Flu season is here!
We thank our physicians in advance for encouraging patients to keep themselves healthy by getting a flu shot.

2013 Medicare Advantage update
See page 18.
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We’re pleased to announce that our 2012-2013 Participating Physician and Other Health Care Professional Office Manual – a single edition that includes information for physicians and other health care professionals who participate in both our PPO and managed care networks – is now available online. See page 31 for details on how to access this manual.

#### Icons throughout the newsletter will alert you to articles relevant to your area.
- **AF**: Ancillary Facilities (Ambulatory Surgery Centers, Dialysis Centers, Hospice Agencies, Rehabilitation Centers, Skilled Nursing Facilities, etc.)
- **AP**: Ancillary Professionals (Ambulance, Durable Medical Equipment Suppliers, Home Infusion, Orthotics, etc.)
- **F**: Acute Care Facilities
- **P**: Physicians and Other Health Care Professionals

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Horizon Blue Cross Blue Shield of New Jersey has joined active users on Facebook with our own corporate page, facebook.com/HorizonBCBSNJ.

You can stay up to date with the latest company news and health and wellness information. Follow us on Twitter™, twitter.com/HorizonBCBSNJ.

See an introductory video explaining how we’re transforming the health care delivery system in New Jersey, youtube.com/BCBSNJ.

Learn how your patients can stay connected with Horizon Blue Mobile anytime, anywhere, mobile.HorizonBlue.com.
Clear Claim Connection

To help you navigate the health care system, Horizon Blue Cross Blue Shield of New Jersey 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 to our participating physicians and other health care professionals. Clear Claim Connection displays Horizon BCBSNJ’s code auditing rules for various code combinations and the corresponding clinical rationale.

Auditing rules are updated regularly for consistency with Claim Payment Policy, new procedure codes, current health care trends and/or medical and technological advances. Clear Claim Connection results are based on the rules in force on the date the query is made.

Auditing rules are applied to the claim based on the date a service is rendered. Actual claims may receive a different editing outcome based on the clinical relationship logic that is in effect at the time the claim is received and processed, and may be affected by other system edits outside of our auditing rules (e.g., member eligibility or other claim processing and/or pricing logic). If a denial is issued for coding, the clinical rationale for the denial will be provided.

### Diagnosis-driven code audit results

Users do not presently have the ability to enter diagnosis codes as criteria within Clear Claim Connection. Code auditing results that are determined primarily by diagnosis code (e.g., male-only diagnosis and female-only diagnosis edits) may not display properly in this tool.

We apologize for this inconvenience and will update you on our progress in addressing this issue.

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

- Mouse over Claim Management.
- Click Clear Claim Connection.

Within Clear Claim Connection, enter the required data to get the appropriate code auditing results. Clear Claim Connection will provide your office with the ability to identify Horizon BCBSNJ’s code auditing rules.

If you have questions, please call the appropriate contact listed below. Representatives are available to help you Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

<table>
<thead>
<tr>
<th>If you are a …</th>
<th>Call …</th>
<th>At …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician or other health care professional</td>
<td>Physician Services</td>
<td>1-800-624-1110</td>
</tr>
<tr>
<td>Representative at an acute care or ancillary facility</td>
<td>Centralized Service Center</td>
<td>1-888-666-2535</td>
</tr>
</tbody>
</table>
Online fee information for behavioral health professionals

Horizon Blue Cross Blue Shield of New Jersey continues to provide a more efficient and productive experience by improving and expanding our online capabilities available to you. We are pleased to announce that beginning in **December 2012**, behavioral health professionals will be able to view fee information online, in real time via NaviNet®.

To access our online Fee Schedule Inquiry tool, please log in to [NaviNet.net](http://www.navinet.net), access Horizon BCBSNJ within the **Plan Central** dropdown menu and:

- Mouse over **Claim Management**.
- Click **Fee Schedule Inquiry**.

Fees may differ based on the type of plan your patient is enrolled in. Refer to your patient’s Horizon BCBSNJ ID card to confirm the plan type.

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

If you have questions about fee information displayed, please contact your Horizon BCBSNJ Network Specialist.

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**Using the Fee Schedule Inquiry tool**

Follow the directions below to use the online Fee Schedule Inquiry tool.

1. Select the appropriate records from the dropdown menu in the **Provider Information** section.
   - Billing Provider.
   - County.
   - Specialty.

2. Click **Submit** to display a list of current fee information for the most common codes for your specialty (in the county indicated).
   
   If you wish to further define your fee information search, proceed to step 3 prior to clicking **Submit**.

3. In the **Service/Procedure Information** section, indicate a specific:
   - Horizon BCBSNJ network.
   - Date of service.
   - CPT code/modifier combination.

4. Click **Submit**.

The fee information provided in this tool is not a guarantee of reimbursement. Claims are subject to all member and group benefit limitations, conditions and exclusions.
Electronic Fund Transfer (EFT) requirement

Horizon Blue Cross Blue Shield of New Jersey requires that all participating physicians, other health care professionals, ancillary professionals and ancillary facilities use EFT.

If you need help registering, we offer an online EFT training course that provides step-by-step instructions to complete the EFT registration process.

To access this online course, registered Navinet® users may log in to NaviNet.net, access the Horizon BCBSNJ Plan Central page and:

• Mouse over References and Resources and click Provider Reference Materials.
• Click Educational Classes.
• Click Electronic Funds Transfer.

If you have questions, please contact your Network Specialist or Ancillary Reimbursement Analyst.

* Oral surgeons and others who perform dental services are exempt from our EFT requirement. Our Dental Explanations of Payment (EOPs) are not available in electronic format. To ensure that oral surgeons and others who perform dental services continue to receive Dental EOPs, we ask that these practitioners not register for EFT until further notice.

The majority of participating practices and facilities have already registered for EFT. If you haven’t done so, register today.

Rendering, referring and attending physician NPI requirement

Horizon Blue Cross Blue Shield of New Jersey requires that all claim submissions include National Provider Identifier (NPI) information to identify rendering, referring and attending physicians, when appropriate.

Since September 2011, we have advised practices and facilities of the need to submit NPI information on all claim submissions.

Please 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 Electronic Data Exchange (EDI) team at 1-888-354-9242, Monday through Friday, between 7 a.m. and 6 p.m., Eastern Time. Or, you may e-mail your inquiry to HorizonEDI@HorizonBlue.com.
Submit Coordination of Benefits (COB) claims to us electronically

Horizon Blue Cross Blue Shield of New Jersey is committed to improving our ability to quickly and accurately process your claim submissions and provide you with reimbursement for the eligible services provided to our members.

To quickly and accurately process your claim submissions, we require that you submit claims, including the following types of COB claims, to us electronically:

- Commercial insurance claims where another payer is primary and Horizon BCBSNJ is secondary.
- Medicare primary claims when Medicare has not already forwarded us their claim and payment information. If your Medicare Electronic Remittance Advice (ERA) or Explanation of Payment (EOP) indicates that a claim has automatically crossed over to us, there is no need to resubmit to us directly.

To electronically submit COB claims to us, your practice management system/clearinghouse must be able to:

- Create or forward claims in the full Health Insurance Portability and Accountability Act (HIPAA) standard format (837) or in a format that contains equivalent information and includes necessary COB fields.
- Include payment information received from the primary payer’s HIPAA standard electronic remittance advice (ERA) or by converting the primary payer’s paper Explanation of Benefits (EOB) into the standard coding used in an ERA.

Reimbursement information required for:

Commercial electronic COB claims

- Adjustment amounts – At both claim level and service line level (if available).
- Adjustment reasons – Contractual obligation, deductible, coinsurance, etc.
- Primary payer paid amount – At both claim level and service line level (if available).

Medicare primary electronic COB claims

- Medicare allowed amount – At both claim level and service line level (if available).
- Adjustment amounts – At both claim level and service line level (if available).
- Adjustment reasons – Contractual obligation, deductible, coinsurance, etc.
- Medicare paid amount – At both claim level and service line level (if available).
- Patient responsibility amount.
- Medicare acceptance of assignment.

Coordination of Benefit (COB) claims can be submitted electronically via a clearinghouse, practice management system vendor or third-party vendor, but not through Horizon BCBSNJ’s website at this time.
Translating paper EOB information into standard ERA codes

Even if you received a paper EOB from another carrier, you can still electronically convey to us how the primary carrier processed a claim. By using HIPAA-approved code values, you can translate the other carrier’s reimbursement payment information and submit it electronically to us.

Note: Please use all standard code values provided by the primary carrier on paper EOB/remittance. There is no need to convert this information.

For more information

Please contact your practice management support team and/or the clearinghouse/vendor through which you submit your electronic claims to inquire about their ability to transmit electronic COB claims.

You may also contact our e-Service Desk’s Electronic Data Exchange (EDI) team at 1-888-554-9242, Monday through Friday, between 7 a.m. and 6 p.m., Eastern Time. Or, you may e-mail your inquiry to HorizonEDI@HorizonBlue.com or fax to 1-973-274-4355.

Submitting COB information electronically:

- The 2320, 2330A, 2330B and the 2430 loops carry a good portion of the COB information a payer needs to process a secondary claim.
- The HIPAA 835 transaction provides most of the necessary information to complete the appropriate segments and elements.
- The HIPAA 835 transaction from the prior payer(s) should provide the CAS segments (loops 2100 and/or 2110), CLP segment (loop 2100) and the SVC segment (loop 2110) that are used to complete the 837 COB transaction.
- The CAS segment information on the 837 COB transactions should come directly from the prior payer(s) HIPAA 835 or Remittance Advice/Explanation of Benefits. This information must never be altered or combined in any manner.
- When completing the COB information on the 837, use the information as it was provided on the prior payer(s) HIPAA 835 or Remittance Advice/Explanation of Benefits.
- Never change or alter any of the prior payer(s) reimbursement information, including the Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes and Remittance Advice Remark Codes. Changing codes is a violation of HIPAA and could result in reimbursement errors or processing delays.
- Before sending a Medicare primary COB claim, please check NaviNet®. If the claim is not showing as crossed over 30 days after you received your Medicare reimbursement, then you may submit the claim electronically. When submitting the claim electronically, include the COB information exactly as you received it on your Medicare ERA populated within the claim record.
Refer to in-network ancillary providers

Horizon Blue Cross Blue Shield of New Jersey is extending the effective date of the Ancillary Claims Filing rules from October 14, 2012 to January 1, 2013. This change may impact how much your Horizon BCBSNJ patients pay out of pocket for these services if referred to an out-of-network provider.

Beginning January 1, 2013, please follow these rules when referring your Horizon BCBSNJ patients for the following ancillary services and products:

- **Independent clinical lab** – The lab must participate with the Blue Plan in the state **where you are located** for the claim to process as in network. This means if the referring physician is located in New Jersey, the independent clinical lab must participate with Horizon BCBSNJ for the claim to process at the in-network level of benefits. If the referring physician 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 physician has office locations in different states, the patient’s claim must be sent to the Blue Plan in the state where the patient received the referral.

- **Durable medical equipment (DME)** – The DME provider must participate with the Blue Plan **in the state where the DME supplies are being purchased or shipped** to process as in network. This means if the Horizon BCBSNJ patient lives in New Jersey and is receiving DME equipment to his/her New Jersey home, the DME provider must participate with Horizon BCBSNJ for the claim to process at the in-network level of benefits. If DME supplies are purchased or shipped to a location outside of New Jersey, the DME provider must send the claim to the Blue Plan approved to process professional claims in that state.

- **Specialty pharmacy** – The specialty pharmacy must participate with the Blue Plan **in the state where the ordering physician is located** for the claim to process at the in-network level of benefits. This means if your office is located in New Jersey, the specialty pharmacy must participate with Horizon BCBSNJ for the claim to process at the in-network level of benefits. If the ordering physician is located outside of New Jersey, the specialty pharmacy must send the claim to the Blue Plan approved to process professional claims in your state.

When referring your Horizon BCBSNJ patients for these ancillary services and products, or any specialized health care, please remember to use in-network providers. Members who do not use participating health care professionals will pay more for their health care.

**Authorization prior to January 1, 2013**

If you completed Horizon BCBSNJ’s authorization process for Horizon BCBSNJ patients prior to January 1, 2013, this rule will not impact your claims for those ancillary services. You can continue to submit these ancillary claims as you have done in the past, directly to the member’s Blue Plan. For any authorization received on or after January 1, 2013, claims will be subject to these new filing and processing rules.

Use our online Provider Directory at [HorizonBlue.com/Directory](http://HorizonBlue.com/Directory) to find participating ancillary providers. This change to our claims processing does not change your Horizon BCBSNJ patients’ benefits. All claims remain subject to the members’ benefits and Horizon BCBSNJ’s policies. For more information about the changes to these ancillary services, visit [HorizonBlue.com/Providers](http://HorizonBlue.com/Providers) and:

- Mouse over **Resource Center**.
- Click **News**.

If you must refer your Horizon BCBSNJ patients to a nonparticipating provider, please remember to follow our **Out-of-Network Consent Policy**. To find a participating health care professional, visit [HorizonBlue.com/Directory](http://HorizonBlue.com/Directory).
Medical Home Program to benefit more New Jersey residents

Horizon Blue Cross Blue Shield of New Jersey is expanding its groundbreaking Patient-Centered Medical Home (PCMH) Program. Initiated in January 2010, Horizon BCBSNJ’s PCMH program is working to transform the state’s health care delivery system by changing incentive structures for health care professionals to reward the value of care patients receive, rather than the volume of care.

In 2012, Horizon BCBSNJ expanded its medical home program to benefit more than 175,000 members. As of November, approximately 80 primary care practices are delivering patient-centered care at 200 locations throughout New Jersey.

“With early results showing that Horizon BCBSNJ’s collaborative medical home program is improving the quality of care and reducing health care costs, we want more of our members to benefit from the program,” said Jim Albano, Vice President, Network Management and Horizon Healthcare Innovations, Horizon BCBSNJ. “By the end of this year, we intend to have more than 200,000 members in Horizon BCBSNJ’s medical home and accountable care programs.”

In a collaboration with health care leaders, Horizon BCBSNJ is developing innovative resources to transform physician practices into medical homes as well as increasing accountability for providing patients with more comprehensive, coordinated care. PCMH practices also focus on ensuring their patients are receiving care that meets evidence-based guidelines for various preventive health screenings and wellness care.

The PCMH program includes Population Care Coordinator nurses. Care Coordinator nurses work directly with physicians and office teams to improve the coordination of treatment for patients and help engage and empower patients to take control of their health. Once established, participating PCMH practices have an opportunity to receive additional outcome-based payments provided they meet specified goals for quality care, increased patient satisfaction and lower costs.

Early results of Horizon BCBSNJ’s PCMH program have been positive. Horizon BCBSNJ members in medical homes received appropriate cancer screenings more frequently and showed greater improvement in controlling diabetes. In addition, Horizon BCBSNJ medical home patients within the PCMH program had a 26 percent lower rate in Emergency Room visits and a 10 percent lower cost of care.

“The success of our patient-centered medical home program and its expansion demonstrate Horizon BCBSNJ’s commitment to working with health care professionals across the state to transform and improve how health care is delivered to patients in New Jersey,” said Robert A. Marino, Chairman and CEO, Horizon BCBSNJ.

If you would like more information about the PCMH program, please e-mail Dr. Steven Peskin at Steven_Peskin@HorizonBlue.com.
24/7 Nurse Line

Thank you for your continued participation in our networks and for all you do to help your patients become and stay healthy.

We want to remind you that some Horizon Blue Cross Blue Shield of New Jersey members have access to 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.

The nurses help to provide members with the necessary health information they need to make informed medical decisions. This helps a member determine if his or her health ailment requires a doctor’s visit.

The 24/7 Nurse Line is not an emergency service. In case of an emergency, members should go directly to the nearest emergency facility.

If your patients have questions regarding their benefits, they should contact Horizon BCBSNJ Member Services at the phone number listed on the back of their ID cards.

Flu season is here!

Every year up to 20 percent of the United States’ population gets the flu.¹ The flu causes 200,000 hospitalizations annually and 36,000 Americans die from flu-related causes.² It is an easily transmitted illness because infected patients are contagious from the day before symptoms appear to approximately one week after.³

We ask you to help educate your patients about the health complications associated with getting the flu and encourage them to get their flu shots this season.

The 2012-2013 vaccine includes the following strains:

- Influenza A (H1N1) component – was included in 2011-2012 vaccine.
- Influenza A strain H3N2-like virus – new for 2012-2013 vaccine.
- Influenza B/Wisconsin/1/2010-like virus (B/Yamagata lineage) – new for 2012-2013 vaccine.

¹ Seasonal Influenza. Centers for Disease Control and Prevention, cdc.gov/flu/about/qa/disease.htm.
² Adult Immunization. Centers for Disease Control and Prevention, cdc.gov/workplacehealthpromotion/evaluation/topics/immunization.html.
³ Key Facts about Influenza (Flu) & Flu Vaccine. Centers for Disease Control and Prevention, cdc.gov/flu/keyfacts.htm.
Do your part to help combat Medicare Part D fraud, waste and abuse

As part of an ongoing national effort to combat fraud, waste and abuse in the Medicare Part D Program, Health Integrity, LLC, the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), routinely requests prescriber prescription verification during the course of an investigation.

If you receive a prescription verification form from NBI MEDIC, we strongly encourage you to complete and promptly return the verification form. A timely and complete response to prescription verification will improve the likelihood of an appropriate action by confirming or eliminating an allegation of wrongdoing and/or preventing the reimbursement for fraudulent prescriptions.

A prescription verification form includes the beneficiary’s name, the name of the medication, the date prescribed and the quantity given. A prescriber is asked to indicate whether he or she wrote the prescription in question and return the form within two weeks.

Unfortunately, NBI MEDIC investigators report only 5 to 10 percent of prescribers respond to these requests.

The inability to obtain prescription verification can:

- Limit the investigator’s ability to determine the validity of the allegation, which could lead to closing a valid complaint due to lack of sufficient evidence;
- Inhibit the investigator’s ability to confirm that the identity of the physician or beneficiary has been compromised; and/or
- Result in a Part D Sponsor reimbursing for invalid prescriptions before a fraudulent or inappropriate payment pattern is substantiated.

Thank you for completing and returning any prescription verification forms you receive and for doing your part to help combat fraud, waste and abuse in the Medicare Part D Program.

For more information, please visit [www.healthintegrity.org](http://www.healthintegrity.org).
Medical record documentation compliance audit results

Horizon Blue Cross Blue Shield of New Jersey conducts periodic quality audits on a sample of individual medical records to ensure compliance with our medical records documentation standards and the Centers for Medicare & Medicaid Service’s (CMS) regulations. In December of 2011, we audited 100 medical records from 20 participating offices. All participating offices exceeded the 80 percent threshold. The average score was 97 percent.

Congratulations to these offices for achieving such high marks and for maintaining current, detailed and well-organized medical records that allow for effective and confidential patient care and quality review. The audit results are compared against our 2009 results in the table below.

Horizon BCBSNJ did not conduct a comparable audit in 2010. The next scheduled audit will take place in the fourth quarter of 2012.

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>2009 SCORE</th>
<th>2011 SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directives (Medicare)</td>
<td>30%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Author Identification</td>
<td>99%</td>
<td>100%</td>
</tr>
<tr>
<td>Dated Entries</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Follow-Up Care</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>Laboratory Results</td>
<td>100%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Legible Entries</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Medication Allergies</td>
<td>99%</td>
<td>97%</td>
</tr>
<tr>
<td>Medical History</td>
<td>98%</td>
<td>92%</td>
</tr>
<tr>
<td>Medical Record Availability</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Medical Record Confidentiality</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Medical Record Organization</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td>Page Identification</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Pediatric Growth Charts</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>Pediatric Immunization Records</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Personal/Biographical Data</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Prescribed Medications</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Presenting Complaints</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Preventive Services/Risk Screening</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td>Provider List</td>
<td>89.9%</td>
<td>100%</td>
</tr>
<tr>
<td>Tobacco, Alcohol &amp; Substance Abuse</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>Updated Problem List</td>
<td>89%</td>
<td>85%</td>
</tr>
</tbody>
</table>

(continues on next page)
Quality Improvement

Your office can easily work towards quality improvement. Simply:

1. Establish a quality standard.
2. Perform a self-audit against the standard.
3. Identify areas for improvement.

We’ve completed step one for you by establishing our medical record documentation standards.

Registered NaviNet® users may review our medical record documentation standards online. Log in to NaviNet.net, access the Horizon BCBSNJ Plan Central page and:

- Mouse over References and Resources and click Provider Reference Materials.
- Click Additional Information.
- Click Medical Record Documentation Standards.

Once you have reviewed our standards, you can perform a self-audit by selecting a random sample of medical records and comparing each record against one, some or all Horizon BCBSNJ’s medical record documentation standards to identify potential areas for improvement. For example, if you notice the names of specialists involved in your patients’ care are not always documented, perhaps the solution is to include a question about other physicians seen during the patient’s initial assessment questionnaire.

Advance Directives

Of the 100 randomly selected medical records reviewed, 14 were for Medicare members. Of those 14 medical records, six (42.9 percent) satisfied the Advance Directives standard (an improvement from 30 percent in 2009). Based on the results of this sample, we encourage offices to focus on improving Advance Directives documentation.

In addition to the information contained in our medical record documentation standards, please also review the brochure titled Advance Directives for Health Care published by the State of New Jersey’s Commission of Legal and Ethical Problems in the Delivery of Health Care. Visit www.state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf to access this brochure.

For more information about advance directives or about our medical records documentation standards, please contact your Network Specialist, Ancillary Account Executive or Hospital Relations Representative.
Horizon Hospital Recognition Program

Consumer demand for information about hospital safety and quality has never been higher. According to a 2008 Kaiser Family Foundation poll, the number of Americans who would choose a hospital with a higher safety and quality, rose 40 percent from 1996 to 2008.¹ Since 2006, Horizon BCBSNJ has partnered with The Leapfrog Group, a not-for-profit organization of employers and other large purchasers of health benefits, to measure hospital quality and improve patient safety.

With national attention focused on the transparency of hospital performance and choice among consumers, Horizon BCBSNJ encourages all of our New Jersey network hospitals to complete the Leapfrog Hospital Survey and participate in our Horizon Hospital Recognition Program. The survey is free to hospitals and the results are used by Horizon BCBSNJ to provide recognition to our New Jersey network hospitals that demonstrate good performance on the various quality and safety measures.

Since the program started in 2006, Horizon BCBSNJ has awarded almost $24 million to our participating network hospitals. The number of New Jersey network hospitals participating in the Leapfrog survey has more than tripled since 2006. Additionally, many New Jersey network hospitals have performed among the top hospitals nationally on the Leapfrog Hospital Survey. For example, Hackensack University Medical Center is the only New Jersey network hospital that was recognized as a top hospital when the program began in 2006 and is still a top hospital over the last two consecutive years, earning our highest financial recognition.

If you have any questions, please contact your Hospital Relations Representative.

Commitment to quality

Horizon BCBSNJ is not unique in recognizing Hackensack University Medical Center. In July 2012, Hackensack University Medical Center was ranked as the number one hospital in New Jersey, and one of the New York metro area’s top four hospitals, according to the U.S. News & World Report’s Annual Best Hospitals Report. We commend the physicians and staff at Hackensack University Medical Center and all of our other network hospitals that have been recognized as Leapfrog Top Hospitals. Their commitment to quality and patient safety is exemplary.

(continues on next page)
The Leapfrog Hospital Survey

The Leapfrog Hospital Survey is the flagship initiative of The Leapfrog Group. The survey is used as an important quality-improvement and benchmarking tool by more than 1,200 hospitals across the country and more than 30 in the state of New Jersey alone.

Since its inception in 2001, the Leapfrog Hospital Survey has evolved alongside the development of new measures of clinical performance into its current form. The survey asks hospitals to report on nationally standardized measures of patient safety, quality and efficiency, including:

- Use of Computerized Physician Order Entry (CPOE), including access to a robust CPOE evaluation tool.
- Presence of intensivists in hospital Intensive Care Units.
- Process, volume and outcomes for high-risk procedures, surgeries or conditions.
- Compliance with the National Quality Forum’s Safe Practices.
- Rates of central-line-associated bloodstream infections.
- Quality of care for common conditions such as heart attack, pneumonia and newborn deliveries.

Leapfrog’s measures are all evidence-based and nationally standardized, offering hospital leaders and clinicians direction on where to focus quality and safety improvement efforts. Additionally, hospitals that participate in Leapfrog’s survey demonstrate their commitment to transparency because Leapfrog’s results are publicly reported for health care consumers and others to view. To find out more about the survey, visit leapfroghospitalsurvey.org.

The deadline to complete the Leapfrog Hospital Survey is December 31.

1 Kaiser Family Foundation 2008 Update on Consumers’ Views of Patient Safety and Quality Information (Jul. 29-Aug. 6, 2008).
Resources to help you determine if your patients need behavioral health care

Horizon Healthcare of New Jersey, Inc. provides our Medicare Advantage members with access to behavioral and substance abuse benefits through Magellan Behavioral Health®.

With an estimated 26.2 percent of Americans ages 18 years and older suffering from a diagnosable mental disorder in a given year¹, collaboration among primary care physicians and behavioral health professionals has never been more essential for the delivery of integrated quality patient care. Magellan Behavioral Health provides physicians with a variety of resources, including screening tools, the Primary Care Physician (PCP) toolkit, patient referral services and expert behavioral health consultants.

Patient Health Questionnaire-9 (PHQ-9)
Recognizing behavioral health disorders is not always easy. The PHQ-9² is a screening tool you can use to help diagnose these disorders. Once completed, the questionnaire can be included in the patient's chart. (See a sample of the form on the next page.)

Primary Care Physician (PCP) Toolkit
The PCP toolkit is a new online resource that provides information and screening tools that can be used to identify potential behavioral health concerns and assist in making behavioral health referrals. The toolkit can be accessed by visiting the Magellan Behavioral Health website at MagellanPCPtoolkit.com.

Referrals and Consultations
To arrange for a referral to a behavioral health professional or request a consultation with a Magellan Behavioral Health Medical Director, simply call the number on the back of the member’s ID card and identify yourself as the treating medical physician. A care manager will work with you to determine the most appropriate resource based on patient need and preference, provider specialty, as well as other specific member requests or considerations.

By striving to improve care coordination, we hope to continue to promote quality care to our members.

Members who have chronic conditions also frequently suffer from depression. If you have a member who has a chronic condition of asthma, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD) or diabetes, you can refer him/her to the Horizon Blue Cross Blue Shield of New Jersey Chronic Care Program by calling 1-888-333-9617, Monday through Friday, between 8 a.m. and 7 p.m. Eastern Time. Upon referral, a case manager will be assigned to his/her case.

² Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and Colleagues, with an educational grant from Pfizer Inc. No permission is required to reproduce, translate, display or distribute.

# Patient Health Questionnaire-9 (PHQ-9)

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>(Use &quot;✓&quot; to indicate your answer)</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For office coding**

\[ \text{Total Score: } \sum (\text{scores}) \]

---

*If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?*

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

---

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
Horizon Blue Cross Blue Shield of New Jersey has communicated to you over the past several months that we are transitioning from contracting with individual radiologists to contracting directly with radiology centers, and that we evaluated the radiology centers to ensure continued proper access, quality and compliance.

As a result of this transition, we also communicated to you that there would be a revised network of radiology providers effective November 1, 2012.

Since the announcements and subsequent mailings, Horizon BCBSNJ received many inquiries and comments indicating that some of the information used to evaluate the radiology centers may have been outdated. Many centers have asked for an opportunity to submit updated information. We also received many accounts of center renovations, including upgraded or new equipment purchases.

As a result of these inquiries, Horizon BCBSNJ has postponed the November 1, 2012 implementation date until we have an opportunity to re-evaluate the centers based upon updated information.

We expect to complete the re-evaluation process by first quarter 2013. We will notify you once the re-evaluation process is complete.

Horizon BCBSNJ has not changed its strategy or the criteria used to evaluate radiology centers, and will continue to transition from contracts with individual radiologists to contracts with radiology centers. We will continue to ensure that the services provided to your patients continue to meet the highest standards of safety and effectiveness.

If you have questions about the changes to our radiology/imaging network, please contact your Network Specialist.

UPDATE: Radiology/Imaging network changes
Horizon Advantage EPO HSA/HRA plans

Beginning in January 2013, Horizon Blue Cross Blue Shield of New Jersey will offer versions of our popular Horizon Advantage Exclusive Provider Organization (EPO) plans that are compatible with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). These new Advantage EPO plans will be available to small, midsize, large and national account employers.

The Horizon Advantage EPO HSA/HRA plans combine a high-deductible Horizon EPO plan with a special savings/spending account. Members may use the accounts to pay for medical expenses not covered by their health plan, including deductibles and coinsurance.

As with other Horizon Advantage EPO plans, members enrolled in Horizon Advantage EPO HSA/HRA plans must use health care professionals who participate in our Horizon Managed Care Network (except in medical emergencies). There are no benefits for out-of-network services.

With these plans, members will have a lower copayment option if they choose a Primary Care Physician (PCP). However, they are not required to choose a PCP. Referrals are not required to see specialists in the Horizon Managed Care Network.

Participating physicians, other health care professionals and facilities should:

- Collect copayments (if applicable) during visits. Copayment information will appear on the member’s ID card.
- Wait until an Explanation of Payment (EOP) is received from Horizon BCBSNJ before billing patients for coinsurance and deductible.

Some versions of this plan will provide enrolled members with BlueCard® benefits for services received outside Horizon BCBSNJ’s service area. However, remember that when services are provided within the Horizon BCBSNJ local service area, members enrolled in Horizon Advantage EPO plans must use health care professionals who participate in our Horizon Managed Care Network.

If you have questions, please call the appropriate contact listed below. Representatives are available to help you Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

<table>
<thead>
<tr>
<th>If you are a …</th>
<th>Call …</th>
<th>At …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician or other health care professional</td>
<td>Physician Services</td>
<td>1-800-624-1110</td>
</tr>
<tr>
<td>Representative at an acute care or ancillary facility</td>
<td>Centralized Service Center</td>
<td>1-888-666-2535</td>
</tr>
</tbody>
</table>

You may identify members enrolled in Horizon Advantage EPO HSA/HRA plans by the following prefixes:

- JGS
- JGT
2013 Medicare Advantage update

In addition to the Medicare Advantage (MA) plans offered in 2012, Horizon Blue Cross Blue Shield of New Jersey will offer a new plan in 2013, Horizon Medicare Blue Group (PPO). For more information about this new Medicare Advantage plan, please see page 20.

Beginning in 2013, there are a few changes to our existing Medicare Advantage plan benefits that we’d like to point out to you.

Horizon Medicare Blue Value (HMO) and Horizon Medicare Blue Access (HMO-POS) Plans

Copayments

Member copayment responsibility may change for services provided by Horizon Managed Care Network physicians, other health care professionals and facilities to members enrolled in Horizon Medicare Blue Value (HMO) and Horizon Medicare Blue Access (HMO-POS). Please review your patients’ ID cards and/or confirm benefits as necessary. Changes may include the following:

- Primary Care Physician (PCP) office copayment may increase from $15 to $20.
- Participating Specialist office copayment may increase from $55 to $40 or $45.*
- Inpatient Behavioral Health/Substance Abuse treatment copayment increases will vary. Check the member's ID card/benefits for details.
- Diabetic Retinal Exam copayment will decrease to $0.

Member cost-sharing for outpatient services

Members enrolled in Horizon Medicare Blue Value (HMO) and Horizon Medicare Blue Access (HMO-POS) will be responsible for 20 percent coinsurance for the following services:

- All services provided in an outpatient setting.
- Medicare Part B Drugs (regardless of the place of service).

Telemonitoring for congestive heart failure

Members diagnosed with congestive heart failure who are enrolled in Horizon Medicare Blue Value (HMO) or Horizon Medicare Blue Access (HMO-POS) will be eligible to receive home telemonitoring services. Feedback will be communicated to Horizon BCBSNJ or to their physician’s office, allowing physicians to better manage a patient’s condition and prevent potentially adverse events.

Prior authorization

Members enrolled in Horizon Medicare Blue Value (HMO) or Horizon Medicare Blue Access (HMO-POS) must obtain prior authorization for speech and cognitive therapy services.

Horizon Medicare Blue Value w/Standard Rx (HMO) Plan

Hearing aid benefit

The annual hearing aid benefit for members enrolled in Horizon Medicare Blue Value w/Standard Rx (HMO) plan will increase to $1,250 ($750 for the first ear and $500 for the second ear). This change brings this benefit in line with all other Horizon Medicare Blue Value (HMO) plans.

Specialist copayment*

The specialist office copayment for members enrolled in our Horizon Medicare Blue Value w/Standard Rx (HMO) plan will increase to $45. However, please note that the office copayment amount for behavioral health specialists cannot exceed $40. The copayment amount that participating behavioral health professionals may accept from members enrolled in our Horizon Medicare Blue Value w/Standard Rx (HMO) is $40.

(continues on next page)
Horizon Medicare Blue TotalCare (HMO SNP)

The following changes will apply to members enrolled in our Horizon Medicare Blue TotalCare (HMO SNP) plan:

- Authorizations will no longer be required for enrolled members to receive chiropractic services.
- Prior authorization must be obtained for cognitive therapy services.
- Family planning services and supplies will no longer be an eligible benefit if provided by an out-of-network physician, other health care professional or facility. Benefits for family planning services and supplies are only eligible if provided by Horizon Managed Care Network physicians, other health care professionals or facilities.
- This plan will no longer provide enrolled members with worldwide coverage for emergencies.
- This plan will continue to cover emergencies within the United States.

Medicare Part D Prescription Drug Plans

Beginning in 2015, we will split the generic drug formulary tier into two tiers: Preferred Generic and Non-Preferred Generic. All Medicare Part D prescription plans in 2015 will now include the following five tiers:

1. Preferred Generic
2. Non-preferred Generic
3. Preferred Brand
4. Non-preferred Brand
5. Specialty Drugs

The Preferred Generic drug tier will have a $0 copayment amount to help encourage members to take their preventive medications which many times fall into this first tier. The Non-Preferred Generic drug tier will require a $4, $5 or $6 copayment amount.

If you have questions, please call the appropriate contact listed below. Representatives are available to help you Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

<table>
<thead>
<tr>
<th>If you are a …</th>
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<td>Representative at an acute care or ancillary facility</td>
<td>Centralized Service Center</td>
<td>1-888-666-2535</td>
</tr>
</tbody>
</table>

*Our Horizon Medicare Blue Value w/Standard Rx (HMO) plan will include a $45 specialist office copayment for 2013. This information will be displayed on member ID cards. However, the office copayment amount for behavioral health specialists, according to the Centers for Medicare & Medicaid Services (CMS) guidelines may not exceed $40. Behavioral health practitioners should only accept a $40 office visit copayment from members enrolled in the Horizon Medicare Blue Value w/Standard Rx (HMO) plan.
Horizon Medicare Blue Group (PPO) is new for 2013

Beginning January 1, 2013, Horizon Blue Cross Blue Shield of New Jersey will offer a new Medicare Advantage (MA) plan – Horizon Medicare Blue Group (PPO).

Our new Horizon Medicare Blue Group (PPO) plan is similar to our existing Horizon Medicare Blue Access (HMO-POS) plan. Enrolled members:

- Access their in-network benefits in our service area by using physicians, other health care professionals and facilities that participate in our Horizon Managed Care Network.
- Access their out-of-network benefits when they receive services from physicians, other health care professionals or facilities not in our Horizon Managed Care Network (including practitioners who participate only in our Horizon PPO Network).

Our new Horizon Medicare Blue Group (PPO) plan differs from our existing Horizon Medicare Blue Access (HMO-POS) plan in that enrolled Horizon Medicare Blue Group (PPO) members may access their in-network benefits outside of our service area by using physicians, other health care professionals and facilities that participate with another Blue Cross and/or Blue Shield plan’s MA PPO network. This arrangement is similar to how the BlueCard® program works.

Horizon Medicare Blue Group (PPO) enrolled member benefits

- No Primary Care Physician (PCP) selection is required.
- No referrals are required.
- Includes in-network and out-of-network benefits.
- Covers all Medicare Part A and Part B benefits, as well as additional supplemental benefits.
- Offered with and without Part D prescription drug coverage. Employer groups may choose to convert their Medicare Advantage coverage they offer employees to Medicare Advantage with Prescription Drug (MAPD) coverage – Horizon Medicare Blue Group w/Rx (PPO).

Horizon Medicare Blue (PPO)

<table>
<thead>
<tr>
<th>Member Name</th>
<th>OFFICE VISIT: $15</th>
</tr>
</thead>
<tbody>
<tr>
<td>J D DOE JR</td>
<td>SPECIALIST: $35</td>
</tr>
<tr>
<td>Member ID Number</td>
<td>EMERGENCY ROOM: $65</td>
</tr>
<tr>
<td>YKM3HZN12345678</td>
<td>RXPIN 004336</td>
</tr>
<tr>
<td>GROUP NUMBER 00-123456</td>
<td>ISSUER (80840)1234567890</td>
</tr>
<tr>
<td>EFFECTIVE DATE 01/01/2013</td>
<td>RXGROUP RXHRZN</td>
</tr>
<tr>
<td>BC/BS PLAN CODES 280/780</td>
<td></td>
</tr>
</tbody>
</table>

Horizon Medicare Blue (PPO) member ID numbers will include either a YKK or YKM prefix.

(continues on next page)
Reimbursement

In addition to seeing Horizon Medicare Blue Group (PPO) members, you may also see members enrolled in other Blue Cross and/or Blue Shield MA PPO plans who reside or travel in our service area. These members will be extended the same contractual access to care. Services provided to these members from physicians, other health care professionals and facilities that participate in the Horizon Managed Care Network will be reimbursed at our negotiated rates.

When in our service area, Horizon Medicare Blue Group (PPO) members, and members enrolled in other Blue Plans’ MA PPO plans will be able to:

- Access the in-network level of benefits when they receive care from physicians, other health care professionals and facilities that participate in the Horizon Managed Care Network. Reimbursement for eligible services provided to Horizon Medicare Blue (PPO) members, and members enrolled in other Blue Plans’ MA PPO plans will be calculated at our managed care rates.

- Access the out-of-network level of benefits when they receive care from physicians and other health care professionals who only participate in the Horizon PPO Network. In this case, reimbursement for services provided to MA PPO members will be calculated at the Centers for Medicare & Medicaid Services (CMS) allowance.

Note: Horizon PPO Network physicians or other health care professionals who have opted out of or are excluded from Medicare are not eligible to receive reimbursement for services rendered to a Medicare Advantage member.

If you have questions about Horizon Medicare Blue Group (PPO), please call Physician Services at 1-800-624-1110, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.
In 2013, Horizon Blue Cross Blue Shield of New Jersey will offer the following health plan options under the State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP):

New SHBP and SEHBP options for 2013

In all SHBP and SEHBP plans, preventive care services, as defined by the Patient Protection and Affordable Care Act (PPACA), provided by a participating provider will have no member cost share (no copayment, not subject to deductible).

Horizon HMO provides SHBP and SEHBP participants with access to 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 office visit copayment amounts (i.e., Horizon HMO1525 has a $15 PCP office visit copayment and a $25 specialist office visit copayment). Members enrolled with Horizon HMO (no numbers following the name) can have a $10 or a $15 copayment, depending on their plan eligibility. The Horizon HMO member copayment for state employees is $15 for a PCP or specialist office visit. The copayment for local government, local education employees and all retirees in the Horizon HMO is $10 per PCP or specialist office visit. The member’s ID card will indicate the appropriate copayment amount.

NJ DIRECT offers SHBP and SEHBP participants coverage in network or out of network in New Jersey and nationwide. With NJ DIRECT, members are not required to choose a PCP, and they can visit physicians and health care professionals who participate in the Horizon Managed Care Network in New Jersey and those who participate in the BlueCard® PPO network outside of New Jersey without a referral.

We offer NJ DIRECT as a standard health plan with copayments and as a high-deductible health plan (HDHP) with a Health Savings Account (HSA) that can be used to pay for qualified medical expenses.

The numbers in the standard health plan names reflect the office visit copayment amounts. NJ DIRECT10 and NJ DIRECT15 have primary care and specialty office visit copayments of $10 or $15. NJ DIRECT1525 has a primary care office visit copayment of $15 and a specialty office visit copayment of $25. NJ DIRECT2030 has a primary care office visit copayment of $20 and the specialty office visit copayment is $30 for adults and $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).

The numbers in the HDHP names reflect the individual deductible, which is doubled for non-single contracts, and is combined for in- and out-of-network medical services and prescription drugs. After the annual deductible is met, the member is responsible for 20 percent of the contracted rate in network and 40 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.

To learn more about the 2013 SHBP and SEHBP health plan offerings, please contact your Network Specialist, Hospital Relations Representative or Ancillary Account Executive.

(continues on next page)
No matter which Horizon BCBSNJ plan members choose, they can rely on us for dependable coverage, health and wellness programs and resources, including:

- **Case Management and Member Advocacy Program** – If a member is facing a complex medical situation, we can help. Through this program, we help individuals manage complex health care situations by simplifying navigation, coordinating care and providing better understanding of policies and procedures.

- **PRECIOUS ADDITIONS®** – Our members who select an in-network Ob/Gyn for prenatal care are eligible for this prenatal education program. In addition to information about pregnancy and prenatal care, PRECIOUS ADDITIONS participants receive a prenatal care class discount and reminders about proper postpartum care and childhood immunizations.

- **24/7 Nurse Line** – If a member has a health question, any time of day or night, they can access our toll-free health information line and online live nurse chat service. A registered nurse will provide the member with the information he or she needs to help make informed health care decisions.

- **Blue365®** – Members can save money through this national program that offers exclusive access to information, discounts and savings, making it easier and more affordable to make healthy choices.

*Blue365 offers access to savings on items and services that members may purchase directly from independent vendors. While Blue365 replaces Horizon BCBSNJ’s existing wellness discounts program, the vast majority of the discounted products and services that were previously available to members under that program are still available through Blue365. To find out what is available through Blue365, visit HorizonBlue.com/Blue365. Please note that the Blue Cross and Blue Shield Association (BCBSA) may receive payments from Blue365 vendors. Also, neither Horizon BCBSNJ nor the BCBSA recommend, warrant or guarantee any specific Blue365 vendor or discounted item or service.*
Horizon Blue Cross Blue Shield of New Jersey has established access standards for our participating primary care-type physicians (e.g., family practitioners, internists, pediatricians) and Ob/Gyns to help ensure that our members receive the timely and efficient care they need. Our Quality Improvement Committee approved the access standards listed below.

The standards below apply to the first available appointment offered by your office. These standards may vary depending on the patient’s situation and history. In certain cases, patients may need to be seen sooner than the time frames below indicate.

**Primary Care and Ob/Gyn Office Hour Requirements**

You must maintain appropriate physician coverage for your practice to assure the availability of covered services 24 hours a day, seven days a week, and be available for office hours and provide appropriate coverage for office hours at least 28 hours per week.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physical exam: Includes annual health assessments, as well as routine gynecological physical exams for new and established patients.</td>
<td>Offer the patient an appointment within four months of the request.</td>
</tr>
<tr>
<td>Routine care: Includes any condition or illness that does not require urgent attention or is not life threatening, as well as routine gynecological care.</td>
<td>Offer the patient an appointment within two weeks of the request.</td>
</tr>
<tr>
<td>Urgent care: Includes medically necessary care for an unexpected illness or injury.</td>
<td>Offer the patient an appointment within 24 hours of the request.</td>
</tr>
<tr>
<td>Emergency care: Includes care for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions or serious dysfunction of a bodily organ or part.</td>
<td>Respond to the patient’s call immediately and advise as to the best course of action. This may include sending the patient to an emergency facility.</td>
</tr>
<tr>
<td>After-hours care</td>
<td>Respond to a patient’s call for urgent or emergent care within 30 minutes of the call.</td>
</tr>
<tr>
<td>Office wait time</td>
<td>No patient is to wait more than 30 minutes for a scheduled appointment. If the wait time is expected to exceed the 30-minute standard, the office needs to offer the patient the choice of waiting or rescheduling the appointment.</td>
</tr>
</tbody>
</table>

(continues on next page)
Horizon Blue Cross Blue Shield of New Jersey conducts a survey of a random sample of participating Primary Care Physicians and Ob/Gyns to determine compliance with our appointment availability, wait times, after-hour protocols and more.

This annual survey allows us to measure how participating physicians are meeting our standards. Here are the results of our most recent survey:

<table>
<thead>
<tr>
<th>Appointment Availability Types</th>
<th>Percentage of Physicians Meeting the Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physical exam within <strong>four months</strong> or less.</td>
<td>99.5%</td>
</tr>
<tr>
<td>Routine care within <strong>two weeks</strong> or less.</td>
<td>93%</td>
</tr>
<tr>
<td>Urgent care within <strong>24 hours</strong>.</td>
<td>94%</td>
</tr>
<tr>
<td>Emergent care <strong>immediately</strong> or refer patient to Emergency Room.</td>
<td>96%</td>
</tr>
<tr>
<td>After-hours care response to patient <strong>within 30 minutes</strong>.</td>
<td>93%</td>
</tr>
<tr>
<td>Office wait time <strong>within 30 minutes</strong> or offered a new appointment.</td>
<td>93%</td>
</tr>
</tbody>
</table>

These results demonstrate the dedication our participating physicians have to their patients. We appreciate your continued cooperation in *Making Healthcare Work* for your patients, our members.
Horizon Blue Cross Blue Shield of New Jersey has established access standards for behavioral health care professionals who participate in our Horizon PPO Network. The standards are approved by our Quality Improvement Committee and help ensure that our members receive timely and efficient care.

The standards may vary depending on the patient’s medical condition. In certain cases, your office may need to see a patient earlier than the standards listed below.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine office visit</strong>: An appointment</td>
<td>Offer the patient a scheduled appointment within 10 days of the request.</td>
</tr>
<tr>
<td>with no extenuating circumstances or</td>
<td></td>
</tr>
<tr>
<td>sense of urgency.</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent</strong>: Any request for behavioral</td>
<td>Offer the patient an appointment within 48 hours of the request.</td>
</tr>
<tr>
<td>health care or treatment that, in the</td>
<td></td>
</tr>
<tr>
<td>opinion of a practitioner with knowledge</td>
<td></td>
</tr>
<tr>
<td>of the patient’s behavioral health</td>
<td></td>
</tr>
<tr>
<td>condition, would subject the patient to</td>
<td></td>
</tr>
<tr>
<td>severe pain or distress that cannot be</td>
<td></td>
</tr>
<tr>
<td>adequately managed without the care or</td>
<td></td>
</tr>
<tr>
<td>treatment that is the subject of the</td>
<td></td>
</tr>
<tr>
<td>request.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-life-threatening emergent</strong>: An</td>
<td>Offer the patient an appointment within six hours of the request.</td>
</tr>
<tr>
<td>appointment for a condition requiring</td>
<td></td>
</tr>
<tr>
<td>rapid intervention to prevent acute</td>
<td></td>
</tr>
<tr>
<td>deterioration of the patient’s clinical</td>
<td></td>
</tr>
<tr>
<td>state, such that gross impairment of</td>
<td></td>
</tr>
<tr>
<td>functioning exists and is likely to result in compromise of the patient’s safety. This</td>
<td></td>
</tr>
<tr>
<td>condition is characterized by sudden</td>
<td></td>
</tr>
<tr>
<td>onset, rapid deterioration of cognition,</td>
<td></td>
</tr>
<tr>
<td>judgment or behavior and is time</td>
<td></td>
</tr>
<tr>
<td>limited in intensity and duration.</td>
<td></td>
</tr>
<tr>
<td><strong>Life-threatening emergent</strong>: An</td>
<td>Offer the patient an appointment immediately or direct them to an emergency resource (i.e., 911 or the hospital Emergency Room).</td>
</tr>
<tr>
<td>appointment for a condition requiring</td>
<td></td>
</tr>
<tr>
<td>immediate intervention to prevent acute</td>
<td></td>
</tr>
<tr>
<td>deterioration of the patient’s clinical</td>
<td></td>
</tr>
<tr>
<td>state, such that gross impairment of</td>
<td></td>
</tr>
<tr>
<td>functioning exists and is likely to result in compromise of the patient’s safety. This</td>
<td></td>
</tr>
<tr>
<td>condition is characterized by sudden</td>
<td></td>
</tr>
<tr>
<td>onset, rapid deterioration of cognition,</td>
<td></td>
</tr>
<tr>
<td>judgment or behavior and is time</td>
<td></td>
</tr>
<tr>
<td>limited in intensity and duration.</td>
<td></td>
</tr>
<tr>
<td><strong>Medication adverse reaction</strong>: An</td>
<td>Offer the patient an appointment within 48 hours of the request.</td>
</tr>
<tr>
<td>appointment for a complaint of an adverse</td>
<td></td>
</tr>
<tr>
<td>side effect due to medication (prescribing behavioral health care professional only).</td>
<td></td>
</tr>
<tr>
<td><strong>Follow-up care after hospitalization</strong>:</td>
<td>Offer the patient an appointment within seven days of the request.</td>
</tr>
<tr>
<td>An appointment after discharge from an</td>
<td></td>
</tr>
<tr>
<td>inpatient psychiatric facility.</td>
<td></td>
</tr>
<tr>
<td><strong>Office wait time</strong></td>
<td>No patient is to wait more than 30 minutes for a scheduled appointment. If the wait time is expected to exceed the 30-minute standard, offer the patient the choice of waiting or rescheduling the appointment.</td>
</tr>
</tbody>
</table>

(continues on next page)
Horizon BCBSNJ conducts a survey of participating behavioral health care professionals to determine compliance with our appointment availability, wait times and more.

This annual survey allows us to measure how well participating behavioral health care professionals are meeting our standards.

The table below summarizes the results of our most recent survey.

<table>
<thead>
<tr>
<th>Appointment Availability Types</th>
<th>Percentage of Physicians Meeting the Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine office visit within <strong>10 days.</strong></td>
<td>92%</td>
</tr>
<tr>
<td>Urgent care within <strong>48 hours.</strong></td>
<td>81%</td>
</tr>
<tr>
<td>Non-life-threatening within <strong>six hours.</strong></td>
<td>27%</td>
</tr>
<tr>
<td>Life-threatening <strong>immediately</strong> or refer patient to emergency resources.</td>
<td>93%</td>
</tr>
<tr>
<td>Medication adverse reaction within <strong>48 hours.</strong></td>
<td>91%</td>
</tr>
<tr>
<td>Follow-up care after hospitalization within <strong>seven days.</strong></td>
<td>94%</td>
</tr>
<tr>
<td>Office wait time <strong>within 30 minutes</strong> or offered a new appointment.</td>
<td>98%</td>
</tr>
</tbody>
</table>

Please review the standards with your office staff. While the 2012 results show improvement, we look forward to collaborating with your office to help improve our members’ access to quality care.

If you have questions, please contact your Network Specialist.
Specialist access standards

In 2012 Horizon Blue Cross Blue Shield of New Jersey established Specialist access standards. These access standards are approved by our Quality Improvement Committee and apply to the first available appointment offered by the participating physician’s office.

The standards may vary depending on the patient’s medical condition. In certain cases, the physician’s office may need to see a patient earlier than the time frames listed below.

**Specialist Office Hour Requirements**

You must maintain appropriate physician coverage for your practice to assure the availability of covered services 24 hours a day, seven days a week, and be available for office hours and provide appropriate coverage for office hours at least 20 hours per week.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine physical exam:</strong></td>
<td>Offer the patient an appointment within <strong>three weeks</strong> of the request.</td>
</tr>
<tr>
<td>Includes any condition or illness that does not require urgent attention or is not life threatening, as well as routine gynecological care.</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent care:</strong></td>
<td>Offer the patient an appointment within <strong>24 hours</strong> of the request.</td>
</tr>
<tr>
<td>Includes medically necessary care for an unexpected illness or injury.</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency care:</strong></td>
<td>Respond to the patient’s call <strong>immediately</strong> and advise as to the best course of action. This may include sending the patient to an emergency facility.</td>
</tr>
<tr>
<td>Includes care for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions or serious dysfunction of a bodily organ or part.</td>
<td></td>
</tr>
<tr>
<td><strong>After-hours care</strong></td>
<td>Respond to a patient’s call for urgent or emergent care within <strong>30 minutes</strong> of the call.</td>
</tr>
<tr>
<td><strong>Office wait time</strong></td>
<td>No patient is to wait more than <strong>30 minutes</strong> for a scheduled appointment. If the wait time is expected to exceed the 30-minute standard, the office needs to offer the patient the choice of waiting or rescheduling the appointment.</td>
</tr>
</tbody>
</table>

(continues on next page)
Horizon BCBSNJ conducts a survey of a random sample of participating Specialists to determine compliance with our appointment availability, wait times, after-hour protocols and more.

This annual survey allows us to measure how our participating physicians are meeting our standards. Here are the results of our recent survey:

<table>
<thead>
<tr>
<th>Appointment Availability Types</th>
<th>Percentage of Physicians Meeting the Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine care within three weeks or less.</td>
<td>94.5%</td>
</tr>
<tr>
<td>Urgent care within 24 hours.</td>
<td>73%</td>
</tr>
<tr>
<td>Emergent care immediately or refer patient to Emergency Room.</td>
<td>92.5%</td>
</tr>
<tr>
<td>After-hours care response to patient within 30 minutes.</td>
<td>80.5%</td>
</tr>
<tr>
<td>Office wait time within 30 minutes or offered a new appointment.</td>
<td>95%</td>
</tr>
</tbody>
</table>

Please review the standards with your office staff. If you have questions, please contact your Network Specialist.
Effective immediately, Horizon Blue Cross Blue Shield of New Jersey will reduce the number of communication pieces that we print and mail to physicians and other health care professionals and convey most of this information in an electronic format.

We will use electronic means to convey information formerly provided to you in letter and postcard mailings (including material adverse change letters), newsletters, office manuals, etc. Electronic communications that we use to convey any material adverse changes to our policies, procedures, fee schedules, and/or capitation rates which may adversely impact your practice will be posted at least 30 days prior to the implementation date of the proposed change.

We remind you that according to your participating Agreement(s)\(^1\), physicians and other health care professionals in our managed care and PPO networks agree that we may communicate with them by electronic means.

If you have questions about communications or how you are receiving them, please contact your Network Specialist.

Where to look for electronic communications

**NaviNet’s Horizon BCBSNJ Plan Central page**

We use the Horizon BCBSNJ Plan Central page within NaviNet to convey information. Make sure you stop to review the information here before beginning to access the various functions and features available to you through NaviNet.

**The Provider Reference Materials (PRM) webpage**

Our PRM webpage also provides 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 regularly visit this page.

Our PRM webpage is accessible through NaviNet. To access the PRM through NaviNet:

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

Please make visiting our PRM webpage a regular part of your daily routine.

**E-mails**

We hope that you are receiving our e-mails and that they’ve provided you with useful information. If you have not received any e-mails from us, it may be because we do not have your e-mail address.

We generate our e-mail address files based on current registered NaviNet users who are affiliated with participating practices. Please make sure you are registered for NaviNet and your e-mail information on NaviNet is accurate.

\(^1\) Please see section 9.11 on page 15 of the HORIZON HEALTHCARE OF NEW JERSEY, INC. AGREEMENT WITH PARTICIPATING PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS (Horizon Managed Care Network Agreement) and/or section 12 on page 6 of the HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY AGREEMENT WITH PARTICIPATING PHYSICIANS AND HEALTHCARE PROFESSIONALS (Horizon PPO Network Agreement).
Updated 2012-2013 network office manual now available online

For 2012, Horizon Blue Cross Blue Shield of New Jersey has created a single, easy-to-use office manual for physicians and other health care professionals who participate in our PPO and managed care networks. Consolidating information into one manual helps streamline our communications and provides one convenient source of information.

Our 2012-2013 Participating Physician and Other Health Care Professional Office Manual contains information, policies, procedures and guidelines to help you work efficiently and effectively with us and provide quality care and services to your patients enrolled in plans offered by Horizon BCBSNJ and other Blue Cross and/or Blue Shield plans.

The manual will:

- Help answer day-to-day questions.
- Assist in providing services to Horizon BCBSNJ managed care and PPO members.
- Provide a convenient list of service numbers.
- Allow you to review managed care and other products offered by Horizon BCBSNJ.

We require that you access our 2012-2013 Participating Physician and Other Health Care Professional Office Manual online. The online version will always include the most updated information.

Amended pages will be posted online for review and printing. Notice of updates made to our manual will be announced online and in this newsletter.

To access the manual:

- Log in to NaviNet.net.
- Access the Provider Reference Materials page.
- Within the User Guides section, click the link under Physician Manual.

If you have questions, please contact your Network Specialist.
Office Manager Advisory Council (OMAC)

Horizon Blue Cross Blue Shield of New Jersey is committed to improving our working relationship with your office. In an effort to achieve that goal, Horizon BCBSNJ formed an Office Manager Advisory Council (OMAC) in 2006. The intent of the OMAC is to improve communication between Horizon BCBSNJ and network physicians and office managers. The OMAC has office manager representation from all parts of New Jersey and across multiple specialties.

The OMAC met earlier this year and discussed a variety of topics, including consumer transparency, health care reform and HIPAA 5010.

By providing a forum for constructive feedback, we hope to:

• Better understand how we can help integrate our business practices into your office.
• Continue to improve on our ability to identify best practices from you.
• Reduce administrative waste as well as gain a fresh perspective and new ideas on process improvement from your viewpoint.

If you have questions about OMAC, or if you would like to be included on the 2015 Office Manager Advisory Council, please contact your Network Specialist.
Please use the chart below to identify specific Horizon Blue Cross Blue Shield of New Jersey contact and mailing information.

<table>
<thead>
<tr>
<th>PREFIX OR AREA</th>
<th>SERVICE #</th>
<th>CLAIMS ADDRESS</th>
<th>CLAIM APPEALS</th>
<th>INQUIRY ADDRESS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>YHB, YHC, YHI, YHK, YHL, YHS, YHY, YYY, YKX, YKM, YKN, JGA, JGD, JGG</td>
<td>1-800-624-1110**</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>For Facilities: ATT, FMA, FMR, JGB, JGD, JGE, JGG, JGH, NCH, NJP, NJX, YHB, YHC, YHI, YHK, YHG, YHD, YHE, YHM, YHN, YHP, YHG, YHS, YHT, YHY, YHH, YHY, YKM, YKN, YKP or other Horizon BCBSNJ prefixes not shown here.</td>
<td>1-888-666-2535**</td>
<td>PO Box 25 Newark, NJ 07101-0025</td>
<td>PO Box 1770 Newark, NJ 07101-1770</td>
<td>PO Box 199 Newark, NJ 07101-1770</td>
</tr>
<tr>
<td>R, 8-digits with the PPO or Basic logo</td>
<td>1-800-624-5078</td>
<td>PO Box 656 Newark, NJ 07101-0656</td>
<td>PO Box 656 Newark, NJ 07101-0656</td>
<td>PO Box 656 Newark, NJ 07101-0656</td>
</tr>
<tr>
<td>Federal Employee Program</td>
<td>1-800-624-1110**</td>
<td>PO Box 1219 Newark, NJ 07101-1219</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>AHX, AWW, BBB, DNB, IRA, NVP, NVY, PFZ, WYE and other National Accounts***</td>
<td>1-800-624-1110**</td>
<td>PO Box 1219 Newark, NJ 07101-1219</td>
<td>Addresses vary. Please review your patient’s ID card.</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>MKV, MKY, MWK, MWJ</td>
<td>1-877-663-7258</td>
<td>PO Box 18 Newark, NJ 07101-0018</td>
<td>PO Box 317 Newark, NJ 07101-0317</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>HSE, NFW, YHD, YHG, YHM, YHP, YHT and other Point of Service members</td>
<td>1-800-624-1110**</td>
<td>PO Box 820 Newark, NJ 07101-0820</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>JGE, JGB, JGH, YHQ, YHX, YKP and other Horizon Direct Access members</td>
<td>1-800-624-1110**</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>NJX, SNJ NJ State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHBP)</td>
<td>1-800-624-1110**</td>
<td>PO Box 820 Newark, NJ 07101-0820</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>YHR, YHW Medigap</td>
<td>1-800-624-1110**</td>
<td>PO Box 1184 Newark, NJ 07101-1184</td>
<td>PO Box 10129 Newark, NJ 07101-3129</td>
<td>PO Box 199 Newark, NJ 07101-0199</td>
</tr>
<tr>
<td>DEH, DMM, DTP, NGM General Motors/Delphi Auto</td>
<td>1-800-456-9336</td>
<td>PO Box 639 Newark, NJ 07101-0639</td>
<td>PO Box 639 Newark, NJ 07101-0639</td>
<td>PO Box 639 Newark, NJ 07101-0639</td>
</tr>
<tr>
<td>BlueCard (out-of-state) claims BlueCard Service Team</td>
<td>1-888-435-4383</td>
<td>BlueCard Claims</td>
<td>PO Box 1301 Neptune, NJ 07754-1301</td>
<td></td>
</tr>
<tr>
<td>Magellan Behavioral Health®</td>
<td>1-800-626-2212</td>
<td>Addresses vary according to product. Please review the behavioral health information on your patient’s ID card.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Care Program</td>
<td>1-888-333-9617</td>
<td>3 Penn Plaza East, PP-13X Newark, NJ 07105-2200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-existing Medical Documentation</td>
<td></td>
<td>PO Box 1740 Newark, NJ 07101-1740</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Policy Clinical Appeals</td>
<td></td>
<td>PO Box 220 Newark, NJ 07101-0920</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Policy Code Edit Inquiries</td>
<td></td>
<td>PO Box 681 Newark, NJ 07101-0681</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim Policy Clinical Determination for PPQ and Indemnity Products</td>
<td></td>
<td>PO Box 220 Newark, NJ 07101-0920</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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

This prefix information is confidential and should only be used to identify health insurance claims/service contact information for Horizon BCBSNJ and/or other Blue Cross and/or Blue Shield Plan patients and not for other purposes and will not divulge any such information to any other party. Reproduction of this information, in whole or in part, is prohibited without the permission of Horizon BCBSNJ.