Introduction

Horizon Blue Cross Blue Shield of New Jersey’s Ancillary Provider Office 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.

It includes information about the plans we offer as well as information about our administrative procedures, policies and guidelines. If you are unable to find what you need in this manual, service numbers and directions to help you access content online are provided.

Failure to comply with the policies and procedures addressed in this manual may constitute a breach of your:

- Ancillary Services Provider Agreement – an agreement established between you and Horizon Healthcare of New Jersey, Inc. for participation in the Horizon Managed Care Network.

- Ancillary Services Provider Agreement – an agreement established between you and Horizon Healthcare Services, Inc. dba Horizon Blue Cross Blue Shield of New Jersey for participation in the non-managed care network.

- Ancillary Services Provider Agreement – an agreement established between you and Horizon Healthcare Services, Inc. dba Horizon Blue Cross Blue Shield of New Jersey for participation in both the managed and non-managed care networks.

Please note: All participating ancillary providers are required to register for:

- NaviNet®, a multi-payer web portal that provides online access to important plan information you will need to conduct your day-to-day business with us, within 30 days of your effective date of participation. See page 114 for more information about NaviNet.

- Electronic Funds Transfer (EFT) – Horizon BCBSNJ requires all ancillary providers to register for EFT upon joining our networks. See page 17 for more information about EFT.

Horizon BCBSNJ may require that communications, including office manuals, newsletters, policies, rules, procedures, credentialing/recredentialing, etc., be conveyed by electronic means.

Updates to the information in this manual will be posted online and/or included in Blue Review, our network newsletter for participating physicians, ancillary providers and staff of ancillary and acute care facilities.

To access this manual online or to review current and past issues of Blue Review online, registered NaviNet users may log in to NaviNet.net, access Horizon BCBSNJ within the Plan Central dropdown menu and:

- Mouse over References and Resources and click Provider Reference Materials.

- Under User Guides, click the link to either: Network Newsletter or Ancillary Manual.

We hope you find this manual helpful. We value our relationship with your office or facility and look forward to building and maintaining our relationship with you.
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Ancillary Provider Office Manual
The BlueCard Program

The BlueCard® Program links participating ancillary providers and independent Blue Cross and/or Blue Shield Plans, across the country and abroad, with a single electronic network for claims processing and reimbursement.

The BlueCard program eliminates the need for you to deal with multiple Blue Plans. Horizon BCBSNJ is your one point of contact* for claims or claims-related questions.

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.

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 or facility 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.

Identifying BlueCard Members

Identifying BlueCard members is critical for 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 Plan’s 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 route claims correctly. It is critical to confirm membership, eligibility and coverage. Ask to see the member’s ID card at each visit.

If there is no prefix on a member’s ID card, that member is not eligible for benefits through the BlueCard program. In this instance, review the member’s ID card for the phone number of the member’s Blue Plan or for other instructions.

Suitcase Logo

The suitcase logos shown here are unique identifiers for BlueCard members.

- Members whose ID cards display the PPO-in-a-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, other health care professionals, hospitals and other facilities.

- Members whose ID cards display the empty 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 phone 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:

- Member’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.
The BlueCard Program

- 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 Ancillary Provider Information
To obtain information about participating ancillary providers in another BCBS Plan’s service area, members may call BlueCard Access at 1-800-810-BLUE (2583).

BlueCard Eligibility and Benefits
There are two fast and easy ways to obtain eligibility and benefits information for your BlueCard patients – by phone 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 Phone
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 phone 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.

Prior Authorization and Medical Management
Your patients who are enrolled through other Blue Cross and/or Blue Shield Plans and who have BlueCard benefits, are responsible for obtaining prior authorizations 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.

All hospital admission and/or concurrent reviews and discharge planning are completed by the patient’s Blue Plan.

You may choose to contact the Blue Cross and/or Blue Shield Plan in which your patient is enrolled to obtain the prior authorization or pre-authorization. To do so, refer to your patient’s ID card for phone number information or call 1-800-676-BLUE (2583).

Inpatient Prior Authorization/Precertification
For dates of service July 1, 2014 and after, network facilities are required to obtain prior authorization/precertification for inpatient facility services for BlueCard patients.

This requirement only applies to inpatient facility services.

Prior authorization, precertification, admission and/or concurrent reviews and discharge planning must be completed by the Blue Cross and/or Blue Shield Plan through which the patient is enrolled.

To obtain prior authorization/precertification for your patients enrolled in BlueCard plans, please call BlueCard Eligibility at 1-800-676-BLUE (2583) or the appropriate phone number listed on the BlueCard member’s ID card, or submit an electronic 278 transaction.

If prior authorization/precertification is required and not obtained for inpatient facility services, the facility will be financially responsible and the member will be held harmless.

Please note: The responsibilities and obligations outlined in this section are applicable to out-of-state Blue Cross and/or Blue Shield members.

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

Horizon BCBSNJ
BlueCard Claims
PO Box 1301
Neptune, NJ 07754-1301

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
The BlueCard Program

appropriate Blue Cross and/or Blue Shield Plan for claim submission instructions.

Please do not send duplicate claims. Check a claim’s status through our Interactive Voice Response (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 that will process the claim and approve reimbursement. The other plan will transmit the approval to us and we will issue reimbursement and an EOP to you.

Behavioral Health and Substance Abuse Claims and Inquiries

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:

Horizon BCBSNJ
BlueCard Claims
PO Box 1301
Neptune, NJ 07754-1301

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 1-888-435-4383 or visit NaviNet.net.

Eligibility/Enrollment Inquiries

Call BlueCard Eligibility at 1-800-676-BLUE (2583) or visit NaviNet.net.

Please note: This claims submission information pertains 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 Claim 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 include appropriate ICD-9, revenue and CPT-4 codes.

Ensure that section 1A of the CMS1500 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 the Blue Cross and/or Blue Shield Plan is not the primary carrier.

• Workers’ compensation situations.

• Stand-alone dental coverage.

• Stand-alone prescription drug coverage.

• Vision care services.

• Hearing care services.

How to Avoid BlueCard Claim Rejections

Horizon BCBSNJ strives to process your BlueCard claims quickly and accurately, but claim rejections do occur.

Below are the most frequent BlueCard claim rejection messages. We 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 phone or online.

**By phone:** 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 phone number of the member’s Blue Plan and call the Plan directly for information.

**Online:** Log in to NaviNet.net and:
- Mouse over Eligibility & Benefits and click Eligibility & Benefits Inquiry.
- Within the Eligibility & Benefits Inquiry screen, click the radio button adjacent to Out Of Area – BlueExchange®/FEP® in the Inquiry Type section.
- Enter the required BlueCard member information.
- Click Search.

**Ancillary Contracts with Two Plans**
If your office or facility staff 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 or facility staff does not participate with the Plan through which the member is enrolled, submit claims to Horizon BCBSNJ.

**How to Avoid Duplicate Claim Denials**
Based on a 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 submissions received for patients who have Medicare as their primary insurance.
- Claim resubmissions received within two weeks of the original claim.
- Claim resubmissions received where the original claim was finalized without generating a reimbursement.

Please review the guidelines here to help decrease the trends identified above. Following these guidelines will help reduce or eliminate the number of duplicate claim denials you receive.

**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:

- Horizon BCBSNJ
- BlueCard Claims
- PO Box 1301
- Neptune, NJ 07754-1301

**Check Claim Status First**
Before resubmitting a claim, please check the status of your claim online at NaviNet.net or by calling our Dedicated BlueCard Service Unit at 1-888-435-4383.

**Submit Corrected Claims with a 579 Form**
Ensure that corrected claim submissions are accompanied by a completed copy of our Inquiry Request and Adjustment Form (579). 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 (Universal Bill [UB] form, other carrier/MEOBs, etc.).

The 579 form may be accessed from our website. Visit HorizonBlue.com/Providers and:
- Click Find a Form in the I Want To... section.
- Click Forms by Type.
- Click Inquiry/Request and click Request Form – Inquiry, Adjustment, Issue Resolution.

**BlueCard Claim Appeals**
Our BlueCard claim appeal process aims to resolve BlueCard claim appeals within 30 to 45 days of their receipt.

As part of our BlueCard claim appeal process, we developed a *BlueCard Claim Appeal Form* (5373). This form is available on our website. To download this form,
visit HorizonBlue.com/Providers and:

- Click Find a Form in the I Want To... section.
- Click Forms by Type.
- Click Appeal/Dispute and click Appeal Form – Medical – BlueCard.

The process and form only support BlueCard-related claim appeals for ancillary providers 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. The claim appeal 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 BlueCard Claim Appeal Form (5373):

- 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 1301
Neptune, NJ 07754-1301

If you have questions about the BlueCard claim appeal process, please call our Dedicated BlueCard Unit at 1-888-435-4383.

* The Submit Claim Appeal function will only display if the BlueCard claim in question is finalized with a zero paid amount and includes a claim message. Claims that are partially paid (one line is approved for reimbursement but another line is denied) must be appealed by mail and accompanied by a completed BlueCard Claim Appeal Form (5373) available within the Provider Reference Materials section of NaviNet.net.

BlueCard Helpful Hints

Send medical records when:

- Requested in writing by Horizon BCBSNJ.
- Requested by the BlueCard Home Plan.

Do not send medical records:

- When a retrospective review is done by the Utilization Review Department via a phone call.
- For a second level medical appeal.

For More Information

Specific information on the BlueCard program is available at bcb.com.
As a participating ancillary provider, you are required to:

Send claims to us before billing your Horizon BCBSNJ patients.

We will process your claims and send you reimbursement for all eligible services. An Explanation of Payment (EOP) will be sent to you outlining patient liability. In some cases, we may reimburse our full allowance; however, some services or products may require a copayment, or be subject to a deductible or coinsurance.

If your patient asks for a copy of his/her bill, please explain that you will file the claim with Horizon BCBSNJ first. 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 or facility and the member.

Copayments, coinsurance or deductibles may be collected in advance but not as a condition for the provision of services.

Please do not bill your Horizon BCBSNJ patients at the time of service for any amounts except for applicable copayments.

Accept our allowance for eligible services as payment in full.

Horizon BCBSNJ will reimburse the lesser of your billed charge or our contracted rates, 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 57.

For ancillary providers participating only in our Horizon Managed Care Network who treat a member enrolled in a Horizon PPO or Horizon BCBSNJ Indemnity plan:

• Claims will be processed according to the member’s out-of-network (OON) benefits.
• Reimbursement will be calculated at the PPO allowance.
• Members are liable only for copayment amounts, coinsurance and/or deductible amounts indicated on the EOP.

You cannot bill members for amounts in excess of the member liability as indicated on our EOP.

For ancillary providers participating only in our Horizon PPO Network who treat a member enrolled in a Horizon BCBSNJ managed care plan that includes out-of-network benefits, for example, Horizon POS, Horizon Direct Access or NJ DIRECT:

• Claims will be processed according to the member’s out-of-network (OON) benefits.
• Reimbursement will be calculated at the PPO rate.
• Members are liable for copayment, coinsurance and/or deductible amounts indicated on the EOP.

For ancillary providers participating only in our Horizon PPO Network who treat a member enrolled in a Horizon BCBSNJ Medicare Advantage plan that includes out-of-network benefits, for example, Horizon Medicare Blue PPO or members enrolled in other Blue Cross and/or Blue Shield MA PPO plans who reside or travel in our service area:

• Claims will be processed according to the member’s out-of-network (OON) benefits.
• Reimbursement will be calculated at the Centers for Medicare & Medicaid Services (CMS) allowance.
• Members enrolled in Medicare Advantage plans are liable only up to the legally allowed amounts as determined by CMS.
• Please note that participating PPO ancillary providers who have opted out of, or who are excluded from, Medicare are not eligible to receive reimbursement for services rendered to a Medicare Advantage member.
Claims Submissions and Reimbursement

For ancillary providers participating only in our Horizon PPO network who treat a member enrolled in a Horizon BCBSNJ managed care plan that DOES NOT include out-of-network benefits, for example, Horizon HMO, Horizon EPO, Horizon Medicare Blue TotalCare (HMO SNP), Horizon Medicare Blue Value (HMO):

• Claims will be denied (except for services that were authorized or provided in emergent situations).

• Reimbursement will not be made.

• Members (except those enrolled in Medicare Advantage plans) are liable up to your total billed amount.

• Members enrolled in Medicare Advantage plans are liable up to the legally allowed amounts as determined by CMS.

National Provider Identifier (NPI)

In accordance with the Centers for Medicare & Medicaid Services (CMS) regulations, ancillary providers who conduct electronic transactions or submit claims to us through a third-party vendor are required to use a NPI. To avoid claim rejection, include NPI information on your standard transactions.

Apply for NPI

If you have not yet applied for an NPI, please visit the CMS website, cms.gov.

• Please note that participating PPO ancillary providers who have opted out of, or who are excluded from, Medicare are not eligible to receive reimbursement for services rendered to a Medicare Advantage member.

• Members (except those enrolled in Medicare Advantage plans) are liable up to your total billed amount.

• Members enrolled in Medicare Advantage plans are liable up to the legally allowed amounts as determined by CMS.

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 haven’t registered your NPI information with us, please do so immediately.

To register by fax:

• Visit HorizonBlue.com/Providers.

• Click Find a Form in the I Want To... section.

• Click Miscellaneous, select the appropriate form:
  – Collection Form - National Provider Identifier - Individual Practitioner-Physician.
  – Collection Form - National Provider Identifier - Facility-Group-Practice.

• Complete the form and fax it to your Ancillary Contracting Specialist.

If you would like paper copies of the NPI Collection forms sent to your office, please call your Ancillary Contracting Specialist.

What to do if you move to a new location

You must notify the National Plan and Provider Enumeration System (NPPES) of your new location within 30 days of the effective date of the move. The CMS encourages health care professionals who were assigned a NPI and who are not covered entities, to do the same.

To submit your address change to NPPES online, please visit nppes.cms.hhs.gov and:

• Click the link within the statement: If you are a Health Care Provider, you must click on National Provider Identifier (NPI) to login or apply for an NPI.

• Click Login following the heading, Want to View or Update your NPI data?

To download a paper NPI update form, please visit:

• cms.gov/cmsforms.

• Click CMS Forms in the left navigation.

• Click CMS 10114 to display the NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM.

If you need to request a form, please call the NPI Enumerator at 1-800-465-3203.

Horizon BCBSNJ also requests that if you update, add or change your NPI information/tax ID, please fax the information to your Ancillary Contracting Specialist or Ancillary Reimbursement Analyst at 1-973-274-4202.
Claim Adjudication Policies

Horizon BCBSNJ adjudicates claims according to our claim editing policy and medical policy guidelines.

Ancillary providers are required to accurately report the services rendered to a member with the correct revenue, diagnosis, CPT and/or HCPCS codes, and for appending the applicable modifiers, when appropriate. The code(s) and modifier(s) must be active for the date of service reported, and describe the services provided during the patient’s encounter.

If our claim processing system does not recognize information on a claim, the claim is manually reviewed. The claim is then reviewed for medical eligibility based on our medical policy guidelines. Our claim policy department will review all required medical documentation from the facility and will determine if further review from the Medical Advisor’s Office is necessary.

To access Horizon BCBSNJ’s Claim Editing Policies, please sign in to NaviNet.net, access Provider Reference Materials and:

- Click Reimbursement and Billing.
- Click Claim Editing Policies.

For more information on our claim adjudication policies, please call your Ancillary Contracting Specialist.

Claims Submissions

Claims are a vital link between your office and Horizon BCBSNJ. Generally, claims must be submitted within 180 days of the date of service. Helpful Hints are provided in this section for your reference.

Rendering, referring and admitting NPI information on claims

Horizon BCBSNJ requires that your claim submissions include National Provider Identifier (NPI) information to identify referring and admitting physicians. Please submit this NPI information on all electronic and paper copy submissions.

Electronic Submissions

Electronic claims submissions help speed our reimbursement to you. We require all ancillary providers to submit claims to us electronically.

Paper Claims Submissions

If paper claims are necessary, we require that all paper claim submissions are printed on an original, government-approved UB-04 or CMS1500 claim forms. Claim submissions that we receive on photocopies of the UB-04 or CMS1500 claim forms or on another carrier’s claim submission forms will not be processed.

Always fill out UB-04 or CMS1500 forms completely and accurately. Pay close attention to required fields to minimize processing delays.

Mail your claims to the appropriate address listed below.

- BlueCard® claims:
  Horizon BCBSNJ
  BlueCard Claims
  PO Box 1301
  Neptune, NJ 07754-1301

- Federal Employee Plan® (FEP®) claims (Plan ID numbers begin with a single R):
  Horizon BCBSNJ
  PO Box 656
  Newark, NJ 07101-0656

- For all other claims:
  Facilities:
  Horizon BCBSNJ
  PO Box 25
  Newark, NJ 07101-0025

  Professionals:
  Horizon BCBSNJ
  PO Box 1609
  Newark, NJ 07101-1609

Horizon BCBSNJ’s electronic payor ID is 22099.

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 at 1-888-334-9242, via email at HorizonEDI@HorizonBlue.com or by fax at 1-973-274-4353.
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 information.

Helpful Hints for Claims Submissions
To assist us with the timely and accurate processing of your claims:

• 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 you treat. Complete the patient information on your claim as it relates to the person being treated.

• Use the subscriber’s and/or patient’s full name. Avoid nicknames or initials.

• Complete the patient’s date of birth.

• Claims must include the entire ID number. Always use the prefixes or suffixes that surround the ID number. The only exceptions are Federal Employee Program (FEP) products. For FEP disregard any characters after the eighth numeric character following the R prefix.

• Complete the group number field on the claim form when it appears on the ID card.

• When you treat a patient due to an injury, be sure to include the date the injury occurred.

• When appropriate, be sure to include the date of onset for the illness you are treating.

• Include rendering, referring and admitting physician NPI information on all appropriate claim submissions.

• 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 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 numbers 1, 2 or 3.

• Always use accurate five-digit CPT-4 or HCPC codes.

• Please use valid, compliant codes for the date on which services were rendered.

• When the patient's primary insurance is traditional Medicare, claims are sent to Horizon BCBSNJ from the Centers for Medicare and Medicaid Services (CMS) national crossover contractor, the Benefits Coordination & Recovery Center (BCRC). Claims are transmitted after the Medicare Payment Floor (14 days) is reached, regardless of when you receive a remittance advice. If you do not receive a payment summary from us, submit the claim 30 days after you receive the Medicare Remittance along with a copy of the Medicare Provider Summary.

• If the patient has any other insurance, please record the patient's Coordination of Benefits (COB) information on the claim form.

Helpful Hints for Paper Claims 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 reimbursement than the traditional methods of manually processed paper claims. The efficiency of processing paper claims through OCR depends on your legible, compliant and complete claim submission. Incomplete and/or illegible claims may be delayed.

To maximize the benefits of OCR, we recommend the following when submitting your UB-04 form or CMS1500 form:

• Always use an original UB-04 form or CMS1500 form for hard copy claim submissions. The 1500 logo on the top left of this form helps expedite claim processing.

• Make sure the print on your UB-04 form or CMS1500 form is clear and dark, and that characters are centered in each box.

• All characters on the UB-04 form or CMS 1500 form need to be intact. We use 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.
Claims Submissions and Reimbursement

- Do not highlight or circle information or apply extraneous stamps or verbiage to the forms. Highlighting, circling and stamps may prevent our scanners from correctly identifying characters.

- Include rendering, referring and admitting physician NPI information on all appropriate claim submissions.

For information omitted from computer-prepared forms, use typewritten instead of handwritten data.

- Do not staple any submitted documents.

- Avoid duplicate claim submissions:
  - Prior to resubmitting claims, please check for claim status online at NaviNet.net or call 1-888-482-8057.
  - Ensure that corrected claim submissions are accompanied by a completed copy of our Inquiry Request and Adjustment Form (579).
  - When submitting a claim for secondary carrier payment, please ensure the primary carrier’s corresponding EOP is included with the UB-04 form or CMS1500 form claim form (patient name, procedures and dates of service must coincide).

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 or Facility 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 and tax ID.
- Check date.
- Check amount.
- Check number.

You may call the e-Service Desk’s EDI team at 1-888-334-9242, Monday through Friday, between 7 a.m. and 6 p.m., Eastern Time, or email HorizonEDI@HorizonBlue.com or send a fax to 1-973-274-4345.

Claim Adjustment Requests

Horizon BCBSNJ encourages all practices to submit claim adjustment requests electronically using the standard HIPAA 837P transaction, as appropriate. Submitting electronic claim adjustment requests simplifies the claim adjustment process and helps to speed adjudication and the payment to providers.

Providers may electronically submit any adjustments that DO NOT require the submission of additional supporting documentation (e.g., medical record, etc) for:

- Local claims (including SHBP and FEP).
- BlueCard claims.*

* BlueCard claim adjustment requests to change subscriber ID, provider Tax ID number or provider suffix cannot be submitted electronically. Please mail these claim adjustment requests to:

  BlueCard Claims
  PO Box 1301
  Neptune, NJ 07754-1301

Contact the vendor or clearinghouse for information about 837 transactions.

For additional information, please contact the Horizon BCBSNJ eService Desk at 1-888-334-9242 or via email at Horizon EDI@HorizonBlue.com. Representatives are available weekdays from 7 a.m. to 6 p.m., Eastern Time.
Claims Submissions and Reimbursement

How to indicate that your 837 transaction is an adjustment request

To indicate that the 837 transaction is an adjustment request, simply include the following required information within the 837 transaction.

1. Frequency code: The frequency code (values 7 or 8) associated with the place of service indicates that this transaction is an adjustment.

2. Adjustment reason: The adjustment reason and narrative explaining why the claim is being adjusted. For example, the adjustment reason could be “number of units” and additional narrative could be “units billed incorrectly, changed units from 010 to 001.”

3. Original reference number: Claim number of the originally adjudicated claim found on remittance advice (the ICN/DCN of the claim to be adjusted).

Please share this information with your vendor or clearinghouse to ensure that electronic transactions are submitted correctly.

Corrected Claims and Inquiries

Provider Services Representatives can accept missing or corrected claim information over the phone. You are no longer required to submit the information in writing for most corrected claim situations.

You do not need to submit corrected information in writing for the following:

- Provider Tax ID#.
- Suffix.
- Diagnosis.
- Patient Name/Information.
- Charges.
- Date of Service.
- Procedure Code.
- Modifier.
- Units.

Please note: This new process does not pertain to claims processed by CareCore National, LLC for radiology services. Please use our 579 form to add multiple bill lines not included in the original claim submission.

However, you may still submit corrected claim requests by mail using our Inquiry Request and Adjustment Form (579). This online form is a fillable PDF, which allows you to complete the required fields online and then print the form for submission. Doing so allows us to use Optical Character Recognition (OCR) software to speed our ability to assign, investigate and resolve your inquiries.

Below are tips to help ensure that your claim inquiries and corrected claim submissions include the information we need to investigate your claims.

- Ensure that your completed 579 form 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 UB-04 form or CMS 1500 form, a Medicare or other carrier Explanation of Benefits, etc.).

To access the Inquiry Request and Adjustment Form (579), visit HorizonBlue.com/Providers and:

- Click Find a Form in the I Want To… section.
- Click Forms by Type, click Inquiry/Request and click Request Form – Inquiry, Adjustment, Issue Resolution.

* 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 579 form.

New Jersey Minimum Standards Mandate

Horizon BCBSNJ, in compliance with New Jersey’s Minimum Standards for Health, Dental and Prescription Benefits (NJAC 11:22-5.1, et seq.), reduced certain copayment amounts for members enrolled in many of our insured Individual, Small Employer, Midsize standard (51 to 99 employees) and Large group accounts.

Since September 1, 2011, copayments for chiropractic care, physical therapy, occupational therapy and speech therapy services for members enrolled in Horizon BCBSNJ insured Individual, Small Employer, Midsize standard (51 to 99 employees) and Large group accounts, do not exceed $30.
Clinical Laboratory Claims
Ancillary providers are required, according to their Ancillary Provider Agreement(s), to refer Horizon Managed Care patients and/or send Horizon BCBSNJ patients’ testing samples to participating clinical laboratories. Failure to comply with the terms of your Ancillary Provider Agreement(s) may result in your termination from the Horizon BCBSNJ networks.

We remind you that Laboratory Corporation of America® Holdings (LabCorp) is the only in-network clinical laboratory services provider for your Horizon BCBSNJ managed care patients (i.e., members enrolled in Horizon HMO, Horizon EPO, Horizon Direct Access, Horizon POS or Horizon Medicare Advantage plans) and any future managed care products.

You may refer members enrolled in Horizon PPO and Indemnity plans, and/or send their testing samples to LabCorp or to one of our other participating clinical laboratories or hospital outpatient laboratories at network hospitals.

To view a list of our participating clinical laboratories, please visit HorizonBlue.com and click Find a Provider. Within the Other Healthcare Services tab, select Laboratory – Patient Centers or Laboratory – (Physician Access Only) under the Service Type dropdown menu and click Search.

The clinical laboratory must participate with the Blue Plan in the state where the referring physician is located for the claim to process at the in-network level of benefits. This means if the referring provider is located in New Jersey, the clinical laboratory must participate with Horizon BCBSNJ for the claim to process at the in-network level of benefits. If the referring provider is located outside of New Jersey, the lab must send the claim to the Blue Plan approved to process professional claims in that state.

If the referring provider has office or facility locations in different states, the patient’s claim must be sent to the Blue Plan in the state where the patient received the referral.

You may refer a Horizon BCBSNJ patient who has out-of-network benefits (or send his or her testing sample) to a nonparticipating clinical laboratory, if that patient chooses to use his or her out-of-network benefits and you follow the guidelines in our Out-of-Network Consent Policy described on page 62.

Please note: Certain self-insured employer groups for whom we administer health care benefits (Novartis and Quest Diagnostics only, as of this printing) have established special benefit arrangements that allow their enrolled members to use the nonparticipating clinical laboratory affiliated with each employer group (i.e., Novartis members may use Genoptix labs, Quest Diagnostics members may use Quest labs) as exceptions to the guidelines of our Out-of-Network Consent Policy. These special benefit arrangements apply ONLY to members/dependents enrolled in these employer group plans.

Durable Medical Equipment (DME) Claims
Claims for Durable Medical Equipment (DME) services must be sent to the Blue Plan in the state in which the equipment was delivered or purchased. The claim will process according to the DME provider’s contractual relationship with the Blue Plan. For example, if the equipment is purchased from a New Jersey DME retail store or delivered to a New Jersey address, that claim must be sent to Horizon BCBSNJ and will process according to the DME provider’s contractual relationship with Horizon BCBSNJ. However, if the equipment is purchased by or delivered to a Horizon BCBSNJ member in Pennsylvania, the claim must be sent to the Pennsylvania Blue Plan and will process based on the DME provider’s contractual relationship with that Pennsylvania Blue Plan and consistent with the member’s Home Plan benefits.

For information on our DME network, see page 60.

Specialty Pharmacy Claims
When you are in the Horizon BCBSNJ Specialty Pharmaceutical Program you’ll obtain specialty pharmaceuticals directly from a specialty pharmacy. Under this program, your office or facility should not submit claims for specialty medications when obtained from our specialty pharmacy providers. These selected providers will bill Horizon BCBSNJ directly for the cost of the medication.

Specialty pharmacy claims must be sent to the Blue Plan in the service area where the ordering physician is located. The claim will process according to the pharmacy’s relationship with that Blue Plan. For example, if the ordering physician is located in New Jersey, send the claim to Horizon BCBSNJ and the claim will process according to the pharmacy’s participating status with Horizon BCBSNJ. However, if the ordering
physician is located in Pennsylvania, the claim must be sent to the Blue Plan in Pennsylvania and will process according to the pharmacy's contractual relationship with the Pennsylvania Blue Plan and consistent with the member's Home Plan benefits.

For information on our Specialty Pharmacy Program, see page 58.

Electronic Funds Transfer
Horizon BCBSNJ requires all ancillary providers to register for Electronic Funds Transfer (EFT) upon joining our networks.

Horizon BCBSNJ reserves the right to re-evaluate the participation status of ancillary providers who do not comply with this requirement.

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.

Please note: EFT will only be used by Horizon BCBSNJ to make deposits into your designated accounts. We will not withdraw any amounts from these designated accounts.

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

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

For professional providers who bill on a CMS1500:
- Visit NaviNet.net and access Horizon BCBSNJ within the Plan Central dropdown menu.
- Click Claim Management.
- Click EFT Registration.

For ancillary facilities:
To start the EFT registration process, please download and complete our EFT Application for Ancillary Facilities (5992) form and mail it to:

Horizon BCBSNJ
3 Penn Plaza PP-14K
Newark, NJ 07105
Attn: Ancillary Reimbursement – EFT Enrollment

To access the EFT Application for Ancillary Facilities (5922) form, visit HorizonBlue.com/Providers and access the Forms section.

If you have questions about this form or the process for ancillary facilities, please contact your Ancillary Reimbursement Analyst.

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

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

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

Prompt Pay
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) must process claims in a timely manner, as required by New Jersey law (Prompt Pay Law).

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

Please note: According to CMS guidelines, a Medicare health plan must pay clean claims from noncontract providers within 30 calendar days of the request, and pay or deny all other claims within 60 calendar days of the request.

In addition, the Health Claims Authorization, Processing and Payment Act (HCAPPA), where it applies, requires any claim
Claims Submissions and Reimbursement

paid beyond the above timeframes to be paid with interest at the rate of 12 percent per annum. As such, interest calculation begins on the 31st day for electronic claims and the 41st day for paper claims (when applicable).

Prompt Pay requirements do not apply to certain lines of business, for example, self-funded businesses we work with as Administrative Services Only (ASO) accounts.

If you have questions about identifying the members to whom Prompt Pay applies, please call Physician Services at 1-800-624-1110 (CMS 1500 submitters) or an Institutional Services Representative (UB-04 submitters) at 1-888-666-2535, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

Additional Interest Payments
Horizon BCBSNJ issues additional interest payments on claims (for certain lines of business) to ancillary providers. 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 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 them from being systemically processed.
- Claims from a physician who balance bills a Horizon BCBSNJ member in violation of their network participation Agreement.
- Claims reimbursed 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.

Requests for Under- and Overpayments
The Health Claims Authorization, Processing and Payment Act (HCAPPA) affects ancillary providers. 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 an ancillary provider 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. However, recapture of an overpayment, beyond the 18-month period, is permitted if there is evidence of fraud, if a physician or health care professional with a pattern of inappropriate billing submits the claim, or if the claim is subject to Coordination of Benefits (COB).

Recapture of overpayments by a health insurer may be offset against an ancillary provider’s future claims if 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 an ancillary provider 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.

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

Please note: Horizon BCBSNJ will not recapture an overpayment made on claims processed for members enrolled in insured group and individual plans covered under HCAPPA until the expiration of the 45-day notice period (except with an ancillary provider’s prior written consent, or if an ancillary provider remits payment directly to Horizon BCBSNJ). Both the paper voucher and the electronic (HIPAA standard 835 transaction) Ancillary Provider Office Manual 18
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.

* The overpayment recapture guidelines noted above do not pertain to overpayments made on claims processed through the BlueCard program for members enrolled in other Blue Cross and/or Blue Shield Plans or for members enrolled in the Federal Employee Program (FEP).

**Underpayment**

Under HCAPPA, no ancillary provider 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 ancillary provider may seek more than one reimbursement for underpayment of a particular claim.
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 Ancillary Provider to Obtain COB Information and to Bill Primary First

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

If you are providing care to 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 23.

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

If you are providing care to a Horizon BCBSNJ subscriber who also has coverage as a subscriber with another health plan and 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.

When providing care to a dependent child, whose parents are not separated or divorced and:

- 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 (see next page) will apply.

When providing care to a dependent child, whose parents are separated or divorced:

- The plan of the parent who has financial responsibility for health care expenses (as determined by the court) is the primary plan, regardless of who has custody of the child.
- For claims for a dependent child whose parents are separated or divorced, but a court has not stipulated financial responsibility, the unmarried parent who has custody is primary. The other parent is secondary.
Coordination of Benefits

- Any coverage through a stepparent married to the custodial parent would be next, and the noncustodial parent’s coverage last.

Birthday Rule
Under the 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
Under the 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 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. After you receive the Explanation of Payment (EOP) from the auto insurance carrier, send it to us with a completed claim form, an itemized bill and a copy of the member’s Explanation of Benefit (EOB). Electronic claims cannot be accepted because of the additional information required to process the claim.
- If the primary carrier is Horizon BCBSNJ, we will need a copy of the automobile declaration sheet with the date of accident between the policy effective date and cancellation date. Be sure to attach an itemized bill and completed claim form.

Automobile insurance is not primary for motorcycle accidents for owner/operators of a motorcycle. However, passengers of motorcycle accidents need to submit any accident-related claims to their auto insurance carrier for consideration.

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 reimbursement 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
33 Washington Street, 11th floor
Newark, NJ 07102-3194

Regulations on New Jersey Insured Group Policy
Special rules apply for Coordination of Benefits (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 ancillary provider 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 ancillary provider 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 ancillary provider 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.)
Coordination of Benefits

- Where the primary plan pays on the basis of Usual, Customary and Reasonable (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 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 ancillary provider 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 ancillary provider 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 and Horizon BCBSNJ’s plan are both HMO plans and the ancillary provider 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 reach 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 to determine if Medicare or the employer group health program is primary:

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

Please see the chart on page 24 for more detailed information.

**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 who is primary, 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 would be primary to Medicare for the Medicare-eligible person.
Coordination of Benefits

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. Even if the wife were Medicare-entitled, they would both be primary with the group insurance because the wife is actively working.

- Patient 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 older than 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 Medicare Secondary Payer (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.

<table>
<thead>
<tr>
<th>Medicare Beneficiary is ...</th>
<th>Medicare is Primary</th>
<th>Group is Primary</th>
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</thead>
<tbody>
<tr>
<td><strong>AGE 65 or older and:</strong></td>
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<tr>
<td>• Actively working for an employer with fewer than 20 employees.</td>
<td>✓</td>
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<tr>
<td>• Actively working for an employer with 20 or more employees.</td>
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<tr>
<td>• Retired but have group coverage through your spouse who is actively working for an employer with fewer than 20 employees.</td>
<td>✓</td>
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<tr>
<td>• Retired, but have group coverage through your spouse who is actively working for an employer with 20 or more employees.</td>
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<td>✓</td>
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<tr>
<td>• Retired, spouse retired.</td>
<td>✓</td>
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</tr>
<tr>
<td><strong>Under age 65 years, on Medicare due to disability and:</strong></td>
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</tr>
<tr>
<td>• Actively working for an employer with fewer than 100 employees.</td>
<td>✓</td>
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<tr>
<td>• Actively working for an employer with more than 100 employees.</td>
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<tr>
<td>• Not an active employee, but have group coverage through a family member who is actively working for an employer with fewer than 100 employees.</td>
<td>✓</td>
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<tr>
<td>• Not an active employee, but have group coverage through a family member who is actively working for an employer with 100 or more employees.</td>
<td>✓</td>
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<tr>
<td>• Not an active employee, but have group coverage through a family member who is not actively working.</td>
<td>✓</td>
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</tbody>
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**Eligible for Medicare due to end-stage renal disease (ESRD) after March 1, 1996, regardless of age:**

- • Within the first 30 months of Medicare eligibility.* |
- • Beyond 30 months of Medicare eligibility. |
- • Medicare eligibility due to age or disability occurred prior to ESRD eligibility and Medicare was the primary payer due to other Medicare secondary payer rules. |

* This does not apply if the member was Medicare-eligible due to age or disability prior to ESRD eligibility and the group health plan was primary due to other Medicare Secondary Payer rules. In this case, the group health plan would remain primary for the first 30 months of ESRD eligibility.

If you need help understanding if Medicare or a group health plan is primary, please call the Medicare Coordination of Benefits Call Center at 1-800-999-1118.
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. The person 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 he/she signs 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, he/she has the right to select Medicare as primary. If the person selects Medicare as primary, he/she must be dropped from his/her 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 SEP and would face increased premiums and be restricted when he/she signs 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, or Medigap policy, may be offered by an employer (if there are less than 20 employees or if the employee is not actively working) or it may be 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.

Individuals who have purchased Medicare Part A benefits 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 primary:

- 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 his/her spouse. This typically occurs when a parent or legal guardian covers a disabled dependent – either child or adult.

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, which 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.
Coordination of Benefits

• 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 35 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 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 local unions that belong to that Health and Welfare Fund has 100 or more employees, then any local union covered by the Health and Welfare Fund’s health plan would be covered by the MSP regulations.

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 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.

• 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 30 months ending on January 1, 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 31, 2008.

End-Stage Renal Disease (ESRD)

A person becomes Medicare-eligible due to ESRD when he or she begins a regular course of renal dialysis. 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.
Coordination of Benefits

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, 1993, 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, 1993, 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 primary.

To determine who is the primary payer, 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 (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.

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.
Effective July 1, 2014, Horizon Behavioral Health transitioned the management of its behavioral health services to ValueOptions of New Jersey, Inc.* from Magellan Behavioral Health, Inc. ValueOptions administers the Horizon Behavioral Health program for eligible members and covered dependents enrolled in Horizon BCBSNJ’s commercial and Medicare Advantage plans.

Horizon Behavioral Health provides integration of all behavioral and medical health services. The services ValueOptions will provide on behalf of Horizon Behavioral Health include:

- Management of existing Horizon Behavioral Health Networks.
- Credentialing and recredentialing processes for behavioral health and substance abuse providers.
- Utilization management.
- Management of provider and member complaints and appeals.
- Enhanced Care and Case Management programs.
- Delivery of provider and member customer services.
- Quality improvement.

Electronic Requirements

Electronic Requirements

Effective January 1, 2015, ValueOptions will require all providers to electronically conduct all routine transactions, including:

- Verification of eligibility inquiries.
- Submission of authorization requests.
- Electronic funds transfer.
- Updating provider profiles.

Additionally, Horizon Behavioral Health reserves the right to require providers to submit claims according to Horizon BCBSNJ’s electronic claims processing procedures. Please refer to page 15 for more information.

Online Resources

ProviderConnect®

ProviderConnect is a secure, password-protected website where providers conduct certain online activities with Horizon Behavioral Health 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Horizon BCBSNJ providers can access the following online activities:

- Authorization requests for all levels of care.
- Concurrent review requests and discharge reporting.
- Verification of eligibility status.
- Submission of inquiries to ValueOptions Provider Customer Service.
- Updates to practice profiles/records.
- Electronic access to authorization letters from ValueOptions.

ValueOptions.com

For access to a number of provider tools and resources relevant to behavioral health, visit the Provider section of ValueOptions.com.

Achieve Solutions®

Achieve Solutions® is an educational behavioral health and wellness information website accessible from ValueOptions.com.

Please refer to the ValueOptions Resource Manual at ValueOptions.com/Horizon for more information.

* ValueOptions of New Jersey, Inc. is a New Jersey corporation licensed by the NJ Department of Banking and Insurance, and is contracted by Horizon BCBSNJ to administer the Horizon Behavioral Health Program.
Provider Identification Numbers

ValueOptions assigns providers with a unique six-digit number (e.g., 123456). This provider number identifies a provider in the ValueOptions system and gives access to ProviderConnect. Providers should contact ValueOptions National Provider Relations at 1-800-397-1630 during normal business hours Monday through Friday, 8 a.m. to 8 p.m., ET, for questions regarding Provider Identification Numbers and/or for assistance in obtaining a Provider Identification Number.

The provider’s service location vendor number is a number that identifies where services are or were rendered. A provider may have multiple vendor locations and each vendor location is given a five-digit number preceded by a letter (e.g., A23456, D45678).

Member Eligibility and Authorizations

Prior to beginning a course of outpatient treatment and/or a nonemergency admission, the provider must contact ValueOptions by using ProviderConnect, the preferred method, to verify member eligibility, and to obtain authorization, where applicable. The provider can also verify eligibility and benefits via NaviNet.

In order to verify member eligibility, the provider will need to have the patient’s name, date of birth and member identification number. The following information should also be available:

- The insured or covered employee’s name, date of birth and member identification number.
- Information about other insurance or health benefit coverage.

Based on the most recent data provided by the employer/benefit plan sponsor, benefit plan administrator and/or where applicable, the sponsoring government agency, ValueOptions will:

1. Verify member eligibility.
2. Identify benefits and associated member expenses under the member’s benefit plan.
3. Identify the authorization procedures and requirements under the member’s benefit plan.

Verification of eligibility and/or identification of benefits and member expenses are not authorization or a guarantee of payment.

Care Management System

Members and participating providers may access the ValueOptions care management system through any of the following avenues:

- 24-hour toll-free emergency care/clinical referral line at 1-800-626-2212 or 1-800-991-5579 (NJ State Health Benefits Program).
- Direct registration of care through ProviderConnect for providers.
- Direct authorization of all levels of care through referral by a ValueOptions Clinical Care Manager (CCM).
- Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams.

If a call is received from a member requesting a referral and/or information about providers in the member’s location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the provider holds and gender. Additionally, the member may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the CCM will assist in arranging care for the member. The name, location and phone number of at least three participating providers will be given to the member.

Utilization Management

The Horizon Behavioral Health Utilization Management program encompasses management of care from the point of entry through discharge using objective, standardized, and widely-distributed clinical protocols and outlier management programs. Intensive utilization management activities may apply for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. Providers are required to comply with utilization management policies and procedures and associated review processes.

Examples of review activities included in the Horizon Behavioral Health Utilization Management program are determinations of medical necessity, preauthorization, notification, concurrent review, retrospective review, care/case management, discharge planning and coordination of care.
Horizon Behavioral Health

The Horizon Behavioral Health Utilization Management program includes processes to address:

- Easy and early access to appropriate treatment.
- Delivery of quality care according to accepted best-practice standards while working collaboratively with providers.
- Needs of special populations, such as children and the elderly.
- Identification of common illnesses or trends of illness.
- Identification of high-risk cases for intensive care management.
- Prevention, education and outreach.

Objective, scientifically based clinical criteria and treatment guidelines, in the context of provider- or member-supplied clinical information, direct the utilization management processes.

Treatment Planning

Providers must develop individualized treatment plans that use assessment data, address the member’s current problems related to the behavioral health diagnosis and actively include the member and significant others, as appropriate, in the treatment planning process. CCMs review the treatment plans with the providers to ensure that they include all elements required by the provider agreement, applicable government program, and at a minimum:

- Set specific measurable goals and objectives.
- Reflect the use of relevant therapies.
- Show appropriate involvement of pertinent community agencies.
- Demonstrate discharge planning from the time of admission.
- Reflect active involvement of the member and significant others as appropriate.

Providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

On Track Outcomes Program

The ValueOptions On Track Outcomes Program is an outcomes management program designed to help providers incorporate member-reported feedback into outpatient psychotherapy sessions with the intended goal of improving outcomes. On Track supports providers as they help members stay “on track” in achieving their goals. This program is based on the completion of the Client Feedback Form (CFF) by the member during the course of receiving psychotherapy services. Participation by members is voluntary.

Please refer to the ValueOptions Resource Manual at ValueOptions.com/Horizon for more information.

Credentialing and Recredentialing

ValueOptions administers credentialing and recredentialing processes for Horizon Behavioral Health. ValueOptions’ credentialing and recredentialing processes are designed to comply with national accreditation standards to which ValueOptions is or may be subject, as well as applicable state and/or federal laws, rules and regulations.

Providers are credentialed and recredentialed, respectively, for participation status for designated services and/or level(s) of services. Should participating providers have other or additional services or levels of services available, additional credentialing and/or recredentialing may be necessary prior to designation as a “provider” for such additional services and/or levels of services.

Decisions to approve or decline initial credentialing applications, to approve recredentialing applications and/or to submit a given credentialing or recredentialing application for further review are made by ValueOptions’ National Credentialing Committee (NCC), or where applicable, by a local ValueOptions-established credentialing committee.

Participating providers have the right to:

- Request review of information submitted in support of credentialing or recredentialing applications.
- Correct erroneous information collected during the credentialing or recredentialing processes.
- Request information about the status of credentialing or recredentialing applications.
All requests to review information must be submitted in writing. Providers may call the National Network Provider Line at 1-800-397-1630, Monday through Friday, 8 a.m. to 8 p.m., ET, to request for the status of an application. Regardless of the above, ValueOptions will not release information obtained through the primary source verification process where prohibited by applicable state and/or federal laws, rules and/or regulations.

Please refer to the ValueOptions Resource Manual at ValueOptions.com/Horizon for more information.

**Provider Complaints, Grievances and Appeals**

Provider complaints regarding issues related to performance (e.g. service complaints, complaints about ValueOptions policies and procedures) should be directed to the Horizon Behavioral Health Customer Service Department at 1-800-626-2212, Monday through Friday, between 8 a.m. and 8 p.m., ET, or in writing to:

**Horizon BCBSNJ**  
Horizon Behavioral Health  
Attention: Complaints  
PO Box 783  
Latham, NY 12110

Horizon Behavioral Health will acknowledge receipt of provider complaints verbally or in writing, and thereafter will investigate and attempt to reach a satisfactory resolution of the complaint within 30 calendar days of receipt of the complaint. Horizon Behavioral Health will notify the provider verbally or in writing of the proposed resolution to the complaint, along with the procedure for filing an appeal (if applicable) should the provider or hospital not be satisfied with the proposed resolution.

Please refer to the ValueOptions Resource Manual at ValueOptions.com/Horizon for more information.
Horizon Healthcare Innovations, a division of Horizon BCBSNJ, is transforming and improving New Jersey’s health care delivery system. We are collaborating and developing solutions to create a health care system marked by high-quality care, increased patient satisfaction and improved affordability. Horizon BCBSNJ is launching programs around new models of patient care and reimbursement.

**Patient-Centered Medical Home (PCMH)** – A PCMH coordinates patients’ health care needs and helps ensure that they receive quality care at the right place and at the right time. This patient-centric approach provides a personalized and comprehensive health care program that enables patients to become engaged in their health care. In creating the PCMH program with participating physicians, we recognized the need to support Primary Care Physicians for the comprehensive care management of their patients. To improve the payment structure, the PCMH model increases reimbursement to support physicians for managing and improving the health of their patients while controlling the cost of care. To help physician groups improve quality outcomes, population care coordinators help the PCMH focus on patients who have chronic health conditions, behavioral health concerns and those who are frequently admitted and discharged from other care facilities. Horizon BCBSNJ is also collecting, analyzing and reviewing timely patient data with physicians and their staffs to give them the information and tools they need to improve the care being provided.

Our patient-centered programs have grown to include Pediatric PCMHs. The differences in children and adults drive different needs in care. Our Pediatric PCMHs are focused on preventive and developmental goals, and target children with chronic conditions, such as asthma and diabetes.

**Episodes of Care (EOC)** – The EOC program is designed to reimburse a single individual or group entity for all of a patient’s care related to a specific procedure or an acute episode within a defined period of time. Using national quality standards and best practices for these procedures, our goals are to achieve better quality outcomes, improve the patient experience and reduce the total cost of care.

For example, an entity may receive a bundled payment to manage a hip replacement episode, which includes pre-admission care, surgery, hospital stay and post-discharge care.

Horizon BCBSNJ has launched Major Joint Replacement, Knee Arthroscopy, Pregnancy and Delivery, Breast Cancer and Colonoscopy EOC Programs. We are also developing EOC programs for coronary artery bypass graft, kidney cancer and other chronic conditions.

**Accountable Care Organization (ACO)** – The goals of an ACO are to create a healthier population, improve the patient experience and control the total cost of care. ACOs are comprised of health care professionals who are responsible for achieving measured patient quality outcomes and avoiding unnecessary and duplicative medical tests and treatments. An effective ACO is built on the foundation of primary care because of its strong focus on preventive and well care to keep patients healthy. We are partnering with health care leaders throughout New Jersey to create innovative ACO models.
Horizon Hospital Network

Horizon BCBSNJ is committed to providing our members access to a wide range of quality acute care facilities located conveniently throughout the region.

Periodically, hospitals may be added to or removed from the network. Blue Review and messages on the Provider Reference Materials page of HorizonBlue.com will advise you of these changes. Participating physicians and other health care professionals should use the Horizon Hospital Network so that members receive the highest level of benefits available under their benefit plans.

Please note: This listing is accurate at time of printing. Please visit our online Provider Directory on HorizonBlue.com for the most current information.

The following is a list of our network acute care facilities: Select hospitals have been identified as Preferred Tier 1 for the Horizon Advance EPO products.

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

**BERGEN COUNTY**
- Englewood Hospital and Medical Center
- Hackensack University Medical Center
- HackensackUMC at Pascack Valley
- Holy Name Medical Center
- 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**
- Inspira Medical Center Vineland
- Inspira Medical Center Bridgeton

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

**GLOUCESTER COUNTY**
- Kennedy Memorial Hospitals –
  - University Medical Center (Washington Township)
- Inspira Medical Center Woodbury

**HUDSON COUNTY**
- Bayonne Medical Center
- Christ Hospital
- Hoboken University Medical Center
- Jersey City Medical Center
- Meadowlands Hospital Medical Center*

**HUNTERDON COUNTY**
- Hunterdon Medical Center

**MERCER COUNTY**
- Capital Health System – Fuld
- Capital Health System – Mercer*
- Capital Health Medical Center Hopewell
- 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
- University Medical Center of Princeton at Plainsboro

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

**MORRIS COUNTY**
- Chilton Hospital
- Morristown Medical Center*
- Saint Clare’s Hospital (Denville *, Dover *)
Horizon Hospital Network

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

**PASSEIC 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.
Inpira Medical Center Elmer

**SOMERSET COUNTY**
Robert Wood Johnson University Hospital Somerset

**SUSSEX COUNTY**
St. Clare’s Hospital/Sussex
Newton Medical Center

**UNION COUNTY**
JFK Medical Center – Muhlenberg Campus*
Overlook Medical Center (Summit, Union*)*
Robert Wood Johnson University Hospital Rahway
Trinitas Regional Medical Center

**WARREN COUNTY**
Hackettstown Regional Medical Center
Saint Luke’s Warren Hospital

**PHILADELPHIA COUNTY, PA**
Children’s Hospital of Philadelphia
Fox Chase Cancer Center
Hahnemann University Hospital
Hospital of the University of Pennsylvania
Jeanes Hospital
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

**DELAWARE COUNTY, PA**
Crozer Chester Medical Center
(Springfield Hospital, Taylor Hospital campuses)
Delaware County Memorial Hospital

**NEW YORK (ORANGE COUNTY)**
Bon Secours Community Hospital*
St. Anthony Community Hospital*

* No inpatient services/limited outpatient services available.

* Not all hospital-based physicians are participating. Hospital-based physicians are identified as anesthesiologists, radiologists, pathologists and ER physicians providing services within the hospital.

Preferred Tier 1 Hospital.

Note: Information is deemed accurate at time of printing and is subject to change. All other in-network hospitals without are considered Tier 2 hospitals for the Horizon Advance EPO plan. The list of Preferred Tier 1 hospitals is subject to change. As hospitals convert to Preferred Tier 1, the physicians affiliated with that hospital shall undergo an evaluation for participation in Horizon Advance EPO.

Currently, all ancillary providers are considered in-network for the Horizon Advance EPO products.
Identification

The member’s 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 phone 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.

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.

Sample ID Cards

Horizon BCBSNJ’s ID cards comply with Blue Cross and Blue Shield Association (BCBSA) branding regulations and New Jersey Department of Banking and Insurance (DOBI) regulations.

Our 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.

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 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.
10 Logo indicating prescription drug coverage, if the member has Prime Therapeutics LLC prescription drug coverage through Horizon BCBSNJ.
11 Website address.
12 Service phone numbers. This information may vary based on the plan.

As an ancillary provider who participates in our Horizon Managed Care Network and/or our Horizon PPO Network, you must, according to the terms of your Agreement, accept our allowance for eligible services provided to Horizon BCBSNJ members (less any applicable copayment, coinsurance or deductible amounts) as payment in full.

For more information about allowances for services provided to members in various Horizon BCBSNJ plans, please see the Claims Submissions and Reimbursement section beginning on page 10.
Identification

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.
7. Claim filing information. This information will vary based on the plan.
8. 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.*
9. Logo indicating prescription drug coverage, if the member has Prime Therapeutics LLC prescription drug coverage through Horizon BCBSNJ.
10. Website address.
11. Service phone numbers. This information may vary based on the plan.

### Sample National ID Card

**Front:**
- **Member Name:** JOHN DOE
- **Member ID Number:** IDC3HZN12345678
- **Group Number:** 75999-0000
- **Type:** FAMILY
- **BC/BS Plan Codes:** 280/780

**Back:**
- **Product Name:**
  - **Office Visit:** $20
  - **Specialist:** $30
  - **Emergency Room:** $125
  - **Inpatient Hospital Copay:** $500
  - **Emergency Room:** $50
  - **Inpatient Hospital Copay:** $500
- **RXBIN:** 016499
- **RXPCN:** HZRX
- **ISSUER:** (808 40) 075990000
- **www.horizonblue.com/nationalaccounts**
- **For Member Use Only:**
  - **Member Services:** 1-800-355-2583
  - **Behavioral Health Services:** 1-800-626-2212
  - **Provider Locator:** 1-800-610-2583
  - **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:** 1-877-686-6875
- **MEMBER CLAIM FILING:**
  - **HORIZON BCBSNJ**
  - **PO BOX 1219**
  - **NEWARK, N.J. 07105-1219**

*Medicare members submit claims to Medicare first.
AN INDEPENDENT COMPANY ADMINISTERING PHARMACY BENEFITS.
Federal Employee Program® (FEP®): ID Cards

1. Member name.
2. Member ID number.
   All characters in this field are important and must be included in all transactions. For FEP plans, the ID number always begins with the R prefix and is followed by eight digits.
   - 104 identifies Standard Option single coverage.
   - 105 identifies Standard Option family coverage.
   - 111 identifies Basic Option single coverage.
   - 112 identifies Basic Option family coverage.
4. Effective date of the subscriber’s contract.
5. The ID card will also have either PPO or Basic in the upper right corner of the ID card, inside the outline of the U.S. map.

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Standard Option

<table>
<thead>
<tr>
<th>Member Name</th>
<th><a href="http://www.fepblue.org">www.fepblue.org</a></th>
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<tbody>
<tr>
<td>IM Sample</td>
<td>R99999999</td>
</tr>
<tr>
<td>Member ID</td>
<td>RxBIN 610239</td>
</tr>
<tr>
<td>Enrollment Code</td>
<td>104</td>
</tr>
<tr>
<td>Effective Date</td>
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</tr>
</tbody>
</table>

Basic Option

<table>
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<tr>
<th>Member Name</th>
<th><a href="http://www.fepblue.org">www.fepblue.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>IM Sample</td>
<td>R99999999</td>
</tr>
<tr>
<td>Member ID</td>
<td>RxBIN</td>
</tr>
<tr>
<td>Enrollment Code</td>
<td></td>
</tr>
<tr>
<td>Effective Date</td>
<td></td>
</tr>
</tbody>
</table>
Horizon BCBSNJ’s goal is to provide prompt responses to our participating ancillary provider inquiries and timely resolution of complaints brought to Horizon BCBSNJ’s attention. To help you with such issues, you are encouraged to use our IVR system by calling 1-800-624-1110.

A service representative is also available 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 phone lines are staffed during regular business hours, Monday through Friday, between 8 a.m. and 5 p.m., ET.

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 Service Only (ASO) accounts*.

Examples of inquiries include, but are not limited to, questions regarding eligibility of members, benefits or a particular claim’s status.

To speed our ability to assign, investigate and resolve your inquiries, please complete and submit our Inquiry Request and Adjustment Form (579). Submission addresses are noted on the 579 form.

To access our Inquiry Request and Adjustment Form, visit HorizonBlue.com/Providers and:

- Click Find a Form in the I Want To... section.
- Click Inquiry/Request.
- Click Request Form – Inquiry, Adjustment, Issue Resolution.

* 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 an ancillary provider, on his/her own behalf, regarding any aspect of Horizon BCBSNJ’s (or 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.

Submit complaints in writing, to:

CMS1500 submitters:
Horizon BCBSNJ
PO Box 199
Newark, NJ 07101-0199

CMS1450/UB-04 submitters:
Horizon BCBSNJ
PO Box 1770
Newark, NJ 07101-1770

Examples of complaints include, but are not limited to:

- Administrative difficulties.
- Claims issues.
- Credentialing.

Complaints relating to claims may typically involve:

- Contract benefit issues.
- CPT-4 code inconsistencies.
- Incorrect coding.
- Reimbursement disagreements.
- Rebundling of charges.

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

No ancillary provider 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.
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 ancillary providers 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:

For inquiries or complaints related to Utilization Management:

Department of Banking and Insurance
Office of Managed Care
PO Box 329
Trenton, NJ 08625-0329

1-888-393-1062

Or, for all other inquiries or complaints:

Department of Banking and Insurance
Consumer Assistance
PO Box 471
Trenton, NJ 08625-0329

1-800-446-7467

What is an HCAPPA Claim Appeal?
A claim appeal is a written request made by an ancillary provider asking for a formal review by Horizon BCBSNJ of a dispute relating to the reimbursement of claims. This includes, but is not limited to, a request for a formal review of a Horizon BCBSNJ Claim Payment Determination described as follows.

Provider Claim Reimbursement Appeal Process
The Health Claims Authorization, Processing and Payment Act (HCAPPA) 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 Program® (FEP®) and Medicare.

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’s (DOBI) required form on or before 90 calendar days following receipt of the health insurer’s claim determination.

The DOBI form, the Application for Independent Health Care Appeals Program may be found within the Forms section of HorizonBlue.com/Providers. This form may also be found on state.nj.us/dobi.

Ancillary providers should include all pertinent information and documents necessary to explain 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 07101-3129

* The HCAPPA appeal process is not the correct process for medical necessity determinations. Medical necessity determination disputes should be appealed through the Independent Health Care Appeals Program (IHCAP).
Inquiries, Complaints and Appeals

A health insurer is required by law to make a determination (either favorable or unfavorable) and notify the ancillary provider of its decision on or before 30 calendar days following its receipt of the appeal form.

- If a favorable determination is made for the ancillary provider, 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 ancillary provider, the health insurer must provide the ancillary provider, instructions for referral to external arbitration.

If the ancillary provider is not timely notified of the determination, or disagrees with the final decision, the ancillary provider may refer the dispute to external arbitration.

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 ancillary provider, 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 44 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.

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 njpicpa.maximus.com for additional information and applications.

Ancillary providers 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. Ancillary providers 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 30 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 ancillary providers 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.

For more details on these requirements, please call Physician Services at 1-800-624-1110 (CMS 1500 submitters) or an Institutional Services Representative (UB-04 submitters) at 1-888-666-2535, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

Ancillary Provider Office Manual

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Inquiries, Complaints and Appeals on Behalf of Members

In addition to the rights you have as an ancillary provider, 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 non-utilization management issues. As with our ancillary-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 ancillary providers’ help in pursuing an inquiry, complaint or appeal on their behalf. Ancillary providers may only pursue these avenues on behalf of their patients if the consent of the patient is obtained.

Please note: The process for inquiries, complaints and appeals for behavioral health providers varies slightly from the above information. Please refer to page 29 or the ValueOptions Resource Manual at ValueOptions.com/Horizon for more information.

Nonutilization 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 ancillary-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).

Our Member Services Representative will be happy to respond to member inquiries or complaints, or those made by an ancillary provider 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 phone lines are staffed during regular business hours, Monday through Wednesday and Friday, between 8 a.m. and 6 p.m., and Thursday, between 9 a.m. and 6 p.m. Eastern Time.

Inquiries or complaints may also be submitted in writing to:

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

Ancillary providers are reminded that, to pursue an inquiry or complaint on behalf of a member through Member Services, he/she must have the consent of the member.

The timeframe for submission and response to member inquiries is similar to those under the ancillary-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 an ancillary provider 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 has the right to revoke his/her consent at any time.

When appealing on behalf of the member, HCAHPA requires that the ancillary provider provides the member with notice of the appeal whenever an appeal is initiated and again at each time the appeal moves to the next stage, including any appeal to the Independent Utilization Review Organization (IURO).
Inquiries, Complaints and Appeals

Nonutilization Management Determination Appeals

Member Appeals – Requesting an Appeal*

Following the receipt of the complaint determination, in appropriate instances, the member/covered person, or an ancillary provider on behalf of, and with the consent of the member or covered person, may request an appeal either orally, in person or by phone 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 phone 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 Appeals 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 phone conference. The Appeals Coordinator makes the appropriate arrangements.

Members/covered persons, or ancillary providers 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/or covered person and/or the ancillary provider who pursued the appeal on their behalf, within two business days of the decision.

Members/covered persons who choose not to appear are notified of the Committee’s decision in writing 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 or ancillary provider.

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 within 72 hours, or sooner, if the medical circumstances dictate.

The member/covered person, or the ancillary provider 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 ancillary providers, 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 medical necessity decision made by Horizon BCBSNJ.

An adverse benefit determination involving a medical necessity decision is a decision to deny or limit an admission, service, procedure or extension of stay based on Horizon BCBSNJ’s medical necessity criteria. Adverse benefit determinations may usually be appealed up to three times. Individual consumer plans and some ASO/self-insured plans only allow one level of 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 policy, and members/covered persons of certain plans, such as individual consumer, 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 benefit determination 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 medical appeals are reviewed within 10 calendar days.

If the denial is upheld, members, ancillary providers, 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 phone 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 ancillary providers, 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 phone on the day of the hearing whenever possible. Written confirmation of the decision is sent to the member/covered person, and/or the ancillary provider who pursued the appeal on their behalf, within five business days of the decision.

Expeditied 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 phone number listed on the first level medical appeal determination letter.

Third Level Medical Appeals

If the Appeals Committee upholds the second level medical appeal, the member or the member’s ancillary provider, 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 Independent Utilization Review Organization (Iouro) only considers appeals on denials based on medical necessity. Denials based on contract issues are not reviewed by the Iouro. The case will be reviewed by a medical expert under contract with an Iouro.

Instructions on how to file with the Iouro are included with the denial letter from the second level medical appeal, where applicable. Third level medical appeals must be filed within four months from the receipt of the notice of determination of the second level medical appeal.

The Iouro will review the appeal and respond to the member or facility, ancillary providers within 45 calendar days.

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

Appeals Relating to Medicare Members
Medicare Advantage members follow a different appeal policy. Please see page 95 for more information or visit HorizonBlue.com/Medicare.

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, log in to NaviNet.net, access Horizon BCBSNJ within the Plan Central dropdown menu and:

- Mouse over References and Resources 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 Ancillary Contracting Specialist.

Health Care Reform and Appeals
The Affordable Care Act (ACA), 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 2014.

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.
Member Rights and Responsibilities

Member Rights

The Horizon BCBSNJ Member Rights and Responsibilities have been reprinted in this section.

As a member, you have the right to:

• Receive information about Horizon BCBSNJ and its services, policies and procedures, products, physicians, appeals procedures, member rights and responsibilities, coverage limitations and other information about the organization and the care provided.

• Be provided with the information needed to understand your benefits and obtain care through the Horizon Managed Care Network.

• Obtain a current directory of participating physicians in our network, upon request. The directory includes addresses, telephone numbers and a listing of physicians who speak languages other than English.

• Receive prompt notification of termination of your PCP or material changes in benefits, services or the Horizon Managed Care Network within 30 days prior to the date of any change or termination, as appropriate.

• Obtain information about whether a referring physician has a financial interest in the facility or services to which a referral is being made.

• Know how Horizon BCBSNJ pays its physicians, so you know if there are financial incentives or disincentives tied to medical decisions.

• Receive from your physician or health care professional, in terms you understand, an explanation of your complete medical condition, such as information regarding your 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 you are not capable of understanding the information, the explanation shall be provided to your next of kin or guardian and documented in your medical record.

• Have full, candid discussions about the risks, benefits and consequences regarding appropriate or medically necessary diagnostic and treatment or nontreatment options with your participating physicians, regardless of cost or benefit options.

• To refuse treatment and to express preferences about future treatment options.

• Receive from your physician or health care professional, in terms you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results of the treatment and reasonable medical alternatives, whether or not these are covered benefits. If you are not capable of understanding the information, the explanation shall be provided to your next of kin or guardian and documented in your medical record.

• Choose and change your PCP within the limits of your benefits and the physician’s availability.

• Have access to your PCP and available 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.

• Call the 911 emergency response system or an appropriate local emergency number in a potentially life-threatening situation, without prior approval. The 911 information is listed on your Horizon BCBSNJ ID card.

• Have your Horizon BCBSNJ plan pay for a medical 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 to you that serious harm could result from not obtaining immediate treatment.

• Choose from appropriate, participating specialists following an authorized referral (if necessary), subject to the specialist’s availability to accept new patients.

• Obtain assistance and referrals to participating health care professionals who have experience in treatment of patients with chronic disabilities.
Member Rights and Responsibilities

- Know all the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences have been explained in a language you understand and be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

- Receive a written explanation why approval of a covered service requested by you or your physician was denied or limited under your Horizon BCBSNJ plan.

- Have a Horizon BCBSNJ physician determine to deny or limit your admission, service, procedure or extension of stay. Our physician who made the decision must directly communicate with your physician or supply your physician with his/her telephone number. You 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 for medically necessary services that were authorized or covered by Horizon BCBSNJ (not including copayments and coinsurance).

- Voice complaints or file internal and external appeals about your plan or the care provided. Please see the Voicing a Concern section of your member handbook.

- File a complaint or appeal with Horizon BCBSNJ or the New Jersey Department of Banking and Insurance. You have the right to receive an answer to your complaint or appeal within a reasonable period of time.

- Know that neither you nor your physician can be penalized for voicing a complaint or appeal about your Horizon BCBSNJ plan or the care provided.

- Participate with your physicians in decision-making regarding your health care.

- Be treated with courtesy and consideration, and with respect for your dignity. You also have the right to privacy.

- Request and receive a copy of your Private Information maintained in Horizon BCBSNJ's records.

- Exercise your privacy right by requesting an amendment of your Private Information that is believed to be inaccurate.

- Formulate and have advance directives implemented.

- Make recommendations for changes to the Horizon Member Rights and Responsibilities Policy.

- Receive covered services from a terminated health care professional who was under contract with us at the time treatment was initiated, for up to four months, where medically necessary. Other periods may apply to obstetrical care, post-operative care, ontological treatment or psychiatric treatment.

- Horizon BCBSNJ or its participating providers will not penalize you for exercising your Rights.

Member Responsibilities

Our statement of member responsibilities includes the following provisions:

Our members have the responsibility to:

- Read and understand this Horizon BCBSNJ Member Handbook, your EOC and all other member materials.

- Use the PCP you selected to receive in-network benefits.

- Coordinate most nonemergency care through your PCP.

- Provide, to the extent possible, information regarding your health that Horizon BCBSNJ and its physicians and other health care professionals need in order to care for you.

- Know how to change your PCP.

- Obtain referrals from your PCP, as appropriate, and use the Horizon Managed Care Network to receive the in-network level of benefits.

- Understand your health problems and participate in developing mutually agreed upon treatment goals and medical decisions regarding your health (to the degree possible).

- Follow the plans and instructions for care that you agreed upon with your physician. If you choose not to comply, you will advise your physician.

- Be considerate and courteous to physicians and staff.

- Make payment for copayments, deductibles and coinsurance as listed in your EOC.

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

- Pay for charges incurred that are not covered under the policy or contract.
Case Management Program

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 or facility staff 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 Chronic Care 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 Program Eligibility

Members who have serious or complex medical conditions, which may be long-term, catastrophic or terminal, are eligible for case management.

Providers 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 or facility – 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 HorizonBlue.com/Providers, mouse over Resource Center and click Patient Health Support or call 1-888-621-5894, option 2.

Chronic Care Program

The right preventive care and early detection of disease are critical to healthy living. At Horizon BCBSNJ, we offer the Chronic Care Program to eligible members who have been diagnosed with one of the chronic conditions listed below:

- Asthma.
- Chronic Kidney Disease (CKD, including members receiving dialysis).
- Chronic Obstructive Pulmonary Disease (COPD).
- Coronary Artery Disease (CAD).
- Diabetes.
- Heart Failure.

The Chronic Care 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 and registered dietitians.
Patient Health Support

To enroll eligible members using our online referral form, visit HorizonBlue.com/Providers, and:

• Mouse over Resource Center and click Patient Health Support.

• Scroll down to the Chronic Care heading and click Chronic Care Program referral form.

To receive information on the programs for any of the conditions listed on the previous page, please call 1-888-333-9617.

Please note that all programs may not be available for all products or lines of business.

**PRECIOUS ADDITIONS® Program**

The PRECIOUS ADDITIONS program is a free, mail only, voluntary educational resource that provides members with valuable health information on their pregnancies.

To receive the most benefit from this program, eligible Horizon BCBSNJ members must 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:

• Online through HorizonBlue.com/PreciousAdditions.

• By calling Member Services at 1-800-355-BLUE (2583).

Once enrolled in the program, your patient will receive useful information, including:

• A pregnancy journal.

• A children’s health guide.

• Newborn enrollment procedures.

• Information about reimbursement (up to $50) for the cost of completing one prenatal/Lamaze course.

Members may call Member Services at any time to disenroll.

Members may call 1-800-355-BLUE (2583) to learn more about the PRECIOUS ADDITIONS Program.

**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.

**24/7 Nurse Line**

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.

**24/7 Nurse Line Chat**

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.

To access the 24/7 Nurse Line chat feature, members can sign in to Member Online Services, mouse over Tools & Resources and click Overview. Then click on the Nurse Chat icon at the bottom right corner to chat with a health care resource.
During chats, nurses can display web pages and suggest other helpful resources related to the topic being discussed. Members can request a transcript of their conversation and web pages for future reference.

*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.*

*Availability of certain programs may require additional purchase by employer groups.*
Payment Summaries and Vouchers

Explanation of Payment
Horizon BCBSNJ’s Explanation of Payment (EOP) helps you obtain the information you need quickly and easily in a simple-to-read format. It includes summary sections, a message center and the following:

- 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/nonpayments.

If you have questions, please call Physician Services at 1-800-624-1110 (CMS 1500 submitters) or an Institutional Services Representative (UB-04 submitters) at 1-888-666-2535, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

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

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. We provide detailed information regarding claims denials. For example, enhanced messages provide 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.
C. Account Receivable Summary
This section highlights all outstanding payments due to Horizon BCBSNJ, detailing the patients’ claim where the A/R was initiated and indicating any monies deducted from your reimbursement to satisfy the A/R. We have limited the number of times a single 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 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 reimbursements are applied toward the active A/R.
- The A/R is completely satisfied.

D. Late Interest Summary
This area details the claims that require Horizon BCBSNJ to pay a late interest payment. The late interest payment will be added to the claim payment on this form.
Payment Summaries and Vouchers

Billing Horizon MyWay Patients
Horizon MyWay Visa®/Debit card
You should wait until you receive an Explanation of Payment (EOP) from Horizon BCBSNJ before billing patients for coinsurance and deductibles, 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 Horizon MyWay Visa®/debit card and/or personalized checks to pay for medical expenses not covered under their health plan. These will process like regular debit cards and checks. Members can use the Visa/debit card or checkbook to pay copayments and other eligible medical expenses.

Horizon MyWay HRA Explanation of Payment
You may receive an additional Explanation of Payment (EOP) for Horizon MyWay HRA patients. This is in addition to the initial Horizon BCBSNJ EOP advising you of available funds in the member’s HRA. This explanation may include payment from that account and an explanation of the final member liability. Please see the following pages for a sample HRA EOP.

Please review the following information to help you understand this statement.
Description of Fields on page 2 of the EOP:
The EOP fields described below are shown on page 55.

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.

Sample Horizon MyWay HRA Explanation of Payment
## Payment Summaries and Vouchers

**Sample Horizon MyWay HRA Explanation of Payment**

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>SUBSCRIBER</th>
<th>HORIZON ALLOWED</th>
<th>MEDICAL LIABILITY</th>
<th>APPROVED AMOUNT</th>
<th>PATIENT RESPONSIBILITY</th>
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</thead>
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<td><strong>Bill Williams</strong></td>
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<td>400.00</td>
<td>100.00</td>
<td>100.00</td>
<td>0.00</td>
</tr>
<tr>
<td>07/12/12</td>
<td>G002</td>
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<td>100.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
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<td>100.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
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<td>0.00</td>
</tr>
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<tr>
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<td></td>
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<td><strong>200.00</strong></td>
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</tr>
<tr>
<td><strong>Mary Jones</strong></td>
<td></td>
<td>150.00</td>
<td>50.00</td>
<td>50.00</td>
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</tr>
<tr>
<td>06/11/13</td>
<td>J001</td>
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<td>50.00</td>
<td>0.30</td>
</tr>
<tr>
<td>06/12/13</td>
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<td>30.00</td>
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<td><strong>30.00</strong></td>
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<tr>
<td><strong>John Jones</strong></td>
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<tr>
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<td>0.00</td>
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<td><strong>200.00</strong></td>
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</table>

*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 Blue Plan. The additional reimbursement enclosed is paid from the patient's HRA account and should be applied to any outstanding patient responsibility.*
# Payment Summaries and Vouchers

Sample Horizon *MyWay* HRA Explanation of Payment

![Image of a payment summary and voucher](HorizonBlue.com)

## TOTAL REMAINING BALANCE OF ACTIVE ARMS

<table>
<thead>
<tr>
<th>ACCOUNT RECEIVABLE:</th>
<th>STATUS: T - TO BE CLOSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILL WILLIAMS</td>
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</table>

## ACCOUNT RECEIVABLE APPLIED TO:

<table>
<thead>
<tr>
<th>BILL #</th>
<th>PAYMENT DATE</th>
<th>AMT</th>
<th>PAY CODE</th>
<th>RTS CODE</th>
<th>TENDER</th>
<th>REMRNT</th>
<th>NET AMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>00001</td>
<td>08/15</td>
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<td>0001</td>
<td>0001</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
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<td>0001</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>00003</td>
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<td>0001</td>
<td>0001</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**DATE TO BE** Date after the payment was applied to the account receivable. **PAYMENT DATE** Date of payment on or after account receivable date. **AMT** Amount applied to the account receivable. **PAY CODE** Code associated with payment. **RTS CODE** Code associated with refund. **TENDER** Amount tendered. **REM RNT** Amount remitted. **NET AMT** Amount due after remittance.
Policies, Procedures and General Guidelines

This section contains information about the policies, procedures and guidelines you are required to follow as a participating ancillary provider.

Failure to comply with any of the following policies and procedures may constitute a breach of your Agreement(s).

Contractual Limits
All benefits are subject to contract limits and Horizon BCBSNJ’s policies and procedures, including, but not limited to, prior authorization and medical management requirements.

Laboratory Services
Participating ancillary providers are required to refer Horizon BCBSNJ patients and/or send Horizon BCBSNJ patients’ testing samples to participating clinical laboratories. Failure to comply with this requirement may result in your termination from the Horizon BCBSNJ networks.

We remind you that Laboratory Corporation of America® Holdings (LabCorp) is the only in-network clinical laboratory service provider for your Horizon BCBSNJ managed care patients (i.e., members enrolled in Horizon HMO, Horizon EPO, Horizon Direct Access, Horizon POS, Horizon Medicare Advantage or Horizon Advance EPO plans).

You may refer members enrolled in Horizon PPO and Indemnity plans and/or send their testing samples to LabCorp or to one of our other participating clinical laboratories or hospital outpatient laboratories at network hospitals.

To view a listing of our participating clinical laboratories, please visit HorizonBlue.com and:

- Click Find a Provider.
- Click Other Healthcare Services.
- Select Laboratory – Patient Centers or Laboratory – (Physician Access Only) under the Service Type dropdown menu and click Search.

You may refer a Horizon BCBSNJ patient who has out-of-network benefits (or send his or her testing sample) to a nonparticipating clinical laboratory, if that patient chooses to use his or her out-of-network benefits and you follow the guidelines in our Out-of-Network Consent Policy. Please see page 62 for more information.

The clinical laboratory must participate with the Blue Plan in the state where the referring physician is located for the claim to process at the in-network level of benefits. This means if the referring provider is located in New Jersey, the clinical laboratory must participate with Horizon BCBSNJ for the claim to process at the in-network level of benefits. If the referring provider is located outside of New Jersey, the lab must send the claim to the Blue Plan approved to process professional claims in that state.

If the referring provider has office or facility locations in different states, the patient’s claim must be sent to the Blue Plan in the state where the patient received the referral.

Please note: Certain self-insured employer groups for whom we administer health care benefits (Novartis and Quest Diagnostics only, as of this printing) have established special benefit arrangements that allow their enrolled members to use the nonparticipating clinical laboratory affiliated with each employer group (i.e., Novartis members may use Genoptix labs, Quest Diagnostics members may use Quest labs) as exceptions to the guidelines of our Out-of-Network Consent Policy. These special benefit arrangements apply ONLY to members/dependents enrolled in these employer group plans.

LabCorp and AtlantiCare Clinical Laboratories
All clinical tests and related services for managed care members must be performed by LabCorp or AtlantiCare Clinical Laboratories (working in collaboration with LabCorp in southern NJ counties) to reduce members’ out-of-pocket costs. This includes routine tests, as well as the most contemporary and sophisticated reference tests.

LabCorp’s complete test menu is available on their website. Visit LabCorp.com and click Test Menu.

A LabCorp representative will contact ancillary providers new to the Horizon Managed Care Network for an orientation session. During the orientation, you will receive the necessary supplies and equipment for the collection, preparation and presentation of all specimens. Included with these items is the procedural information that you will need for specimen collection and test reporting.
LabCorp Patient Service Centers or AtlantiCare Clinical Laboratories will draw blood and perform other necessary tests.

To learn more about locations:

- Access the Provider Directory on HorizonBlue.com.
- Visit LabCorp.com or call 1-888-LabCorp (522-2677).
- Visit AtlantiCare.org.

To refer members to a Patient Service Center (PSC), please complete a requisition form. Remember to include your LabCorp account number on the form. This ensures that neither your office nor the member is billed for the tests.

Online and Phone Appointment Scheduling
LabCorp offers appointment scheduling at all PSC locations. Patients may visit LabCorp.com/PSC to select a convenient PSC and schedule an appointment for laboratory testing or call LabCorp Customer Services at 1-800-745-0233 and select the scheduling option from the patient menu.

LabCorp also provides a variety of electronic connectivity solutions to help with test ordering and result delivery. Visit LabCorp.com and click Connectivity Solutions under the I Am a Health Care Provider heading to learn more.

Enhanced Tracking System
LabCorp has partnered with UPS Logistics Technology® to implement a courier and transportation service enhanced tracking system called RoadNet®. This world-class logistics tool includes Global Positioning System (GPS) capabilities that allow LabCorp’s distribution and logistical professionals to track vehicle and courier movement to provide even more reliable, accurate and timely specimen pick-ups.

RoadNet’s suite of integrated software applications automates the pick-up and delivery process, enabling LabCorp’s Service Representatives to electronically relay information immediately to a central server using handheld mobile devices equipped with scanners. LabCorp pick-up and delivery times are verifiable and monitored electronically to ensure quality and accuracy.

LabCorp Affiliates
The following LabCorp companies participate with Horizon BCBSNJ’s Managed Care and PPO plans.

- Accupath Diagnostics Laboratories, Inc. dba US Labs
- Dianon Systems, Inc.
- Dynacare Northwest, Inc.
- Esoterix Genetic Laboratories, LLC
- Esoterix, Inc.
- Home HealthCare Laboratory of America
- Laboratory Corporation of America
- Laboratory Corporation of America Holdings
- Litholink Corporation
- National Genetics Institute
- United Dynacare, LLC
- ViroMed Laboratories, Inc.

LabCorp Contact Information
For questions or service, please call LabCorp at 1-800-631-5250. For specimen pick-up, please call LabCorp at 1-800-253-7059.

Specialty Pharmacy
The Horizon BCBSNJ Specialty Pharmaceutical Program can help you obtain office-based and administered specialty medications from a contracted specialty pharmacy provider that will directly supply your office or facility, at your convenience.

When you participate in this voluntary program, you’ll obtain specialty pharmaceuticals directly from a specialty pharmacy. Under this program, your office should not submit claims for specialty medications when obtained from our specialty pharmacy providers. These selected providers will bill Horizon BCBSNJ directly for the cost of the medication.
To access information about the Specialty Pharmacy Program for office-based therapies, visit HorizonBlue.com/Providers and:

- Mouse over Services & Programs and click Pharmacy Programs.
- Click Specialty Pharmaceutical Program.

To access information about the Specialty Pharmacy Program for therapies obtained by members through their pharmacy benefit, visit HorizonBlue.com/Members and:

- Mouse over Services and click Specialty Rx Program.

Specialty pharmacy claims must be sent to the Blue Plan in the service area where the ordering physician is located. The claim will process according to the pharmacy’s relationship with that Blue Plan. For example, if the ordering physician is located in New Jersey, send the claim to Horizon BCBSNJ and the claim will process according to the pharmacy’s participating status with Horizon BCBSNJ. However, if the ordering physician is located in Pennsylvania, the claim must be sent to the Blue Plan in Pennsylvania and will process according to the pharmacy’s contractual relationship with the Pennsylvania Blue Plan and consistent with the member’s Home Plan benefits.

Medical Necessity Determinations for Injectable Medications

To help ensure that our members receive the appropriate and medically necessary care regarding the use of certain intravenous immunoglobulin (IVIG), oncology and rheumatoid arthritis injectable medications, Horizon BCBSNJ instituted a Medical Injectables Program Determination (MIP) program with ICORE Healthcare, LLC (ICORE), a specialty pharmaceutical management company.

Please see page 141 for more information.

Physicians must obtain a Medical Necessity and Appropriateness Review (MNAR) 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 MNAR program.

As of July 1, 2013, the medical necessity review of oncology-related medications Aranesp, Epogen and Procrit (formerly administered by CareCore National, LLC) is part of our MIP administered by ICORE.

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, Horizon BCBSNJ contracts with ValueOptions to administer our members’ behavioral health and substance abuse benefits.

You may call Horizon Behavioral Health at 1-800-626-2212 to refer most patients for behavioral health or substance abuse care. A referral is not required if services are approved by Horizon Behavioral Health.

If Horizon 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.

Audiology and Hearing Aid Benefits

Audiology Distribution, LLC, doing business as HearUSA, works with Horizon BCBSNJ to administer hearing benefits and provide related products and services through their HEARx network of independently practicing audiologists, hearing care professionals and company-owned hearing centers.

Horizon BCBSNJ works with HEARx to provide audiology services, hearing aids and discounts on certain services to our enrolled members. The information below outlines the role that HEARx Centers play in various member benefits.

Please note: The benefit information provided here is not a guarantee of reimbursement. Claim reimbursement is subject to member eligibility and all member and group benefit limitations, conditions and exclusions. Please confirm member audiology benefits and hearing aid benefit amounts before providing services.
Members enrolled in Horizon Medicare Advantage plans that do not include out-of-network benefits may receive audiology/hearing aid benefits through HEARx as follows:

- Members enrolled in these plans must use a HEARx Center for audiology services and hearing aids that are medically necessary, including batteries.
- Members who reside in a New Jersey county without a HEARx Center may request that their Primary Care Physician (PCP) refer them to a participating Horizon Managed Care Network audiologist. Hearing aid benefits for members who reside in a New Jersey county without a HEARx Center are reimbursable directly to the member for hearing aids/batteries supplied by any non-HEARx provider.

Members enrolled in Horizon Medicare Advantage plans that include out-of-network benefits may receive audiology/hearing aid benefits through HEARx as follows:

- Members enrolled in these plans must use a HEARx Center for in-network audiology services and hearing aids that are medically necessary, including batteries.
- Members who reside in a New Jersey county without a HEARx Center may use any participating Horizon Managed Care Network audiologist on an in-network basis. Hearing aid benefits for members who reside in a New Jersey county without a HEARx Center are reimbursable directly to the member for hearing aids/batteries supplied by any non-HEARx provider.
- Members who choose to use their out-of-network benefits (understanding that they will incur more cost sharing responsibility) may obtain services from a non-HEARx provider.

Members enrolled in any other Horizon BCBSNJ managed care plan (Horizon HMO, Horizon Direct Access, Horizon EPO and Horizon POS etc.) may receive audiology/hearing aid benefits through HEARx as follows:

- Though not required, these members may choose to use a HEARx Center or use any other participating Horizon Managed Care Network audiologist on an in-network basis.
- Please note that benefits for audiology and hearing aids for members enrolled in other Horizon BCBSNJ managed care plans may vary. Please confirm member benefits before providing services.

Members enrolled in any other Horizon BCBSNJ plan may receive audiology/hearing aid benefits through HEARx as follows:

- Any enrolled Horizon BCBSNJ member is entitled to receive a 15 percent discount on the cost of a hearing aid purchased from a HEARx Center.

Use our online Provider Directory to locate a HEARx Center. Visit HorizonBlue.com/Directory, click the Other Health Services tab and:

- Select Audiology within the Service Type menu.
- Enter your ZIP Code and indicate a Search Radius, or select your County.
- Click Search.

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 can expect 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:

- Visit HorizonBlue.com and click Find a Provider.
- Click Other Healthcare Services.
- Under the Service Type dropdown menu, select the appropriate ancillary type.
Claims for DME services must be sent to the Blue Plan in the state in which the equipment was delivered or purchased. The claim will process according to the DME provider’s contractual relationship with the Blue Plan. For example, if the equipment is purchased from a New Jersey DME retail store or delivered to a New Jersey address, that claim must be sent to Horizon BCBSNJ and will process according to the DME provider’s contractual relationship with Horizon BCBSNJ. However, if the equipment is purchased by or delivered to a Horizon BCBSNJ member in Pennsylvania, the claim must be sent to the Pennsylvania Blue Plan and will process based on the DME provider’s contractual relationship with that Pennsylvania Blue Plan and consistent with the member’s Home Plan benefits.

Mammography Benefits
New Jersey health plans must provide coverage of mammograms at specified intervals for women based on age and/or medical necessity.

This mandate applies to all contracts and policies beginning on May 1, 2014 upon renewal, with the exception of State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP) members. The mandate will apply to SHBP and SEHBP members beginning January 1, 2015.

Existing coverage for female members includes:

- One baseline mammogram examination for women who are at least 35 years of age.
- A mammogram examination every year for women age 40 and over.
- A mammogram examination at ages and intervals deemed medically necessary by a woman’s doctor in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors.

The coverage required for an ultrasound evaluation, MRI scan, 3D mammography or other additional testing may be subject to utilization review, including periodic review of the medical necessity of the additional screening.

Expanded coverage for female members now includes an ultrasound evaluation, a magnetic resonance imaging (MRI) scan, a three-dimensional (3D) mammography and other additional testing of an entire breast or breasts, after a baseline mammogram examination, if:

- The mammogram demonstrates extremely dense breast tissue,
- The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense or extremely dense breast tissue,
- The patient has additional risk factors for breast cancer, including but not limited to, family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the patient’s doctor.

Ob/Gyn Services
Female members can go directly to a participating Ob/Gyn for treatment of routine gynecological and obstetrical conditions without a referral from their PCP. However, prior authorization is still required for certain services.

Routine gynecological and obstetrical conditions do not include infertility-related services. Members who have infertility benefits must access those benefits in accordance with their contracts.

Participating obstetricians may directly provide or refer* members to participating physicians and other health care professionals for the following services when these services are medically necessary:

- Home uterine monitoring (Maternity Management).
- Elective hysterectomies.
- Fetal non-stress tests (after the first three).
- Terbutaline pump.
- All pregnancy ultrasounds (after the first two).

Certain professional services and all hospital activity needed during the pregnancy (except outpatient radiology and same-day surgeries) must receive prior authorization. For information on when to call for authorization, please see page 122.

* The Ob/Gyn may not refer to another specialist if the subsequent visit is not Ob-related.
Infertility Services
Physicians and ancillary providers must notify Horizon BCBSNJ and obtain approval for certain infertility treatments. This applies to Horizon HMO, Horizon POS and Horizon Direct Access plans. It is your responsibility to obtain this approval where required.

For additional information, please call an Institutional Services Representative (UB-04 submitters) at 1-888-666-2535, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

Out-of-Network Consent Policy and Procedure
Horizon BCBSNJ’s Out-of-Network Consent Policy* encourages our members to use participating physicians, ancillary providers and facilities, and helps 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 physicians and ancillary providers. All physicians, ancillary providers and facilities 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 ancillary providers to ensure that, whenever possible, their Horizon BCBSNJ patients are referred to participating physicians, ancillary providers 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.

* The Out-of-Network Consent Policy does not apply to members enrolled in plans that do not include out-of-network benefits [e.g., Horizon HMO, Horizon EPO, Horizon Medicare Blue Value (HMO), Horizon Medicare TotalCare (HMO SNP) etc.].

Participating physicians and ancillary providers 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, ancillary provider or facility to provide services to the member. If Horizon BCBSNJ agrees that a participating physician, ancillary provider 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 ancillary providers are required to do the following:

- Advise the member of the nonparticipating status of the physician, 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 (including deductible, coinsurance and any amount that exceeds the plan’s allowance).

- Advise the member of a participating physician, ancillary provider 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, 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.

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

To access our Out-of-Network Consent Policy, registered NaviNet® users may visit and log in to NaviNet.net, select Horizon BCBSNJ within the Plan Central dropdown menu and:

- Mouse over References and Resources and click Provider Reference Materials.

- Click Additional Information.

- Click Out-of-Network Consent Policy.

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

To access our Out-of-Network Consent Form, visit HorizonBlue.com/Providers and:

- Click Find a Form in the I Want To... section.

- Click Forms by Type.

- Click Consent and click Consent Form – Out-Of-Network.

Call your Ancillary Contracting Specialist if you have questions or would like copies of the above-referenced information mailed to you.
When out-of-network claims are received, the participating ordering and/or rendering physician or ancillary provider 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.

Horizon BCBSNJ reserves the right to audit a participating physician or ancillary provider 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.

Inpatient Care Services
To maximize their benefits, members should use network facilities (e.g., residential treatment centers or skilled nursing facilities). Inpatient care will be provided in semi-private accommodations.

When medically necessary, members can be referred to a nonparticipating facility if their need for medical treatment cannot be accommodated through our ancillary provider network. Such referrals must be made to fully licensed, accredited facilities and must be authorized by Horizon BCBSNJ if treatment is to be covered for plans with no out-of-network benefits, or covered at an in-network level for plans that do have out-of-network benefits.

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. For a list of other services that generally require authorization, please see page 122.

In emergency situations, you must notify us at 1-800-664-BLUE (2583).

Referring to Nonparticipating Physicians and Ancillary Providers
On rare occasions, you may need to refer a patient to a nonparticipating physician or ancillary provider. Doing so requires authorization for Horizon HMO members and Horizon POS members, if benefits are to be accessed on an in-network basis. Please keep in mind that these requests are handled on an individual basis and require medical review.

Access our Provider Directory on our website, HorizonBlue.com, for information about the participation status of specific physicians or ancillary providers.

For information about our Out-of-Network Consent Policy, please see page 62.

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.

Copayment Collection
Ancillary providers may only collect applicable office visit copayments at the time of service, according to the Agreement(s) signed with Horizon BCBSNJ.

Copayments, coinsurance or deductibles may be collected in advance, but not as a condition for the provision of services by the provider.

However, in certain situations, the copayment listed on a Horizon BCBSNJ member ID card should not be collected at the time of service.

Patients Enrolled in Consumer-Directed Healthcare (CDH) High-deductible Plans
High-deductible health insurance plans offered in conjunction with a Health Savings Account (HSA) are required to apply all services, excluding preventive care services, toward the plan’s deductible. The high-deductible health insurance plans we offer to employer groups for use in conjunction with Health Reimbursement Arrangements (HRAs) follow this same plan design.

Copayments for members enrolled in CDH plans only apply after a patient’s deductible has been satisfied.

Please submit your claims and wait until you receive our Explanation of Payment (EOP) and CDH EOP (for
those members enrolled in HRA plans) before billing the member for any amount, including copayments.

**Copayments and Dual Eligible Patients**

Patients enrolled in any Horizon BCBSNJ plan who have secondary coverage through Horizon NJ Health (New Jersey Medicaid benefits) are not responsible, and should not be billed, for any copayment or coinsurance amounts under their primary coverage.

Ancillary providers agree not to bill or seek to collect any copayment or coinsurance from any such person, but to seek payment from Horizon NJ Health for any remaining balances.

**Patients Enrolled in Plans Without Copayments**

Some Horizon BCBSNJ plans, including Horizon Medicare Blue TotalCare (HMO SNP), do not include a member copayment. If the member ID card does not indicate a copayment, please do not collect any amount from the patient at the time of service.

**Copayments and Preventive Care Services**

As mandated by the ACA, most health insurance plans allow members to receive preventive care services without copayments or other cost sharing. This means that preventive services, including screenings, checkups and counseling, are covered with no out-of-pocket costs if the member sees an in-network ancillary provider and receives only preventive care services during the visit. Please do not collect preventive care copayments from your Horizon BCBSNJ patients.

However, based upon the services that are provided during the course of a scheduled preventive visit, it may be appropriate for you to collect a nonpreventive copayment from a Horizon BCBSNJ member. We encourage you, in such circumstances, to discuss with your patients the nonpreventive treatment/services that they received.

**Please note:** The ACA allows group health plans offering custom benefits (plans in force on or before March 23, 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.

For more information about preventive services, please visit HealthCare.gov.

**Professional Responsibility**

Ancillary providers 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 ancillary providers 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.

**Credentialing and Recredentialing Obligations**

You are required to comply with the standards of participation identified in the Horizon BCBSNJ’s Credentialing/Recredentialing Policy for Ancillary Providers.

We strongly encourage you to review this policy. To access this policy online, please log in to NaviNet.net, access Horizon BCBSNJ within the Plan Central dropdown menu and:

- Mouse over References and Resources and click Provider Reference Materials.
- Click Service.
- Click Horizon BCBSNJ Credentialing/Recredentialing Policy for Ancillary Providers.

Participating ancillary providers 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.

Ancillary providers 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.

Ancillary providers 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 health care professionals must be recredentialed every 36 months. Our recredentialing process begins approximately six months prior to the recredentialing date. Ancillary providers who fail to provide the necessary information in a timely manner are subject to termination of their Agreement(s).

Standards for participation may be reviewed online in our Horizon BCBSNJ Credentialing/Recredentialing Policy for Ancillary Providers.

• Six months prior to your recredentialing due date, Horizon BCBSNJ begins the recredentialing process. Horizon BCBSNJ will reach out to you by phone, fax and mail to request that you provide updated and/or missing information.

• If Horizon BCBSNJ 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 Horizon BCBSNJ does not receive a response from these 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.

Recredentialing Vehicle
You will be provided a copy of the Ancillary Recredentialing Application form in the Horizon BCBSNJ recredentialing notification package.

Hard copy recredentialing information and required source documents may be submitted to Horizon BCBSNJ by mail at:

Horizon BCBSNJ
Health Affairs, PP-12K
3 Penn Plaza East
Newark, NJ 07105

You may also submit information to Horizon BCBSNJ by fax at 1-973-274-4339.

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.

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 NaviNet.net.

• You may ask the member for a copy of his or her signed application or, for Medicare Advantage members, a copy of their confirmation of enrollment letter.

• Your patient may present a proof of coverage letter or virtual ID card, obtained by visiting HorizonBlue.com. Please treat the proof of coverage letters and virtual ID cards as you would any other Horizon BCBSNJ ID card.

If the member’s status is 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.
Asking a Member to Select Another Ancillary Provider
The patient/provider 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 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 ancillary provider.

If the member does not select a new ancillary provider, please follow up with a letter to the member personally signed by your facility or office.

Nonsolicitation of Our Customers
Horizon BCBSNJ provides information on our customers and health benefit plans (and administrative services arrangements) to enable ancillary providers 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 ancillary provider, 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.

Termination Letters
If you decide to terminate your Agreement(s), please send a request for termination notice to your Ancillary Contracting Specialist.

Effective Date of Termination
Your effective date of termination (unless another date is agreed upon by you and Horizon BCBSNJ) will be:

- 90 days following the receipt of your termination letter from Horizon BCBSNJ networks without cause.
- 60 days following receipt of your termination letter from Horizon BCBSNJ networks with cause.

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 Ancillary Contracting Specialist. We, in turn, notify those members who are receiving a course of treatment of your termination from the Horizon Managed Care Network or Horizon PPO Network prior to the effective date of your termination. Authorizations are established for any members who require continued care.

Our Request for Continuity of Practitioner Care for Medical Benefits form is available online and may be completed by a member or by your office on behalf of a member.

To access this form, visit HorizonBlue.com/Providers, and:

- Click Find a Form in the I Want To... section.
- Click Forms by Plan Type.
- Click Medical and click Request Form – Continuity of Practitioner Care for Medical Benefits.

Continued Provision of Care
In most instances, you must treat existing Horizon BCBSNJ patients for up to four months beyond your effective date of termination if they are in the midst of an ongoing course of treatment.

Members undergoing certain courses of treatment are granted longer periods of care as indicated below:

- Psychiatric treatment: Up to one year.
- Pregnancy, through postpartum evaluation: six weeks after delivery.
Policies, Procedures and General Guidelines

- Post-operative care: Up to six months.
- Oncological treatment: Up to one year.

You are required to accept our reimbursement 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 medical management requirements.

If you have questions, please contact your Ancillary Contracting Specialist.

Rescinding a Request to Terminate
If you decide to rescind a recently submitted termination request, please contact your Ancillary Contracting Specialist in writing before the effective date of termination.

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
3 Penn Plaza East, PP-09P
Newark, NJ 07105-2200

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
Urgent care is defined as a non-life-threatening condition that requires care by a physician or health care professional within 24 hours.

In situations requiring urgent care, members are instructed to contact their Primary Care Physician, who can then assess the situation and coordinate the appropriate medical treatment.

If you recommend urgent treatment at your facility or office and the member goes to a hospital ER instead, the resulting charges will be the member’s responsibility.

Collection of Member Liability: Deductible and Coinsurance
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 (deductible and/or coinsurance), as indicated on the Explanation of Payment (EOP) you receive.
You are required to accept our allowance for eligible services as payment in full.

To protect our members, Horizon BCBSNJ forbids participating ancillary providers 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 our members in advance of your billing practices for the collection of member liability and of any fees or interest that you charge when member liabilities are not paid in a timely manner.

**Confidentiality of Medical Records and Personal Information**

Ancillary providers 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.

**Medical Records Requests by Patients**

We reprint, on the following pages, an excerpt of the actual regulation of the State of New Jersey 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**

(13:35-6.5) 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.

3. 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)3i 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, 1993. 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 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.

3. 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 per page or $100 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to $10 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
   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 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: The Medical Record fee does not apply to Horizon BCBSNJ’s request for medical records.

Clinical Practice Guidelines

Horizon BCBSNJ’s clinical practice guidelines (CPGs) are available to all participating ancillary providers.

These guidelines were adopted from nationally known organizations such as the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, the American Psychiatric Association, the Agency for Health Care Policy and Research, the American Society of Addictive Medicine and the American Diabetes Association. They also include Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications.

Horizon BCBSNJ’s CPGs

Registered users of NaviNet can view, print or download our CPGs. To view this information online:

- Log in to NaviNet.net.
- Select Horizon BCBSNJ within the Plan Central dropdown menu.
- Mouse over References and Resources click Provider Reference Materials.
- Under Additional Information, click Clinical Practice Guidelines.

Copies of our CPGs can also be mailed to you. Email your request to: QualityManagement_Coordinator@HorizonBlue.com.

Behavioral health CPGs can be found in the ValueOptions Resource Manual at ValueOptions.com/Horizon. If you have questions, please call 1-800-626-2212.

Please note: The Horizon BCBSNJ CPGs do not constitute medical advice, authorization, certification, approval, explanation of benefits, offer of coverage, contract or guarantee of reimbursement. The CPGs are confidential and proprietary. They are to be used only as authorized by Horizon BCBSNJ and its affiliates. The contents of these CPGs are not to be copied, reproduced or circulated to other parties without the express written consent of Horizon BCBSNJ. The contents of these CPGs may be updated or changed without notice. However, benefit determinations are made in the context of CPGs existing at the time of the decision, and are not subject to later revision as the result of a change in guidelines.
Never Events Guidelines

The term “never events” is used to reference adverse events or errors in medical care that are clearly identifiable, preventable and present serious consequences to patients. Never events include hospital-acquired conditions and wrong surgeries.

Horizon BCBSNJ follows the Centers for Medicare & Medicaid Services’ (CMS) reimbursement policy for never events, including certain conditions identified by the state of New Jersey. Horizon BCBSNJ will not reimburse hospitals for any services related to wrong surgeries and may reduce reimbursements to hospitals for services to treat hospital-acquired conditions that were not present on admission. Members must be held harmless for any reimbursement for services related to never events, including hospital-acquired conditions and wrong surgeries. Horizon BCBSNJ will conduct a clinical quality review of all claims with the identified never events and hospital-acquired conditions listed below. Any claim issues identified during our review will be presented to the hospital for further review, as appropriate. Hospital medical records may be requested to facilitate the review. Hospitals should include a Present on Admission (POA) indicator on all claims.

Never Events Subject to Review

Hospital-Acquired Conditions (HACs)
- Pressure ulcers, stages III and IV.
- Catheter-associated urinary tract infections.
- Vascular catheter-associated infection.
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG).
- Air embolism.
- Blood incompatibility.
- Foreign object retained after surgery.
- Falls and trauma (fracture, dislocation, intracranial injury, crashing injury, burn, electric shock).
- Surgical-site infections following certain orthopedic procedures.
- Surgical-site infections following bariatric surgery for obesity.
- Manifestations of poor glycemic control.
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

Wrong Surgeries:
- Surgery performed on a wrong body part.
- Surgery performed on a wrong patient.
- Wrong surgical procedure performed.

Please note: HACs were included on CMS’ list of never events as of October 1, 2008. Wrong surgeries were adopted by CMS on January 15, 2009.
This section provides an overview of many of the products we offer and/or service.

Additional product information is available online:

- Log in to NaviNet.net and select Horizon BCBSNJ within the Plan Central dropdown menu.
- Mouse over References and Resources and click Provider Reference Materials.
- Click Products.

**Your Responsibilities**
The following responsibilities apply to you as a participating ancillary provider:

- 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 (deductible and/or coinsurance), as indicated on the Explanation of Payment (EOP) you receive.
- You are required to accept our allowance for eligible services as payment in full.

**Pre-existing Exclusions**
The Affordable Care Act (ACA) removed the pre-existing medical condition exclusion for both new employer-based health insurance plans and new individual health insurance plans. Health insurance companies cannot charge higher premiums for current and past health problems, gender and a person’s occupation. Also, insurers cannot refuse to sell coverage or renew coverage because of a pre-existing medical condition and cannot deny claim payments because of a pre-existing medical condition. The removal of the pre-existing condition exclusion has been in place since 2010 for children under age 19 years.

The ACA does not require health insurers to remove the pre-existing condition exclusion from Medicare, Medigap and Medicaid plans.

The effective date of the removal of the pre-existing condition exclusion will vary:

- Individual and 51+ custom plans (includes Midsize 100 to 499 employees, Large, Labor, Jumbo and National groups): Pre-existing condition exclusion removal will be based on plan or policy year on and after January 1, 2014.
- Small employer groups (two to 50 employees), Midsize 51 to 99 standard employer groups and Public Sector groups: Horizon BCBSNJ intends to remove pre-existing condition exclusions on a turnkey basis on January 1, 2014.

The State Health Benefits Program and Federal Employee Program do not have pre-existing condition restrictions.

**Horizon Managed Care Network**
If you are a participating Horizon Managed Care Network ancillary provider, members enrolled in the following plans use their in-network benefits when they receive care from you.

**HMO**
- Horizon HMO
- Horizon HMO Access
- Horizon HMO Access Value
- Horizon HMO Coinsurance
- Horizon HMO Coinsurance Plus
- Horizon HMO (SHBP)
- Horizon HMO1525 (SHBP)
- Horizon HMO2030 (SHBP)

**Direct Access**
- Horizon Direct Access
- Horizon Advantage Direct Access
- Horizon Direct Access Value
- NJ DIRECT10 (SHBP)
- NJ DIRECT15 (SHBP)
- NJ DIRECT1525 (SHBP)
- NJ DIRECT2030 (SHBP)
- NJ Protect

**EPO**
- Horizon Advance EPO
- Horizon Advantage EPO
- Horizon Basic & Essential EPO
- Horizon Basic & Essential EPO Plus
- Horizon Patient-Centered Advantage EPO

*Members enrolled in these plans do not have out-of-network benefits, except in the event of an emergency.*
Products

- Horizon Patient-Centered Advantage EPO Silver
- Horizon Patient-Centered Advantage EPO Bronze

**Consumer-Directed Healthcare (CDH)**
- Horizon EPO HSA/HRA
- Horizon HMO Access HSA *MyWay*
- Horizon *MyWay* HSA (Direct Access)
- NJ DIRECT HD1500 (SHBP)
- NJ DIRECT HD4000 (SHBP)

**Medicare Advantage**
- Horizon Medicare Blue Value (HMO)*
- Horizon Medicare Blue Value w/Rx (HMO)*
- Horizon Medicare Blue Access Group (HMO-POS)
- Horizon Medicare Blue Access Group w/Rx (HMO-POS)
- Horizon Medicare Blue Choice w/Rx* (HMO)
- Horizon Medicare Blue (PPO)
- Horizon Medicare Blue Group (PPO)
- Horizon Medicare Blue Group w/Rx (PPO)
- Horizon Medicare Blue TotalCare (HMO SNP)*

**POS**
- Horizon POS

* Members enrolled in these plans do not have out-of-network benefits, except in the event of an emergency.

**Horizon HMO**
Horizon HMO members select a PCP who will either provide the necessary care or refer them to the appropriate specialist or facility. Members receive full benefit coverage, including coverage for preventive care, when services are provided or referred by their PCP.

**Copayments**
Horizon HMO offers various office visit copayments. Please carefully check the member’s ID card for the copayment amount due for an office visit.

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

**Well Care**
Well care, such as routine adult physicals and well child care, are 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 HMO members may go directly to participating Ob/Gyns for obstetrical and gynecological-related care. They do not require a referral from their PCP for these services. However, certain infertility services require prior authorization.

Most members do not need a referral from their PCP or Ob/Gyn for routine mammography services (CPT Codes 76090, 76091 and 76092). Please give these members a prescription to present to the radiology center.

**Annual Vision Exam**
If included in their contract, members are eligible for one routine vision exam per year by a participating physician or other health care professional. This service does not require a referral from the PCP. Members are also eligible for a vision hardware reimbursement every two years.

Most members who have diabetes may go directly to a participating eye care physician for a dilated retinal exam without a referral from their PCP. Advise the member to check their Horizon HMO member handbook or Evidence of Coverage for specific details.

**Chiropractic Coverage**
Most Horizon HMO members may go directly to participating chiropractors. This means they may not require a referral from their PCP to visit a participating chiropractor (subject to plan limitations).

**Behavioral Health/Substance Abuse Care**
Physicians may contact Horizon Behavioral Health to refer most patients for behavioral health or substance abuse care.

**Horizon HMO Access and Horizon HMO Access Value**
Under Horizon HMO Access plans, members may receive care from 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 preselected PCP.
### Products

#### 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 and other professional health care services.

#### Coinsurance
Some Horizon HMO Access members are required to pay a coinsurance payment for most services not performed in an office setting, including Durable Medical Equipment.

#### 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 referrals, they are not needed. Coverage limitations exist and vary per contract.

#### Horizon HMO Access Value
The Horizon HMO Access and the Horizon HMO Access Value plans are identical except that Horizon HMO Access Value includes:

- A higher specialist copayment amount.
- A lower maximum out-of-pocket amount.
- A higher hospital inpatient copayment amount.

#### Horizon HMO Coinsurance and Horizon HMO Coinsurance Plus
The Horizon HMO Coinsurance and Horizon HMO Coinsurance Plus plans are managed care products. They require PCP selection, use of the Horizon Managed Care Network and referrals/precertification to receive benefits. Out-of-network services are not covered under these plans.

These plans offer 100 percent coverage after office visit copayment for all services received in a network practitioner’s office. For all other network services, coverage is subject to deductible and coinsurance. The deductible applies to all services rendered outside of the physician’s office except for:

- Diagnostic lab work and X-ray.
- Emergency Room care.
- Prescription drugs.

#### Horizon HMO (SHBP)
- Horizon HMO1525 (SHBP)
- Horizon HMO2030 (SHBP)

Horizon BCBSNJ offers members of the State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP) access to the four following HMO options:

- Horizon HMO10.
- Horizon HMO15.
- Horizon HMO1525.
- Horizon HMO2030.

These plans provide safe and effective care through physicians, health care professionals and facilities that participate in the Horizon Managed Care Network. Horizon HMO members must select a Primary Care Physician (PCP) and referrals are required.

The numbers in the health plan names reflect the physician office visit copayment levels:

- Horizon HMO10 and Horizon HMO15 feature a $10 and $15 physician (PCP and specialist) office visit copayment, respectively.
- Horizon HMO1525 and Horizon HMO2030 plan options feature split copayment levels. The lower copayment level in each of these plans ($15 and $20) applies to office visits to PCPs. The higher copayment level in each of these plans ($25 and $30) applies to office visits to specialist office visits.
These plans also offer:

- 100% coverage for preventive services (physical exams, well-child care, immunizations) in network. All SHBP and SEHP plans offer preventive care services, as defined by the Patient Protection and Affordable Care Act (PPACA) with no member cost share (no copayment, not subject to deductible) when provided by a participating practitioner.
- Access to specialty care with a referral from your PCP. (Referrals are not required for chiropractic care).
- Guest Membership in our “Away from Home” care program if you or a covered family member will be traveling or out of the area for a longer period.

**Horizon Direct Access**

Our Horizon Direct Access products allow 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 required. PCPs are encouraged to refer members to participating physicians and ancillary providers.

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, comprehensive network of participating physicians, facilities 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 62.

**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 referrals, they are not needed. Coverage limitations exist and vary per benefit plan.
**Chiropractic Coverage**
Horizon Direct Access members are eligible for chiropractic care from a participating chiropractor. Referrals are not needed. Coverage limitations exist and vary per benefit plan.

**Horizon Advantage Direct Access**
Horizon Advantage Direct Access plan are similar to Horizon Direct Access plans but include:

- Split copayments: Lower office visit copayments for PCP visits and higher office visit copayments for all other physicians. Members are not required to select a PCP; however, the lower copayment for PCP services is only available for a PCP-type doctor (a participating physician specializing in family practice, general practice, internal medicine or pediatrics).

- Separate (and higher) out-of-network deductible amounts and maximum out-of-pocket (MOOP) levels to help discourage out-of-network utilization. The deductible and MOOP do not cross accumulate between the in-network and out-of-network benefits.

- These plans also include a $2,000 benefit maximum for out-of-network ambulatory surgery centers.

**NJ DIRECT**
NJ DIRECT administers six direct access plans on behalf of the New Jersey State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP).

All NJ DIRECT plans:

- Do not require PCP selection or referrals.

- Allow members to receive care in or out of network.

- Require prior authorization for certain services (refer to the online prior authorization list).

- Use the Horizon Managed Care Network in New Jersey and the national BlueCard PPO network outside of New Jersey.

- Cover eligible preventive care services, as outlined in the federal health care reform law, the Patient Protection and Affordable Care Act (PPACA), with no member cost share when rendered in network.

**NJ DIRECT copayment plans**
SHBP/SEHBP members may select one of four copayment plans:

- **NJ DIRECT10**
- **NJ DIRECT15**
- **NJ DIRECT1525**
- **NJ DIRECT2030**

For these plans, NJ DIRECT will pay the full cost of in-network services (based on contracted rate), in most cases, after appropriate member copayment per visit. Services rendered out of network are subject to deductible and a percentage of coinsurance based on plan allowance.

- The number in the plan name (10, or 15, 1525, 2030) refers to the primary and specialty provider office visit copayment.

- **NJ DIRECT10** and **NJ DIRECT15** have primary and specialty office visit copayments of $10 or $15.

- **NJ DIRECT1525** has a primary office visit copayment of $15; specialty office visit copayment is $25.

- **NJ DIRECT2030** has a primary office visit copayment of $20; specialty office visit copayment is $30 for adults, $20 for children. A child is defined as eligible until the end of the year in which age 26 is reached. Once the 26th year is completed, the member is considered an adult (including disabled dependents who have extended coverage).

- Primary office visit copayments apply to primary care physicians (internists, general practitioners, family practitioners, pediatricians, PAs, APRNs.)

- Specialty office visit copayments apply to in-network specialist visits including non-routine Ob/Gyn services, short-term therapist visits (occupational therapy, speech therapy, physical therapy, respiratory therapy, and cognitive therapy) and chiropractic visits.

- The Emergency Room copayment (waived if admitted) varies by plan.

- The appropriate copayment amounts are indicated on the member's ID card.

- Nonbiologically based mental illness behavioral health services (in-network) are subject to coinsurance.
High-Deductible (HD) Health Plans

SHBP/SEHBP members may select one of two high-deductible plans.

- NJ DIRECT HD1500
- NJ DIRECT HD4000

In the High-Deductible Health Plans, all eligible services (except for eligible preventive services) are subject to deductible, coinsurance and out-of-pocket maximums before services will be considered for benefit. No copayments apply. The plan is combined with a Health Savings Account (HSA) that can be used to pay for qualified medical expenses.

- The number in the plan’s name (1500, 4000) refers to the individual deductible, which is doubled for non-single contracts, and is combined for in- and out-of-network medical services and prescription drugs.
- Members are responsible for expenses, in and out of network, up to the deductible.
- After the annual deductible is met, the member is responsible for 80 percent of the contracted rate in network and 60 percent of the plan allowance out of network.
- If eligible expenses reach the out-of-pocket maximum, eligible services will be covered at 100 percent, subject to all provisions of the plan.

For more information about NJ DIRECT, please visit HorizonBlue.com/SHBP and click Plan Information.

SHBP/SEHBP: Multiple coverages prohibited

A New Jersey state law enacted in 2010 prohibits multiple coverage under the State Health Benefits Program (SHBP) and/or the School Employees’ Health Benefits Program (SEHBP).

This means:

- If eligible expenses reach the out-of-pocket maximum, eligible services will be covered at 100 percent, subject to all provisions of the plan.
- An employee or retiree cannot be enrolled for coverage as both a subscriber and a dependent under the SHBP and/or SEHBP.
- An employee cannot be enrolled for coverage as an employee and as a retiree under the SHBP/SEHBP.
- Children cannot be enrolled as dependents for coverage under both SHBP/SEHBP covered parents.
- NJ DIRECT members who have coverage under a non-SHBP/SEHBP plan can maintain enrollment in NJ DIRECT and the non-SHBP/SEHBP plan.

NJ Protect

In partnership with the state of New Jersey, Horizon BCBSNJ offers two plans to address the needs of uninsured New Jersey residents who have pre-existing medical conditions – NJ Protect 100/70 and NJ Protect 80/70.

With our NJ Protect plans, members have comprehensive health care benefits and the freedom to choose physicians and other health care professionals from our Horizon Managed Care Network and hospitals and facilities from our Horizon Hospital Network, or physicians and hospitals outside the network.

Benefits are paid at the highest level when members receive care in network. Though we encourage members to select a Primary Care Physician (PCP) upon enrollment in a NJ Protect plan, it is not required.

Members must meet the following requirements to be eligible. Members:

- Must be a United States citizen or a national or lawfully present in the United States.
- Must be a New Jersey resident.
- Must have been uninsured for at least six consecutive months.
- Must have a pre-existing medical condition or have been denied health coverage because of a health condition.
- Are not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan or Medicare Part A or B.
Horizon Advance EPO
Horizon Blue Cross Blue Shield of New Jersey developed a new insurance product called Horizon Advance EPO. This product will be primarily offered to the most price-sensitive health insurance consumers purchasing coverage on and off the Health Insurance Marketplace (Exchange).

Horizon Advance EPO coverage is effective beginning January 1, 2014. Horizon Advance EPO coverage will be made available to consumers for review and purchase during the open enrollment period beginning in October 2013.

Primary Care Physician (PCP) Selection
Members will be required to select a PCP participating in the Horizon Advance EPO product. Members will not receive benefits for services rendered by practitioners who have not been identified as part of Horizon Advance EPO.

Horizon Advance EPO does not include out-of-network benefits. In addition, members enrolled in Horizon Advance EPO have no access to the BlueCard® network for out-of-area care. Therefore, should a nonparticipating practice submit a claim for a member in the Horizon Advance EPO product, no reimbursement will be provided from Horizon BCBSNJ.

Cost Sharing
Horizon Advance EPO offers various office visit copayments, deductibles and coinsurance amounts based on the place of service and type of plan. Members should present their Horizon BCBSNJ ID card. Carefully check the member’s ID card for the copayment due for an office visit.

Laboratory Services
Members are required to use an in-network provider (LabCorp).

No Out-of-Network Benefits
Members enrolled in the Horizon Advance EPO product will not have benefits for out-of-network services. Currently, all managed care, ancillary providers are considered in network for this product. Members must use physicians and other health care professionals who participate in Horizon Advance EPO products, except in cases of medical emergencies.

Pharmacy/Prescription Benefits
Each product includes a pharmacy benefit. Prescription medication benefits are included in both Horizon Advance EPO plans being offered on and off the Health Insurance Marketplace (Exchange). Members must use a participating pharmacy. Cost sharing varies based on plan.

Preferred Tier 1 Hospitals
Members will be encouraged to access Preferred Tier 1 hospitals to maximize their benefits. Members using Preferred Tier 1 hospitals will have lower cost sharing than those who receive services at other network hospitals.

Preventive Care
Preventive care for members is covered at 100 percent with no out-of-pocket cost, when provided by their selected PCP.

Prior Authorizations
Prior authorizations are required for certain services.

Referrals
Referrals are required. PCPs must refer to specialists who participate with Horizon Advance EPO product in order for their patients to receive coverage. The online Provider Directory will be regularly updated with information on included specialists and we encourage referring physicians to use that resource to identify cost-effective referrals for their patients. In addition, comprehensive information on Preferred Tier 1 hospitals will also be available. Referrals to Preferred Tier 1 hospitals will help patients obtain the most cost-effective options for care.

Vision
Limited vision coverage is included for children.
Horizon Advantage EPO
Horizon Advantage Exclusive Provider Organization (EPO) plans provide in-network only benefits through the Horizon Managed Care Network.

PCP Selection
Members enrolled in Horizon Advantage EPO plans are NOT required to select a Primary Care Physician.

Referrals
Referrals are NOT required for members to see specialists who participate in the Horizon Managed Care Network.

No Out-of-Network Benefits
Members enrolled in Horizon Advantage EPO plans have NO benefits for out-of-network services. Members enrolled in Horizon Advantage EPO plans must use physicians who participate in our Horizon Managed Care Network (except in the case of medical emergencies).

BlueCard Program Access
Certain employer groups may choose to provide their members with access to the BlueCard® PPO program.

If a member’s Horizon Advantage EPO ID card includes the: PPO-in-the-suitcase logo or the empty-suitcase logo, they have access to the BlueCard® PPO program for services provided outside our local service area. The PPO-in-the-suitcase logo identifies a member who has benefits for medical services received outside Horizon BCBSNJ’s service area. It does not mean that these members can see a participating Horizon PPO Network physician or other health care professional.

The Horizon Advantage EPO plans must use physicians who participate in our Horizon Managed Care Network (except in the case of medical emergencies).

Horizon Patient-Centered Advantage EPO
Three Horizon Patient-Centered Advantage EPO plans are offered to employer groups and provide in-network only benefits through the Horizon Managed Care Network. These plans build upon our patient-centered programs, which include our Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO) programs (see page 33).

Horizon Patient-Centered Advantage EPO
Horizon Patient-Centered Advantage EPO Silver
Horizon Patient-Centered Advantage EPO Bronze

Our Horizon Patient-Centered Advantage EPO plans are similar to our other Horizon Advantage EPO plans, except these plans use different member cost-sharing levels to encourage enrolled members to select and use a Primary Care Physician (PCP) affiliated with one of our established PCMH and/or ACO practices. Horizon Patient-Centered Advantage EPO members incur a lower out-of-pocket expense when they select and use a PCP who participates in one of our patient-centered programs. No PCP selection is required. However, members pay less out of pocket when they select and use a PCP who participates in our patient-centered programs.

Referrals are not required for members to see specialists who participate in the Horizon Managed Care Network. Preventive services, screenings and immunizations are covered with no member cost sharing when services are received from an in-network provider. Except in the case of medical emergencies, members have no benefits for out-of-network services. Referrals are not required to see specialists. Members must use LabCorp for laboratory services.

Member cost sharing for primary care and specialist visits vary for each plan. Please confirm specific benefits for members enrolled in each Horizon Patient-Centered Advantage EPO plan.
Horizon Basic and Essential EPO and Horizon Basic and Essential EPO Plus

The Basic and Essential EPO plans provide limited benefits on an in-network only basis and were designed to keep premiums affordable. They do not offer comprehensive coverage and there are no out-of-network benefits, except in a medical emergency situation.

To access benefits, eligible members must use participating physicians, other health care professionals and facilities in the Horizon Managed Care Network except in the case of medical emergencies. There are no out-of-network benefits.

Horizon BCBSNJ is no longer selling or renewing these products to our members. However, members may still have coverage for these products until the end of 2014.

Consumer-Directed Healthcare (CDH) Plans

Horizon BCBSNJ offers innovative Consumer-Directed Healthcare (CDH) products that 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.

Key Features of CDH Plans

Copayments – Physicians, ancillary providers 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 required for specialists – This reduces the administrative process for you and members.

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

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

Horizon MyWay – Direct Access Plan Design

The Horizon MyWay Direct Access product combines a high-deductible Horizon Direct Access plan with a spending/savings account. This health plan offers in- and out-of-network benefits and covers preventive care at 100 percent in network. Members maximize benefits by using participating managed care physicians, other health care professionals and participating facilities.

You can identify Horizon MyWay HRA/HSA Direct Access members by the following ID card prefixes:

- JGB
- JGE
- JGH

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.

You can identify Horizon MyWay HRA/HSA PPO members by the following ID card prefixes:

- JGA
- JGD
- JGG
Horizon MyWay – HMO Access Plan Design
The Horizon MyWay HMO Access product combines a high-deductible Horizon HMO Access plan with a spending/savings account. This health plan offers in-network benefits only and covers preventive care at 100 percent. Members must use participating managed care physicians, other health care professionals and contracting facilities.

See page 75 for more information about HMO Access plans.

You can identify Horizon MyWay HSA HMO Access members by the following ID card prefix:

- YHH

SHBP/SEHBP High-Deductible Plans
The New Jersey State Health Benefits Program (SHBP) and the School Employees’ Health Benefits Program (SEHBP) committees offer enrolled members access to two high-deductible plans designs: NJ DIRECT HD1500 and NJ DIRECT HD4000. These plans offer in- and out-of-network benefits and include $0 copayments for preventive care services. Members maximize benefits by using participating managed care physicians, other health care professionals and participating facilities.

See page 76 for more information about these plans.

You can identify NJ DIRECT HD1500 and NJ DIRECT HD4000 members by the following ID card prefix:

- NJX

Horizon Advantage EPO HSA/HRA*
The Horizon Advantage EPO HSA/HRA plans combine our Exclusive Provider Organization plan with either a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). These plans provide in-network only benefits through the Horizon Managed Care Network. Members enrolled in Horizon Advantage EPO plans are NOT required to select a Primary Care Physician and referrals are not required for members to see specialists who participate in the Horizon Managed Care Network.

See page 80 for more information about these EPO plans.

You can identify Horizon Advantage EPO HSA/HRA members by the following ID card prefixes:

- JGR.
- JGS.
- JGT.

* Horizon Advantage EPO HSA/HRA plans are effective January 1, 2013.
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 visit 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, you should bill us first. We will provide you with an Explanation of Payment (EOP) advising you of our reimbursement 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. For information on when to call for authorization, please see page 122.

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 radiology center.

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. 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. You can identify these members by the YHG alpha prefix on their ID card. These groups cover annual eye exams (with a referral) 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, 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 carrier’s 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 the benefit plan, a request for prior authorization and/or claim reimbursement is automatically subject to a screening process based upon the member’s qualifying pre-existing time period and the specific clinical situation.

Pre-existing conditions do not apply to individuals age 19 and under. 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.

**Horizon PPO Network**
If you are a participating Horizon PPO Network health care professional, members enrolled in the following plans use their in-network benefits when they receive care from you.

**PPO**
- BCBS Service Benefit Plan (FEP PPO)
- BlueCard PPO
- Horizon Advantage PPO
- Horizon High Deductible PPO Plan D
- Horizon PPO

**Indemnity**
- Basic Blue™ Plan A
- BlueCare®
- Comprehensive Health Plan
- Comprehensive Major Medical
- Horizon Basic Health Plan A
- Horizon Basic Plan A/50
- Horizon Comprehensive Health Plan A
- Horizon High Deductible Plan C
- Horizon High Deductible Plan D
- Horizon MSA Plan C
- Horizon MSA Plan D
- Horizon Traditional Plan B, C, D
- Major Medical
- Medallion
- Network Comprehensive Major Medical
- Wraparound

**Fixed Fee**
- Medical/Surgical Fixed Fee 14/20 Series
- Medical/Surgical Fixed Fee 500 Series
- Medical/Surgical Fixed Fee 750 Series
- Student Program

**Consumer-Directed Healthcare (CDH)**
- Horizon MyWay HRA
- Horizon MyWay HSA

**Horizon PPO**
Horizon PPO plans provide members a choice of physicians and hospitals without having to select 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 provide access to 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.

**Federal Employee Program**
The Federal Employee Program (FEP) is a fee-for-service plan (with standard and basic options) with a preferred provider organization that is sponsored and administered by the Blue Cross and Blue Shield Association and participating Blue Cross and/or Blue Shield Plans.

FEP is a traditional type plan that encourages members to use Preferred or in-network physicians, other health care professionals and facilities to receive the highest level of benefits.

FEP members may be identified by their unique ID card (see page 38). Member ID numbers include an R prefix and 8 digits.

Plan highlights include:
- PPO reimbursement levels.
- Referrals are not required.
- Some services may require prior authorization.

**Standard Option**
Members have the freedom to receive covered services from both Preferred and non-Preferred health care professionals, hospitals and facilities.
Members who have the Standard Option have a calendar year deductible, and services are subject to a copayment or coinsurance. The annual deductible is $350 per person/$700 per family. Routine care provided by a Preferred health care professional is covered in full. Office visits for:

- **Primary Care Physician (PCP)/other health care professional Preferred:** $20 copayment. Specialist Preferred: $30 copayment,
- **Specialist non-Preferred:** Subject to deductible and 35 percent of plan allowance plus difference between plan allowance and billed charge.
- **Lab, X-ray and other diagnostic tests Preferred:** Subject to deductible and 15 percent coinsurance. Non-Preferred: Subject to deductible and 35 percent of plan allowance plus difference between plan allowance and billed charge.
- **Preventive Care adult and children Preferred:** No member liability. Non-Preferred: Subject to deductible and 35 percent coinsurance plus any difference between the allowance and the billed charge.
- **Maternity professional care Preferred:** No member liability. Non-Preferred: Subject to deductible and 35 percent coinsurance plus any difference between the allowance and the billed charge.
- **Physical, occupational, speech therapies:** 75-visit limit for any one or a combination of all three.
- **Preferred PCP/other health care professional:** $20 copayment per visit. Non-Preferred: Subject to deductible and 35 percent of plan allowance plus any difference between plan allowance and billed charge.
- **Surgery Preferred:** Subject to deductible then 15 percent of Plan allowance. Non-Preferred: Subject to deductible and 35 percent of plan allowance plus any difference between plan allowance and billed charge.
- **Inpatient hospital Preferred:** $250 per admission copayment, unlimited days. Non-Preferred: $350 per admission copayment, 35 percent of allowance and any difference between allowance and charge.
- **Outpatient hospital (medical/surgery) Preferred:** Subject to deductible and 15 percent coinsurance. Non-Preferred: Subject to deductible and 35 percent of plan allowance plus any difference between allowance and charge.

**Basic Option**

Member’s benefits are limited to care performed by Preferred health care professionals, hospitals and facilities, except in certain situations, such as emergency care.

With the Basic Option, members do not have a calendar year deductible; however, most care under the Basic Option is subject to a copayment amount. Routine care provided by a Preferred health care professional is covered in full. Office visits for:

- **PCP/other health care professional office visit:** $25 copayment.
- **Specialist office visit:** $35 copayment.
- **Blood tests, EKG, Lab tests, pathology services Preferred:** $0.
- **EEG/Ultrasound/X-rays Preferred:** $25 copayment.
- **Bone density, CT scans, MRI/Pet scans Preferred:** $75 copayment.
- **Preventive care adult and children Preferred:** $0.
- **Maternity professional care Preferred:** No member liability, inpatient $150 copayment.
- **Physical, occupational, speech therapies:** 50 visit limit any one or combination of all three.
- **Preferred Primary Care Physician or other health care professional:** $25 copayment per visit and for a specialist $35 copayment.
- **Surgery Preferred:** $150 per performing surgeon.
- **Inpatient hospital Preferred:** $150 per day copayment, up to $750 per admission for unlimited days.
- **Outpatient hospital (medical/surgery) Preferred:** $75 copayment.

For more information about FEP plans, please call 1-800-624-5078 or visit www.fepblue.org.
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 BlueSM Plan A.
- BlueCare®.
- Comprehensive Health Plan (CHP).
- Comprehensive Major Medical (CMM).
- Horizon Basic Health Plan A/50.
- Network Comprehensive Major Medical.

Horizon Comprehensive Health Plan A

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

Brief benefit description:

- Deductible $250.
- Coinsurance Inpatient services 80%; other care 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%, 70/30%, 60/40%.
- Office Visits/Medical Care Covered after deductible.
- Well Child Care/Adult Physicals $300 annually per covered person (except newborns). $500 maximum for newborns up to age 1 year. Not subject to deductible or coinsurance.
- Lab and X-ray Covered after deductible.
- Maternity Related 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 serve 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, $300/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 serve 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 serve 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%, 70/30%.
- 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%, 70/30%.
- Office Visits/Medical Care: Covered after deductible.
- Well Child Care/Adult Physicals: Call Physician Services for patient benefits if no indication appears on their 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
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., the Federal Employee Program [FEP®]). 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.

Income limits for 14/20 Series
- Single, unmarried: $14,000
- Single, married: $20,000
- Parent and child: $20,000
- Husband and wife: $20,000
- Family: $20,000
- Student: N/A

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 serve 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. Maternity-related services are not covered.

Brief benefit description:
- Deductible: None.
- Coinsurance: None.
- Office Visits/Medical Care: One consultation per hospital admission. Medical care covered in hospital only. Office visits are only covered if the patient also has Major Medical.
- Well Child Care/Adult Physical: Not covered.
Products

- Lab and X-ray Covered with annual dollar benefit maximums.

Custom Plans: Major Accounts

Certain nationally located or large New Jersey-based accounts design custom 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.

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 phone numbers of dedicated service teams.

Major accounts have unique benefits. For patient-specific information, please call Physician Services at 1-800-624-1110, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

National Account Open Access Plan

A growing number of national account groups are providing open access plan coverage to their employees residing in New Jersey. Members enrolled in these national account open access plans use their in-network level of benefits when they use physicians, other health care professionals and facilities that participate in the Horizon Managed Care Network.

Special features of these national account group plans include:

- The option to select a Primary Care Physician (PCP).
- No referrals.
- Fee-for-service reimbursement for eligible services at the Horizon Managed Care Network allowance.

In-Network Benefit Level

To maximize their benefits, members in these open access plans must use physicians, other health care professionals or facilities that participate in the Horizon Managed Care Network.

Out-of-Network Benefit Level

Out-of-network benefits apply to members who use other physicians, health care professionals or facilities, including physicians or health care professionals who participate only in our Horizon PPO Network.

BlueCard Coverage

The member ID cards for these open access plans include the PPO-in-a-suitcase logo. This logo indicates that these BlueCard members have access to in-network coverage when traveling outside New Jersey.

Prefixes

Below is a list of prefixes to help you identify members enrolled in these national account open access plans. The list is current as of printing.

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANK</td>
<td>Assisted Living</td>
</tr>
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<td>KTM</td>
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<td>SBU or SNA</td>
<td>Silgan Containers Manufacturing Corp.</td>
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Products

TPP  NYC Transit MTA
UGK  Central Garden & Pet
ULP  Pepsico – Tropicana
UQU  Pepsico – Quaker Oats

If you submit paper claims, please mail paper claims for these members to:

Horizon BCBSNJ BlueCard Claims
PO Box 1301
Neptune, NJ 07754-1301

If you have questions, please call our Dedicated BlueCard Unit at 1-888-435-4383.

Medicare Plans
These plans provide safe and effective care through physicians, ancillary providers and facilities that participate in the Horizon Managed Care Network (for Medicare Advantage plans) or that participate with Medicare (Medicare Supplemental plans).

Horizon Medicare Advantage Products
We are an approved Medicare Advantage (MA) Organization and offer several Medicare Advantage products to Medicare beneficiaries in place of Medicare Parts A and B:

- Horizon Medicare Blue Value (HMO).
- Horizon Medicare Blue Value w/Rx (HMO).
- Horizon Medicare Blue Choice w/Rx (HMO).
- Horizon Medicare Blue Access Group (HMO-POS)
- Horizon Medicare Blue Access Group w/Rx (HMO-POS).
- Horizon Medicare Blue TotalCare (HMO SNP).
- Horizon Medicare Blue (PPO).
- Horizon Medicare Blue Group (PPO).
- Horizon Medicare Blue Group w/Rx (PPO).

Members enrolled in these products use our extensive Horizon Managed Care Network and must go to providers who accept Medicare assignment. These products 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 convert Medicare Advantage to Medicare Advantage with Prescription Drug coverage:

- Horizon Medicare Blue Value w/Rx (HMO).
- Horizon Medicare Blue Choice w/Rx (HMO).

Horizon Medicare Blue Access Group (HMO-POS)
This point-of-service plan is a group offering giving members the option of selecting a PCP. 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 convert Medicare Advantage to Medicare Advantage with Prescription Drug coverage.

Horizon Medicare Blue TotalCare (HMO SNP)
This Special Needs Plan (SNP) is available to a subset of New Jersey residents who are eligible for both Medicare and Medicaid coverage. This $0 premium plan is designed to provide more focused and specialized health care to plan members. This plan provides benefits for all medically necessary and preventive care services covered under Medicare Part A, Medicare Part B and Medicaid. This plan also provides benefits for prescription drugs and medications eligible under Medicare Part B, Medicare Part D and Medicaid.

Horizon Medicare Blue (PPO), Horizon Medicare Blue Group (PPO) and Horizon Medicare Blue Group w/Rx (PPO)
We offer new Medicare Advantage plans to allow enrolled group and consumer members to obtain in-network benefits outside our local service area by leveraging a Blue Cross and Blue Shield Association (BCBSA) program that makes Blue Plans’ provider networks available to other Plans’ enrolled Medicare Advantage (MA) PPO members.

Similar to the BlueCard network arrangement, our MA PPO plans will allow members who travel to, or reside in
another service area, to obtain in-network care as long as they use a practitioner or facility that participates in another Blue Plan’s MA PPO network.

**MA PPO Group Members**

You will be able to identify Horizon Medicare Blue (PPO) members – as well as other Plans’ MA PPO members – by the MA-in-the-suitcase logo included on the member’s ID card.

Horizon Medicare Advantage (PPO) offers in-network and out-of-network benefits and covers all Medicare Part A and Part B benefits, and additional supplemental benefits.

No PCP selection or referrals are required for members enrolled in Horizon Medicare Advantage (PPO) plans.

Like all of our Medicare Advantage plans, Horizon Medicare Advantage (PPO) members use the Horizon Managed Care Network to access the in-network level of benefits in New Jersey.

Members enrolled in these MA PPO plans who see participating PPO network physicians or other health care professionals (who do not also participate in the Horizon Managed Care Network) will access their out-of-network benefits.

Enrolled employer group members who reside or travel in another service area may receive care at the in-network level of benefits as long as they use a practitioner or facility that participates in that other Blue Plan’s MA PPO network. The member may only go to providers enrolled in Medicare.

Enrolled employer group members who reside in a state where there is no Blue Plan MA PPO Network will receive the in-network level of benefits in accordance with the CMS Employer Group Waiver Plan policy. They may only go to providers enrolled in Medicare.

Group members may convert their Medicare Advantage coverage to Medicare Advantage with Prescription Drug (MAPD) coverage – Horizon Medicare Blue Group w/Rx (PPO).

**MA PPO Individual Members**

Enrolled members who travel in another service area may receive care at the in-network level of benefits as long as they use a practitioner or facility that participates in that other Blue Plan’s MA PPO network. Individual members must live in our filed service area. (Sussex County).

**Out-of-Area MA PPO Members**

In addition to seeing members enrolled in our Horizon Medicare Blue (PPO) plans, you may also see MA PPO members who are enrolled through other Blue Cross and/or Blue Shield Plans. These members will have the same contractual access to care as local members. Services provided to these members will be reimbursed in accordance with our negotiated rates.

**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.

Chiropractors should call Physician Services to verify copayment.

**Case Management**

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

**Copayments and Coinsurance**

Our Medicare Advantage plans offer various office visit copayments. In other health care settings, coinsurance may be required.

Copayment amounts and coinsurance percentages, if applicable, are printed on the member’s ID card.

**Please note:** Members enrolled in our Horizon Medicare Advantage TotalCare (HMO SNP) plan have no cost sharing responsibilities for any services they receive.

**Vision Benefits**

Members enrolled in the Horizon Medicare Blue TotalCare (HMO SNP) have access to providers within
the Davis Vision Network for certain services. Members enrolled in Horizon Medicare Blue TotalCare (HMO SNP):

- Must use a participating Davis Vision optometrist for routine vision services (annual eye exam).
- Must use a participating Horizon Managed Care Network ophthalmologist or optometrist for nonroutine vision services.
- Must use a participating Davis Vision provider for vision hardware (glasses and/or contact lenses). Vision hardware is not an eligible benefit if a provider outside the Davis Vision network is used.

The most current information about the Davis Vision network is available online. To access this information, please visit HorizonBlue.com/Directory and click Vision Services.

Audiology/Hearing Aid Benefits
Audiology Distribution, LLC, doing business as HearUSA, partners with Horizon BCBSNJ to administer hearing benefits and provide related products and services through their HEARx network of independently practicing audiologists, hearing care professionals and company-owned hearing centers.

Members enrolled in MA plans with NO out-of-network benefits
Members enrolled in Horizon Medicare Blue Value (HMO), Horizon Medicare Blue Value w/Rx (HMO), Horizon Medicare Blue Choice w/ Rx (HMO) and Horizon Medicare Blue TotalCare (HMO SNP) must use a HEARx Center for audiology services and hearing aids that are medically necessary, including batteries.

If these members reside in a New Jersey county without a HEARx Center, they may request that their Primary Care Physician (PCP) refer them to a participating Horizon Managed Care Network audiologist. These same members who reside in a New Jersey county without a HEARx Center will be reimbursed directly for hearing aids/batteries supplied by any non-HEARx provider.

Members enrolled in MA plans with out-of-network benefits
Members enrolled in Horizon Medicare Blue Access Group (HMO-POS) and Horizon Medicare Blue Access Group w/Rx (HMO-POS) may use a HEARx Center for in-network audiology services and hearing aids, including batteries, that are medically necessary.

If these members choose to use their out-of-network benefits (understanding that they will incur more cost sharing), they may obtain services from a non-HEARx provider.

If these members reside in a New Jersey county without a HEARx Center, they may use any participating Horizon Managed Care Network audiologist on an in-network basis. These same members who reside in a New Jersey county without a HEARx Center will be reimbursed directly for hearing aids/batteries supplied by any non-HEARx provider.

Use our online Provider Directory to locate a HEARx Center. Visit HorizonBlue.com/Directory, click Other Health Services and:

- Select Audiology within the Service Type menu.
- Enter your ZIP Code and indicate a Search Radius, or select your County.
- Click Search.

Dual Eligibles
CMS issued new requirements for Dual Eligibles. This subset of members 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.

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.

Please also see page 96 for important information about appeals for Dual Eligible members enrolled in our Horizon Medicare Advantage TotalCare (HMO SNP) plan.

Emergency and Urgent Care Definitions
For 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.

For 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 Standards for Medicare Members**

According to the Centers for Medicare & Medicaid Services (CMS), all information included within a medical record must be legible for review by an approved CMS coder and must include the following information to document a face-to-face encounter.

- The physician or other health care professional must authenticate the services provided or ordered by including either a hand-written or electronic signature along with his/her credentials. The following types of signatures are not acceptable:
  - Stamp signatures.
  - Signature of a physician other than the treating physician.
  - Signature of a nurse or other office professional on the physician’s behalf.
  - Statements that indicate: Signed but not read; Dictated but not signed/read; etc.

- The medical record should include sufficient information to ensure that a reviewer can determine the date on which a particular service was performed/ordered.

- The medical record should include sufficient documentation to support the diagnoses billed.

- Each page of a medical record must include the patient’s name.


**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.

If you or the member disagrees with a coverage determination we have made, the decision may be appealed. 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 determination.

In some cases, the standard pre-service 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 pre-service determination for a Medicare Advantage patient if, in your opinion, the health or the ability of your patient to function could be harmed by waiting for a medical necessity determination.

Expedited determinations may be requested by calling 1-800-664-BLUE (2583).

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: 1-877-798-5903**

**Medicare Part D Prescription Drug Determinations**

Requests for a coverage determination will be responded to within 24 hours for an expedited request (or sooner if the member’s health requires us to) or within 72 hours for a non-expedited coverage determination.
Part D drug coverage determinations include:

- Prior authorization determinations for those drugs that require prior authorization.
- Requests that we cover a Part D drug that is not on the plan’s List of Covered Drugs (Formulary).
- Requests that we waive a restriction on the plan’s coverage for a drug, including:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called step therapy.)
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug patients can have.
- Requests that we pay for a prescription drug the member already purchased (a coverage decision about payment).

Expedited Medicare Part D drug determinations may be requested by calling 1-800-693-6651.

Non-expedited Medicare Part D drug determinations may be requested in writing to:

Prime Therapeutics LLC
Attn: Medicare Appeals Department
1305 Corporate Center Drive
Bldg N10
Eagan, MN 55121
Fax: 1-800-693-6703

Horizon Medicare Advantage Member Appeals
Members have the right to appeal any decision regarding our reimbursement or our denial of coverage based on medical necessity. Appeals may be requested verbally or in writing.

Medical records and your professional opinion should be included to support the appeal.

Based on the medical circumstances of the case, a Horizon BCBSNJ physician reviewer will determine if the request qualifies as an expedited appeal. However, the member, physician or other authorized representative acting on behalf of the member may request an expedited appeal based on the medical circumstances of the case.

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.

Details about how to pursue various appeals and appeal levels will be communicated in writing as part of each coverage determination and/or appeal determination notification.

Medical Appeals for Medicare Services
Generally, 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). Expedited appeals are processed within 72 hours.

A completed Appointment of Representative (AOR) form or other court-appointed document indicating the member’s consent may be required for a physician to pursue post-service appeals on behalf of the member.

To file an expedited appeal, the member may call 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-02P
Newark, NJ 07105-2200

Pre-service appeal requests may be faxed to 1-856-638-3143.

Post-service appeals (appeals for payment) may be faxed to 1-973-466-4090.

Medicare Part D Prescription Appeals
Generally, we have up to seven days to process an appeal pertaining to a post-service denial of coverage decision or claim for a Medicare Part D prescription drug and up to 72 hours to process an appeal pertaining to a coverage decision of a Medicare Part D prescription drug the member has not yet received. Expedited appeals are processed within 24 hours.

To file an expedited Medicare Part D appeal, the member may call 1-800-693-6651.
To request a Medicare Part D prescription drug appeal in writing, members should write to or fax:

Prime Therapeutics LLC
Attn: Medicare Appeals Department
1305 Corporate Center Drive
Bldg N10
Eagan, MN 55121

Fax: 1-800-693-6703

Other Appeals for Horizon Medicare Advantage TotalCare (HMO SNP)
Because Horizon Medicare Advantage TotalCare (HMO SNP) members have Medicare and receive assistance from Medicaid, appeals for these members may follow different processes depending on the service in question.

- Appeals for Medicare benefits follow the same process as for all other Horizon BCBSNJ Medicare Advantage plans.
- Appeals for Medicaid benefits follow the same process as for other non-Medicare related appeals. Please see the Utilization Management or Medical Appeals section beginning on page 122 for more information.

Additional Appeal Rights for Medicaid Services
Members enrolled in the Horizon Medicare Advantage TotalCare (HMO SNP) plan also have the right to file for a Medicaid Fair Hearing. Medicaid Fair Hearings must be requested within 20 days of a Horizon BCBSNJ determination letter about a Medicaid service.

Members have the right to represent themselves at the Medicaid Fair Hearing or to be represented by an attorney, family, friend or other spokesperson.

Requests for Medicaid Fair Hearings must be made to:

New Jersey Department of Human Services
Division of Medical Assistance and Health Services
Fair Hearing Services
PO Box 712
Trenton, NJ 08625-0712

Pennsylvania Department of Health
Office of Medical Assistance
Medicaid Fair Hearings
PO Box 60006
Harrisburg, PA 17106-0006

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 usps.com/zip4.

Medicare Supplemental (Medigap)
We offer a variety of Medicare Supplemental Products to our members who have Original Medicare as their primary insurance coverage.

These Medigap 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), we offer a new set of standardized Medigap plans. The new plans, to distinguish them from the previously offered Medigap plans (which we continue to service, but no longer sell), are identified by a YHW prefix on their ID card and are referred to as Horizon Contemporary Medigap Plans.
We offer the following Horizon Contemporary Medigap Plans:

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

For more information about Horizon Contemporary Medigap Plans, please visit [HorizonBlue.com/Medicare](http://HorizonBlue.com/Medicare) and click [Horizon Medicare Supplement](#).

Horizon Contemporary Medigap Plans are the only Medigap plans we offer for sale.

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.

- Horizon Medigap Plans A.
- Horizon Medigap Plan C.
- Horizon Medigap Plan F.
- Horizon Medigap Basic Plan I.
- Horizon Medigap Plan I with Rx.
- Horizon Medigap Plan J.
- BCBSNJ 65.
- BCBSNJ 65 Select.
- Super 65.

Members enrolled in the above Medigap plans are identified by a [YHR](#) prefix on their ID card.

**Medicare Part D**

We also offer Medicare Part D Prescription Drug coverage to our members who have Original Medicare as their primary insurance coverage.
Ancillary Provider Responsibility
Ancillary providers should not recommend any treatment they feel is professionally unacceptable. You have sole responsibility for the quality and type of health care service you provide to your patients.

Ancillary providers are free to communicate openly with a member about all appropriate diagnostic testing and treatment options, including alternative medications, regardless of benefit coverage limitation.

The Role of the Primary Care Physician
The Primary Care Physician (PCP) coordinates care received by the managed care member in the primary care setting, as well as from specialty care physicians, other health care professionals and facilities; including Federally Qualified Health Centers (FQHCs). Internists, general physicians, family physicians and pediatricians are all credentialed as PCPs. Certain managed care plans require that members select a PCP. Other managed care plans encourage, but do not require a PCP selection.

Members should see their PCP for the appropriate referral for specialty care services.

PCPs also have a role in the development of certain policies and procedures. Through participation in our Quality Improvement and other committees, physicians provide valuable feedback to develop medical policies and protocols.

The Role of the Participating Specialist
Participating specialists work in partnership with the PCP to provide appropriate, quality and cost-effective medical care to our members. PCPs refer members for specialty care services as a part of the treatment plan. Participating specialists play a critical role by providing efficient care within their area of expertise and within the scope of the member’s treatment plan. Participating specialists also participate in Horizon BCBSNJ’s Quality Improvement, Medical Management and Credentialing Committees, where they are actively involved in the formation of policies and procedures, as well as peer-review activities.

Communication in the Health Care Process
To help ensure the success of the health care treatment plan, it is essential for all parties to share information. The PCP usually begins the process by completing a referral to a participating ancillary provider, including the reason the member is being referred. Upon seeing the patient, it is the responsibility of the participating specialist to share his or her findings and treatment plan with the PCP.

Although it is expected that the participating ancillary provider will communicate his or her findings and treatment plan to the PCP, requests for authorization of diagnostic procedures and/or hospitalizations may be made directly by the participating ancillary provider to Horizon BCBSNJ.

This dynamic exchange of information enhances access to as well as the quality and effectiveness of the managed care delivery system.

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 directive 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.

- **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.

- **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.

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 [state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf](http://state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf).

Registered NaviNet users may review our Medical Record Documentation Standards online by logging in to NaviNet.net, access Horizon BCBSNJ within the Plan Central dropdown menu and:

- Click References and Resources and then click Provider Reference Materials.
- Under the Additional Information heading, click Medical Records Documentation Standards.

For other information on medical records for quality-of-care complaints and guidelines for your Medicare patients please see page 94.

**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. This does not apply to Urgent Care Centers. Horizon BCBSNJ does not oblige providers to violate state licensure regulations.

**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.

**Medicare Participation**

Physicians or health care professionals who have opted out of (or have been excluded from) Medicare may not participate in our Horizon Managed Care Network. Participating physicians or health care professionals who opt out of (or become excluded from) Medicare will be terminated from the Horizon Managed Care Network.

**Cultural Competency**

Horizon BCBSNJ’s membership represents many cultural, ethnic, linguistic and racial backgrounds.

To meet the needs of our members, including those that have limited English proficiency or reading skills, you are required to ensure that all clinical and nonclinical services are accessible to all members in a manner that:

- Honors and is compatible with their cultural health beliefs and practices,
- Is sensitive to cultural diversity and
- Fosters respect for their cultural backgrounds.

We use the AT&T Language Line service to help our service representatives communicate with callers in more than 140 languages, 24 hours a day, seven days a week.

**Medical Records**

You agree that Horizon BCBSNJ and its 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 you provided under your Agreement.
Provider Responsibilities

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.

Horizon BCBSNJ does not provide reimbursement for the reproduction of medical records, to cover postage and/or for any other miscellaneous costs associated with retrieval of a member’s medical record.

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 ancillary provider. Complaints that include potential medical quality-of-care issues will be referred to our Quality Case Review Committee – 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 Committee investigate the complaint. You are required to respond to such requests under the terms and conditions of your participating Agreement(s) 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.

• Ancillary providers 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 file a complaint with the New Jersey State Board of Medical Examiners.

Commitment to Improving Relationships
We are making significant business practice improvements to increase transparency in the reimbursement of claims, to reduce administrative overhead and to improve interactions between Horizon BCBSNJ and participating ancillary providers. These improvements include the following:

• Horizon BCBSNJ fee schedules for commonly used procedures are available to physicians online, by CD-ROM, electronically or via mail.

• Generally, Horizon BCBSNJ will not recover overpayments to ancillary providers after more than 18 months from the original payment, and will provide notice in advance and information regarding any such overpayments.

• A determination of medical necessity by Horizon BCBSNJ will not subsequently be revoked absent evidence of fraud or misrepresentation in obtaining the determination or material change in the condition of a patient prior to services being provided.

• Horizon BCBSNJ’s standard ancillary provider contracts do not include most favored nations clauses.

• Horizon BCBSNJ will not hinder the free, open and unrestricted exchange of information between ancillary providers and plan members regarding the nature of medical treatment, provider options, coverage and the right to appeal and the right of the ancillary provider to advocate on the member’s behalf.

• Significant claims edits are posted in our Provider Reference Materials section on NaviNet.net. A significant claim edit is an edit that Horizon BCBSNJ reasonably believes will cause the denial or reduction in payment for a particular CPT Code or HCPCS Level II Code more than 250 times per year on the initial review of submitted claims.

• Horizon BCBSNJ will not require the use of pharmacy risk pools.

We believe these practices will benefit you, our members and the quality of health care in New Jersey. We hope these commitments improve our business relationship and simplify your day-to-day interactions with us.

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.
Provider Responsibilities

• You change the name of your company or facility name.
• Your tax ID number or address changes or you join or leave a group practice.
• You fail to maintain required medical malpractice insurance.
• You are indicted, convicted of, or plead guilty to a criminal offense, regardless of the nature of the offense.
• You are subject 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 your Ancillary Contracting Specialist.

Please see credentialing and recredentialing obligations on page 64.

Referring a Patient

Horizon BCBSNJ is proud of our comprehensive network of participating physicians, ancillary providers and facilities. We remind participating physicians, ancillary providers and facility staff in our Horizon Managed Care Network about the important role referrals play in helping to ensure that your patients maximize their benefits.

Referring physician responsibilities

• All referrals for patients enrolled in managed care plans* should be created electronically through either our IVR system by calling 1-800-624-1110 or via NaviNet.net.
  – Primary Care Physicians (PCPs) may create electronic Primary referrals to specialists or facilities.
  – Ob/Gyns may create Primary referrals for Ob/Gyn-related services only.
  – Participating specialists may create Refer-On referrals to radiology centers and ambulatory surgery centers.
• All referrals for patients enrolled in managed care plans must be made to specialty care physicians, ancillary providers or facilities that participate in the Horizon Managed Care Network. Visit our Online Provider Directory at HorizonBlue.com to confirm participation status.
• We recommend that all referring physicians print a Referral Confirmation and:
  – Include that information within the patient’s medical record.
  – Provide a copy to the member to present when they visit the referred to practitioner or facility.

* Horizon Direct Access members do not need referrals to visit physicians who participate in our Horizon Managed Care Network.

Referred to provider responsibility

• Specialty care physicians, ancillary providers or facilities that participate in the Horizon Managed Care Network and to whom a Horizon BCBSNJ managed care member has been referred, must confirm that a referral was obtained by the referring physician prior to providing services.
  – Registered users of NaviNet® may review and print a Referral Confirmation quickly and easily at any time.
  – You may request a fax copy of a Referral Confirmation or create a secondary referral through our IVR system by calling 1-800-624-1110.

To learn more about creating, submitting and reviewing referrals, as well as printing Referral Confirmations, registered NaviNet users may view a tutorial. Simply:

• Visit NaviNet.net and log in by entering your User Name and Password.
• Select Horizon BCBSNJ within the Plan Central dropdown menu.
• Click NaviNet.
• Click NaviNet Information Demo.

Member Nondiscrimination

Horizon BCBSNJ does not discriminate in its delivery of health care services based on race, color, creed, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, marital status, claims experience, medical or mental health history or status, pre-existing medical/health conditions, need for health care services, 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 and ensure it does not occur. In the event that a Horizon Medicare Blue TotalCare (HMO SNP) member is assigned to your office or facility, you must accept assignment without discrimination.

**Health Care Fraud and Abuse Investigation**

Health care fraud, waste and abuse are national problems that affect us all. According to the Federal Bureau of Investigation (FBI), $80 billion, of the approximately $2.7 trillion the United States spends on health care annually, 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 such activity.

Health care fraud, waste and abuse can take many forms, including:

- Performing unnecessary health care services or procedures for the sole purpose of producing more billings and insurance payments.
- Falsifying a patient’s diagnosis to justify tests, surgeries or other procedures.
- Supplying durable medical equipment that patients do not need.

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.

For reports of suspected fraud related to behavioral health services, please contact Horizon Behavioral Health’s Special Investigations Unit at 1-800-397-1630 or send documents and/or inquiries to:

Horizon Behavioral Health, Inc.
National Headquarters
ATTN: Special Investigations Unit
240 Corporate Boulevard
Norfolk, VA 23502

As a Medicare Advantage and Medicare Part D plan sponsor, we also work closely with the Centers for Medicare & Medicaid Services (CMS) to investigate and prosecute all instances of fraud, waste and abuse involving those lines of business. Our dedicated Medicare Advantage and Medicare Part D Fraud, Waste and Abuse Hotline is 1-888-889-2231. You may also send documents and/or inquiries to:

Horizon BCBSNJ
Investigations
Riverfront Plaza
PO Box 200145
Newark, NJ 07102-0303

All information is strictly confidential.
The Quality Management Program consists of two major components: clinical and service. The range of the clinical activities is extensive, encompassing preventive care, 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 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 ancillary providers include:

- 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;
- A mechanism for evaluating all providers of care; and
- A system to monitor ancillary provider 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.
- Monitoring member satisfaction and participating network physicians’ response and feedback on plan operations.
- 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 medical management processes as defined in the Medical 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 ancillary providers 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 ancillary provider has a process to make records available to covering health care professionals and others, as needed. Physician 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 health care professional requesting medical records.
Quality Management

• **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 health care professional 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 phone 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** – The medical record contains an entry for each patient visit stating the reason for the visit and the applicable diagnosis/treatment plan.

• **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 health care professional.

• **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 years.

• **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 ancillary providers 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.

**Medicare Advantage Medical Record Retention**
Ancillary providers are required to maintain medical and business 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 ancillary provider. Complaints that include potential medical quality-of-care issues will be referred to our Quality Case Review Committee (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 or facility may be asked to provide medical records and documentation to help the committee 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.

Ancillary providers 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 file a complaint with 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, ancillary 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).

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, NCQA.org.

Please note: You may not charge Horizon BCBSNJ for copies of medical records when they are requested for medical review, claim review or as part of a medical record or HEDIS audit.
Horizon Hospital Recognition Program
The Horizon Hospital Recognition Program (HHRP) 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 New Jersey hospitals are required to report their data through the Leapfrog Hospital Survey™. Leapfrog Hospital Survey elements include:

- Computerized Physician Order Entry (CPOE).
- Evidence-Based Hospital Referral (EBHR).
- ICU Physician Staffing (IPS).
- Safe Practices Score (SPS).

This program acknowledges hospitals for generating improved clinical performance and for sustaining superior performance.

Visit our website, HorizonBlue.com/Providers, for additional details about the program.

Blue Distinction Centers
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 that we recognize 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 bcbs.com/why-bcbs/blue-distinction/

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 help 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 [cms.gov](http://cms.gov) for more information on approved transplant programs.
Horizon BCBSNJ has a comprehensive network of contracted ancillary providers throughout our region.

If a PCP determines a patient, who is enrolled in a Horizon BCBSNJ managed care plan that requires referrals, needs care from a specialist or facility, the PCP should refer the patient to a specialty care physician, other ancillary provider or facility participating in the Horizon Managed Care Network.

Referrals serve several purposes. They:

- Provide a mechanism to manage the appropriate use of specialty care services.
- Expedite communication between the PCP, specialist, facility and Horizon BCBSNJ, allowing for efficient and prompt reimbursement of services.
- Provide clinical information for data analysis and medical outcomes.

To help ensure that your patients receive the highest level of benefit coverage, it is important to make sure all referrals to a physician, ancillary provider or hospital are obtained prior to services being rendered.

- Horizon BCBSNJ requires that all referrals are created electronically through either NaviNet.net or our IVR system. We do not accept paper referrals.
- Referrals must be completed before the specialist's services are rendered.
- Referrals are valid for 365 days from the date of issuance and must include the referring physician’s name, the name of the hospital and the approved number of visits.
- Generally, the maximum number of visits per referral is 12. However, referrals for dialysis treatment may be created for up to 160 visits.
- PCPs and Ob/Gyns in the Horizon Managed Care Network can submit initial referrals to specialists in the network. These are called Primary referrals.
  Ob/Gyns may issue Primary referrals for Ob/Gyn-related services only.
- Specialists in the Horizon Managed Care Network can submit secondary referrals to network radiology centers or to ambulatory surgery centers or hospital outpatient departments for same day surgery. These are called Refer-On referrals.
- Referrals are required for members enrolled in Horizon Advance EPO, Horizon HMO, Horizon Medicare Blue Value (HMO), Horizon Medicare Blue Value w/Rx (HMO), Horizon Medicare Blue Choice w/Rx (HMO) and Horizon Medicare Blue TotalCare (HMO SNP) plans.
- Referrals are not required for members enrolled in Horizon HMO Access, Horizon Direct Access, NJ DIRECT10, NJ DIRECT15, NJ DIRECT1525, NJ DIRECT2030, Horizon Advantage EPO, Horizon Medicare Blue Access Group (HMO-POS), Horizon Medicare Blue Access Group w/Rx (HMO POS), Horizon Medicare Blue (PPO), Horizon Medicare Blue Group, (PPO) or Horizon Medicare Blue Group w/Rx (PPO) plans when they use physicians, other health care professionals or facilities that participate in the Horizon Managed Care Network.
- Referrals are not valid for out-of-network services.
- Any referral for a member enrolled in a Horizon HMO, Horizon Medicare Blue Value (HMO), Horizon Medicare Blue Value w/Rx (HMO), Horizon Medicare Blue Choice w/Rx (HMO) or Horizon Medicare Blue TotalCare (HMO SNP) to a nonparticipating physician, ancillary provider or facility requires prior authorization from Horizon BCBSNJ.
- Referrals are required for members enrolled in Horizon POS plans to receive the in-network benefit level.
- Although referrals or approval from Horizon BCBSNJ are not required for members enrolled in managed care plans that include the option of receiving care from nonparticipating physicians, other health care professionals or facilities, these services are generally subject to higher out-of-pocket expense than in-network services. Participating referring physicians are required to follow the guidelines set forth in our Out-of-Network Consent Policy.

Please see page 62 information about our Out-of-Network Consent Policy.
Referring to a Specialist
If a PCP determines a patient needs care from a specialist, the PCP should refer the patient to a specialty care physician or other health care professional participating in the Horizon Managed Care Network.

Visit our online Provider Directory, HorizonBlue.com/directory to confirm the participation status of specific physicians.

Extended Referrals
A patient’s PCP may obtain authorization from our Medical Management Department to allow the specialist to exercise authority and control care provided for a chronic condition (e.g., HIV, cancer, diabetes and transplants). This includes performing tests and treatment and referring to other specialists, hospitals and facilities, as necessary.

If the PCP determines the need to refer a member to a participating specialist for a chronic condition, the PCP must call Medical Management for authorization at 1-800-664-BLUE (2583).

Referring to a Facility for Chemotherapy
Only chemotherapy services rendered at a facility require a referral.

Electronic Referral Requirement
Horizon BCBSNJ requires that all referrals are created electronically through either NaviNet.net or our IVR system. We do not accept paper referrals.

Submitting Referrals through NaviNet
Registered users of NaviNet may create, submit and review referrals with just a few clicks of the mouse.

To learn about creating, submitting and reviewing referrals and printing referral confirmations, registered NaviNet® users may log in to NaviNet.net, access Horizon BCBSNJ within the Plan Central dropdown menu and:

• Click NaviNet.

• Click NaviNet Information Demo.

Here are a few tips to help make using online referral submissions even easier:

• After entering the subscriber ID number, select the name of the patient being referred. The subscriber information, along with the patient information will prepopulate the referral.

• Search for the ETIN number, which will prepopulate the referred-to physician information.

• You can create multiple consecutive referrals for the same patient without having to re-enter the patient’s information.

• The system speeds up online referral submissions by saving the following frequently used information as favorites:
  – ETIN or tax ID numbers.
  – Number of visits.

• Download/print a Referral Confirmation at any time.

Online Demo
Learn about creating online referral submissions by viewing the NaviNet tutorial:

• Visit NaviNet.net and log in by entering your User Name and Password.

• Select Horizon BCBSNJ within the Plan Central dropdown menu.

• Click NaviNet.

• Click NaviNet Information Demo.

Submitting Referrals through the IVR System
Referrals may be submitted via our IVR system. To access our easy-to-use IVR system, please call 1-800-624-1110.

After submitting a referral through our IVR system, you can request a fax copy of that referral through the IVR. Or, if you are a registered user of NaviNet, you can view and/or print the applicable Referral Confirmation Receipt(s) through NaviNet.net.

Before you submit a referral using IVR, you will need:

• Either your provider ID number, tax identification number (TIN) or National Provider Identifier (NPI).

• The ID number or Social Security Number of the patient being referred.

• The birth date (month, day and year) of the patient being referred.

• The electronic tax identification number (ETIN), TIN, NPI or Medicare ID of the specialist or facility the patient is being referred to.

• Your fax number to receive a fax copy of the referral (optional).
Referrals

Submitting a primary referral
1. From the IVR main menu, say referrals or press 4.
2. From the Referrals menu, say submit or press 1.
3. Say primary or press 1.
4. Say or enter the patient’s ID number or Social Security Number.
5. Say or enter the patient’s eight-digit date of birth (mm/dd/yyyy).
6. Say or enter the ETIN, TIN, NPI or Medicare ID of the specialist who you are referring the patient to.
7. Say or enter the number of visits. (The maximum number of visits, per referral, is 12. The maximum number of dialysis visits, per referral, is 160.)
8. Confirm the information you have entered, when prompted.
9. Say or enter your fax number, when prompted.
10. Listen for and make note of the referral number.

Submitting a Secondary Referral
1. From the IVR Main menu, say referrals or press 4.
2. From the Referrals menu, say submit or press 1.
4. Say the Referral Number for the applicable primary referral. You may enter it via touch-tone if it is all numeric digits.
5. Say or enter the ETIN, TIN, NPI or Medicare ID of the hospitals, radiology centers, or ambulatory surgical centers that you are referring to.
6. Follow steps 7 through 10 under Submitting a Primary Referral.

Checking Referral Status on the IVR
1. From the IVR main menu, say Referrals or press 4.
2. From the Referrals menu, say Status or press 2.
3. Enter the patient’s ID number or Social Security Number.
4. Enter the patient’s eight-digit date of birth (mm/dd/yyyy).
5. Listen for a list of referral status records.
6. Listen for your opportunity to provide your fax number to request a fax copy of the referral.

IVR System Tips
Here are a few tips to make it easier to submit referrals through the IVR:

- Listen carefully to the prompts and speak your response in a clear voice.
- Information containing letters should be spoken.
- If you think you made a mistake in entering information, simply wait.
- To return to the main menu at any time, say main menu.

To review other best practice hints for creating referrals through the IVR:

- Visit NaviNet.net and log 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 the link under IVR Referrals within the User Guides section.
- Click the link to open the IVR Helpful Hints PDF.

Viewing Referral Confirmations Online
After submitting a referral through our IVR system, you can view and/or print the applicable Referral Confirmation Receipt(s) through NaviNet.net.

1. A few minutes after submitting a referral through the IVR, log in to NaviNet.net.
3. Search submitted referrals in the appropriate date range.
4. Click the appropriate referral confirmation number to see the details.
This section includes the phone numbers you can 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 access online training courses.

At Horizon BCBSNJ, your satisfaction is important to us. We understand that as an ancillary provider, 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.

**Interactive Voice Response (IVR) System**

The Interactive Voice Response (IVR) system, an innovative technological enhancement, expands your options for contacting us, allowing you to obtain the information you need in a more convenient manner. You can access information 24 hours a day, seven days a week, generally including weekends and holidays, and get instant answers to many questions previously handled only 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 (Physician Services) or 1-888-666-2535 (Institutional Services) and exploring all the information and services that it has to offer.

**IVR**

Use your natural voice or the touchtone keypad to enter the patient's ID number 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 the touchtone option when there is excessive background noise.**
- **Say numbers one digit at a time.**
- **When speaking numbers, please say zero rather than O.**
- **You may return to the main menu at any time by saying main menu.** You may also say repeat or help.
- **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...*
  - **Claims** to check claim status or reimbursement.
  - **Eligibility and Benefits** to verify that a patient is enrolled under a Horizon BCBSNJ plan or to check their benefits (FEP® benefits and eligibility are separate menu options).
  - **Authorizations** to check the status of an authorization.
  - **Referrals** to refer a patient for a treatment or check the status of an existing referral (if needed).
  - **Duplicate Vouchers** to request a duplicate voucher.

If you need help or information that you may not be able to access through our IVR system, call 1-800-624-1110 (Physician Services) or 1-888-666-2535 (Institutional Services), Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

**Referral Submissions through the IVR System**

Primary Care Physicians (PCPs), Ob/Gyns and specialists participating in our managed care network may use our IVR system to submit referrals for their Horizon BCBSNJ managed care patients.

Please see the Referrals section on page 108 for more information.
At Your Service

**PREFIX OR AREA** | **SERVICE NUMBERS** | **CLAIM SUBMISSIONS** | **CLAIM APPEALS** | **CLAIM INQUIRIES** *
---|---|---|---|---
JGA, JGB, JGC, JGD, JGE, JGF, JGG, JGH, JGI, JGJ, JGL, JGM, JGR, JGS, JGV, JBW, JGX, JGY, JHZ, JHY, JYH, JYI, JYM, JYN, JYO, JYP, JYQ, JYR, JYS, JYT, JYU, YH, YHY, YHY, YYY, YPK, YKP, YKR and other Horizon PPO, Indemnity, Direct Access and Medicare Advantage members. | 1-800-624-110** | PO Box 1609 Newark, NJ 07101-1609 | PO Box 10129 Newark, NJ 07101-3129 | PO Box 199 Newark, NJ 07101-0199

For Facilities: ATT, DEH, DMM, DTP, FMA, FMR, JGA, JGB, JGD, JGE, JGF, JGG, JGH, JGI, JGJ, JGL, JGM, JGR, JGS, JGV, JBW, JGX, JGY, JHZ, JHY, JYH, JYI, JYM, JYN, JYO, JYP, JYQ, JYR, JYS, JYT, JYU, YH, YHY, YHY, YYY, YPK, YKP, YKR and other Horizon BCBSNJ prefixes not shown here. | 1-888-666-2535** | PO Box 25 Newark, NJ 07101-0025 | PO Box 1770 Newark, NJ 07101-1770 | PO Box 1770 Newark, NJ 07101-1770

R, 8-digits with the PPO or Basic logo Federal Employees Program | 1-800-624-5078 | PO Box 656 Newark, NJ 07101-0656 | PO Box 656 Newark, NJ 07101-0656 | PO Box 656 Newark, NJ 07101-0656

FMA, FMR, NCH, YHF, HSG, HWA, HWV and other National Accounts*** | 1-800-624-4758 | PO Box 247 Newark, NJ 07101-0247 | PO Box 247 Newark, NJ 07101-0247 | PO Box 199 Newark, NJ 07101-0199

AHX, AWW, BBB, DNB, IRA, NVP, NYY, PFZ, WYE and other National Accounts*** | 1-800-624-1110** | PO Box 1219 Newark, NJ 07101-1219 | Addresses vary. Please review your patient’s ID card. | PO Box 199 Newark, NJ 07101-0199

MKV, MKY, MWK, MWJ | 1-877-663-7258 | PO Box 18 Newark, NJ 07101-0018 | PO Box 317 Newark, NJ 07101-0317 | PO Box 199 Newark, NJ 07101-0199

JGK, JGN, JGD, HSE, NFV, NJX, SNJ, YHD, YHG, YHH, YMH, YHP, YHP, YHT and other HMO, EPO, POS and NJ State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBPI) members. | 1-800-624-1110** | PO Box 820 Newark, NJ 07101-0820 | PO Box 10129 Newark, NJ 07101-3129 | PO Box 199 Newark, NJ 07101-0199

YHR, YHV Medigap | 1-800-624-1110** | PO Box 1609 Newark, NJ 07101-1609 | PO Box 10129 Newark, NJ 07101-3129 | PO Box 199 Newark, NJ 07101-0199

DEH, DMM, DTP, NGM General Motors/Delphi Auto | 1-800-456-5336 | For Professionals: PO Box 639 Newark, NJ 07101-0639 | For Professionals: PO Box 639 Newark, NJ 07101-0639 | For Professionals: PO Box 639 Newark, NJ 07101-0639

BlueCard® (out-of-state) claims BlueCard Service Team | 1-888-435-4383 | BlueCard Claims PO Box 1301 Neptune, NJ 07754-1301 | Addresses vary according to product. Please review the behavioral health information on your patient’s ID card. | For Professionals: PO Box 639 Newark, NJ 07101-0639

Horizon Behavioral Health℠ | 1-800-626-2212 | Horizon BCBSNJ Horizon Behavioral Health PO Box 10191 Newark, NJ 07101-3189. | Addresses vary according to product. Please review the behavioral health information on your patient’s ID card. | For Professionals: PO Box 639 Newark, NJ 07101-0639

Chronic Care Program | 1-888-333-9617 | 3 Penn Plaza East, PP-12X Newark, NJ 07105-2200 | | |

Pre-existing Medical Documentation | PO Box 1740 Newark, NJ 07101-1740 | | | |

Claim Policy Clinical Appeals | PO Box 220 Newark, NJ 07101-9020 | | | |

Claim Policy Code Edit Inquiries | PO Box 681 Newark, NJ 07101-0681 | | | |

Claim Policy Clinical Predetermination for PPO and Indemnity Products | PO Box 220 Newark, NJ 07101-9020 | | | |


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* Please do not send medical documentation with your claim if it has not been requested.

** Corrected claim submissions that are mailed must be accompanied by a completed Inquiry Request and Adjustment Form (579).

*** These numbers can also be used to access our Interactive Voice Response (IVR) system to create referrals and for service information.

This prefix information is confidential and should only be used to identify Horizon BCBSNJ and/or other Blue Cross and/or Blue Shield Plan patients and not for other purposes and may not be divulged to any other party. Reproduction of this information, in whole or in part, is prohibited without the permission of Horizon BCBSNJ.

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Ancillary Provider Office Manual

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Other Service Areas
Horizon BCBSNJ has a number of more specialized service areas that provide more specific information and assistance with authorizations and prior authorizations. For the representative in 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 prior authorization, a representative from Physician Services (CMS 1500 submitters) or an Institutional Services Representative (UB-04 submitters) can provide both the information you need and a service reference number that documents the information you were provided.

- BlueCard® Dedicated Unit – Phone: 1-888-435-4383
- BlueCard/Out-of-state members (eligibility, benefits and prior authorizations) – Phone: 1-800-676-BLUE (2583)
- CareCore National, LLC (CareCore) (prior authorization/medical necessity determinations) – Phone: 1-866-496-6200 (Radiology and cardiology) 1-866-241-6603 (Pain management) Fax: 1-800-637-5204 (Radiology services) 1-888-785-2480 (Cardiology services) 1-800-649-4548 (Pain management)
- e-Service Desk – e-Business (Online capabilities inquiries and help) – Provider_Portal@HorizonBlue.com Phone: 1-888-777-5075 Fax: 1-973-274-4353
- e-Service Desk - Electronic Data Interchange (EDI) (data feed issues) – HorizonEDI@HorizonBlue.com Phone: 1-888-334-9242 Fax: 1-973-274-4353
- Home care – Phone: 1-800-664-2583 Fax: 1-800-492-2580
- ICORE Healthcare (medical necessity and appropriateness reviews of specific injectable medications) – Phone: 1-800-424-4508
- Infertility services – Fax: 1-973-274-4410
- National Provider Identifier (NPI) submission – Fax: 1-973-274-4416
- NaviNet® NaviNet.net – Phone: 1-888-482-8057
- Notices of admission for out-of-state and non-network facilities – Phone: 1-888-621-5894
- Ancillary provider profile changes – Contact your Ancillary Contracting Specialist.
- Physical Therapy Unit – Phone: 1-888-789-3457 Fax: 1-800-723-5188
- Prior authorizations – Phone: 1-800-664-BLUE (2583) Fax: 1-877-798-5903

Utilization Management Contact Information
If you need to obtain prior authorization for a Horizon BCBSNJ member, please call 1-800-664-BLUE (2583).
For prior authorizations for Medicare Blue TotalCare HMO SNP members, please call 1-732-919-5395.

To access our Utilization Management Department after business hours and on weekends, physicians and ancillary providers should call our after-hours emergent clinical issues phone number, 1-888-223-3072.

Please see the Utilization Management section, beginning on page 122, 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. A referral is not needed for behavioral health care if authorization is obtained.

With few exceptions, Horizon BCBSNJ and its subsidiary, Horizon Healthcare of New Jersey, Inc., contract with Value Options to administer our members’ behavioral health and substance abuse benefits. Call 1-800-626-2212 to speak with a Horizon 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 Horizon Behavioral Health to refer most patients for behavioral health or substance abuse care. A referral is not required if services are approved by Horizon Behavioral Health.
If Horizon 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.

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

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

**Copies of Agreements**
Ancillary providers can request a copy of your ANCILLARY SERVICES PROVIDER AGREEMENT by contacting your Ancillary Contract Specialist.

**Ancillary Contract Specialists**
Ancillary Contract Specialists are dedicated to providing service to you and your office staff. Your Ancillary Contract Specialist is available to educate your staff on billing and administrative policies and procedures and the products you service. They are also available to respond to special problems or concerns. If you need assistance, please contact your Ancillary Contract Specialist.

**NaviNet.net**
All participating physicians ancillary providers are required to register for NaviNet within 30 days of your effective date of participation.

Through NaviNet, a multi-payer web portal, you will have access to the important Horizon BCBSNJ information (eligibility, benefits, claims status, online explanations of payments, etc.) that you need to conduct business with us on a day-to-day basis.

By using NaviNet, you will have access to Horizon BCBSNJ information, as well as the online information of many other New Jersey health plans.

- To learn more about NaviNet, please visit NaviNet.net/about-navinet.
- To access a NaviNet Information Demo, please visit HorizonBlue.com/Providers and:
  - Click See Reference Materials in the I Want To... section and select NaviNet.

**Billing Company Access to NaviNet**
If you employ the services of a billing company, we want to remind you that you can help increase their effectiveness and efficiency by encouraging them to register and use NaviNet to carry out their day-to-day responsibilities on your behalf.

To register for NaviNet, the billing company should:
2. Follow the instructions and complete the online NaviNet New Registration Request Application using your company's tax ID number. Ensure that Yes is selected in response to the question: *Is your office a billing agency?*

   Upon submission of the NaviNet New Registration Request Application, a NaviNet enrollment specialist emails an authorization form and instructions to the billing company contact.

3. Complete the authorization form. The billing company will need to obtain a signature from your office to grant them access to the information on your behalf.
4. Fax the completed and signed authorization forms to NaviNet to the fax number provided.

Following the receipt of a completed authorization form, NaviNet processes the enrollment request and emails NaviNet login credentials to the billing company contact.

If your billing company is registered for NaviNet and does not have access to your information, please ask them to forward a copy of the authorization form (see step 3 above) they originally received from NaviNet for you to sign. For help registering, please call NaviNet Customer Care at 1-888-482-8057.

**NaviNet Online Capabilities**
We continue to improve and expand the online capabilities available to you to provide a more efficient and productive experience. Below are some of the online capabilities you can access through NaviNet:

- Claim Inquiry (*local and out-of-state members*).
  - Blue Exchange Claims Appeal.
  - Claim Attachments.
  - Explanation of Payment (EOP).
- Claim Submission (CMS 1500 and UB04).
- Clear Claim Connection.
Service

- COB Questionnaire Submission.
- EFT Registration.
- Eligibility and Benefits Inquiry (local and out-of-state members).
- Fee Schedule Inquiry (applicable to Family Planning Centers and Federally Qualified Health Centers).
- Horizon Healthcare Innovations.
- ITS Host Claim Appeal Submission.
- Medical Attachment Submission.
- Payment Status Inquiry.
- Physical and Occupational Therapy Authorization.
- Pre-existing Condition Attachment Submission.
- Provider Data Reporting.
- Provider Reference Materials.
- Referral/Authorization Inquiry.
- Referral Submission.
- Statement of Payment Inquiry.

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

Clear Claim Connection
To help you navigate the health care system, Horizon BCBSNJ offers the McKesson Clear Claim Connection™, a web-based code editing disclosure solution. Clear Claim Connection is designed to help ensure our claim reimbursement policies, related rules, clinical edit clarifications and clinical sourcing information are easily accessible and transparent for our participating physicians and health care professionals. Clear Claim Connection displays Horizon BCBSNJ’s code auditing rules for various code combinations and the corresponding clinical rationale.

To access Clear Claim Connection, log in to NaviNet.net, access Horizon BCBSNJ within the Plan Central dropdown menu and mouse over Claim Management and click Clear Claim Connection.

Within Clear Claim Connection, enter the required data to obtain the appropriate code auditing results. Clear Claim Connection will provide your office with the ability to identify Horizon BCBSNJ’s code auditing rules.

Please note: This auditing reference tool will provide results that reflect the reimbursement policies on the current date, not necessarily the service date. Displayed results are not a guarantee of how your actual claim will be processed. Claim reimbursement is subject to member eligibility and all member and group benefit limitations, conditions and exclusions.

Pre-existing Attachment Submission
We continue to streamline and improve our process to help decrease how long it takes to investigate potential pre-existing medical conditions. You can now electronically submit the following information to us:

- Completed pre-existing condition questionnaires.
- Completed pre-existing condition attestation forms.
- Medical record information.

To submit completed pre-existing condition questionnaires, attestation forms or related medical record information to us, registered users may log in to NaviNet.net and:

1. Mouse over Claim Management and click Claim Status Inquiry.
2. Search for and locate the claim in question.
3. Click the Claim Number to proceed to the Claims Details screen.
4. Click Submit Attachments within the Claims Detail screen.
5. Within the Submit Attachments for Pre-Existing Condition screen that displays, select one of the following Attachment Types: Pre-Existing Attestation Form, Pre-Existing Medical Records, Pre-Existing Questionnaire Form, Pre-Existing Additional Medical Records.
6. Click Browse then locate and attach the appropriate file(s) from your computer. A maximum of five attachments may be uploaded per submission. Each submission cannot exceed 10MB (combined size) for all attachments.
7. Click Submit Attachments.
8. Record the Confirmation Number that is generated for easier and faster follow up with Physician Services.
Provider Data Maintenance
Horizon BCBSNJ reminds our participating ancillary providers of the importance of ensuring that the demographic information within our files is accurate, current and complete. Inaccurate or incomplete information may cause problems and/or delays in the processing of claims, referrals and reimbursement to your office.

To ensure that your demographic information is accurate, current and complete, we ask that you regularly review your demographic information and initiate any necessary updates. To make updates to your demographic information, please fax to your Ancillary Contracting Specialist.

Provider Data Reporting
The Provider Data Reporting functionality, available through NaviNet, is a self-service, analytic reporting module providing participating providers with access, based on tax ID number, to claim summary analytical reporting for up to 36 months of data.

Provider Data Reporting allows you to review original and adjusted claims data by:

- Month.
- Quarter.
- Year.

Each report view provides a comparison between the current information (month, quarter or year) with claims data from the prior month, quarter or year, and the month, quarter or year prior to that. The reports provide statistics about processed claims, including:

- Number of claims.
- Percentage of electronic submissions.
- Percentage paid.
- Percentage denied.
- Percentage pended.
- Pending claim charges.

The reports also provide dollar amounts related to both paid and denied claims, including (where appropriate):

- Charges.
- Eligible amounts.
- Coinsurance amounts.
- Copayments.
- Deductible amounts.
- Medicare payments.
- Horizon BCBSNJ paid.
- Other insurance paid.

Users can drill down on many of the details displayed in Provider Data Reporting reports to get an even more detailed perspective on claims information.

Like many of our other reports available through NaviNet, Provider Data Reporting allows you to export and print report data in either a PDF or Microsoft Excel format. To access this report functionality from NaviNet.net, participating offices may click Provider Data Reporting within the Horizon BCBSNJ Plan Central page.

We’ve scheduled enhancements to make our Provider Data Reporting functionality much more dynamic. Watch for online alerts and articles in future issues of Blue Review.

Please note: The claims data used in the Provider Data Reporting is not real-time data but is updated on a weekly basis. Content updates and system maintenance are performed each Friday at 5 p.m., Eastern Time (ET), and continue through Monday at 8 a.m., ET. During this time, you may experience delays in generating reports and possible claim data discrepancies as the data is being refreshed.

Discrepancies in claim data from week to week may be the result of the inclusion of the most recent claims data (including newly processed claims and adjustments to previously processed claims) as well as the deletion of the oldest claim data (claims that fall outside the 36-month window) from the system.

Fee Schedule Inquiry Information Online Fee Schedule
Horizon BCBSNJ makes fee information (for some specialties) available to you online immediately. To access online fee schedule information, including Injectable Medication Fee Schedule Information, please visit NaviNet.net and log 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.

Injectable Medication Fee Information is updated on a quarterly basis (on or around the first day of February, May, August and November).

HorizonBlue.com

Horizon BCBSNJ makes most of our administrative information and important forms available online so that you have access to what you need, when you need it.

Our website provides the tools and resources you need to do business with us, including the ability to:

• View and print the most commonly used forms, including the:
  – W-9 Tax Form.
  – Fax Prior Authorization Request (8319) Form.
  – Inquiry Request and Adjustment (579) Form.

• Watch a tutorial on the Professional Payment Voucher.

• Review the Claims Information Quick Reference Guide that highlights service phone numbers, claims and inquiry addresses and appeals/predetermination information for specific prefixes and suffixes.

Online Forms
Horizon BCBSNJ makes most of our forms available online. To access our forms:

• Visit HorizonBlue.com/Providers.

• Click Find a Form in the I Want To... section.

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 HorizonBlue.com/Providers.

• Click Find a Form in the I Want To... section.

Our forms are organized into the following sections:

• Forms by Plan Type.
• Forms by Specialty Type.
• Forms by Type.
• Miscellaneous.
• W9 Form-Medical.
• W9 Form-Dental.

If you do not have access to the Internet, please contact your Ancillary Contracting Specialist for copies of any of our forms.

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.

Assessing the online W-9 form is easy:

• Visit HorizonBlue.com/Providers.

• Click Find a Form in the I Want to...section.

Provider Reference Materials

Our Provider Reference Materials (PRM) page provides you with access to important information (including newsletters, office manuals, access to our Medical Policy Manual, information on reimbursement and billing, etc.) as well as the latest news and alerts we post for your review. We encourage you to visit this page on a regular basis.

Our PRM is accessible through NaviNet® or our website. To access the PRM

• Log in to NaviNet.net.
• Access Horizon BCBSNJ within the Plan Central dropdown menu.
• Mouse over References and Resources and click Provider Reference Materials.

or
• Visit HorizonBlue.com/Providers.

• Click See Reference Materials in the I Want To... section.

While you may access the PRM page through NaviNet or our website, the content that displays may vary based on how you got there. PRM content that we reserve for access only by participating physicians and other health care professionals will only display if you access the PRM via NaviNet.

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

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 forms.
  – Policies and agreements.

To access this page:

• Visit NaviNet.net and log 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.

Interactive Online Classes
Online courses are available to provide valuable information about Horizon BCBSNJ products, initiatives and other topics. Courses are available to all participating ancillary providers, 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 email 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 Ancillary Contract Specialist.

Provider Directory
Information on participating ancillary providers, their office locations, specialty information, office phone numbers and hospital affiliations can be found at HorizonBlue.com/directory.

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 your information is accurate. Updates to your demographic information may be performed online or requested by fax.
Provider File Change Request Form
You may also initiate changes to your demographic information by fax. Complete a copy of our Provider File Change Request Form (9093) and fax it, along with all necessary supporting documents (e.g., W-9, NPPES Letter, SS4, etc.) to 1-973-274-4302.

To access our Provider File Change Request Form (9093), please visit HorizonBlue.com/Providers and:

• Click Find a Form in the I Want To... section.
• Click Forms by Plan Type and click Medical.
• Click Request Form-Medical-Change Provider File Info.

Electronic Data Interchange
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 American National Standard Institute (ANSI) 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
• Institutional and Professional Claims (837).
• Eligibility Inquiry and Response (270/271).
• Request for Authorization/Review (278A).
• Referrals (278R).
• Claim Status and Response (276/277).
• Benefit Enrollment and Maintenance (834).
• Claim Payment Advice (835).
• 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 reimbursement 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, call the eService Desk’s EDI team toll-free at 1-888-334-9242, Monday through Friday, between 7 a.m. and 6 p.m., Eastern Time, or send an email to HorizonEDI@HorizonBlue.com or send a fax to 1-973-274-4345.

Standards for Electronic Transactions
Horizon BCBSNJ complies with all current HIPAA (Health Insurance Portability and Accountability Act) standards. Per HIPAA rules, covered entities (health plans, health care clearinghouses, physicians, other health care professionals and facilities) must use accepted standards when electronically conducting 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.

You must submit electronic transactions using Version 5010 standards.

Horizon BCBSNJ continues to work with our trading partners to ensure they are able to conduct administrative transactions using the new HIPAA standards.

If you have questions about Version 5010, please email HIPAA@HorizonBlue.com.

ICD-10
Under a new provision signed into law on April 1, 2014, the implementation of ICD-10 diagnosis and inpatient procedure codes has been delayed. The U.S. Department of Health and Human Services (HHS) has indicated a new compliance date requiring the use of ICD-10 effective October 1, 2015, and continuing the use of ICD-9 through September 30, 2015.
Horizon BCBSNJ intends to be fully compliant with all CMS regulations and mandated dates for acceptance of ICD-10. We will continue to work with our providers and business partners to ensure that our supporting systems, policies and procedures comply with mandated requirements and do not interrupt day-to-day business processes. We are currently working to ensure ICD-9 codes will continue to be processed without disruption on and after October 1, 2014. Please note that Horizon BCBSNJ will not accept ICD-10 claims before October 1, 2015.

Horizon BCBSNJ is completing technical remediation currently underway and plans to delay full integrated testing until 2015. We will continue to conduct electronic Claims Acknowledgement testing with providers as requested. If you would like to participate in Claims Acknowledgement testing with Horizon BCBSNJ, please send an email to ICD10ProviderReadiness@horizonblue.com.

Effective January 6, 2014, Horizon BCBSNJ began accepting the revised version of the CMS 1500 Claim Form (version 02/12) that accommodates coding changes for ICD-10. We will continue to accept claims submitted on either CMS 1500 Claim Form (version 08/05) or CMS 1500 Claim Form (version 02/12).

To stay informed on any further directives issued for ICD-10 compliance, please visit cms.gov/icd10.

Please also visit HorizonBlue.com/Providers for more information on our continued implementation of ICD-10. Click on Provider Reference Materials, and then click ICD-10.

Rendering, Referring and Attending Physician NPI Requirement

Horizon BCBSNJ captures National Provider Identifier (NPI) information for rendering, referring and attending physicians.

In September 2011, we asked providers to begin submitting NPI information on all appropriate electronic and paper copy claim submissions.

Ensure that your claim submissions include rendering, referring and attending physician NPI information to avoid claim transaction rejections and/or delays in the processing of your claim submissions.

If you have technical questions about NPI or questions regarding electronic transactions, please call our e-Service Desk's EDI team at 1-888-334-9242, Monday through Friday, between 7 a.m. and 6 p.m., Eastern Time. Or, email your inquiry to HorizonEDI@HorizonBlue.com.

Deductible Information

Customer Service 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.
Special Programs

National Consumer Cost Tool (NCCT)
The online *National Consumer Cost Tool* (NCCT) helps Blue Cross and/or Blue Shield Plan members increase their awareness of health care costs. Blue Plan members have the opportunity to view cost estimates, expressed in a range, for various commonly performed treatments and procedures. Based on the specific treatment category and geographic area chosen by the member, the cost estimates display for each facility along with the name, location and phone number.
Utilization Management

Horizon BCBSNJ’s Utilization Management Program is based on the premise that quality medical care is the single most important element in delivering cost-effective care. Our Utilization Management 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, Utilization Management activities are intended to identify optimal modes of practice and, when possible, to help ensure ancillary providers 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 Utilization Management Program:

• Bases Utilization Management 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 Utilization Management 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 Utilization Management reviews incentives to encourage denials of coverage or service and does not provide financial incentives to ancillary providers 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 Utilization Management Program functions under the HCAPPA definition in much the same way as it has previously (when applicable). Our medical policies and 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 reimbursement of claims, is available at HorizonBlue.com.

When to Call for Authorization

You must contact Horizon BCBSNJ before rendering services to our members who require prior authorization.

Benefits will always dictate coverage; some services are subject to individual benefit limitations. The individual protocols and criteria that Horizon BCBSNJ uses to render utilization management decisions are available upon request.

Authorizations older than six months, in accordance with industry standards, will not be honored by Horizon BCBSNJ and will require a new review of the current clinical circumstances.

While the services that require prior authorization vary from product to product and from plan to plan, the services listed below generally require prior authorization.

• All inpatient admissions including:
  – All acute rehabilitation admissions.
  – All skilled nursing facility (SNF), sub-acute and acute rehabilitation admissions.
  – Behavioral health and substance abuse admissions (prior authorization performed by Horizon Behavioral Health).

• All possible cosmetic/plastic/reconstructive services including:
  – Blepharoplasty and other cosmetic eyelid surgery.
  – Breast reconstruction and reduction for gynecomastia.
  – Complex skin lesion/scar repair.
  – Lipectomy or excision of excessive skin.

• Advanced Imaging Services (AIS) – See page 135 for information.

• Ambulance transportation – Ground and air (non-emergent).

• Bariatric procedures.

• Cardiac radiology – See page 133 for information.

• Cognitive therapy.
• CT scans – See page 135 for information.
• Durable medical equipment (DME) purchases greater than $500. Most DME rentals require authorization.
• Home health care.
• Home infusion.
• Hospice care – Inpatient.
• Infertility services, when required by contract.
• Certain possible investigational or experimental procedures.
• Behavioral health services for nonbiologically-based mental illness (inpatient and certain outpatient). Prior authorization for many Horizon BCBSNJ plans is performed by ValueOptions. Please refer to the ValueOptions Resource Manual for more information.
• Ob/Gyn procedures:
  – Home uterine monitoring (Maternity Management).
  – Inpatient elective hysterectomies.
  – Terbutaline pump.
• Occupational therapy.
• Orthognathic surgery.
• Orthotics/prosthetics. Please refer to the orthotics/prosthetics mandate information within our online Medical Policy Manual. (Authorization is not required for most items for members enrolled in insured plans or the State Health Benefits Program.)
• Out-of-network requests for members enrolled in managed care plans that do not include out-of-network benefits. For members enrolled in plans that include out-of-network benefits, prior authorization is required for a hospital-based activity or if a service request is for the in-network level of benefits for a service that would otherwise be covered at the out-of-network level (in addition to the services described in this list).
• Outpatient testing, including but not limited to:
  – Psychological/developmental/neuropsychological testing.
  – Neurobehavioral status exam.
• Pain management injections and treatment.
• Out-of-network hemodialysis for Horizon HMO members.
• Physical therapy.
• Private duty nursing.
• Sinus surgery, rhinoplasty and rhytidectomy.
• Specialty pharmaceuticals, such as Botox, IVIG, Flolan.
• Speech therapy for certain contracts.
• Transplant services, except corneal transplants.
• Trigger point injections.
• UPPP (Uvulopalatopharyngoplasty).
• Vein stripping/sclerotherapy.

STAT lab testing in the outpatient department of a hospital requires prior authorization. Routine laboratory tests for managed care plans must be performed by LabCorp or AtlantiCare Clinical Laboratories.

Listing current at time of printing.
Online Prior Authorization Lists
Lists of services and supplies requiring prior authorization are available on our website. Accessing this information online will save you time by eliminating the need to call Physician Services or an Institutional Services Representative to confirm whether or not prior authorization is required for particular services.

To access our prior authorization lists, log in to NaviNet.net, access Horizon BCBSNJ within the Plan Central dropdown menu and:

- Mouse over References and Resources and click Provider Reference Materials.
- Click Utilization Management.
- Click the link under the Prior Authorizations heading.
- Click the product or group in question to review the appropriate prior authorization list.

Obtaining Authorization
To obtain authorization, please call our Utilization Management Department at 1-800-664-BLUE (2583).

Please note: Retroactive authorizations will not be granted. As an ancillary provider, it is your responsibility to make sure all authorization procedures are followed. If authorization is needed for services you are referring for or rendering and no authorization is obtained, claim reimbursement may be limited or denied, and if denied, the member may not be billed for the service.

Authorization for Behavioral Health and Substance Abuse Services
To submit and review authorization requests pertaining to behavioral health and substance abuse services, please log into ProviderConnect®, accessible from ValueOptions.com. Please refer to the ValueOptions Resource Manual at ValueOptions.com/Horizon for more information on ProviderConnect and the authorization process for behavioral health providers.

Authorization by Fax Program
Most ancillary providers can use our Authorization by Fax program to obtain authorizations.

To use this program, complete a Fax Prior Authorization Request form. Specific forms by specialty type can be found on NaviNet. To access specialty forms:

- Visit HorizonBlue.com/Providers.
- Click Find a Form in the I Want To... section.
- Click Forms by Type.
- Click Authorizations and then click the request form for your specialty type.

Please include the CPT-4 procedure codes and the ICD-9 diagnosis codes when you fax the information.

Upon review of all routine, nonurgent requests, the Prior Authorization Department will send you a Fax Determination notification as soon as possible, not to exceed 15 days from our receipt of all required clinical information for commercial plans (14 days for Medicare). Urgent requests are determined as soon as possible, not to exceed 72 hours from receipt, based on the medical urgency of the case.

If you receive a denial notification for a patient, you may discuss the determination with the physician who rendered the decision. If the physician’s name and phone number are not on the denial notification, please call our Utilization Management Department at 1-800-664-BLUE (2583).

Online Authorization for PT and OT Services
In most cases, Horizon BCBSNJ authorizes the initial 12 visits of outpatient physical therapy or occupational therapy (PT/OT) services upon receipt of an initial claim from a participating physical therapist or occupational therapist. You will no longer need to obtain a prior authorization for an initial 12 visits of PT or OT services. Eligibility and benefits must be confirmed prior to providing the service.
A prior authorization must be obtained in the following situations:

- Other PT or OT services have already been authorized in the current calendar year.
  - Need to review annual benefit limits.
- Diagnosis-related temporomandibular joint (TMJ) disorders.
  - Need to review for benefit and medical necessity.
- Treatment for work-related injuries.
- Patients under 19 years of age.
  - Review for medical necessity.
- Pre-existing condition clause on the member’s policy.
  - Limited applicability under Health Care Reform commencing in 2014.
- More than 12 visits are required.
- All services from nonparticipating providers.

Prior authorizations can be requested using either our:

- Online Physical and Occupational Therapy Authorization tool available in NaviNet.net, or
- Revised Physical Therapy Fax Authorization Form (7073) available in the Forms section of HorizonBlue.com/Providers. No other forms will be accepted.

From HorizonBlue.com/Providers, select Forms, then Forms by Type. Select Authorizations and scroll to Physical Therapy Fax Authorization Form.

Please remember that you still must check member eligibility and benefits by logging onto NaviNet.net prior to treating the patient. Claims processing and reimbursement for services provided are subject to member eligibility and all member and group benefits, limitations, and exclusions.

Please note: The PT/OT tool is for the use of rendering physical therapy and occupational therapy providers only. This tool cannot be used to create referrals for physical therapy or occupational therapy services.

Please include the CPT-4 procedure codes and the ICD-9 diagnosis codes when you fax the information.

Upon review of all routine, nonurgent requests, the Prior Authorization Department will send you a Fax Determination notification as soon as possible, not to exceed 17 days from our receipt of all required clinical information. Urgent requests are determined as soon as possible, not to exceed 72 hours from receipt, based on the medical urgency of the case.

If you receive a denial notification for a patient, you may discuss the determination with the physician who rendered the decision. The physician’s name and phone number will be on the denial notification.

Timeframes for Authorization/Additional Information Requests

Horizon BCBSNJ follows HCAPP-mandated timeframes, where applicable, when responding to requests for authorization or when requesting additional information from an ancillary provider.*

HCAPP mandates that health insurers respond to requests for authorizations as soon as possible but not greater than 72 hours. Hours for current urgent care situations including inpatient admissions 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 HCAPP.

Generally, all nonemergent inpatient admissions and some outpatient services require an authorization. For urgent admissions, HCAPP 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 timely to an authorization request, it is deemed an approval of the request.

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 HCAPP 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 HCAPPA (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, HCAPPA 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 circumstances.

* Members/covered persons enrolled in certain plans, such as ASO and self-insured accounts, are not affected by HCAPPA and their authorization information may not be honored by the subsequent carrier.

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.

For members who have small group coverage, care or treatment for the condition in question must have been received in the six months prior to the effective date.

A pre-existing condition limitation exclusion 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 carrier’s letterhead indicating the effective and terminating dates of coverage, can nullify or reduce the pre-existing wait period if the coverage was in effect within 63 days of the new coverage’s effective date.

Based on the member’s pre-existing limitation clause under the benefit plan, a request for prior authorization and/or claim reimbursement 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.

Based upon the requirements of the Affordable Care Act (ACA), pre-existing condition exclusions and waiting periods have been eliminated for enrollees under the age of 19 for plan years starting on September 23, 2010. They will be eliminated for enrollees ages 19 and over during 2014 for most health insurance plans. This includes employer-based group health plans and newer individual health plans. The exact date that the pre-existing condition exclusion will be eliminated depends on the start date of the plan or policy year. The change takes effect with the start of the first plan year on or after January 1, 2014.

The ACA allows exceptions for certain grandfathered plans. These are group health plans created, or individual health insurance policies purchased, on or before March 23, 2010. These grandfathered plans do not have to eliminate restrictions on preexisting conditions.
Utilization Management

Pre-existing Condition Medical Record Process

To help us quickly finalize your claim submissions, we may require you to submit medical records so that we can investigate possible pre-existing conditions and complete medical necessity determinations. When requested, the information must be returned to us within 10 days of your receipt of our request. To submit this information to us, you can electronically submit medical records through NaviNet.net, or fax requested medical record documentation to us using our dedicated, toll-free medical records fax number, 1-888-778-8891.

Horizon BCBSNJ no longer requires ancillary providers to complete and return an Attestation Form as part of the pre-existing condition determination process. This change is for claims with a newly diagnosed condition and total charges of less than $3,000 for a member enrolled in a policy that includes an active pre-existing condition waiting period. In place of the Attestation Form, Horizon BCBSNJ will send one, more detailed questionnaire – regardless of the claim total charge or the diagnosis code submitted – to request the information needed to promptly render a decision and finalize your claim submission. The fully completed questionnaire will enable us to render a determination in the majority of instances without a request for additional information.

To reduce the number of requests for medical records, Horizon BCBSNJ conducts ongoing reviews of our list of diagnosis codes that do not require clinical pre-existing condition review.

As an ancillary provider, you can visit HorizonBlue.com/Providers to reference Horizon BCBSNJ’s Medical Policies and our claim submission requirements. This will help you better understand when we require medical records to be submitted to support your claim. On a continuous basis, we review our Medical Policies and make revisions to those policies that no longer require medical record documentation.

Horizon BCBSNJ relies on the information provided by ancillary providers to expedite claim adjudication. If claims are reimbursed 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 reimbursements, subject to the Health Claims Authorization, Processing and Payment Act (HCAPPA)

BlueCard Members: Precertification/Prior Authorization

Out-of-state Blue Cross and/or Blue Shield Plan members are responsible for obtaining precertification and prior authorization for services as defined by their contract.

Ancillary providers must contact the Blue Cross and/or Blue Shield Plan where the patient is enrolled to obtain the precertification, prior authorization or any other type of authorization required services. To do so, refer to the patient’s ID card for phone number information or call 1-800-676-BLUE (2583).

Home Infusion

Home Infusion providers need to request authorizations through Novologix, visit Horizon-NJ-Request.com.

Inpatient Care

Timeframes for Authorization Requests

Horizon BCBSNJ responds to all submitted information for inpatient admissions authorization within 24 hours of receipt of all required information.

Timeframes for Additional Information Requests

If Horizon BCBSNJ requests additional clinical information to approve or deny an authorization request, the post-acute facility must respond to our request within 72 hours.

If additional information is not received within 72 hours, the Post-Acute Facility Case Management Department or the physician will be advised, in writing, of case closure via the daily log. When additional information is received, a review for medical necessity will occur.
Utilization Management

Initial and Concurrent Review
A Horizon BCBSNJ registered nurse will be assigned to your facility to review clinical information on a daily, or as-needed, basis. Your Horizon BCBSNJ case manager will also help your facility plan for and obtain the necessary authorizations for discharge planning and transition of care needs.

Nationally recognized guidelines are used to assess the medical appropriateness of inpatient admissions and continued stays. These guidelines include, but are not limited to, the Milliman Care Guidelines®. We will provide a copy of the criteria used for an individual determination upon request. Cases failing to meet the guidelines for medical necessity are reviewed by a licensed Medical Director.

Timeframes
A daily post-acute facility UM log will be provided to the post-acute facility’s designated representative, noting the case numbers and approval status for reviewed inpatient admissions.

To access a copy of our Post-Acute Facility Request form (5336), visit HorizonBlue.com/Providers and:

- Mouse over the Forms tab and select Forms by Type.
- Click Authorizations.
- Select Request Form - Authorization for Post-Acute Facility Intake.

After Hours Access
On weekends, holidays and after regular business hours, Horizon BCBSNJ staff are available to provide utilization management services and help with basic discharge planning. During these times, do not call your facility-assigned registered nurse. Instead, please call our After Hours Access Line at 1-888-223-3072.

No Notice of Admissions/Lack of Clinical Information Determinations
If additional clinical information is needed, the Post-Acute Facility Case Management Department will be notified, verbally of the information needed. If additional information is not received within 72 hours, the Post-Acute Facility Case Management Department or the physician will be advised, in writing, of case closure via the daily log. When additional information is received, a review for medical necessity will occur.

When complete admission/concurrent review information is:

- Received, an approval, denial or determination of an alternate level of care will be communicated to the Post-Acute Facility Case Management or Utilization Review Department within 24 hours of receipt.
- Not received prior to the patient’s discharge due to the member not providing correct or complete insurance information to the hospital, the hospital should contact their assigned Horizon BCBSNJ inpatient case manager for a retrospective review.

Peer-to-Peer Discussions
Horizon Blue Cross Blue Shield of New Jersey provides post-acute facilities with the opportunity to informally discuss any non-behavioral health utilization management medical necessity denial decision with a Horizon BCBSNJ physician or other appropriate reviewer. A peer-to-peer discussion must be requested within 72 hours of notification of the adverse determination.

Horizon BCBSNJ notifies each facility how to contact Horizon BCBSNJ’s physician or other appropriate reviewer to discuss a denial. Horizon BCBSNJ does not consider the discussion between the Horizon BCBSNJ physician and or other appropriate reviewer and the member’s treating practitioner to be an initiation of a formal appeal request, although a formal appeal based on the outcome of the discussion may be requested.

If Horizon BCBSNJ issues a denial due to a lack of necessary information and subsequently receives a phone call or the required information, the Horizon BCBSNJ practitioner who issued the initial denial may review the case with the new information and overturn it.

On weekends, holidays and after regular business hours, treating practitioners should submit peer-to-peer requests to our After Hours Access Line at 1-888-223-3072.
Utilization Management

Transportation
Reimbursement for ambulance transportation at the end of any post-acute facility stay varies and is subject to benefit and medical necessity determinations by Horizon BCBSNJ. Transportation for Horizon BCBSNJ members can be reviewed with the assigned case manager.

Post Acute Services
Authorizations
Although the services that require authorization vary from product to product and plan to plan, the following will require authorization:

• All acute rehabilitation hospital, sub-acute, skilled nursing facility and transitional care services.
• Non-emergent ambulance transport.
• Transfers to another facility (in or out-of-network).
• Other services as listed in guidelines.

If prior authorization is not obtained when required, payment may be denied or reduced.

Please note: Some services are subject to individual benefit limitations. It is extremely important to verify a patients’ coverage for Post Acute Care, even if a patient believes they have Medicare as their primary coverage. The patient may have a Horizon BCBSNJ plan that is actually their primary coverage and if appropriate prior authorization is not obtained, an admission will not be covered.

Post Acute Rehabilitation Criteria
A patient at this level of rehabilitation should demonstrate the following criteria:

• Medium to high endurance.
• Good rehabilitation potential based on pre-morbid/prior level of function status.
• Cognitive status does not preclude the individual from active participation in a treatment plan.
• Co-morbid medical conditions do not inhibit the individual from active participation in therapeutic activity.
• The patient must be able to tolerate two to three hours of therapy per day, that includes two or more modalities one of which must be physical therapy.

Skilled Nursing Facility Rehabilitation Criteria
• Require daily rehabilitation, six days per week.
• 1 to 1-1/2 hours per day (one to two disciplines).
• Therapy is geared towards gait training, transfer training and ADL training.
• Needs intermittent nursing service assessments (i.e., vs. monitoring, lung sounds, O2, IV, etc.).
• Needs skilled therapeutic intervention (i.e., enteral feedings, trach suctioning, wound care, etc.).
• Specific treatment plan and attainable goals in a defined period of time.
• Anticipation of community reentry in a defined period of time or move to another level of care (home with home care services or to custodial LTC).
• Average length of stay depends on the intensity of care.
• Wound care: multiple Stage I or II with other comorbidities or Stage III and IV with daily treatment.
• Enteral feedings (guideline for Medicare: more than 501cc per day G tubes, J tubes).
• Established/routine trach care.
• Pulmonary toilet and/or suctioning more than 3 times per day.

Ambulance Transportation
Most Horizon BCBSNJ plans cover ambulance transport under the following conditions. The patient:

• Has an ambulance benefit.
• Is being transferred to the nearest approved acute care facility.
• Is bedbound.
  – Unable to get out of bed.
  – Unable to sit in a chair or wheelchair.
  – Unable to ambulate.
• Requires emergency medical care that can’t be provided by the post acute care facility.
• Needs two or more persons for transfers.
Post Acute Facility (PAF) Referral Process

Horizon BCBSNJ’s post acute facility referral process is outlined below.

• The hospital discharge planner at the acute care facility is notified that a patient’s discharge plan includes rehabilitation.
• The hospital discharge planner notifies the post acute facility (PAF) intake unit. For subacute level and SNF level of care the request will be called into the PAF intake unit.
• Physical, occupational and/or speech therapy evaluations are faxed to the PAF intake coordinator by the hospital discharge planner or social worker.
• The information is reviewed and an approval or denial is issued.
  – If approved, the PAF nurse will contact the hospital discharge planner or social worker with the authorization number; level of care and length of stay, as well as the PAF case manager’s name and number. The case will then be sent to the PAF Case manager who will follow the case in the rehabilitation facility.
  – If denied, the PAF nurse will notify the discharge planner or social worker at the hospital. A denial letter will be sent to the acute care hospital requesting the authorization, together with the member and physician. Alternate discharge options will be offered.

Reviews

Horizon BCBSNJ requires the following reviews from a PAF:

• History, physical and initial evaluations are due within 24 hours of admission to the rehabilitation facility.
• Update reviews will consist of current therapy notes, any medical updates, discharge plan and estimated date of discharge.
• As a result of facility ongoing case management, each clinical update received shall include a request for continued number of days required to reach realistic goals with supporting rationale provided.

• Each request shall be submitted on the form designed by the PAF team to help you provide us with concise and accurate medical information regarding a patient’s continued stay.

To access a copy of our Post Acute Facility Continued Stay Request form (6637), visit HorizonBlue.com/Providers and:

• Mouse over the Forms tab and select Forms by Type.
• Click Authorizations.
• Select Post Acute Facility Continued Stay Request form (6637)

Discharge Planning

PAFs should begin:

• Discharge planning upon a patient’s arrival, or as early as possible to identify assistive devices and other Durable Medical Equipment (DME) that will be needed.
• Family training before the patient is ready for discharge.
• To provide documentation of steps being taken to achieve realistic discharge plan with secondary options being noted.
• Step training before patient is ready for discharge.

Helpful Hints

• Initial therapy evaluations should include prior level of function assessment, goals and estimated length of stay.
• When providing rehabilitation notes on physical therapy, occupational therapy, speech therapy or cognitive therapy, parameters for reporting functionality in each category should be the same as those categories previously reported. This will facilitate more effective tracking and measurement of patient’s progress.
• Report any changes in the patient’s medical status and any impact they may have on the patient’s ability to participate in rehabilitation therapies.
• Short term and long term goals should be specific and measurable. It is the facility’s responsibility to know the patient’s last covered day and to provide updates in a timely fashion.
• Updates may be required more frequently than on a weekly basis particularly as a patient is nearing a
Utilization Management

point of being able to be discharged.

• Copies of actual progress notes may be requested when updates are inadequate.

Advance Discharge Notice from a Post Acute Facility for Medicare Advantage Members

Medicare Advantage members will receive a Notice of Medicare Non-Coverage prior to the date the coverage for the post acute stay ends. The Notice of Medicare Non-Coverage must be presented to the member when issued, signed and the signed letter must be returned to the PAF case manager within 24 hours.

Right to Appeal a Decision for Medicare Advantage Members

A member has the right to an immediate, independent medical review (appeal), while their services continue, of the decision to end Medicare coverage of these services.

• If a member chooses to appeal, the independent reviewer will ask for the member’s opinion. The reviewer will also look at their medical records and/or other relevant information. Members do not have to prepare anything in writing, but they have the right to do so if they wish.

• If a member chooses to appeal, the member and the independent reviewer will each receive a copy of the detailed explanation about why the coverage for services should not continue. The member will receive this detailed notice only after they have requested an appeal.

• If a member chooses to appeal and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, neither Medicare nor the member’s Medicare Advantage plan will pay for these services after that date.

• If a member stops services no later than the effective date indicated above, the member will avoid financial liability.

Immediate Appeal Requests for Medicare Advantage Members

• The member must make their request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.

• The member’s request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date.

• The QIO will notify the member of its decision as soon as possible, generally by no later than the effective date of this notice.

• The member can call their assigned QIO to appeal, or if they have questions.

Other Appeal Rights for Medicare Advantage Members

If the member misses the deadline for requesting an immediate appeal with the QIO, they still may request an expedited appeal from their Medicare Advantage plan. If their request does not meet the criteria for an expedited review, the member’s Medicare Advantage plan will review the decision under its rules for standard appeals.

Appeals for Members Not in Medicare Advantage Plans

Please see page 42 for information on the medical appeals process for members not enrolled in Medicare Advantage plans.

Dedicated Medical Records Addresses

Horizon BCBSNJ is improving services for participating providers. To help ensure effective and efficient processes, we have created a dedicated address for medical records and medical documentation. Please use the address below when sending medical documentation for Utilization Management determinations:

Horizon BCBSNJ
Medical Documentation
PO Box 1268
Newark, NJ 07101-1268
Utilization Management

Please forward the following information to the dedicated address:

- Information to complete a clinical review of an inpatient stay.
- Required documentation to make a determination on a service.
- Emergency Room records for Horizon HMO and Horizon Medicare Advantage members.
- In vitro fertilization records.
- Physical therapy records.
- Home care records.
- Home infusion records.
- Post acute facility records.

Addresses for Determination Appeals
If you are appealing a determination, please send documentation to the appropriate address for your location.

Northern Region: providers in northern New Jersey (Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren counties) and New York may send documentation to:

Horizon BCBSNJ
PO Box 420, PP-14E
Newark, NJ 07101-0420

Southern Region Providers: providers in southern New Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem counties), Pennsylvania and Delaware may send documentation to:

Horizon BCBSNJ
PO Box 110, MT-03W
Mount Laurel, NJ 08054-1121

- If you have additional medical documentation on a current or retrospective inpatient stay, please work directly with your allocated Horizon BCBSNJ Inpatient Case Management (ICM) nurse.
- If you receive a request from Horizon BCBSNJ for medical records, please submit them to the post office box indicated on the request.
- Billing departments at the facility should work closely with the Case Management department to ensure records are sent to Horizon BCBSNJ only when necessary.

Programs Administered by CareCore
Horizon BCBSNJ contracts with CareCore National, LLC (CareCore), a nationally recognized, physician-owned management services company, to manage nonemergency radiology services, Advanced Imaging Services (MRI, CT, PET Scans, Nuclear Medicine including Nuclear Cardiology), cardiac imaging services, radiation therapy and pain management services provided to members enrolled in many of the plans we offer. The following services that are provided to members enrolled in many of our plans are subject to review by CareCore:

- Nonemergency radiology services.
- Advanced Imaging Services (AIS) (MRI, CT, PET scans, nuclear medicine including nuclear cardiology).
- Cardiac imaging services.
- Radiation therapy.
- Pain management services.

CareCore helps ensure that medically necessary and appropriate services are provided to our members. CareCore also provides clinical consultation and support to ancillary providers. They help in scheduling radiology/imaging services for our members.

CareCore provides:

- Real-time online authorizations.
- Online guidelines, quick reference guides and program documents.
- Health plan links, which allow access to real-time data regarding employer group and/or provider activity.
- Consumer information resource links, which provide valuable information on procedures, as well as educational tools for members.
Services that Require Prior Authorization (PA)/Medical Necessity Determination (MND)
The following services require that the referring physician obtain a PA/MND:

- Radiology/Cardiology.
  - CT/CTA/CCTA scans.
  - MRI/MRA.
  - PET/CT scans.
  - Nuclear medicine studies (including nuclear cardiology).
- Pain management injection therapies.
- Radiation therapy – MND only.

PA/MND through CareCore is not required for:

- Emergency Room visits.
- Inpatient stays.
- Patients enrolled in
  - The Federal Employee Program (FEP).
  - BlueCard (out of state) plans.
  - Medigap plans.
- Members for whom Horizon BCBSNJ is the secondary carrier.

PA/MND Numbers
A PA/MND number is formatted as follows: One alpha character, followed by nine numbers, followed by the CPT code (for example, A123456789-79999).

One PA/MND number is assigned per approved service.

To verify and review authorizations, MND approvals and their expiration dates, visit CareCoreNational.com, or call CareCore 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.

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.

Medical Criteria
The medical criteria used to issue PAs and MNDs are posted publicly and can be found on CareCore’s website, CareCoreNational.com/page/Criteria.aspx.

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 1-800-918-8924, extension 11858.

Appealing Clinical Decisions
Ancillary providers may appeal a clinical decision by writing to:

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

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

Claim Appeals
Claim appeals should not be sent to CareCore. All claims-related inquiries should be sent directly to Horizon BCBSNJ. Refer to the member’s ID card for details.

CareCore Resources
For access to a number of CareCore tools and resources, visit CareCoreNational.com:

- Click Resources and Information to display CareCore process tutorials, fax forms, worksheets and more.
- Click Criteria to review CareCore’s criteria for referring ancillary providers.

CareCore Contact Information
Visit CareCoreNational.com.

CareCore maintains separate phone and fax numbers for the following programs:

- Advanced Imaging Services (AIS), Cardiac Imaging Program and Radiology Program (phone): 1-866-496-6200.
Utilization Management

Participating Referring Ancillary Provider Responsibilities

Participating referring ancillary providers are responsible for following our CareCore program requirements:

- It is the referring ancillary provider's responsibility to validate if a PA/MND is required for services to be provided to a Horizon BCBSNJ member.

  To validate if a member's plan requires a PA/MND, visit CareCoreNational.com and select Authorization/Eligibility Lookup, or call 1-866-496-6200.

- If a PA/MND is required, it is the referring physician's responsibility to initiate the process.

  To initiate the process, visit CareCoreNational.com and sign in with your ordering Provider user ID and password. You may also call or fax CareCore.

  Please note: CareCore maintains separate phone and fax numbers for each program. Please see the program specific information that follows for appropriate numbers.

- The referring provider is not permitted to delegate PA/MND responsibilities to rendering facilities or third parties. These measures are intended to safeguard patients' personal health information (PHI), streamline the clinical review process and ensure the authenticity and reliability of the clinical information used in PA/MND determinations.

  Please note: Improper delegations and attempts by rendering facilities, third parties or persons other than the ordering provider to obtain PA/MNDs may impact continued network participation.

- Only the referring provider may call the peer-to-peer line to discuss a case with a CareCore Medical Director. Please call 1-800-918-8924, extension 11858, to contact a CareCore Medical Director.

- The referring provider's office is responsible for supplying any and all clinical documentation to support the medical necessity of the procedure being requested.

- The referring provider's office should refer Horizon BCBSNJ members to participating sites for radiology services. Participating site information is available at HorizonBlue.com/Directory or by calling CareCore Radiology Scheduling at 1-866-969-1234.

Participating Rendering Site Responsibilities

Participating rendering sites have a responsibility to ensure that the guidelines/protocols of our CareCore program are followed:

- Prior to scheduling a service, the rendering site must validate that a member's plan requires a PA/MND. To validate that a member's plan requires a PA/MND, use the Authorization/Eligibility Lookup feature on CareCore's website, CareCoreNational.com or call 1-866-496-6200.

  If a PA/MND is required and has not been obtained, the service should be rescheduled and the rendering site must advise the patient to contact the referring provider. Once a PA/MND has been obtained the patient can schedule a new appointment for services.

- Prior to rendering services, the rendering site must verify that a PA/MND has been obtained and the site location is accurate. To verify this information, visit CareCoreNational.com or call 1-866-496-6200.

  Services provided without a PA/MND in place may result in claim denials. Participating facilities or hospitals may not seek payment from the member in these instances. A retroactive benefit review will not be conducted.

- After rendering services, the rendering site must notify CareCore if there was a change to the procedure performed.

  Rendering sites must notify CareCore within two days if a service provided differs from the service indicated on the PA/MND (for example, if an MRI of the brain without contrast was performed, but an MRI of the brain with contrast is indicated on the PA/MND). If services are performed after hours, leave a voice mail message for CareCore, include patient information and changes, if applicable.

- All AIS claim submissions, including claims for professional components, for services provided to members enrolled in plans that require PA/MND, must include CareCore’s PA/MND number.

- Prior authorizations are effective from the clinical approval date only, not from the date of the request.
Actual benefit determination cannot be made until the claim is received and will be subject to the provisions of the patient’s present health benefits contract, including any applicable deductible, coinsurance and/or coordination of benefits. Reimbursement is dependent on the patient being an eligible Horizon BCBSNJ member at the time the services are incurred. This authorization will be affected should the claim submitted differ from the information provided at the time of this request.

Helpful Hint: When using CareCore’s website, print out the screen shot that shows the patient’s eligibility. The information on the screen is the most current eligibility information. CareCore’s website does not store past eligibility information.

Radiology Program
CareCare works with Horizon BCBSNJ to manage the radiology services and AIS (CT/CTA/CCTA scans, MRI/MRAs, PET/CT scans, nuclear medicine studies, including nuclear cardiology) provided to our members through prior authorization/medical necessity determinations (PA/MNDs) with the providers.

- Services provided include:
  - Scheduling of radiology services.
  - Claim correct coding and privileging assistance.
  - A variety of forms are available to help you with claims processing. Please visit HorizonBlue.com/Providers and mouse over Services & Programs and click CareCore National.

Contact Information
Advanced Imaging Services (AIS) – Radiology Program: Call 1-866-496-6200 or visit CareCoreNational.com.

AIS that Require PA/MND
Prior authorization (PA) or Medical Necessity Determination (MND) is required for several Horizon BCBSNJ products (e.g., Horizon HMO, Horizon POS, NJ DIRECT, NJ PLUS, Horizon Direct Access, insured Horizon PPO and Medicare Advantage plans) for the following services:

- CT/CTA scans.
- MRI/MRA.
- PET scans.
- Nuclear medicine studies (including nuclear cardiology).

Prior authorizations are effective from the clinical approval date only, not from the date of the request. The PA/MND is valid for 45 days.

Prior authorization for AIS does not apply to services rendered during Emergency Room visits or inpatient stays.

Prior to rendering services, the rendering site must verify that a PA/MND has been obtained by the referring physician and that the site location is accurate. To verify that a PA/MND has been obtained, visit CareCoreNational.com or call 1-866-496-6200.

Services provided without a PA/MND in place may result in nonpayment of services. If prior authorization is not obtained for services, those services will not be eligible for reimbursement. Participating facilities may not seek payment from the member in these instances. A retroactive benefit review will not be conducted.

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

CareCore performs site visits of radiology centers and offices on our behalf to ensure compliance with our diagnostic radiology quality standards.

Please review our quality standards and initiate any corrective actions to comply 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 HorizonBlue.com/Providers and:

- Click Search Medical Policies in the I Want To... section.
- Click Medical Policy Manual.
- Search for and click Standards for Diagnostic Radiology/Imaging Facilities/ Freestanding-Office including Surgi-Centers and Diagnostic Dental Radiographic Imaging.
Utilization Management

Medical Criteria
Medical criteria are posted publicly and can be found on CareCore’s website, CareCoreNational.com/page/Criteria.aspx.

Additional forms can be found on our website. Please visit HorizonBlue.com/Providers, and:

- Mouse over Services & Programs and click CareCore National.

These documents describe correct coding logic for billing CPT code combinations and the applied recognized sources or standards defined by CPT definition, CMS edits, etc.

Relative value units (RVUs) are available on the CMS website. Visit cms.gov/PhysicianFeeSched/PFSRVF/list.asp.

Radiology Scheduling Line
- Referring physicians can call CareCore at 1-866-496-6200, Monday through Friday, between 7 a.m. and 7 p.m., Eastern Time, or go to CareCoreNational.com to obtain a prior authorization or medical necessity determination (PA/MND). At the end of the review, the referring physician is given a case number.

- Upon approval, CareCore will contact the member by phone and schedule the procedure at a participating Horizon BCBSNJ facility. If CareCore cannot get in touch with the member, CareCore will assign a site based on a mile radius of the member’s ZIP code.

- Members can call CareCore directly at 1-866-969-1234 for scheduling assistance. Members can change their radiology site locations any time prior to services being rendered.

- The referring physician is faxed a notice that includes the PA/MND number and the site location.

All other non-AIS radiology/imaging services can be scheduled through the Scheduling Line. A tracking number will be issued to the caller for all services scheduled at radiology facilities.

Cardiac Imaging Program
CareCore works with Horizon BCBSNJ to manage the Cardiac Imaging Program for our members through prior authorization/medical necessity determinations (PA/MNDs) with physicians. CareCore helps ensure that medically necessary and appropriate cardiac imaging services are provided for our members, provides clinical consultation to our participating physicians, facilities and ancillary providers and helps schedule cardiac imaging services.

All participating physicians, facilities and ancillary providers that perform any cardiac procedures should visit HorizonBlue.com to review our quality standards and initiate any necessary corrective actions to come into compliance with our standards.

- Services provided by CareCore include:
  - Echocardiogram studies
  - Pediatric cardiology.
  - Credentialing and privileging
  - Online cardiology prior authorization program.

Contact Information
AIS – Cardiac Imaging Program: Call 1-866-496-6200, or fax 1-888-785-2480 or visit CareCoreNational.com.

Cardiac Imaging Services that Require PA/MND
An ordering physician must request a PA/MND which is required for several Horizon BCBSNJ products (i.e., Horizon HMO, Horizon POS, NJ DIRECT, NJ PLUS, Horizon Direct Access, insured Horizon PPO and Medicare Advantage plans) for the services listed below.

- Diagnostic studies.
- Nuclear medicine studies (including nuclear cardiology).
- Echo stress.
- Diagnostic left heart catheterization.
- Cardiac PET.
- Cardiac MRI.
- Coronary CT angiography (CCTA).
- Echocardiograms.

Prior authorization for AIS does not apply to services rendered during Emergency Room visits or inpatient stays.
Utilization Management

Prior to rendering services, the rendering site must verify that a PA/MND has been obtained and that the site location is accurate.

To verify that a PA/MND has been obtained, visit CareCoreNational.com or call 1-866-496-6200. Services provided without a PA/MND in place may result in nonpayment of services. If prior authorization is not obtained for services, those participating facilities may not seek payment from the member in these instances. A retroactive benefit review will not be conducted.

Echocardiography
- PA/MND is required for all members who are referred for an echocardiogram.
- Refer to the current year Radiology/Imaging CPT codes requiring PA. These codes are listed on CareCoreNational.com or on HorizonBlue.com.

Please note: CareCore will not accept a request for a PA/MND from the rendering radiology site/hospital. However, the rendering provider must verify if PA was given or a pre-service medical necessity determination was made, by calling CareCore at 1-866-496-6200 or via CareCore’s website, CareCoreNational.com.

Pediatric Cardiology Notification Process
This notification process only relates to pediatric cardiology since the patient encounter differs from adult cardiology patient encounters. To avoid issues with mismatched authorization numbers, claims or possible imaging setbacks, please ensure that CareCore identifies your physicians as pediatric cardiologists.

Pediatric cardiologists may contact CareCore for notification before performing diagnostic cardiac imaging exams or post diagnostic cardiac imaging exams, providing it is done on the same day.

Pediatric Pre-service Notification Procedure
If a cardiologist performs a screening echocardiography as part of the pediatric patient evaluation, then a pre-service notification must be called into CareCore when a pediatric patient evaluation appointment is scheduled.

The physician’s office calls CareCore before the patient comes in for the appointment and advises that the echocardiogram is for a pediatric patient.

When the physician’s office calls CareCore, the following information must be available:
- Patient demographics, including insurance information.
- Clinical rationale for the exam, as well as the specific CPT code(s) that will be performed.

A notification number will be given to the physician’s office at the time of the call.

If upon review of the patient’s information, the cardiologist needs to change the approved procedure, the physician’s office must notify CareCore of the new procedure code within 48 hours after the procedure is performed. If the exam is performed on a Friday or after hours, then you may enter the information through the CareCore Physician’s Portal at CareCoreNational.com. You may also leave a message with the date of service that exam was performed, or you may call back the next business day to report the procedure.

If this change to service is not recorded, the claim will be denied because the new CPT code will not match the approved CPT code.

The notification number is time stamped and must correspond to the date the service was performed. If there is a discrepancy, the claim will be denied. If authorization is not obtained for services, those participating facilities may not seek payment from the member in these instances. A retroactive benefit review will not be conducted.

Pediatric Post-service Notification Procedure
In situations when the pediatric cardiologist deems it necessary to perform an echocardiography on the patient during the patient’s exam, the physician may scan the patient and then notify CareCore.

When the physician’s office calls CareCore, the following information must be available:
- Patient demographics, including insurance information.
- Clinical rationale for the exam, as well as the specific CPT code that was performed.

CareCore will provide the pediatric cardiology notification number, which is linked to the CPT code requested.

Applicable CPT codes are available at CareCoreNational.com or HorizonBlue.com.

Pediatric cardiology notification may be made by calling CareCore at 1-800-918-8924, faxing 1-888-785-2480 or visiting CareCoreNational.com.

Please note: This excludes AIS which require Prior Authorization or pre-service Medical Necessity Review.
Pain Management Authorization Program
Horizon BCBSNJ is committed to helping ensure that the health care provided to our members is of high quality and consistent with nationally recognized clinical guidelines. With this commitment in mind, and in conjunction with CareCore, we have implemented an enhanced medical management prior authorization program for pain management services.

• Services provided by CareCore include:
  – Online pain management prior authorization (PA) program.
  – Online pain management resources, including Horizon BCBSNJ’s Medical Policies.

Contact Information
Pain Management Authorization Program: Call 1-866-241-6603 or fax 1-800-649-4548 or visit CareCoreNational.com.

Pain Management Medical Policies
The Horizon BCBSNJ medical policies on pain management were developed using recognized evidence-based guidelines, and incorporate criteria derived from published materials that are supported by nationally recognized agencies, such as the American Academy of Pain Management and the National Institutes of Health. Horizon BCBSNJ medical policies reflect current community standards of practice and recognized medical practice guidelines.

Pain Management Services that Require PA
A list of pain management services requiring PA and guidelines for various pain management services are available online.

To access this information, visit HorizonBlue.com/Providers, and:
• Mouse over Services & Programs and click CareCore National.
• Click Pain Management Program.

Pain Management Services PA Exclusions
The prior authorization requirement does not apply to services rendered in the Emergency Room or during an inpatient stay.

You may verify if a member’s benefit plan requires PA by using CareCore’s website, CareCoreNational.com.

Pain Management PA Process
If pain management services are prescribed, our subscribers and their dependents must contact Horizon BCBSNJ before services are provided to ensure that they are eligible for reimbursement.

If prior authorization (PA) is not obtained for pain management services, those services will not be eligible for reimbursement. You may not seek payment from the member in these instances. A retroactive benefit review will not be conducted.

Radiation Therapy Program
CareCore works with Horizon BCBSNJ to help coordinate the radiation therapy services provided to Horizon BCBSNJ members who are diagnosed with cancer.

CareCore works with the treating radiation oncologist and reviews his or her treatment plan to determine the medical necessity and 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.

• Services provided include:
  – Radiation therapy utilization management.
  – Online tools.

Radiation Therapy Benefit Management tutorials are available at CareCoreNational.com.

Contact Information
Radiation Therapy Program: Call 1-866-242-5749 or visit CareCoreNational.com.

Radiation Therapy Program Criteria
CareCore’s extensive evidence-based criteria is based on the National Advisory Committee review of evidence-based literature and is in alignment with existing American College of Radiology (ACR) and American Society for Therapeutic Radiology and Oncology (ASTRO) guidelines.

To access the criteria, log in to CareCoreNational.com and:
• Click Radiation Therapy.
• Click Criteria and select Radiation Therapy Management.
Radiation Therapy Services that Require MND
MND is required for the following radiation therapy services that treat the following conditions:

- Bone metastases.
- Brain metastases.
- Breast cancer.
- Cervical cancer.
- Endometrial cancer.
- Gastric cancer.
- Head/neck carcinoma cancer.
- Non-small cell lung cancer/small cell lung cancer (NSCLC/SCLC) and other cancer diagnoses that require radiation treatment.
- Pancreatic cancer.
- Primary central nervous system lymphoma.
- Primary central nervous system neoplasms.
- Prostate adenocarcinoma cancer.
- Rectal adenocarcinoma cancer.

Please note: The review of chemotherapy drugs are not included in this CareCore program.

Plans that Require MND for Radiation Therapy
MND applies to radiation therapy services provided to members enrolled in the following plans:

- Horizon HMO.
- Horizon HMO Access.
- Horizon Point of Service (POS).
- Horizon Direct Access.
- Indemnity.
- Horizon PPO.
- Horizon Medicare Advantage plans.
- New Jersey State Health Benefits Program (SHBP) or School Employees’ Health Benefits Program (SEHP) plans.
- Small group plans, regardless of product.

Radiation Therapy MND Exclusions
MND does not apply to, and is not required for, radiation therapy services provided to:

- BlueCard members.
- Members enrolled in self-funded groups.
- Members enrolled in Horizon NJ Health.
- Members enrolled in the Federal Employee Program (FEP).
- Members enrolled in Medigap plans.
- Members whose Horizon BCBSNJ coverage is secondary to another insurance plan.
- Services rendered during an Emergency Room visit or inpatient stay.

Radiation Therapy Program MND Process
To initiate a radiation therapy request, the physician providing the radiation treatment plan must complete all questions on the specific worksheet. The worksheet can be downloaded from CareCore’s website.

Requests must be submitted via CareCoreNational.com, or by phone at 1-866-242-5749. No requests may be faxed.

Submitting a Clinical Appeal
If a request does not demonstrate medical necessity, you will be notified in writing. This notice will provide detailed instructions on how to submit clinical appeals.

If a pre-service MND is not obtained, reimbursement may be delayed pending a post-service medical necessity review.

- This post-service medical necessity review will be conducted by CareCore, applying the same medical policies used during a pre-service MND.
- The time limit for initiating a post-service MND is 18 months from the date of service.
Worksheets
CareCore makes worksheets specific to each cancer type available on their website, CareCoreNational.com. The worksheets help 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.
  - Fractions.
  - Treatment technique.
  - Boost.
  - Fields.

Requesting an MND for Radiation Therapy
1. If MND is required by Horizon BCBSNJ, the physician or other health care professional must initiate a case online by going to CareCoreNational.com or calling CareCore at 1-866-242-5749.

Some Horizon BCBSNJ health plans are not reviewed by CareCore (see previous page). In those cases, the physician or other health care professional must contact Horizon BCBSNJ directly.

2. A determination will be forwarded via fax and/or by non-certified mail, if approved, to the referring radiation oncologist who initiates the case. The MND will include:
   - Patient demographics.
   - Facility name.
   - MND number.
   - Type of therapy approved.
   - Number of fractions/angles approved.
   - Any special procedures requested.

3. When the case has an MND and the treatment plan changes because additional services, fractions, dosimetry or port films are required, the facility must contact CareCore to update the clinical information and MND approval prior to billing for these procedures. If this is not completed, then the services will be denied for No MND.

4. If the patient has been treated and claims submitted for the treatment are denied due to insufficient clinical information to establish a MND for the services rendered, the clinical rationale and/or updated treatment form should be submitted to CareCore. The ancillary provider may also call CareCore to provide the medical rationale for services rendered.

5. Any claim that denies for procedure(s) rendered which were excluded from the original approved treatment plan, benefit or eligibility reason is considered a claims appeal.

6. Clinically related appeals with additional clinical information and the associated MND number can be faxed to CareCore at 1-866-699-8128, Attention: Radiation Therapy Appeal.

7. Horizon BCBSNJ’s Claim Appeal Department contact information may be found on the patient’s Horizon BCBSNJ EOB and/or health care professional’s EOP forms.

MND Timeframes
If/when all necessary clinical information is provided and it meets the clinical criteria, physicians who:

- Submit an online request can obtain an MND online in real time.
- Call CareCore can receive an MND number by the end of the call.

Determinations will be made as soon as possible and in urgent circumstances no later than 72 hours from the receipt of all required clinical information.

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

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

Partial Approval Notice
A partial approval notice informs the facility of approved and non-approved services for the requested treatment plan. It also contains clinical appeal information. If you receive a partial approval, you will need to submit additional clinical information to CareCore to support the medical necessity of the remainder of the treatment plan.

Claim Denials
Claims may be denied for a variety of reasons. Please review denial reason code and description on the Explanation of Payment (EOP) you receive to help determine your next steps.

• If your claim is denied due to a lack of an MND, submit an 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.

For any other issues with radiation therapy claims, please call CareCore Customer Service at 1-866-242-5749.

Medical Injectables Program (MIP)
Horizon BCBSNJ is committed to providing our members with access to high-quality health care that is consistent with nationally recognized clinical criteria and guidelines. With this commitment in mind, we have implemented a Medical Injectables Program (MIP). This program changes our processes in regard to the review and approval of certain injectable medications in accordance with Horizon BCBSNJ’s Medical Policy criteria and guidelines.

Effective July 1, 2013, ICORE Healthcare, LLC (ICORE), a specialty pharmaceutical management company working on our behalf, conducts determinations of medical necessity and appropriateness reviews (MNARs) for certain intravenous immunoglobulin (IVIG), oncology and rheumatoid arthritis injectable medications.

ICORE conducts reviews of injectable medications administered:

• At a freestanding or hospital-based dialysis center.
• In an outpatient facility.
• In a patient’s home.
• In a physician’s office.

ICORE will not perform MNARs on injectable medications administered:

• During an inpatient stay,
• In an observation room, or
• In an Emergency Room.

Reimbursement of claims will be delayed or denied if an MNAR determination is not obtained prior to the administration of any of the medical injectables included in this program.

Online Information
To access online information about the MIP and ICORE, please sign in to NaviNet.net, access our Provider Relations Materials (PRM) page and:

• Click Services and Programs.
• Click ICORE HealthCare.

Injectable Medications Included in the MIP
A list of the IVIG, oncology and rheumatoid arthritis injectable medications that are subject to MNAR as part of the MIP is available online.

Please sign in to NaviNet.net, access our Provider Relations Materials (PRM) page and:

• Click Services and Programs.
• Click ICORE HealthCare.

• On the ICORE HealthCare page, click the link: View the list of injectable medications and the HCPCS codes subject to medical necessity and appropriateness review here.
Utilization Management

Plans Included in the MIP
The MIP applies to services provided to members enrolled in the following Horizon BCBSNJ products/plans:

- HMO.
- EPO.
- POS.
- Direct Access.
- PPO.
- Indemnity/Traditional.
- BlueCard Home.
- New Jersey State Health Benefits Program (SHBP)
- School Employees’ Health Benefits Program (SEHBP) plans.
- Medicare Advantage plans (including members enrolled in Horizon Medicare Blue (PPO) and Medicare Blue TotalCare (HMO SNP) plans).

MIP Exclusions
The MIP does not apply to, and MNAR determination is not required for, those intravenous immunoglobulin (IVIG), oncology and rheumatoid arthritis injectable medications provided to:

- Members enrolled in Horizon NJ Health.
- Members enrolled in the Federal Employee Program (FEP).
- Members enrolled in Medigap plans.
- Members whose Horizon BCBSNJ coverage is secondary to another insurance plan.
- Members receiving services rendered during an Emergency Room visit or in an observation room, or during an inpatient stay.

ICORE Contact Information
Visit icorehealthcare.com or call ICORE at 1-800-424-4508.

MNAR Process
Ordering physicians may obtain an MNAR online at icorehealthcare.com.

To access ICORE’s online tool, please visit icorehealthcare.com, click the Health Plan Partners icon, log in and:

1. Click Get an Authorization, read the overview and click Continue.
2. Enter the Member/Patient information, Click Search.
3. Select a provider from the drop-down menu.
4. Enter the Brand Name/Generic Name or Procedure Code and click Search. Then select the appropriate drug brand link in the results list.
5. Select the Yes or No radio button to add (or not add) additional medication(s). Then click Continue.
6. Click the ICD-9 Code lookup icon, enter your search criteria, click Search and then select the appropriate ICD-9 code. On the Reason Selection page, enter remaining details and then click Continue.
7. On the Question and Answer page, answer clinical questions and select Next.
8. On the Submission Confirmation page, click Submit after confirming that the information entered is correct.

If you have any questions about ICORE’s online tool, please email ICORE Specialty Drug Support at ISDS@magellanhealth.com.

Urgent MNAR requests
Urgent requests to obtain an MNAR determination may be initiated by calling ICORE at 1-800-424-4508.

A request is considered urgent if:

- Following the standard MNAR process may seriously jeopardize the life or health of the member, or the ability of the member to regain maximum function.
- Following the standard MNAR process would subject the member to severe pain that could not be adequately managed without the medical pharmaceutical treatment being requested.
Utilization Management

Information required to complete an MNAR
Ordering physicians should have the following information available when contacting ICORE to obtain a pre-service MNAR determination:

- Ordering provider name, address and office telephone and fax numbers.
- Rendering provider name, address and office telephone and fax numbers (if different from ordering provider).
- Member name, date of birth, gender and identification number.
- Member height, weight and/or body surface area.
- Anticipated start date of treatment (if known).
- Requested injectable medication(s).
- Dosing information and frequency.
- Diagnosis (ICD-9 code) and disease state severity.
- Past therapeutic failures (if applicable).
- Concomitant medications.

Additional information may be required depending on the injectable medication. For more specific criteria, please visit the ICORE Healthcare page within the Services & Programs section of HorizonBlue.com/Providers to access comprehensive MNAR clinical reference sheets available for the injectable medications in this program.

MNAR Timeframes
Once all the required information is provided to ICORE, a determination can be issued. The request may be delayed if additional clinical documentation is required.

Urgent requests will be completed as soon as possible following the receipt of all necessary information.

Nonurgent requests will be completed as soon as possible based on the medical urgency of the case, but in no more than three business days of receiving all necessary information.

Tracking and Determination Record Numbers
An ICORE tracking number (which consists of only numbers) is assigned at the initiation of an MNAR request. An ICORE determination record number (which can be identified by the letter I as the second to last character) is assigned when a final determination is made.

MNAR Denials and Appeals
ICORE will issue a letter for all adverse decisions of requests for MNAR. Appeal instructions will be included in all denial letters.

Generally, a provider may dispute an adverse decision that was based on medical necessity by following the instructions below.

- For non-Medicare members, providers should call ICORE at 1-800-424-4508.
- For Medicare members, the appeal must be submitted in writing to:
  ICORE HealthCare, LLC.
  Atttn: Appeals Department
  PO Box 1459
  Maryland Heights, MO 63043
  Appeal Fax: 1-888-656-6805

Peer-to-Peer Consultations
Physicians who do not agree with ICORE’s determination may discuss the case in detail with an ICORE Medical Director by calling 1-800-424-4508, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time (ET).
This section is designed to help you understand some of the terminology you may encounter in this manual, at our seminars, when speaking to one of our representatives or when reading our newsletter.

**ACA (Affordable Care Act)**
The ACA is often referred to as the federal health care reform law. The ACA aims to reform the public and private health insurance industry and expand health insurance coverage and access for more than 30 million Americans. The ACA is sometimes referred to as the PPACA, the Patient Protection and Affordable Care Act.

**ACO (Accountable Care Organization)**
An ACO is a group of health care professionals assuming collective responsibility for care of a specific group of patients. An ACO receives financial incentives to improve health care quality, control costs and increase patient satisfaction.

**actuarial value**
Actuarial value is a measure of the average value of benefits reimbursed by the health insurance plan. It is calculated as the percentage of benefit costs a health insurance plan expects to reimburse for a standard population, taking into account cost sharing provisions. Placing an average value on health plan benefits enables consumers to compare different health plans more easily.

In the health insurance exchanges mandated by the ACA, plans may offer four metallic plans: Bronze (60 percent actuarial value), Silver (70 percent), Gold (80 percent) and Platinum (90 percent).

**adjusted community rating**
Adjusted community rating is a pricing method under which health insurers are permitted to vary premiums based on specific demographic characteristics (e.g., age, gender, location), but not on the health status or claims history of policyholders. The health care reform law allows premium variation based on age and tobacco use.

**Agreement**
The Agreement is the general name of the signed contract (including any amendments) between Horizon Healthcare of New Jersey, Inc. and/or between Horizon Healthcare of New Jersey, Inc. dba as Horizon Blue Cross Blue Shield of New Jersey and ancillary providers.

- Ancillary Services Provider Agreement – an agreement established between you and Horizon Healthcare of New Jersey, Inc. for participation in the Horizon Managed Care Network.
- Ancillary Services Provider Agreement – an agreement established between you and Horizon Healthcare Services, Inc. dba Horizon Blue Cross Blue Shield of New Jersey for participation in the non-managed care network.
- Ancillary Services Provider Agreement – an agreement established between you and Horizon Healthcare Services, Inc. dba Horizon Blue Cross Blue Shield of New Jersey for participation in both the managed and non-managed care networks.

**Ancillary Provider**
A provider of medical services or supplies that is not an acute care hospital or a physician.

Some bill as professional providers, for example:
- Adult medical daycare services.
- Ambulance.
- Cardiac monitoring.
- Diabetic education services.
- Durable medical equipment.
- Home infusion therapy.
- Family Planning Centers.
- Federally Qualified Health Centers.
- Laboratory.
- Mobile diagnostic services.
- Pediatric medical day care services.
- Personal care assistant services.
- Prosthetics and orthotics.
- Sleep Laboratory.
- Urgent Care Centers.
- Wound care services.
Some bill as institutional providers, for example:

- Acute rehabilitation.
- Ambulatory surgery center.
- Behavioral health/substance abuse.
- Comprehensive outpatient rehabilitation facility (CORF).
- Dialysis.
- Home health.
- Hospice.
- Lithotripsy.
- Outpatient rehabilitation centers.
- Skilled nursing facilities.
- Subacute/transitional care unit.

**authorization/certification**

Under a member’s benefits plan, 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 helps to ensure 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.

Services or procedures that do not specifically require authorization may still be subject to medical necessity review.

**capitation**

A predetermined monthly rate paid to a Primary Care Physician (PCP) for each member on his or her panel enrolled in certain Horizon BCBSNJ managed care plans.

**CMMI (Center for Medicare and Medicaid Innovation)**

The CMMI, also called the Innovation Center, is a unit within the Centers for Medicare & Medicaid Services (CMS). Under the health care reform law, the CMMI is responsible for overseeing demonstrations and pilot projects aimed at increasing efficiency and quality of Medicare, Medicaid and the federal Children’s Health Insurance Program (CHIP), and for working with private payers on new models of health care delivery and reimbursement.

**coinsurance**

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

**Consumer-Directed Healthcare**

Consumer-Directed Healthcare (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 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 in a benefit year.

**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.
**guaranteed issue**
Guaranteed issue is the requirement that health insurers sell or renew a health insurance policy to anyone who requests coverage, without regard to health status, use of services or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason. The federal health care reform law requires that all health insurance be sold on this basis beginning in 2014.

**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 the Federal Employee Program® (FEP®) and Medicare.

**health care fraud, waste and abuse**
Health care fraud, waste 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. 17:33A-1 et seq.

**Health Insurance Exchanges (HIX)**
Health Insurance Exchanges are state health insurance marketplaces for individuals and small employer groups. HIX aim to make selecting insurance easier and more transparent by standardizing products, enrollment, operations and oversight.

**Horizon HMO (Health Maintenance Organization)**
A product in which members receive health benefits through their selected PCP or are referred by that physician to Horizon Managed Care Network health care professionals. Generally, no coverage is available when members do not access care through their PCP, except in the case of a medical emergency or routine Ob/Gyn care.

**Horizon Direct Access**
A product in which members receive health benefits through participating physicians and health care professionals without a referral from a 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 Managed Care Network**
A network of independent primary and specialty care physicians, other health care professionals and facilities that have contracted with us to render in-network medical services to members enrolled in managed care plans.

**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 (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).
- State-of-the-art tools, education and support to help members make informed decisions about health care and related spending.

**Horizon POS (Point of Service)**
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.

**Horizon PPO Network**
A network of independent primary and specialty care physicians, other health care professionals and facilities that have contracted with us to render medical services to members enrolled in PPO and Indemnity plans.
individual mandate
The individual mandate is the requirement in the health care reform law that all individuals maintain health insurance. The mandate requires that starting in 2014, everyone who can purchase health insurance for less than 8 percent of their household income do so or pay a tax penalty.

in-network benefits
In-network benefits are the highest level of benefits available to enrolled members and are accessed by using physicians, other health care professionals, clinical laboratories, outpatient or inpatient facilities, etc., that are in the Horizon Managed Care Network or Horizon PPO Network and/or care coordinated through a PCP (as applicable).

Independent Payment Advisory Board (IPAB)
The IPAB was established by the health care reform law. It is authorized to recommend proposals to limit Medicare spending growth.

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 93 for the definition of medical emergency as it pertains to Medicare members.

Medical Loss Ratio (MLR)
MLR is the basic financial measurement used in the health care reform law. MLR requires health plans to spend a certain percentage of premium dollars to pay customers’ medical claims as well as provide activities that improve the quality of care.

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 diagnosis or treatment of that covered person’s illness, injury or disease.

Horizon BCBSNJ’s Medical Management (MM) program (formerly Utilization Management) functions under the HCAPPA definition in the same way as it has previously. Our Medical Policies and MM criteria, used to help us reach decisions about medical necessity for coverage purposes, comply with the HCAPPA definition standard.

This definition 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 Employee Program® (FEP®) and Medicare.

member or patient
A person eligible for health care benefits under a Horizon BCBSNJ plan. This individual is either a subscriber or a dependent of the subscriber.
Glossary

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

National Provider Identifier (NPI)
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). NPI uniquely identifies 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.

There are two types of NPIs:

Type 1 (Individual) NPI
All physicians and other health care professionals are required to obtain a Type 1 (Individual) NPI.

- Physicians or other health care professionals who practice as a sole proprietorship are not considered organization health care providers for purposes of the NPI Final Rule and thus cannot obtain a Type 2 (Organization) NPI.

Type 2 (Organization) NPI
Physicians or other health care professionals who are incorporated need to obtain both a Type 1 (Individual) NPI and a Type 2 (Organization) NPI. If a practitioner incorporates him/herself as a health care provider, that corporation/organization is required to obtain and use Type 2 (Organization) NPI.

Ancillary providers who have formed an LLC (Limited Liability Company) may need to obtain and use two NPIs depending on how the LLC is set up.

- Practitioners who form a single-member LLC (i.e., disregarded entities) are only eligible for a Type 1 NPI.
- Providers classified as a partnership or corporation who have formed an LLC are required to obtain both a Type 1 and Type 2 NPI.

out-of-network benefits for managed care network
A reduced level of benefits that occurs when a member’s PCP does not coordinate a Horizon POS member’s care or when a Horizon Direct Access, Horizon MyWay, Horizon Medicare Blue Access Group (HMO POS) or Horizon Medicare Blue Access Group w/Rx (HMO POS) member uses a physician or other health care professional, outpatient or inpatient facility, etc., that is not in the Horizon Managed Care Network.

out-of-network benefits for PPO network
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 professional who has entered into an Agreement with Horizon Healthcare of New Jersey, Inc. or Horizon BCBSNJ, to be in the Horizon Managed Care Network or Horizon PPO Network, respectively.

participating physician
A physician or physician group who has entered into an Agreement with Horizon Healthcare of New Jersey, Inc. or Horizon BCBSNJ, to be in the Horizon Managed Care Network or Horizon PPO Network, respectively.

participating specialist
A duly licensed physician or health care professional, other than a PCP, who has entered into an Agreement with Horizon Healthcare of New Jersey, Inc. or Horizon BCBSNJ, to be in the Horizon Managed Care Network or Horizon PPO Network, respectively.
PCMH (Patient-Centered Medical Home)
A PCMH is a model for providing comprehensive, coordinated primary care services. A PCMH facilitates communication and shared decision making between a patient, his/her Primary Care Physician, other providers and a patient’s family.

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. Predetermination decisions are based solely on the medical information provided. Predetermination decisions are not contractually required under the member’s benefit plan but are provided as a service to the member (or physician or health care professional) making the request.

Primary Care Physician (PCP)
A duly licensed family physician, general health care professional, internist or pediatrician who has entered into an Agreement with us to be in the Horizon Managed Care Network and who has been selected by a member enrolled in a Horizon BCBSNJ managed care plan that requires the selection of a PCP or offers the option to select a PCP.

A PCP is responsible for coordinating all aspects of medical care for those members who have selected him or her as the member’s PCP. These responsibilities include personally providing medical care or referring members to the appropriate source for medical care, whether that source is a specialist, other health care professional or facility. In addition, other specialists or health care professionals with appropriate qualifications may serve as a member’s PCP where Horizon BCBSNJ so agrees.

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 PPO or Horizon BCBSNJ Indemnity members as his or her first contact for an undiagnosed health concern, as well as continuing care of varied medical conditions.

rate review
The health care reform law creates a new federal role to examine any annual premium increases to Individual and Small Group health plans that exceed 10 percent. The federal government will work with state insurance departments to conduct an annual review of these rate increases and insurers must provide justification of such increases on their websites.

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

retainer-based medicine
Retainer-based medicine refers to programs in which a participating physician or other health care professional charges patients a retainer fee (annually, or with any other frequency) to become or remain a member of his/her panel and receive any treatment.

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 health care benefits 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 93 for the definition of urgent care as it pertains to Medicare members.
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