult Primary Care Physician. This may include helping them choose a new physician and transferring medical records. You also may need to assist with the transfer of specialty care to adult subspecialists.

For more information or additional resources about this process, visit the Got Transition/Center for Health Care Transition Improvement website at gottransition.org. The center works to improve adolescents’ transition from pediatric to adult health care through the use of new and innovative strategies for health professionals and families.

Sources: Healthychildren.org; American Academy of Pediatrics
Members 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 benefit determination involving a post service medical necessity decision made by Horizon BCBSNJ.

An adverse benefit determination involving a post service medical necessity decision includes a decision to deny a service or procedure based on Horizon BCBSNJ’s medical necessity criteria. Adverse benefit determinations may usually be appealed up to three times, including the right to an external review by an independent review organization. ¹

To initiate a first level medical appeal in response to an adverse benefit determination, please send a letter providing the medical rationale for the appeal and include all pertinent supporting documentation and submit it to us as follows:

By Fax: 1-732-938-1417

By Mail: Horizon BCBSNJ Claim Policy Appeals Dept.
Mail Station PP-09E
PO Box 220
Newark, NJ 07101-0420

Please ensure your patient’s name and Horizon BCBSNJ member ID number are noted on all submitted pages of the appeal request and supporting documentation.

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 medical appeals are reviewed within 10 calendar days.

If the denial is upheld, information will be provided about submission of a second level medical appeal if available through the member’s benefits.

This and other important information is included in our 2017 Participating Physician and Other Health Care Professional Office Manual. To access this manual, registered NaviNet users may visit NaviNet.net, select Horizon BCBSNJ from the My Health Plans menu and:

- Mouse over References and Resources and click Provider Reference Materials
- Mouse over Resources and click Manuals & User Guides

If you have questions, please contact your Network Specialist.

¹ Individual consumer plans and some ASO/self-insured plans only allow one internal level of appeal, followed by an external appeal. Members/covered persons enrolled in some plans do not have the appeal rights described here. For example, our Medicare Advantage members follow a different appeal process.
New UM Review Process for Certain Molecular and Genomic Diagnostic Laboratory Testing Services

On July 3, 2017, we will implement a new specialty utilization management program in collaboration with eviCore healthcare (eviCore) for certain molecular and genomic diagnostic laboratory testing services. Through this collaboration, which will be known as Horizon BCBSNJ’s Molecular and Genomic Testing Program, eviCore will conduct pre-service Medical Necessity Determination (MND) reviews of certain molecular and genomic diagnostic testing services that are rendered in the following settings:

• Physician’s office
• Clinical laboratory

PA/MND of these services will provide improved quality of care and outcomes through better coordination of care among Horizon BCBSNJ, the patients and their physician care teams from diagnosis through treatment and recovery.

Through the Molecular and Genomic Testing Program, eviCore will conduct pre-service MND reviews of certain molecular and genomic tests to:

• Determine medical necessity; and
• Help ensure the testing is performed by an appropriately qualified Horizon BCBSNJ participating laboratory provider whenever possible.

Physicians are strongly encouraged to obtain a pre-service MND from eviCore prior to ordering molecular and genomic diagnostic testing for their Horizon BCBSNJ patients to ensure that services will be considered medically necessary.

Rendering clinical laboratory providers are encouraged to validate that an approved pre-service MND has been obtained from eviCore by confirming it with the ordering physician or by contacting eviCore.

Claims for molecular and genomic testing services provided on and after July 3, 2017, for which no pre-service MND was obtained, will be delayed or denied while information for eviCore to conduct post-service MND is requested and reviewed. Claims for molecular and genomic testing deemed not medically necessary through post-service review will not be considered for reimbursement.

How to obtain pre-service MND for molecular and genomic testing

To obtain pre-service MND from eviCore, referring physicians should:

• Submit a request online through www.eviCore.com; or
• Call 1-844-224-0493, between 7 a.m. and 7 p.m., Eastern Time (ET).

To learn more about this new program, including claim editing information, visit HorizonBlue.com/molecularnotice.

1 This program applies only to laboratory services to be provided to members enrolled in Horizon BCBSNJ fully-insured products, as well as Administrative Services Only (ASO) accounts that have elected to participate in the Molecular and Genomic Testing Program administered by eviCore. Note: Members enrolled in Medicare Advantage (MA) plans are excluded from this program.
Our Episodes of Care Programs

We continue our efforts to change the care paradigm in New Jersey through our portfolio of patient-centered programs. Our increasing use of value-based reimbursement is helping us make the move from fee for service, where the focus is on all of the care rendered by one particular practice or provider, to value-based care where the focus is on all of the care rendered to one particular patient, across the full continuum of care.

Our value-based Episodes of Care (EOC) programs are designed to engage specialists in this change. The EOC programs look at the full spectrum of services related and delivered for a specific medical condition, illness, procedure or health care event during a defined period of time.

<table>
<thead>
<tr>
<th>Implemented</th>
<th>EOC Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Total Hip Replacement</td>
</tr>
<tr>
<td></td>
<td>Total Knee Replacement</td>
</tr>
<tr>
<td>2013</td>
<td>Knee Arthroscopy</td>
</tr>
<tr>
<td></td>
<td>Low-Risk Pregnancy</td>
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<tr>
<td></td>
<td>Colonoscopy</td>
</tr>
<tr>
<td>2014</td>
<td>Combined Low-/High-Risk Pregnancy</td>
</tr>
<tr>
<td>2015</td>
<td>Breast Cancer</td>
</tr>
<tr>
<td></td>
<td>Congestive Heart Failure</td>
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<tr>
<td>2016</td>
<td>Coronary Artery Bypass Graft</td>
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<tr>
<td></td>
<td>Hysterectomy</td>
</tr>
<tr>
<td></td>
<td>Crohn’s Disease (with Behavioral Health)</td>
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<tr>
<td></td>
<td>Prostate Cancer</td>
</tr>
<tr>
<td></td>
<td>Prostatectomy</td>
</tr>
<tr>
<td></td>
<td>Colon Cancer</td>
</tr>
<tr>
<td></td>
<td>Lung Cancer</td>
</tr>
<tr>
<td>2017</td>
<td>Low Back/Laminectomy</td>
</tr>
<tr>
<td></td>
<td>Diverticulitis</td>
</tr>
<tr>
<td></td>
<td>Gastroesophageal Reflux Disease/Upper Endoscopy</td>
</tr>
<tr>
<td></td>
<td>Shoulder Replacement</td>
</tr>
</tbody>
</table>

Our EOC programs are quality-driven models that focus on improving the value of care the patient receives. These programs aim to standardize and optimize the delivery and cost of care rendered. Physicians review information about patients with like conditions and like outcomes, to eliminate variation and optimize both care and cost of care.

Our model is retrospective and upside only, which creates a no-risk environment for providers and Horizon BCBSNJ to learn together, to collaborate and figure out how to create the outcomes and experiences for our members.

Horizon BCBSNJ is very proud to have the largest EOC program in the country for commercially-insured patients. Our innovative approaches and collaboration with our contracted partners has improved all pillars of the triple aim, and has changed the spirit of the relationships we have with our providers. Our EOC model is being studied and replicated around the nation.

If you’d like to learn more about our EOC programs, please email Kim Eason, EOC Recruitment Manager, at Kim_Eason@HorizonBlue.com.

EOC Programs

Since 2010, Horizon BCBSNJ has implemented 19 EOC programs including a variety of specialties.
Risk Adjustment: Impacts, Benefits and Key Insights

Horizon BCBSNJ helps physicians and other health care professionals better understand risk adjustment. Risk adjustment impacts you and your patients. It is important to document your medical records and code to the highest level of specificity aligned with the International Classification of Diseases, Tenth Revision (ICD-10).

Horizon BCBSNJ supports three risk adjustment programs:

- Commercial risk adjustment
- Medicare Advantage risk adjustment
- Medicaid risk adjustment

The risk adjustment programs rely on accurately coded claims and accurately documented medical records. Understanding and reporting a patient’s true risk helps stabilize premiums and protect patients against the negative effects of adverse risk selection.¹

Accurate and complete coding allows Horizon BCBSNJ to correctly identify patients who could benefit from our Chronic Care and Complex Case Management programs. These programs, offered free of charge, focus on education and improving the health of our members.

Benefits of Risk Adjustment

Risk adjustment provides many benefits including:

- Better health management
- Decreased administrative burdens
- Clinical documentation education and feedback

Physicians and other health care professionals are asked to code for any condition that is monitored, evaluated, assessed or treated (M.E.A.T.) during the patient’s visit. Documentation should also include all medical conditions affecting the management and/or treatment of the patient and accurately reflect the patients’ overall level of disease severity.¹

The following activities, at least yearly, can decrease administrative burdens by reducing retrospective chart retrieval requests:

- Thoroughly documenting all medical conditions (acute, chronic, status and history)
- Accurately coding to the highest level of specificity
- Reporting all coded conditions on the claim

The patient’s medical record can provide additional insight into his or her condition, which may not be found in the claims. Also, reviewing charts on a yearly basis helps Horizon BCBSNJ look for ways to improve clinical documentation and adhere with the Centers for Medicare & Medicaid Services (CMS) and ICD-10 guidelines.

Using unspecified codes does not allow for accurate disease identification, which results in patients not being included in our Chronic Care and Complex Case Management programs. Additionally, the use of unspecified codes may require the submission of medical records to appropriately identify a patient’s health status and accurately recognize his or her risk.²

To achieve consistency and ensure the highest level of quality care is provided, patients with chronic conditions must be monitored, evaluated, assessed and/or treated at least once per year.

Risk Adjustment Programs

Commercial Risk Adjustment (CRA) – is administered by Horizon BCBSNJ as a result of the Affordable Care Act (ACA) and is overseen by CMS. Most Americans are required to maintain health care coverage and risk adjustment seeks to facilitate affordable coverage regardless of the patient’s health status.

These are members insured through our small group and individuals plans that purchase insurance on or off the Health Insurance Marketplace. CRA products are primarily Horizon Advantage EPO and OMNIA® Health Plans, but

(continues on next page)
Risk Adjustment: Impacts, Benefits and Key Insights (continued)

also include HMO, Direct Access and Point-of-Service with a metallic identifier after the name of the product (e.g., Bronze, Silver, Gold).³

The risk is captured through a combination of ICD-10 codes submitted via claims and medical record reviews. The chronic conditions must be submitted on an annual basis.¹,²

**Medicare Risk Adjustment** – is administered by Horizon BCBSNJ and is overseen by CMS.

The primary plans are Horizon Medicare Blue (PPO), Horizon Medicare Blue Value (HMO), Horizon Medicare Blue Patient-Centered w/Rx (HMO) and Dual Eligible Special Need Plans (D-SNP). Like CRA, Medicare risk is captured through a combination of ICD-10 codes submitted via claims and medical record reviews. The chronic conditions must be submitted on an annual basis.⁴

**Medicaid Risk Adjustment** – is administered by Horizon NJ Health and is based on the guidelines for the state of New Jersey. Risk is captured solely by ICD-10 codes submitted via claims. Claims should be filed for every encounter, even if the service is capitated.

By keeping the acronym M.E.A.T in mind, coding of all symptomatic and underlying conditions on an annual basis will support the success of the risk adjustment programs.

If you have any questions about the risk adjustment programs, a Provider Educator is available to assist you. Use the chart below to determine your contact.

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monique Hodge</td>
<td><a href="mailto:Monique_Hodge@HorizonBlue.com">Monique_Hodge@HorizonBlue.com</a></td>
<td>Atlantic, Camden, Mercer, Middlesex, Monmouth and Somerset Counties</td>
</tr>
<tr>
<td></td>
<td>1-973-466-6706</td>
<td></td>
</tr>
<tr>
<td>Kevin Jennings</td>
<td><a href="mailto:Kevin_Jennings@HorizonBlue.com">Kevin_Jennings@HorizonBlue.com</a></td>
<td>Burlington, Cumberland, Essex, Gloucester, Hunterdon, Morris, Salem, Union and Warren Counties</td>
</tr>
<tr>
<td></td>
<td>1-973-466-4623</td>
<td></td>
</tr>
<tr>
<td>Susan Pakulski</td>
<td><a href="mailto:Susan_Pakulski@HorizonBlue.com">Susan_Pakulski@HorizonBlue.com</a></td>
<td>Bergen, Cape May, Hudson, Ocean, Passaic and Sussex Counties</td>
</tr>
<tr>
<td></td>
<td>1-732-256-7134</td>
<td></td>
</tr>
</tbody>
</table>

With a focus on providing quality of care for our members, your patients, healthier outcomes can be achieved.

For additional information, visit [HorizonBlue.com/riskadjustment](http://HorizonBlue.com/riskadjustment).

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¹ Florida Blue Quality Revenue Program Management. Risk Adjustment, Medicare and Commercial.
³ Horizon Blue Cross Blue Shield of New Jersey 2016 Managed Care Benefits-at-a-Glance. April 2016.
Based on current National Committee for Quality Assurance (NCQA) HEDIS® recommendations, when caring for patients after a hip or vertebral fracture, you should:

- Order a Bone Mineral Density (BMD) test (if not completed when the patient was in the hospital) and/or
- Initiate pharmacologic treatment (unless contraindicated)

These evidence-based, best practices are used to measure your quality performance.

HEDIS Osteoporosis Management in Women Who Had a Fracture (OMW) is defined as the percentage of women ages 67 to 85 years who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. (Fractures of finger, toe, face and skull are not included in this measure).

**Guidelines for the Prevention and Treatment of Osteoporosis**

- Counsel on the risk of osteoporosis and related fractures.
- Advise on a diet that includes adequate amounts of total calcium intake (1,000 mg/day for men ages 50 to 70 years; 1,200 mg/day for women age 51 and older and men ages 71 and older).
- Advise on vitamin D intake (800 to 1,000 IU/day) including supplements, if necessary, for individuals ages 50 years and older.
- Recommend regular weight-bearing and muscle-strengthening exercise to improve agility, strength, posture and balance; maintain or improve bone strength; and reduce the risk of falls and fractures.
- Assess risk factors for falls and offer appropriate modifications (e.g., home safety assessment, balance training exercises, correction of vitamin D insufficiency, avoidance of central nervous system depressant medications, careful monitoring of antihypertensive medication and visual correction when needed).
- Advise on cessation of tobacco smoking and avoidance of excessive alcohol intake.

**Resources Available for You and Your Patients**

National Osteoporosis Foundation: Patient booklets in English and Spanish, exercise DVDs to help patients who have low-bone density and PowerPoint presentations: [cme.nof.org/resources.aspx](http://cme.nof.org/resources.aspx)

To request an osteoporosis guideline to be mailed to your practice for future reference, or if you have questions, please call the Horizon Healthy Journey program at 1-844-754-2451.

Horizon BCBSNJ has partnered with Magellan Rx to coordinate care for members after a fracture. A representative from Magellan Rx may contact your practice regarding your patients’ current care and scheduling a BMD test or prescribing pharmacotherapy where clinically appropriate.

We appreciate your collaboration and support of Horizon BCBSNJ’s clinical initiatives.

**Sources:**


Patients Who Have Diabetes and Their Annual Exam

Have you seen your patients with diabetes in the last six months? Is your practice tracking the appointments and monitoring tests for your diabetic patients?

If you haven’t seen your patients who have type 1 or type 2 diabetes yet this year, this is a reminder that even your controlled diabetics should be seen and monitored throughout the year. In addition to an office visit, make sure you:

- Order a Hemoglobin A1c test at least once per calendar year
- Order a nephropathy screening test once per calendar year
- Refer patient to an eye care professional for a retinal or dilated eye exam every year. This is to check for damage to the eye from diabetes
- Ensure patients are taking their diabetic medications

To learn more about your practice’s current HEDIS performance for this or other measures, or for assistance in compliance with the HEDIS guidelines, call 1-844-754-2451.

We engage members with Medicare Advantage plans through our Horizon Healthy Journey program to remind them of services and screenings they’re due for. These members may be contacted via phone or mail, and can earn gift card incentives for completing eligible screenings.

Are You Using the Prior Authorization Procedure Search Tool?

Using Horizon BCBSNJ’s online search tool helps make it easier for you to determine if services require prior authorization for your fully-insured Horizon BCBSNJ patients. Our Prior Authorization Procedure Search Tool allows you to enter a CPT® or HCPCS code and select a place of service (e.g., inpatient, outpatient, office, home) to determine if the particular service provided in the selected service setting requires a prior authorization.

Access the Prior Authorization Procedure Search tool on HorizonBlue.com/priorauthtool or by signing into NaviNet and selecting Horizon BCBSNJ within the My Health Plans menu.

The tool, as well as certain prior authorization lists for members of Administrative Services Only (ASO) groups, is accessible on HorizonBlue.com/priorauthorizations. To determine if a patient is fully-insured or part of an ASO group, please refer to the back of the member’s ID card.

Fully-insured members’ cards will state: “Insured by Horizon Blue Cross Blue Shield of New Jersey.”

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Are You Using the Prior Authorization Procedure Search Tool? (continued)

ASO members’ cards will state: “Horizon Blue Cross Blue Shield of New Jersey provides administrative services only and does not assume financial risk for claims.”

For more information, or if you have questions, please contact your Network Specialist.

1 Our Prior Authorization Procedure Search Tool presently will only display results for fully-insured Horizon BCBSNJ plans. Prior authorization information for members enrolled in self-insured, Administrative Services Only (ASO) plans, Medicare or Medicaid products cannot be accessed through this tool. The information provided by this tool is not intended to replace or modify the terms, conditions limitations and exclusions contained within health benefit plans issued or administered by Horizon BCBSNJ.

2 In the event a conflict between the information contained on the tool and member plan documents, member plan documents shall prevail. This application is intended for informational purposes only. The results provided by this tool are not a guarantee of payment. Claim processing is subject to member eligibility and all member and group benefit limitations, conditions and exclusions.

Alphanumeric Prefixes Planned for Future Member ID Cards

Effective April 15, 2018, Blue Cross and/or Blue Shield Plans (including Horizon BCBSNJ) may begin using alphanumeric prefixes on member ID cards. Currently, most Horizon BCBSNJ member ID cards display a three-character alpha prefix in the first three positions of the member’s ID number.

Existing member’s alpha prefixes will not change. However, if an existing member moves to a new product and that new product is assigned an alphanumeric prefix, then their alpha prefix will change to an alphanumeric prefix. New alphanumeric prefixes will only be assigned to new plans or new products.

The three-position alpha prefix is a foundational component of the BlueCard® Program. When Horizon BCBSNJ members or members of other Blue Cross and/or Blue Shield Plans arrive at your office or facility, please continue to ask to see their current member ID cards at each visit. Doing so will help you:

• Identify the member’s product
• Obtain health plan contact information
• Submit claims

These will remain unchanged:

• Stand-alone vision and pharmacy when delivered through an intermediary model
• Stand-alone dental products
• The BCBS FEP – The letter “R” appears in front of the member ID number

How does this impact me?

Horizon BCBSNJ and other Blue Plans are providing advance notice of this upcoming change so that practices and facilities may analyze and remediate their own systems, as appropriate, to ensure they will allow a three-character alphanumeric prefix format.

System modifications to allow for numeric characters should be implemented effective April 15, 2018.

Member ID cards and prefixes are for identification purposes only; they do not guarantee eligibility or payment of your claim. Always verify patient eligibility by signing in to NaviNet.

1 Follow instructions on these ID cards to verify eligibility, submit claims and obtain health plan contact information.
New Jersey Opioid Law Takes Effect

Overview: P.L. 2017, Chapter 28, the New Jersey Substance Use Disorder Law

On February 15, 2017, New Jersey Governor Christie enacted P.L. 2017, Chapter 28, The New Jersey Substance Use Disorder Law, which sets certain coverage requirements for the treatment of substance use disorders and regulates prescriptions of opioid drugs. This law:

• Requires New Jersey insurers to cover inpatient and outpatient treatment of substance use disorders at in-network facilities
• Puts certain restrictions on prior authorization or utilization management for the first 180 days per plan year of medically necessary inpatient and outpatient treatment of substance use disorders
• Places certain restrictions on prescribed opioids, such as a five-day supply limit on initial prescriptions issued by a New Jersey prescriber for acute pain, which was effective March 1, 2017 pursuant to emergency rules

The following is a high-level overview of substance use disorder coverage implications that are effective May 16, 2017:

• Horizon BCBSNJ must be notified of a member’s admission and the initial treatment plan within 48 hours of the member’s admission or initiation of treatment.
• For the first 180 days per plan year of inpatient and outpatient stay, treatment of substance use disorders must be provided when determined to be medically necessary by the member’s licensed physician, psychologist or psychiatrist without any prior authorization or other prospective utilization management requirements.
• Benefits for the first 28 days of treatment (inpatient stay, intensive outpatient and partial hospitalization services) during each plan year must be provided without any prior authorization, retrospective review or concurrent review of medical necessity.
• Covered persons are entitled to 28 days of inpatient care during a plan year and a separate 28 days of intensive outpatient and partial hospitalization care per plan year.
• Benefits for days 29 and after of inpatient care can be subject to concurrent review. A request for approval of inpatient care beyond the first 28 days must be submitted for concurrent review before the expiration of the initial 28-day period.
• Concurrent review is allowed at two-week intervals. If it is determined that the stay is not medically necessary, 24-hour notice is required and the stay must be covered until the day after all the appeals are exhausted, even when the determination is upheld.
• Benefits for days 29 and after of intensive outpatient or partial hospitalization services during each plan year cannot be subject to concurrent review.
• After the first 180 days per plan year, Horizon BCBSNJ can make necessity determinations, prior authorization or retrospective review and other utilization management requirements.
• Except in the case of an in-network exception, a person covered under a PPO or POS plan who voluntarily uses an out-of-network provider, will not be entitled to the protections of the law with respect to those out-of-network services.

Please call Horizon Behavioral Health at 1-800-626-2212 to determine what, if any, substance use disorder implications of the law apply to a particular Horizon BCBSNJ patient.

The following is a high-level overview of pharmacy coverage implications that are effective May 16, 2017:

• Prior authorization and medical necessity determination criteria for Suboxone (buprenorphine/naloxone) and buprenorphine were removed effective March 13, 2017 for all members with Horizon Pharmacy coverage, excluding those that use the NetResults formulary. Prior authorization and medical necessity determination criteria still apply to Medicare Part D (MAPD and PDP) and Medicaid lines of business.
• Benefits for outpatient prescription drugs for substance use disorder must be provided when determined to be medically necessary by the member’s physician, psychologist or psychiatrist without any prior authorization or other prospective utilization management requirements. These include opioid substitutes and other medication-assisted treatments (e.g., the use of medications in combination with counseling and behavioral therapies).

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New Jersey Opioid Law Takes Effect (continued)

• Pursuant to emergency rules effective March 1, 2017, New Jersey prescribers cannot issue an initial prescription for an opioid drug exceeding a five-day supply for the treatment of acute pain and must be at the lowest effective dosage of an immediate-release drug. This applies to all Horizon BCBSNJ members (including Medicare Advantage, Medicare Prescription (Part D), Medigap, Medicaid and Federal Employee Program® (FEP®) members).
  – “Acute pain” means pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last only a short period of time.
  – “Acute pain” does not include chronic pain, pain being treated as part of cancer care, hospice or other end-of-life care, or pain being treated as part of palliative care.
• Effective May 16, 2017, members will pay a cost share that is based on the amount prescribed.

This law does NOT apply to Medigap, Medicaid and FEP members.
  – Members will pay a cost share that is prorated when they receive their initial prescription for five days of opioids.
  – A subsequent prescription for the same opioid within 30 days of the initial five-day fill will also be prorated if less than a 30-day supply.

For your patients with Horizon Pharmacy coverage, please call the Pharmacy Services number on the back of their ID cards for information on their pharmacy coverage. More information is available at nj.gov/dobi/bulletins/blt17_05.pdf.

1Coverage for these services is based on market segment implementation. Please call Horizon Behavioral Health at 1-800-626-2212 to determine what, if any, substance use disorder coverage implications of the law apply to a Horizon BCBSNJ member. Please call the Pharmacy Services number on the back of the member’s ID card for information on a member’s pharmacy coverage. Note: the law applies to all State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP) members, effective May 16, 2017.

Target: BP™ Can Help Increase Blood Pressure Control Rates

There is growing evidence that high blood pressure is a contributing factor to major health conditions, including heart attack, heart failure and stroke. Optimal blood pressure is key to preventing these diseases as well as cardiovascular disease, the number one cause of death in the United States. High blood pressure also currently costs American employers $46 billion annually and is expected to reach $274 billion by 2030.

Target: BP™

For these reasons, the American Heart Association (AHA) and American Medical Association (AMA) have collaborated to establish Target: BP™. Target: BP is a free clinical hypertension management initiative that aims to encourage health care professionals and health service organizations to improve high blood pressure diagnosis and control rates with their patients. AHA and AMA will support Target: BP participants in helping their patients reach this goal by:

• Offering access to easy-to-use tools and resources on TargetBP.org.
• Providing access to tools and resources for systems and process changes at the practice and health system level to optimize blood pressure management.
• Recognizing those who successfully manage high blood pressure among their patient population.

The goal of Target: BP is to move blood pressure control rates from the current national rate of 54 percent to 70 percent or higher across the country. By joining Target: BP practices can help their patients take control of their heart health and live stronger, longer healthier lives.

For more information, or to register for Target: BP, please visit TargetBP.org.

You may also email Courtney Nelson, Senior Director of Community Health for New Jersey, at Courtney.Nelson@heart.org.

Sources: heart.org, ama-assn.org, TargetBP.org
At Your Service

CLAIM SUBMISSION
All claims should be submitted electronically. Use Payer ID 22099 if you use a vendor or clearinghouse. Primary claims, including claims using a legacy provider ID (TIN + suffix), behavioral health claims and claims requiring a medical record, can be submitted from the Horizon BCBSNJ page after logging in to NaviNet.net.

PROFESSIONAL CLAIMS
HCAPPA Appeals: Use Appeal a Claims Determination form and mail to PO Box 10129, Newark, NJ 07101-3129
General Appeals: Use 579 form and mail to PO Box 54, Newark, NJ 07101-0054
Inquiries: Use 579 form and mail to PO Box 199, Newark, NJ 07101-0199

FACILITY CLAIMS
Appeals/Inquiries: Use 579 form and mail to PO Box 1770, Newark, NJ 07101-1770

FEP®
Claim Inquiries:
PO Box 656, Newark, NJ 07101-0656
Reconsiderations/Appeals: 1-800-624-5078
PO Box 10181, Newark, NJ 07101
Precertification: 1-800-664-2583
Care Management and Health and Wellness: 1-866-697-9696

BLUECARD®
Claim Appeals/Inquiries:
PO Box 1301, Neptune, NJ 07754-1301 1-888-435-4383

ELIGIBILITY AND BENEFITS
Log in to NaviNet.net and access the Horizon BCBSNJ page. Mouse over Eligibility & Benefits and select Eligibility & Benefits Inquiry.

PRIOR AUTHORIZATIONS (PA) AND UTILIZATION MANAGEMENT
Most PAs should be requested online using the Horizon BCBSNJ’s online Utilization Management Request Tool. After logging into NaviNet.net, select Horizon BCBSNJ within the My Health Plans menu, mouse over Referrals and Authorization, then select Utilization Management Requests.

PT/OT Services
From NaviNet.net, access Horizon BCBSNJ within the My Health Plans menu, mouse over Referrals and Authorizations and select Physical and Occupational Therapy Authorization.

Outpatient Advanced Imaging and Pain Management
eviCore healthcare: 1-866-496-6200

Drug Authorizations
From NaviNet.net, access Horizon BCBSNJ within the My Health Plans menu and select Drug Authorizations.

Alternate Request Methods
Prior Authorization Unit: 1-800-664-2583

HORIZON BEHAVIORAL HEALTHSM 1-800-626-2212
Unless otherwise noted on the member ID card, mail claim forms to PO Box 10191, Newark, NJ 07101-3189. Please refer to the ValueOptions Resource Manual at ValueOptions.com/Horizon for more information.

HORIZON CARE@HOME PROGRAM
Horizon BCBSNJ conducts the review of requests for: Home Health Services (including in-home nursing services, physical therapy, occupational therapy and speech therapy). Prior authorization requests for these services must be submitted using Horizon BCBSNJ’s Online Utilization Management Request Tool via NaviNet.

CareCentrix conducts the review of requests for Horizon Care@Home services for: Durable Medical Equipment (including Medical Foods [Enteral], and Diabetic and Other Medical Supplies); Orthotics and Prosthetics and Home Infusion Therapy Services, including hemophilia. Call 1-855-243-3321 to initiate the review of these services.

IVR and PHONE INQUIRIES
Provider Services: 1-800-624-1110
Institutional Services: 1-888-666-2535
Find forms at HorizonBlue.com/providers/forms.
Blue Review

A Newsletter for Participating Physicians and Other Health Care Professionals, Acute Care Facilities and Ancillary Staff

Blue Review is written and produced by Enterprise Communications at Horizon Blue Cross Blue Shield of New Jersey. We welcome your comments and suggestions on this publication. Write to:

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This document contains references to brand name prescription medicines that are trademarks or registered marks of pharmaceutical manufacturers that are not affiliated with Horizon Blue Cross Blue Shield of New Jersey, the Blue Cross and Blue Shield Association or Prime Therapeutics.

Horizon Pharmacy and its network of participating pharmacies are administered by its contracted pharmacy benefits manager, Prime Therapeutics LLC.

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