New Medicare Product Offered

Horizon Medicare Blue Patient-Centered w/Rx (HMO) focuses on improving the quality of care and patient satisfaction while reducing cost for our members.

Comply with our Out-of-Network Referral Policy

Participating physicians and other health care professionals must refer Horizon BCBSNJ patients – and send their testing samples – to participating laboratories.

A Look at Our Quality Programs

Read about our chronic care and case management programs.

Help Us Improve Patient Health Measures

Help us ensure quality health care for our members by reviewing HEDIS® quality measures.
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**Use NaviNet to Submit Medical Records for Claims**

When we request a medical record for a claim, please submit the records through NaviNet®. Medical records include anesthesia reports, pathology reports or operative reports, etc.

Attachments should be submitted in response to our request for additional information. Do not use this process for appeals.

The Submit Attachments link displays on the Claim Status Details screen for finalized claims. Attachments must be in TIF, TIFF, JPG, JPEG or PDF formats. Four files can be attached for each submission.

You can review claim submission guidelines on our website at HorizonBlue.com.

**Amendments to Participating Agreements**

Horizon BCBSNJ has mailed Amendments that will alter the network Agreement(s) of participating physicians, other health care professionals, network hospitals and certain ancillary providers.

The Amendments include provisions for risk adjustment-related activities, electronic notices and reference-based benefits, among others. The effective dates of the Amendments are identified in the mailing.

Please read the Frequently Asked Questions on HorizonBlue.com/Providers to learn more about the Amendments.

**Icons throughout the newsletter will alert you to articles relevant to your area.**
Horizon BCBSNJ has announced an agreement with CareCentrix of New Jersey, Inc. to create a new home health care services program, Horizon Care@HomeSM.

The new program, effective **July 1, 2015***, will help us improve the quality of the following services provided in the home to Horizon BCBSNJ members:

- Durable Medical Equipment
- Orthotics and Prosthetics
- Home Infusion Therapy Services
- Home Health Services, including in-home nursing services, physical therapy, occupational therapy and speech therapy
- Medical Foods (Enteral)
- Diabetic and Other Medical Supplies

Through the Horizon Care@Home program, CareCentrix will credential, manage and maintain a network to provide the above-listed services to Horizon BCBSNJ members. CareCentrix will also perform the utilization review of all requests for Horizon Care@Home services and will render all initial utilization management determinations of medical necessity.

CareCentrix has more than 16 years of home care services management experience in New Jersey and maintains a substantial ancillary services provider network. Many of the providers that participate in Horizon BCBSNJ’s ancillary services network already participate in CareCentrix’s network.

*The starting date of the new Horizon Care@Home program as described is subject to the NJ Department of Banking and Insurance’s review of the management services contract between the parties.

Ancillary services providers that participate with Horizon BCBSNJ but not with CareCentrix will have the opportunity to join the CareCentrix network if providers meet CareCentrix’s contracting criteria and requirements, allowing the providers to continue serving Horizon BCBSNJ members.

For additional information, call CareCentrix at **1-855-243-3324**.
New Medicare Product Offered:
Horizon Medicare Blue Patient-Centered w/Rx (HMO)

Our new Medicare product, Horizon Medicare Blue Patient-Centered w/Rx (HMO), focuses on improving the quality of care and patient satisfaction while reducing cost for our members.

The product, which was effective January 1, 2015, uses a subset of health care professionals that participate in the managed care network. Group practices from our existing Horizon Managed Care Network were selected for inclusion in Horizon Medicare Blue Patient-Centered w/Rx (HMO) based on one or more of the following criteria:

- Risk-adjusted cost efficiency at the group practice level using Episode Treatment Group (ETG) data. To qualify for the ETG analysis, providers were required to have a minimum of 50 episodes of care from June 2012 through July 2013.
- Geographic access and coverage standards.

To help minimize member confusion, participation in Horizon Medicare Blue Patient-Centered w/Rx (HMO) is at the group level with all physicians and other health care professionals practicing within the group practice are included or excluded.

- All physicians or health care professionals affiliated with a participating Tax Identification Number (TIN) will be considered in network when practicing with/on behalf of that participating group practice as it pertains to services rendered to Horizon Medicare Blue Patient-Centered w/Rx (HMO) members.
- If a physician or other health care professional also happens to be affiliated with a group practice that is not participating in this product, that physician will be considered out of network for this product when practicing with/on behalf of that nonparticipating group practice as it pertains to services rendered to Horizon Medicare Blue Patient-Centered w/Rx (HMO) members.

As a result of this evaluation, some individual Primary Care Physicians (PCPs) within an excluded group may also be excluded.

All hospitals in our current Horizon Hospital Network participate in Horizon Medicare Blue Patient-Centered w/Rx (HMO) product.

Reimbursement is at the managed care fee schedule. PCPs will be reimbursed based on their current payment methodology (fee for service or capitation). Capitated health care professionals will be reimbursed at existing negotiated rates.

There are no out-of-network benefits, except in the event of an emergency. Horizon Medicare Blue Patient-Centered w/Rx (HMO) does not offer access to the BlueCard® network, except in the event of an emergency while traveling outside of New Jersey.

For more information about how practices were selected, view our administrative policy, Physician and Health Care Professional Participation Status in Products that utilize a subset of an existing Horizon Network Policy, accessible through NaviNet.net under Provider Reference Materials.
A Closer Look: Features of Horizon Medicare Blue Patient-Centered w/Rx (HMO)

Let’s take a closer look at some of the features of Horizon Medicare Blue Patient-Centered w/Rx (HMO).

Members are required to use only those practitioners that participate in the Horizon Medicare Blue Patient-Centered w/Rx (HMO) product. Members will not receive benefits for services rendered by providers who do not participate in this product.

Members have a tiered medical cost share for PCP services and maximize their benefits by using a participating PCP affiliated with one of our patient-centered programs, including Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs). This means members have lower out-of-pocket costs when they pre-select and use a patient-centered PCP who participates with Horizon Medicare Blue Patient-Centered w/Rx (HMO). Members will still have access to a subset of the other participating PCPs that are not affiliated with the patient-centered program, but at a greater cost to the member.

The Plan design:

- Requires members to select a participating PCP.

  – When a member uses a patient-centered PCP who participates with Horizon Medicare Blue Patient-Centered w/Rx (HMO) for nonpreventive care, a $10 or $15 copayment applies.

  – When a member uses a participating PCP who is not affiliated with one of our patient-centered programs, a $35 copayment applies.

  – There is a $50 copayment when a member visits a participating specialist.

- Includes preventive services, screenings and immunizations covered with no member cost share when services are received from an in-network provider. The plans cover one routine physical per year.

- Requires referrals.

For more details about plan benefits, visit the Products link at HorizonBlue.com/Providers.
New Imaging/Sleep Management Program for National Accounts Announced

Effective January 1, 2015, certain self-insured employer group health plans administered by Horizon BCBSNJ will implement an integrated advanced imaging and sleep management program for National Account members.

Horizon BCBSNJ has contracted with AIM Specialty Health® to provide evidence-based clinical guidelines for elective, outpatient CT, MRI, nuclear cardiology, PET, echocardiography exams and sleep management exams for educational and quality purposes. Anticipated care in these areas are reviewed in advance, but this not a formal utilization management program.

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and free-standing surgery centers), urgent care centers or 23-hour observations are not included in this program.

One goal of this program is to provide you and Horizon BCBSNJ members with information to make informed choices about where to receive care. Information available through the program could mean significant savings for members who have coinsurance plans and pay a percentage of costs out of pocket.

Please check your member’s ID card to verify if your patients are included in the program.

You can request a review of anticipated services at aimspecialtyhealth.com/goweb or by calling 1-866-766-0250. This number is also displayed on the back of the member’s ID card.

Horizon BCBSNJ members will not be denied benefits or access to services if they do not choose to receive services at the lower-cost options available. Program outreach will exclude pediatric and cancer patients. The program is applicable only to beneficiaries enrolled in certain National Account self-insured groups. It does not replace our existing advanced radiology management programs with CareCore National, LLC, which serve the majority of our insured membership, including the New Jersey State Health Benefits Program (SHBP).

If you have any questions about who to contact for the pre-service review of anticipated services, check the member’s Horizon BCBSNJ member ID card or call 1-866-766-0250.

AIM, on our behalf, will also use the Blue Cross Blue Shield Association’s National Consumer Cost Transparency (NCCT) data set for transparency purposes. AIM will share NCCT imaging facility cost information with staff during the clinical review process to promote awareness. AIM will also make outbound phone calls to members to inform them of the imaging facility options available.
Telehealth Pilot Expanded

Our telehealth pilot program, Horizon CareOnline™, launched in August 2014, has expanded and now includes members enrolled through the National Account employer groups listed below.

- BASF
- DSM
- Honeywell
- Ingersoll Rand
- York

Horizon CareOnline is also available to all members enrolled in our individual consumer products.

Horizon CareOnline is offered through Amwell, a leader in telehealth. Horizon CareOnline enables eligible members to conduct video consults with U.S. board-certified physicians for the evaluation and management of nonemergent symptoms, 24 hours a day, 365 days a year.

Clinical services are provided by Online Care Group, the nation’s first and largest primary care group devoted to telehealth. The physicians, providing services through Horizon CareOnline, are licensed and board certified, and have, on average, 15 years of experience providing primary and urgent care.

Physician education and experience profiles as well as physician ratings/reviews posted by other patients will be available to help members make informed decisions when selecting a telehealth physician.*

Horizon CareOnline is offered as a convenience for these Horizon BCBSNJ members. It is not intended to replace the relationship a member has with his or her primary care physician. To ensure that primary care practices are aware of information provided through Horizon CareOnline, members can opt to have summaries of telehealth consultations generated and sent to their primary care physician.

We will update our network regarding any change to, or expansion of, this program.

*State laws regarding telehealth vary. New Jersey regulations allow online visits but prohibit a physician practicing online from prescribing medications.

Amwell is an independent company that supports Horizon Blue Cross Blue Shield of New Jersey in the administration of telemedicine services.
Pharmacy Corner: Formulary Changes Announced

Changes to our commercial formularies were determined at the Pharmacy and Therapeutics (P&T) Committee’s meeting in November 2014. The most up-to-date commercial formularies can be found at HorizonBlue.com/formulary.

<table>
<thead>
<tr>
<th>Commercial Formulary Changes*- November 2014 P&amp;T</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Moved from Non-Preferred to Preferred Status</strong></td>
</tr>
<tr>
<td><strong>Brand</strong></td>
</tr>
<tr>
<td>Zydelig</td>
</tr>
<tr>
<td>Zykadia</td>
</tr>
<tr>
<td>Evzio</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>New Drugs Reviewed and Remaining in Non-Preferred Status</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brand</strong></td>
</tr>
<tr>
<td>Hemangeol</td>
</tr>
<tr>
<td>Jublia</td>
</tr>
<tr>
<td>Myalept</td>
</tr>
<tr>
<td>Orenitram</td>
</tr>
<tr>
<td>Purixan</td>
</tr>
<tr>
<td>Qudexy</td>
</tr>
<tr>
<td>Sitavig</td>
</tr>
<tr>
<td>Tanzeum</td>
</tr>
<tr>
<td>Velphoro</td>
</tr>
<tr>
<td>Vogelxo</td>
</tr>
</tbody>
</table>

*Changes were effective December 1, 2014.
Pharmacy Corner  (continued from page 8)

Recent changes to our Medicare formularies can be seen in the table below. The most up-to-date Medicare formularies can be found at HorizonBlue.com/Medicare/formulary.

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Formulary Status</th>
<th>Prior Authorization (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sivextro</td>
<td>tedizolid phosphate</td>
<td>Added</td>
<td>Y</td>
</tr>
<tr>
<td>Invokamet</td>
<td>canagliflozin and metformin hydrochloride</td>
<td>Added</td>
<td>N</td>
</tr>
<tr>
<td>Plegridy</td>
<td>peginterferon beta-1a</td>
<td>Added</td>
<td>Y</td>
</tr>
<tr>
<td>Entyvio</td>
<td>vedolizumab</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Tanzeum</td>
<td>albiglutide subcutaneous injection</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Jardiance</td>
<td>empagliflozin</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Striverdi</td>
<td>olodaterol inhalation spray</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Ruconest</td>
<td>recombinant C1 esterase inhibitor</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Eliquis</td>
<td>apixaban</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Zontivity</td>
<td>vorapaxar</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Jublia</td>
<td>efinaconazole topical solution 10%</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Acticlate</td>
<td>doxycycline hyclate</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Sitavig</td>
<td>acyclovir buccal tablet</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Vogelxo</td>
<td>testosterone gel CIII</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Evzio</td>
<td>naltrexone hydrochloride injection</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Rasuvo</td>
<td>methotrexate subcutaneous</td>
<td>Not Covered</td>
<td>–</td>
</tr>
<tr>
<td>Eloctate</td>
<td>antihemophilic factor (recombinant) Fc fusion protein</td>
<td>Not Covered</td>
<td>–</td>
</tr>
</tbody>
</table>

To request a printed copy of the formularies, please call Pharmacy Member Services at 1-800-370-5088.
CarePoint Health – Christ Hospital Terminates Hospital Contract

CarePoint Health – Christ Hospital (Christ Hospital) terminated its hospital contract with Horizon BCBSNJ, effective 11:59 p.m., January 30, 2015.

Horizon BCBSNJ continually works to maintain a balance between keeping health care affordable for our more than 3.7 million members and reimbursing our network health care professionals and hospitals reasonably and fairly. We take this obligation seriously. Unfortunately, we could not agree to the demands for rate increases made by Christ Hospital.

Under New Jersey state law and the terms of the Horizon BCBSNJ hospital contract, Christ Hospital is required to extend the terms of the Horizon BCBSNJ hospital contract for four months beginning January 31, 2015 through May 31, 2015. Therefore, all Horizon BCBSNJ members may continue to use Christ Hospital as an in-network hospital through May 31, 2015, as a period of transition of care.

Beginning June 1, 2015, Christ Hospital will be out of network for all Horizon BCBSNJ members.

- Horizon BCBSNJ members enrolled in plans with no out-of-network benefits will have no coverage for nonemergency services at Christ Hospital.

- Horizon BCBSNJ members enrolled in plans that include out-of-network benefits may continue to use Christ Hospital on an out-of-network basis. Members should understand that they may incur higher out-of-pocket expenses using an out-of-network facility.

As always, in an emergency situation, patients should go immediately to the nearest emergency facility, without worrying about network affiliations, to receive care.

We appreciate the help of participating physicians in referring Horizon BCBSNJ patients to participating facilities unless the member has and wishes to use his or her out-of-network benefits and understands that a greater financial responsibility may be involved. All Horizon Hospital Network facilities may be located through our online Provider Directory.

For more information, please read the CarePoint Health – Christ Hospital Termination Q&As for Participating Physicians available at HorizonBlue.com/Providers.
Utilization Management Policy Issued

Our Utilization Management (UM) policy gives treating or attending physicians the right to discuss any initial UM denial determination with the Horizon BCBSNJ reviewing physician who issued the decision. Each UM denial determination includes the reviewing physician’s name and phone number.

Horizon BCBSNJ’s UM Department may be reached at 1-800-664-BLUE (2583), Monday through Friday, between 8 a.m. and 5 p.m. After business hours and on weekends, physicians and other health care professionals may call our after-hours clinical operations at 1-888-223-3072 for urgent determinations of UM inquiries.

For additional information about our UM processes and our criteria, please visit HorizonBlue.com/Providers and:

- Mouse over Policies & Procedures.
- Select Utilization Management.

Are You Using CareAffiliate?

Our online utilization management tool is growing in popularity with physicians and other health care professionals who submit authorization requests easily and securely online through NaviNet.

We encourage you to watch the training presentation or review the training manual at HorizonBlue.com/CareAffiliate to see how CareAffiliate will save your office time and lower administrative costs.

CareAffiliate’s main features include:

- Authorization requests.
- Viewing status of authorization requests.
- For Horizon BCBSNJ, specialty pharmacy authorization requests for medications including, but not limited to: Hyaluronic acid, RhoGAM®, Thyrogen®, Vivitrol®, Xiaflex® and Xolair® (asthma).

The turnaround time for nonurgent prior authorization requests is up to 14 calendar days of receipt. The turnaround time for urgent prior authorization requests is within 72 hours of receipt.

Providers can access CareAffiliate from NaviNet.net. Select Horizon BCBSNJ Plan Central page, mouse over Referrals and Authorization, then select Utilization Management Requests.

For more information, visit HorizonBlue.com/CareAffiliate.
Chronic Episodes of Care Program Launched

We’ve launched our first chronic Episodes of Care (EOC) program, congestive heart failure (CHF). The CHF episode joins the suite of EOC programs launched between 2010 and 2013. We currently have over 56 practices in our EOC programs at locations in New Jersey and Pennsylvania. At the end of 2014, our practices completed at least 8,000 episodes.

Prior to January 1, 2015, procedural EOC programs were offered to specialists in our networks. Procedural EOC programs have a shorter duration than a chronic episode. These EOC programs include:

- Hip Replacement
- Knee Replacement
- Knee Arthroscopy
- Colonoscopy
- Pregnancy

The EOC programs’ goal is to reward providers for improvements made to patient experiences and outcomes while optimizing cost. We work to collaboratively transform the practices in the programs to meet these goals.

For more information, please contact Kim Eason, Manager, Partner Contracting, Outcomes and Relationship Specialist, at 1-973-466-8448.
Testing for ICD-10

We continue to work with our providers and business partners to ensure that we will be fully compliant with all mandated requirements for ICD-10 on **October 1, 2015**.

We are proud to announce our partnership with HighPoint Solutions to offer a scenario-based testing tool to professional providers. This tool presents pre-defined, clinically based narratives that are grouped into specialty-specific medical scenarios.

Participants receive a total of three medical scenarios. Each scenario presents three clinical narratives that document a specific health care encounter and give enough information to determine an ICD-10 diagnosis code. Participants review the narratives and enter the ICD-10 code they deem appropriate. Using anonymous testing identifications, peer reports allow you to view and compare your selections with those of other participants within your specialty.

We are committed to supporting our providers in their readiness for ICD-10. We believe this testing tool can help to:

- Identify commonly used or specialty-specific diagnosis codes used in your practice,
- Improve patient documentation by ensuring it includes the necessary information for coding accuracy, and
- Encourage coders and clinicians to start thinking about ICD-10 in their day-to-day activities.

If you are interested in scenario-based, or claim acknowledgement testing, please send an email to **ICD10ProviderReadiness@HorizonBlue.com**. Claim acknowledgement testing requires submission of an electronic 837 institutional or professional transaction with the return of a 277 or 999 acknowledgement.

If you have questions about ICD-10, please contact your Network Specialist, Ancillary Contracting Specialist or email **ICD10Communications@HorizonBlue.com**.

For more information, please visit our website at **HorizonBlue.com/Providers**. Mouse over **Resources**, select **Initiatives**, then select **ICD-10**.
Comply with our Out-of-Network Referral Policy

As a participating practitioner, your patients rely on you to help them navigate the health care system by referring them, and forwarding their laboratory testing samples, to participating physicians, other health care professionals, facilities and ancillary providers, including participating clinical laboratories.

Additionally, as a participating physician or other health care professional, you have agreed to adhere to the policies and procedures in your Agreement, which include referring your Horizon BCBSNJ patients – and sending their testing samples – to participating providers.

It is critical that you review, understand and comply with the requirements outlined in our Out-of-Network Referral Policy in the event that you refer any patients enrolled in plans that include out-of-network benefits to any nonparticipating provider.¹

Participating physicians and other health care professionals may only refer Horizon BCBSNJ patients enrolled in plans that include out-of-network benefits (or send their testing samples) to a nonparticipating provider if:

- That patient chooses to use his or her out-of-network benefits, and understands that doing so may result in higher out-of-pocket expenses.
- The participating physician or other health care professional follows the requirements outlined in our Out-of-Network Referral Policy, which includes having the member sign our Out-of-Network Consent form.

¹ Our Out-of-Network Referral Policy applies to all participating physicians and other health care professionals in the Managed Care and/or PPO networks who make referrals for health care services to Horizon BCBSNJ members/covered persons enrolled in products that include out-of-network benefits, including POS, Direct Access, PPO (including Federal Employee Program® [FEP®] plans), State Health Benefits Program (SHBP) and School Employees’ Health Benefits Program (SEHB) plans, and Horizon Medicare Advantage plans.

Participating physicians and other health care professionals who do not comply with our Out-of-Network Consent Policy will be at risk of an audit.

If you have questions about this policy, please speak with your Network Specialist.

To read our Out-of-Network Referral Policy, log in to NaviNet.net, and
- Select Provider Reference Materials.
- Mouse over Policies & Procedures and select Policies.
- Select Administrative Policies.
- Select Out-of-Network Referral Policy.

Our Out-of-Network Consent Form is available in the Forms section of HorizonBlue.com.

Clinical Labs
The decision to choose a participating clinical laboratory provider is not always within the member’s control. We rely on participating practitioners to forward their Horizon BCBSNJ patients’ testing samples to participating clinical laboratories. The agreements we maintain with participating clinical laboratories help us manage the costs associated with laboratory services and, in turn, help control premium costs for enrolled members and groups.
Blue Physician Recognition Revised for 2015

The criteria for the Blue Physician Recognition (BPR) program have been revised to include new measures such as cholesterol management for patients who have diabetes and all-cause readmission. These revisions help us better align our network initiatives with the current industry focus on primary care services as well as important chronic medical conditions.

The program identifies and distinguishes our highest performing participating practices in clinical quality. The description and the complete listing of eligible specialties and clinical quality measures are online at HorizonBlue.com/QRP.

The majority of the clinical quality measures are Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Medicare Star measures.

If you have any questions or feedback regarding BPR, send an email with your practice name and tax identification number to ContactUs@HorizonBlue.com, and include Attn: Charlene Roberts in the subject line.
Quarterly Claims Update

On April 1, 2015, we will implement the claim editing rules identified in the quarterly claim editing update report. This report reflects McKesson’s ongoing review of current claim processing/claim editing practices.

These claim editing changes are based on recommendations of various medical societies and organizations, medical policy and literature research and standards, and input from academic affiliations. Changes may also reflect the implementation of new and/or revised Horizon BCBSNJ administrative, reimbursement and/or medical policies.

Claims that are processed on and after April 1 will follow those updated adjudication rules. We reserve the right to adjust claims for services provided on the noted implementation date above that do not follow our updated claim editing rules.

Additional information about our claim editing policies is available on our website.

If you have questions, please speak with a Physician Services representative at 1-800-624-1110 or an Institutional Services representative at 1-888-666-2535, Monday through Friday, between 8 a.m. and 5 p.m.

McKesson’s ClaimsXten™

We use McKesson’s ClaimsXten, a clinically-based claims editing solution, to help ensure that our code and claim editing rules are accurate and consistent with standard business practice to enable us to process claims efficiently and provide accurate reimbursement.

We work with McKesson to carry out quarterly ClaimsXten updates that include changes based on McKesson’s ongoing review of current claim processing/claim editing practices, incorporating guidelines from industry-standard and essential clinical coding sources, as well as the implementation of new and/or revised Horizon BCBSNJ administrative, reimbursement and/or medical policies.

Clear Claim Connection™

Participating physicians, other health care professionals and facilities can review how updated claim editing rules impact reimbursement for certain code combinations by using the McKesson Clear Claim Connection available on NaviNet®.

Log in to NaviNet.net, select Horizon BCBSNJ Plan Central and:

- Mouse over Claim Management.
- Select Clear Claim Connection.
Communication Begins With You ... the Physician

The Consumer Assessment of Healthcare Providers and Systems® (CAHPS) annual survey, used by all health plans seeking National Committee for Quality Assurance (NCQA®) accreditation, asks members to comment on various topics and respond to the following four questions:

How often did your physician:

1. Listen to you carefully?
2. Explain things in a way that was easy to understand?
3. Show respect for what you had to say?
4. Spend enough time with you?

Interestingly, survey results have uncovered that members’ interpretation of a “physician who communicates well” includes the following:

- Provides complete information using language the patient can understand. Keep it simple! Avoid using highly technical language or jargon. At the conclusion of the appointment, review and summarize the patient’s concerns and your medical instructions.
- Encourages participation in decision-making and treatment options. Patients want to be informed of treatment alternatives, and in general, want to be involved in treatment decisions when more than one treatment alternative exists. Patients are more likely to adhere to a treatment plan if they feel they have been involved in deciding the course of treatment.

We encourage you to continue to make communication with your patients a priority.

NJWELL Update on Health Screenings

Patients who are State Health Benefits Program/School Employees’ Health Benefits Program (SHBP/SEHBP) members may ask their doctors to submit health information so they can earn NJWELL activity reward points. You may be asked to complete a NJWELL Physician Biometric Health Screening Form for a health screening you conducted or ordered between November 1, 2014 and October 31, 2015. Data on this form includes:

- Total cholesterol, HDL, total TC/HDL ratio
- Glucose values
- Blood pressure and pulse readings
- Body Mass Index (BMI)
- Date of the health screening and physician’s signature

Eligible participants earn NJWELL reward points for having a physical exam between November 1, 2014 and October 31, 2015. You can complete the biometric health screening form during the exam.

Completed forms must be received by Summit Health by October 31, 2015. Forms may be faxed to 1-248-864-4409, ATTN: Data Integrity Group, or mailed to:

Summit Health
ATTN: Data Integrity Group
27175 Haggerty Road
Novi, MI 48377

NJWELL aims to improve the health and well-being of SHBP/SEHBP employees and their covered spouses/partners by encouraging and rewarding them for taking steps toward wellness. Additional information about this program is available on HorizonBlue.com/SHBP.
Eye on Quality: Chronic Care and Case Management Programs

Our quality health care programs give members the support and resources they need to make the right health care decisions. You may refer patients for services or patients may request services themselves. Members may also be selected based on claims data, health risk assessments completed by the member, or pharmacy or utilization data.

Occasionally, members are hesitant to participate in the programs or do not feel they have a chronic condition. In these instances, we may contact your office for help with member engagement or to clarify medical information if you are the member’s PCP. We may also contact your office to notify you of missing clinical metrics or any concerns about the member’s health.

Participation in these programs is voluntary, confidential and free to eligible* members.

**Chronic Care Program**

Our Chronic Care Program promotes healthy living for eligible* members by reinforcing the health goals you set with your patient. Through a series of assessments, phone calls and targeted mailings, an interdisciplinary team of nurses and registered dietitians work with you to help patients understand their chronic illness.

Emphasis is placed on diet, treatment plan and medication compliance, in addition to the early identification of signs and symptoms. Home monitoring services are also available to eligible members who have heart failure and require more intensive follow up.

Eligible members diagnosed with one or more of the following conditions may participate:

- Asthma (adult and pediatric programs available)
- Chronic kidney disease (CKD), including members receiving dialysis
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Diabetes (adult and pediatric programs available)
- Heart failure

To enroll your eligible Horizon BCBSNJ patients using our online referral form, visit [HorizonBlue.com/Patient-Health-Support](http://HorizonBlue.com/Patient-Health-Support).

**Case Management Program**

Our Case Management Program provides professional guidance for members and their families who are faced with a complex medical situation, and can help them use the health care system more efficiently.

Case Management is suggested for members who have certain complex illnesses or issues such as:

- Cancer
- Newborn abnormalities
- Heart surgery
- Organ transplant
- High-risk pregnancy
- Severe injury or paralysis
- Extensive home care or home infusion
- Ventilator management

*Not all programs are available to all Horizon BCBSNJ members.*

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Our specially trained Case Managers are registered nurses who,

- Provide information to help empower your patients to make informed decisions about their health care.
- Coordinate health care services to help maximize the member’s benefits.
- Connect members with a pharmacist to assist with understanding their medications.
- Coordinate meetings with an interdisciplinary care team to discuss their plan of care.
- Help with securing authorizations for services.
- Refer your patients to other valuable resources when required, such as behavioral health coaches, dental and vision care.
- Make post-discharge follow up phone calls.
- Provide information about community resources.

For more information on our Chronic Care Program or to refer a member, call 1-888-333-9617, Monday through Friday, 8 a.m. through 7 p.m.

For more information about our Case Management Program or to refer a member or speak to a nurse, please call 1-888-621-5894, Monday through Friday, 8 a.m. through 7 p.m.
Helping Our Members Quit Smoking

Under the Affordable Care Act (ACA), insurance coverage for tobacco cessation interventions were made available to many insurance holders. The intention of the coverage was to improve member access to treatment, improve smoking cessation rates and reduce smoking-related diseases and health care costs associated with tobacco use.

New guidance was recently received from the Departments of Labor, Health and Human Services (HHS) and U.S. Treasury specifying in greater detail the tobacco cessation services that health insurers are required to cover. The departments will consider a non-grandfathered* group health plan or health issuer to be in compliance with this requirement if the plan covers, without member cost sharing (such as deductibles, coinsurance or copayments), screening for tobacco use and a maximum of two tobacco cessation attempts per year for tobacco product users. The two cessation attempts include four tobacco-use counseling sessions of at least 10 minutes each without prior authorization required and FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications), when prescribed by a health care professional without prior authorization required.**

Effective January 1, 2015, preventive services benefits available through our prescription plan include:

- Over-the-counter products – $0.
- Prescription
  - Generic medicine and brand medicine without generics available – $0.
  - Brand medicine with generics available –
    standard plan coverage, which may result in member cost share.
- Day supply limit*** – 180 day limit for the following three tobacco cessation therapies:
  - Nicotine Replacement Therapy (NRT) products
  - Bupropion products
  - Chantix

A prescription from a doctor is required for the member to obtain the over-the-counter products and the prescription products at the $0 cost share. Additionally, the prescription must be filled at a participating retail or home delivery pharmacy, as the prescriptions will be processed through the member’s pharmacy benefit plan.

For more information, visit HorizonBlue.com/Providers.

* This mandate does not apply to grandfathered plans.

**The FDA has approved seven smoking-cessation medications: five nicotine medications (patch, gum, lozenge, nasal spray and inhaler) and two non-nicotine pills (bupropion and varenicline).

***The day supply limit applied to these FDA-approved tobacco cessation medications is 180 days per member, per 365 days. After the 180-day limit (two 90-day prescribed courses of treatments) is reached, further prescribed courses of treatments will be processed on an exception basis subject to the member’s benefits.
Improving health care quality is a goal all health care professionals and health insurers share.

NCQA, a private, not-for-profit organization dedicated to improving health care quality, develops quality standards and performance measures for a broad range of health care entities. Like other health plans, Horizon BCBSNJ uses HEDIS measures to set improvement goals and track the quality of care for its members.

Sheila Linehan, RN, MPH, Director of Quality Management at Horizon BCBSNJ, sees a vital link between HEDIS measures and health care professionals.

“Although NCQA is the accreditation body for health plans, HEDIS measures help providers demonstrate the quality of the care delivered to their patients,” explained Ms. Linehan. “[For example,] If we have strong HEDIS results in the diabetes management measures, it is largely due to the fact that our members are accessing care and receiving the necessary tests and follow up to manage their diseases, a direct result of the care they receive from their clinicians.”

Diabetes management is one focus of improvement. Horizon BCBSNJ tracks members who have diabetes to ensure they receive A1C and nephropathy screenings on time, have regular eye exams and control their blood pressure. Members with diabetes who are not following the established recommendations are contacted by case managers or coordinators who encourage them to see their physicians or other health care professionals.

Horizon BCBSNJ is also heavily focused on:
- Cancer screening, for breast, cervical and colorectal cancers.
- Cardiac screening, for controlling blood pressure and medication adherence.
- Childhood immunizations.

Horizon BCBSNJ is also working to have the clinicians deliver timely messages to patients who are not regularly seeing their doctors.

“A message from your own doctor — instead of your health plan — can be much more impactful,” said Ms. Linehan.

HEDIS measures are also used in various physician recognition programs developed by NCQA, including:
- Diabetes Recognition Program
- Government Recognition Initiative Program
- Heart/Stroke Recognition Program
- Patient-Centered Medical Home (PCMH)
- Patient-Centered Specialty Practice Recognition
- Physician Practice Connections

We also uses HEDIS measures for physician recognition with our Blue Physician Recognition and our patient-centered programs. HEDIS measures are also used for measuring performance for the CMS Medicare STAR program.

For additional information, visit NCQA.org.

Help Us Improve Patient Health Measures

How can you help improve 2015 HEDIS results?

- Encourage patients to schedule appropriate preventive and recommended screenings.
- Document a patient’s previous history, immunizations and screenings.
- Use appropriate coding and CPT® Category II codes when submitting claims.
- Provide requested documentation for HEDIS data collection.
- Use participating clinical laboratories.
FEP® Updates for 2015

Blue Health Assessment

Your patients who are enrolled in the Blue Cross and Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP®), can take the Blue Health Assessment* (BHA) to address health risks. They can even take the BHA multiple times throughout the year to update their plan and see their progress. The simple assessment takes a few minutes to complete on a computer or smartphone and your patients will receive an action plan that they can discuss with you.

In 2015, once members complete the BHA they are eligible for a $50 MyBlue® Wellness Card to use for qualified medical expenses. Two adult members on a contract are eligible for this incentive. They can also earn up to an additional $35 credit on their card by completing three goals with an Online Health Coach.

If your patients want to learn more, please have them visit www.fepblue.org.

* The BHA is only offered to Blue Cross and Blue Shield Service Benefit Plan members.

Diabetes Management Incentive Program

The Diabetes Management Incentive Program provides members with critical education, assists in improving blood sugar control and helps to manage or slow the progression of complications related to diabetes.

To be eligible for this program, Service Benefit Plan members must be 18 years of age or older and complete the BHA. This program is limited to two adult members on a contract.

Members will receive credit on their MyBlue Wellness Card when specific activities are completed. Once members earn the maximum of $75 under the Diabetes Management Incentive Program, they will not earn additional credits to the MyBlue Wellness Card for completing additional activities under this incentive in 2015.

Men Covered for BRCA Testing

BRCA testing is now covered for both male and female Service Benefit Plan members. Eligible members are covered for genetic counseling and evaluation and preventive BRCA testing for men and women. The new criteria require all members to receive genetic counseling and evaluation prior to testing as well as prior approval. If prior approval is not received, the Plan will perform a medical review to validate family history and genetic counseling were done prior to testing. Males must also meet family criteria as described in the 2015 Blue Cross and Blue Shield Service Benefit Brochure available at www.fepblue.org.

Preventive Hepatitis C screening

Preventive care benefits for adult Service Benefit Plan members will allow one Hepatitis C screening per calendar year.

PPO Urgent Care Centers

The copayment for medical emergency care provided at Preferred urgent care centers for Standard Option has been reduced in 2015. Members have a $30 copayment per visit; accidental injury care continues to have a $0 cost share within the first 72 hours of the injury.

The copayment for accidental injury and medical emergency care provided at Preferred urgent care centers for Basic Option members has also been reduced in 2015. Members have a $35 copayment per visit.
At Your Service

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

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

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

FEP®
Claim Inquiries: PO Box 656, Newark, NJ 07101-0656
Reconsiderations/Appeals: 1-800-624-5078
PO Box 10181, Newark, NJ 07101
Precertification: 1-800-664-2583
Case Management and Health and Wellness: 1-866-967-9696

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

SHBP/SEHBP
Claim Appeals/Inquiries: PO Box 199, Newark, NJ 07101-0820
Provider Services: 1-800-624-1110
Institutional Services: 1-888-666-2535
Utilization Management: 1-800-664-2583
Advanced Radiology – CareCore National: 1-866-496-6200
Behavioral Health Precertification: 1-800-991-5579

IVR and PHONE INQUIRES
Provider Services: 1-800-624-1110
Institutional Services: 1-888-666-2535
Find forms at HorizonBlue.com/Providers/Forms.

ELIGIBILITY AND BENEFITS
Log in to NaviNet.net and access our Plan Central page. Mouse over Eligibility & Benefits and select Eligibility & Benefits Inquiry.

PRIOR AUTHORIZATIONS (PA) AND UTILIZATION MANAGEMENT
Most PAs should be requested online using the CareAffiliate tool. After logging into NaviNet.net, select Horizon BCBSNJ Plan Central, mouse over Referrals and Authorization, then select Utilization Management Requests.

PT/OT Services
From NaviNet.net, access Horizon BCBSNJ Plan Central page, mouse over Referrals and Authorization and select Physical and Occupational Therapy Authorization.

Outpatient Advanced Imaging and Pain Management CareCore National: 1-866-496-6200

Drug Authorizations
From NaviNet.net, access Horizon BCBSNJ Plan Central page and select Drug Authorizations.

Alternate Request Methods
Home Care/IV Infusion Services: 1-800-492-2580 (fax)
Infertility Services: 1-973-274-4410 (fax)
Physical Therapy Unit: 1-800-723-5188 (fax)
Prior Authorization Unit: 1-800-664-2583 (phone) or 1-877-798-5903 (fax)

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