UPDATE-National Provider Identifier (NPI) Mandate

The Centers for Medicare & Medicaid Services recently announced a contingency plan for implementation of the National Provider Identifier. As a result of this announcement, Excellus BlueCross BlueShield has developed the following strategy to accommodate the contingency plan.

Claims: From now until further notice (including all dates after May 22, 2007), please continue submitting all claims to us using your Provider Identification Number (PIN) or a combination of your NPI plus PIN. Because of the CMS ruling, we are not in a position to accept claims billed with NPI only at this time.

IVR and Web Tool Functions: Also until further notice, please continue to use your PIN to access our Interactive Voice Response (IVR), QuickLink, BlueExchange, and to make member eligibility and claim inquiries on our Web site, excellusbcbs.com.

If you have not already obtained your NPI, please contact Fox Systems, Inc. immediately. You may reach Fox Systems at (800) 465-3203, or apply online at www.nppes.cms.hhs.gov. Please share your NPI information with us as soon as you receive it.

We will update you each month with more information related to our contingency plan. Thank you for your patience as we work through these new NPI developments. If you have any questions, please contact Provider Service.

Talk to your patients about generic drugs. They’re safe, effective and affordable.
**Vaccine Reimbursement Increase**

Our participating providers have voiced concerns regarding the overhead associated with obtaining vaccines. In response to these concerns, and with provider input, we have increased our vaccine reimbursement methodology to Wholesale Acquisition Cost (WAC) plus 5 percent. This increased rate will be effective as of June 1, 2007.

WAC is derived from manufacturer list pricing as obtained through Medi-Span® or Red Book®. When Medi-Span and Red Book pricing differs, we will use the higher of the two. Due to the rapid changes in vaccine pricing, we will refresh these rates bimonthly, starting June 1, 2007. June 2007 rates will be based on WAC rates in effect on May 1, 2007. Subsequent bimonthly updates (August, October and December) will be based on WAC rates in effect the month prior to the update, plus 5 percent.

**Correction to Member Newsletter**

We have recently discovered that the Excellus BCBS “To Your Health” HMO/POS member newsletter (Spring 2007 issue) contains a slight formatting error. We are bringing this to your attention in the event that one of our members asks you about it. The piece in question is titled “Give Your Baby the Best Start You Can.” The article includes a chart with prenatal guidelines.

The text under Second Trimester should read: “Between 15 and 20 weeks, evaluation may include:

- Amniocentesis, to test for chromosomal abnormalities, genetic birth defects and certain other conditions.”

We apologize for any confusion this may cause and thank you for helping to clear up any questions that your patients, our members may have related to this piece.

To view our prenatal guidelines or other clinical practice guidelines, visit our Web site at excellusbcbs.com. Click on For Providers, then Patient Care and select Clinical Practice Guidelines from the left menu.

**No Coverage for Electrical Stimulation or Supplies**

Keep in mind that Excellus BCBS does not currently provide coverage for electrical stimulation procedures or supplies per medical policies 1.01.01 Electrical Stimulation and 1.01.48 Neuromuscular Electrical Stimulation. The exception to this is Transcutaneous Electrical Nerve Stimulation, which is covered when medically appropriate, as indicated in our Electrical Stimulation policy.

Please take a moment to review the details of these medical policies if you are considering recommending these procedures or supplies to one of our members. Copies of these policies are available on our Web site, excellusbcbs.com. Just click on For Providers and then click on the link entitled “View Our Medical Policies.”

As always, we will continue to study peer-reviewed literature and re-evaluate our medical policies as it becomes necessary.

**Health Coaching Supports Your Patients**

We recognize that management of patients with chronic diseases such as diabetes is complex. For patients that need more individualized attention, call your Provider Service line to make a referral to a Health Coach.

When providing support to your patients with chronic conditions, health coaches place special emphasis on the importance of managing the comorbidities that may exist. This ‘whole person support’ helps patients:

- Understand their diagnoses
- Become motivated to actively manage their health
- Learn self-care skills and follow your treatment plan
Request for Claim Adjustment on Our Web Site

The Request for Research/Claim Adjustment paper form you’re accustomed to using is now accessible as an interactive form on the Web. This feature allows you to complete the form online and submit it electronically. You may access this electronic form at excellusbcbs.com. From the Provider home page, click Online Services, then choose Claims from the menu at left and click on Request Claim Adjustment. You must be a registered user to access this secure section of our Web site.

We hope that this new way to submit requests for claim research/adjustment is more convenient for you. If you prefer to submit a paper form, you may download it from our Provider home page. Just click Administration then Forms & Templates. The form is located under Billing and Remittance.

The Request for Adjustment form should only be used when you are certain that a claim adjustment is necessary. Adjustment requests can include, but are not limited to, claims that denied for membership or other insurance reasons where the files have since been updated, adjustments to correct a procedure code, claims that denied requesting additional information (which you are sending along with the adjustment form), payment was made in error, or the claim was paid at an incorrect amount or to an incorrect payee.

Claims that deny duplicate should not be sent on a Request for Adjustment form unless your office rendered two identical procedures on the same day, and only one was paid. Questions regarding all other duplicate denials, especially in regards to BlueCard claims, are handled by Provider Services.

You can find additional information regarding the use of our various forms in the Provider Manual section of our Web site, as well as in your Provider Toolkit. If you are still uncertain as to which form to use, or if your question or request does not fall into one of the categories above, you may contact Provider Services for clarification, or request office staff training from your Provider Relations representative.

Please note: Do not use this Web form when we request additional information on a claim that was not paid. Please submit a new claim with the requested information.

Medicare Advantage Reviews – THANK YOU!

The Excellus BCBS Medicare Division would like to thank our providers and their office staff for all of the cooperation and assistance we received with the medical record reviews performed this past fall and winter. The criteria for review were set by the Centers for Medicare & Medicaid Services Risk-Adjustment Methodology Program. The medical record review assisted the Health Plan to comply with diagnosis code reporting guidelines designed by CMS.

The coding and billing guidelines used for this review were taken from the following resources: ICD-9-CM, the American Health Association (AHA) Coding Clinic, and CMS guidelines.

CMS has identified the following areas for process improvement to help ensure accurate medical coding compliance each year.
• Ensure definitive ICD-9-CM diagnosis code selection, specification and sequencing.
• Make documentation legible, clear, and concise.
• Clearly document patient’s name, date of service, and signature of practitioner on each page of the medical record.
• File medical record documentation in chronological order.
• Report chronic conditions each year at the patient’s annual physical.
• Document acute and/or chronic condition in the patient’s progress note to reflect that over-the-counter/prescription drugs are actively managed at the date of service.

We hope the above information is helpful to you and your practice. We look forward to working with you as we continue to improve the integrity of data we receive and report to CMS. We appreciate the time you spent researching, locating, and providing the requested charts, and for the courtesy extended to our reviewer.
Upcoming CMS Medical Records Review

With the completion of 2006 claim submissions to Centers for Medicare & Medicaid Services, we will be asking for your assistance to collect additional ICD-9CM diagnosis coding data from office records dated January 1, 2006 through December 31, 2006.

For those practitioners who participate in the Medicare Advantage program, CMS requires that all diagnoses, including chronic conditions managed during the calendar year, be submitted with a correct ICD-9CM diagnosis code. These additional codes assist the member’s risk score accuracy and better predict the level of resources needed to care for the member.

An Excellus BCBS Medicare Division coding specialist will contact your office soon to set up a convenient time for the record review. If there are only a small number of reviews or it is your office preference, you may fax or mail the office records in place of the on-site record review.
Medical Policy/Protocol Update- May 2007

To ensure that the development of corporate medical policies occurs through an open, collaborative process, we encourage our participating practitioners to become actively involved in medical policy development. Each month, draft policies are posted in the Provider section of our Web site, excellusbcbs.com, for participating practitioners’ review and comment. Click on For Providers, then Medical Policies. Next, click on Preview & Comment on Draft Policies located at the bottom of the menu on the left side under Medical Policies. The following policies are tentatively scheduled to be available for comment in May 2007:

- Implantable Bone Conduction Hearing Aids (new)
- Magnetic Resonance Imaging of the Breast
- Total Hip Resurfacing
- Transendoscopic Therapies for GERD
- T-Wave Alternans

Corporate medical policies are used as a guide. Coverage decisions are made on a case-by-case basis and in accordance with the member's contract. While a technology or service may be medically necessary, payment of benefits is subject to the member's eligibility on the date the service is rendered and the benefit/exclusion provisions in the member's contract. Before rendering care, providers should verify the member's eligibility for the service by calling the Provider Service Department of your local plan.

Complete detailed policies are available on our Web site at excellusbcbs.com. Click on For Providers menu option, then on View Our Medical Policies. Questions regarding medical policies may be directed to your Provider Relations representative or to the Provider Service Department of your local health plan.

Medical policies are also located on the Web site for Excellus BCBS members at excellusbcbs.com. To access our policies, members need to click on For Members, followed by Health and Wellness, then View our Medical Policies.

Medical policies apply to commercial and Medicaid products only when a contract benefit for the specific service exists. Excellus BCBS medical policies only apply to Medicare products when a contract benefit exists and where there are no national or local Medicare coverage decisions for the specific service. A brief description of the Centers for Medicare & Medicaid Services coverage has also been provided for Excellus BlueCross BlueShield medical policies at the end of each medical policy if a CMS coverage determination exists. Please refer to CMS for medical policies pertaining to Medicare contracts. Web sites for review of CMS policies are:


Please note: Although medical policies are effective on the date they are approved by the Medical Policy Committee, updates to the claims processing systems may not occur for up to 90 days.

The following new and updated medical policies have been reviewed and approved by the Corporate Medical Policy Committee, including practitioner representatives from Excellus BlueCross BlueShield, Central New York Region, Central New York Southern Tier Region, Utica Region, and Rochester Region.

NEW POLICIES recently approved

There were none to report. (Continued on next page)
**CURRENT POLICIES recently updated**

**Home Automatic External Defibrillators and Wearable Defibrillator Vests** are considered medically appropriate options for patients who meet the criteria for an implantable cardiac defibrillator but who are not candidates for implantation of the device. This may include the use as a temporary or bridge device for patients who meet the criteria for an ICD and are awaiting cardiac transplantation. Approval of a home AED is also contingent on having a caregiver who is capable (trained) and available to use a home AED. All other uses for a home AED or wearable defibrillator vest are considered investigational.

**Gastric Electrical Stimulation** has been developed as an alternative treatment for patients with refractory gastroparesis. The high frequency device delivers timed impulses to the gastric muscles that are intended to stimulate gastric myoelectric activity, with the goal of improving stomach emptying and relieving the symptoms of nausea and vomiting. Gastric electrical stimulation is considered investigational for the treatment of any disease or condition, including, but not limited to, gastroparesis and morbid obesity, as this device has not been proven to be effective in improving clinical outcomes.

**CURRENT POLICIES recently updated with minimal changes**

The following policies required only minimal changes (e.g., updating of references, changing language to meet legal needs). The **coverage intent of the policies was not altered**. These policies were recently approved for updating by the Health Plan medical directors and are available on our Web site.

- Automated Ambulatory Blood Pressure Monitoring
- Biofeedback
- Corneal Ultrasound Pachymetry
- Endometrial Ablation
- Endoscopic Injection of Bulking Agents for Vesicoureteral Reflux
- Evoked Potentials
- Hyperthermia
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Optical Coherence Tomography
- Photodynamic Therapy for Subfoveal Choroidal Neovascularization
- Prolotherapy
- Signal-averaged Electrocardiogram
- Small Bowel Transplantation and Multivisceral Transplantation
- Treatment of Tinnitus
- Transmyocardial Revascularization
- Transrectal Ultrasound
- Viscosupplementation of the Knee for Osteoarthritis
Controlling High Blood Pressure

May is National High Blood Pressure Education Month

Our most recent HEDIS measurement showed that 73 percent of our members with hypertension had a blood pressure that was adequately controlled (less than 140). Relative to other health plans nationally, this performance is in the 90th percentile. However, there are still a large number of individuals whose blood pressure is not controlled.

As you are aware, therapy begins with lifestyle modification. If BP goal is not achieved, thiazide-type diuretics should be used as initial therapy for most patients. Most hypertensive patients will require two or more antihypertensive medications to achieve their BP goal. When BP is greater than 20 mm-Hg above systolic goal or 10 mmHg above diastolic goal, consideration should be given to initiate therapy with two drugs, either as a separate prescription or in fixed-dose combination. The most effective and cost-efficient second drug is a generic angiotensin-converting enzyme inhibitor (ACE inhibitor).

Once antihypertensive drug therapy is initiated, most patients should return for follow-up and adjustment of medications at monthly intervals or until the BP goal is reached. More frequent visits will be necessary for stage two hypertension or with complicating comorbid conditions.


Microalbuminuria: So, What’s a Little Protein?

Microalbuminuria, if persistent, is a marker of eventual diabetic kidney disease and of cardiovascular death. It is measurable early in diabetes and modifiable to slow and hopefully halt the progression to end stage renal failure. Our most recent HEDIS measurement showed that 50 percent of Excellus BCBS members with diabetes had microalbuminuria screening.

Microalbuminuria cannot be detected by the standard office multi-test dipstick. If the urine by standard dipstick is positive for protein, your patient with diabetes is likely to have overt proteinuria and more advanced kidney disease. In these patients, there is no further value in testing the urine for microalbuminuria.

There are three methods of testing urine for microalbuminuria: measurement of spot urinary albumin to creatinine ratio, 24-hour urine collection with albumin and creatinine, and a timed 8-hour or overnight urine collection to measure the albumin to creatinine ratio. Microalbuminuria is present if urinary albumin excretion is equal to or greater than 30 mg/24 hour (equivalent to 20 µg/min on a timed specimen or 30 mg/g creatinine on a random sample).

Once a patient with diabetes has been identified to have persistent microalbuminuria, treatment should be either initiated or intensified. Angiotensin-converting enzyme inhibitors (ACE inhibitor) and angiotensin receptor blockers (ARBs) reduce microalbuminuria. Use of a generic ACE inhibitor is the most cost-effective therapy. Reducing hemoglobin AIC and achieving optimal blood pressure is also an important part of management. Annual microalbuminuria screening is recommended, even for those patients who are already on an ACE inhibitor or ARB.

(Continued on next page)
NYSDOH Requirements for HIV Counseling, Testing and Care of HIV Positive Individuals

In New York, many people with HIV do not know their HIV status and many others do not receive an HIV diagnosis until after they have already advanced to AIDS.

The New York State Department of Health (DOH) has HIV counseling, testing and reporting requirements, along with guidelines to help increase HIV testing, ensure entry into care and increase laboratory reporting. The DOH provides resources such as forms for informed consent and release of medical information and phone numbers for HIV information, referrals, or testing. Information about rapid test technology and reporting requirements are also provided.

This information is available in the Excellus BCBS Provider Manual and on our Web site at excellusbcbs.com. If you do not have Internet access, you may obtain a copy by calling the Quality Management Department at (800) 574-2390.
ClaimCheck Update

In the February issue of this newsletter, we notified you that our ClaimCheck Knowledge Base edits will be updated in early summer to accommodate the 2007 CPT/HCPCS codes and edits. The new edits will reflect the national coding practices that have been in effect since January 1, 2007, as well as our local medical policies. This notification serves to provide additional information regarding updates to “assistant surgeon” designations.

Per McKesson, ClaimCheck “now uses the American College of Surgeons (ACS) as its primary source for determining assistant surgeon designations. This rationale is based on the fact that the ACS determines these designations using clinical guidelines versus statistical measures. McKesson concurs that clinical necessity is critical to determining assistant surgeon reimbursement policies.”

You may verify procedure codes by accessing the Clear Claim Connection code auditing reference tool on our Web site, excellusbcbs.com. Be sure to include Modifier 80 along with the procedure code. If Clear Claim Connection indicates that assistant surgeon is disallowed, this will require the operative report for medical necessity review.

To access Clear Claim Connection from the Provider home page, click on Administration, then select Billing Resources and click on Check Clinical Editing. You will be asked to select your region and the type of service. Once you accept the Terms of Agreement, you will be asked to log into the Clear Claim Connection Web site. Please note that the information provided by Clear Claim Connection is only a reference tool and should not be considered a guarantee of payment.

Medicare Advantage Overview

Medicare Advantage is the alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as “traditional Medicare”). The Medicare Advantage program offers Medicare beneficiaries several product options, including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans. All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services (e.g., enhanced vision and dental benefits) as well. In January 1, 2006, many Medicare Advantage plans began offering Medicare prescription drug coverage for their members under the new Medicare Part D benefit program.

Medicare Advantage plans may allow in-network and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage for all Medicare Advantage members prior to providing service, since the level of benefits and coverage rules may vary.

Here are some important things to remember with the Medicare Advantage program:

Ask for the member’s ID card. Medicare Advantage members have an ID card that contains the BlueCross BlueShield logo in addition to a Medicare Advantage logo. While these members may also carry the traditional Medicare card, they should present and use the Medicare Advantage ID card with the BlueCross BlueShield logo.

Verify eligibility by visiting our Web site at excellusbcbs.com. Click on For Providers and then select Checking Eligibility, Claims & Referrals Online. If the member is an out-of-area BlueCard subscriber, select Members of Other BlueCross Plans. You must be a registered user to access this secure area of our Web site. Have the member’s ID card handy, as you will be asked to provide the ID number, including the three-character alpha prefix. You may also call BlueCard at (800) 676-2583 to check eligibility.

Submit claims to your local Excellus BCBS office. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by your local Excellus BlueCross BlueShield. Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility and balance billing limitations. It is important to indicate whether you accept Medicare assignment on these claims.
LIPITOR® COVERAGE UPDATE

Generic statins are Excellus BlueCross BlueShield’s first choice of therapy. All generics are proven safe and effective in reducing cholesterol levels and are covered under the Three-Tier prescription drug benefit at the lowest copayment amount (Tier One).

Recently, we notified Lipitor prescribers and their patients that beginning June 5, 2007, Lipitor will be moving to Tier Three. To clarify how this will apply to your Lipitor patients, please read the summary below.

Existing Patients on Lipitor:
- May continue coverage at the Tier Three copayment level with no prior authorization required
- Note: Current Lipitor patients requiring a high potency statin may switch to Crestor® (Tier Two copayment level) without prior authorization requirements

New Patients Starting on Lipitor:
- Need to try a generic statin first before Lipitor will be covered. This became effective October 3, 2006
- Lipitor 80 mg (only) - patients prescribed Lipitor 80 mg do not need a trial of a generic statin before approval

The Lipitor tier change applies to your patients with a Three-Tier benefit. It does not apply to Medicare Part D members.

For additional information, please visit our Web site at excellusbcbs.com or e-mail us at myrxconnection.com.
FDA Announces Drug Withdrawals, Recalls and Safety Warnings

Last month, the FDA announced that several drugs have either been removed from the market or were issued safety warnings. FLRx has notified our affected members who were prescribed these medications within the last 120 days and we have provided physicians with patient listings. Claims for pergolide, Zelnorm® and trimethobenzamide suppositories will no longer be processed through our system.

**Pergolide Products (March 29):** Pergolide drug products (Permax®) used to treat Parkinson’s disease, were removed from the market due to a serious risk for heart valve damage. Two studies published in the New England Journal of Medicine in January 2007 demonstrated a link between pergolide and cardiac valve regurgitation. (NEJM 356:29-38. and NEJM 356:39-46.) For patients currently taking pergolide, the FDA is recommending that prescribers assess the patient’s need for dopamine therapy, and if continued therapy is necessary, substitute an alternative agent. Pergolide should not be stopped abruptly, rather dosing should be gradually decreased. ([http://www.fda.gov/cder/drug/advisory/pergolide.htm](http://www.fda.gov/cder/drug/advisory/pergolide.htm))

**Zelnorm® (March 30):** Novartis Pharmaceuticals Corporation has voluntarily discontinued the marketing of Zelnorm based on the recent findings of an increase in risk of serious cardiovascular adverse events associated with its use. Zelnorm is approved for short-term treatment of women with irritable bowel syndrome with constipation and for patients younger than 65 years with chronic constipation. This action was based on the analysis of 29 short-term, randomized, controlled trials involving over 18,000 patients which showed an increased risk in cardiovascular adverse events (angina, heart attack, stroke, etc.) associated with Zelnorm use when compared to placebo. From this analysis, the FDA has concluded that the benefits from Zelnorm do not outweigh the risks. The absolute difference in cardiovascular events was small, but statistically significant (0.1% in the Zelnorm group and 0.01% in the placebo group).

The FDA recommends that patients taking Zelnorm seek immediate medical attention if they experience severe chest pain, shortness of breath, dizziness, sudden onset of weakness or difficulty walking, or other symptoms of heart attack or stroke. ([http://www.fda.gov/cder/drug/advisory/tegaserod.htm](http://www.fda.gov/cder/drug/advisory/tegaserod.htm))

**Suppository Products Containing Trimethobenzamide (April 6):** The FDA issued a press release stating that as part of its ongoing efforts to review unapproved marketed drugs and the DESI project, manufacturers will no longer be permitted to produce and distribute suppository forms of trimethobenzamide, a medication typically used for the treatment of nausea and vomiting. These products are also sold under the names Tigan®, Tebamide®, T-Gen®, Trimazide®, and Trimethobenz®. The FDA has determined that these products lack evidence of efficacy. This notice does not apply to other FDA-approved dosage forms of trimethobenzamide, such as capsules and injections. All companies currently producing these suppositories will be required to cease shipping by May 9, 2007. ([http://www.fda.gov/bbs/topics/NEWS/2007/NEW01601.html](http://www.fda.gov/bbs/topics/NEWS/2007/NEW01601.html))
**Grifulvin V® Oral Suspension and Griseofulvin V Oral Suspension (April 10):**
Ortho Dermatological, a Division of Ortho-McNeil Pharmaceutical, Inc. manufacturer of Grifulvin V® Oral Suspension and griseofulvin V Oral Suspension (manufactured by Patriot Pharmaceuticals, L.L.C.), voluntarily recalled certain lots of the drugs from the U.S. market. These medications are approved for treatment of ringworm and other fungal infections.

The recall is supported by the FDA and follows two reports of glass fragments found in bottles of the liquid formulation only (no other dosage form has been recalled). There have been no reports of adverse events from the reported glass fragments.

The lots which contained the bottles with glass fragments were shipped to distributors in the United States only between August 23, 2005 and March 14, 2007. Lot numbers can be found on the back of the product label only on four-ounce (120 mL) glass bottles filled by the manufacturer. Lot numbers are also posted on the FDA Web site (www.fda.gov) and at www.aboutgrifulvin.com.

Patients in possession of the medication should contact the pharmacy where they purchased the drug to determine if they have the product that has been recalled.

**Combivir® Safety Warning (April 10)**
GlaxoSmithKline (GSK) issued a warning with regard to misbranded bottles of Ziagen tablets labeled as Combivir. This alert was issued after two bottles labeled as Combivir were found to contain Ziagen. The FDA believes that the problem was isolated to one pharmacy in California. However, a letter was issued to all pharmacies encouraging them to check all bottles in stock and notify GSK immediately if they found something other than Combivir in bottles labeled as Combivir.

**Zanaflex® (tizanidine) (April 11)**
Acorda Therapeutics and the FDA informed health care professionals of changes to the “Contraindications and Warnings” sections of the product labeling for Zanaflex, used to treat spasticity. In pharmacokinetic studies where tizanidine was co-administered with either fluvoxamine or ciprofloxacin (CYP1A2 inhibitors), the serum concentration of tizanidine was significantly increased and potentiated its hypotensive and sedative effects.

Although there are no clinical studies evaluating the effects of other CYP1A2 inhibitors on tizanidine, co-administration of tizanidine with other CYP1A2 inhibitors (zileuton, other fluoroquinolones, antiarrythmics, cimetidine, famotidine, oral contraceptives, acyclovir and ticlopidine) should be avoided.

http://www.fda.gov/medwatch/safety/2007/safety07.htm#Zanaflex

**Update to FluMist® Article Published in Rx Facts:** The current 2006 CDC guidelines recommend influenza vaccination in children age 6 to 59 months, extending the age range for routine vaccination from previously reported 6-23 months (January 2007 issue of Rx Facts). The current CDC guidelines can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5510a1.htm
NOTICE OF NATIONAL PROVIDER IDENTIFIER FOR
TYPE I INDIVIDUAL PRACTITIONER OR TYPE II GROUP PRACTICE

Instructions:
- Please use the template included on the back of this sheet or create your own spreadsheet in the format we have provided. The template is also available for completion on our Web site, excellusbcbs.com.
- Complete all fields applicable to your practice.
- If completing for a group practice, please include all of the required information for each practitioner in the group.
- Please coordinate with other practice administrators if the members of your group participate in other group practices as well.
- Send the completed form(s) to one of the following:
  1. Fax Number: (800) 561-6504
  2. E-mail the form as an attachment to: NPIEXCEL@excellus.com
  3. Mail to: Attn: Techniplex
     NPI Project
     165 Court Street
     Rochester, NY 14647-0001

(continued on reverse)

Note: We will use this form to update the provider file repository containing your practice-specific information. We do not issue NPI numbers. You must obtain your NPI from the enumerator, Fox Systems, Inc. For additional information, visit www.FOXsys.com or apply for your NPI online at nppes.cms.hhs.gov.
***The fields located in the box below are required for Group Practices*****

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<th>Group Name (if applicable)*</th>
<th>Group NPI # (1)</th>
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*Please note that the Group name must match your name used for IRS reporting

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This form serves as notification that the providers listed above have obtained a National Provider Identifier (NPI) through Fox Systems, Inc.
NOTICE OF NATIONAL PROVIDER IDENTIFIER FOR TYPE II NONHOSPITAL/ANCILLARY PROVIDER

This form serves as notification that the provider listed below has obtained a National Provider Identifier through Fox Systems, Inc.

Instructions: Please complete all applicable fields. If you’ve obtained individual NPI(s) for subparts, please list each entity and send the completed form to one of the following:
1. Fax Number: (800) 561-6504
2. E-mail the form as an attachment to: NPIEXCEL@excellus.com
3. Mail to: Attn: Techniplex
   NPI Project
   165 Court Street
   Rochester, NY 14647-0001

NAME: __________________________________________

TAX ID NUMBER: ___________________________ LIC/CERT NUMBER (if app.): ____________________

NPI NUMBER          TAXonomy CODE          DIVISION/DEPT.

_________________________________________  ______________________  _________________________

_________________________________________  ______________________  _________________________

_________________________________________  ______________________  _________________________

_________________________________________  ______________________  _________________________

PROVIDER TYPE:
__ Laboratory                  __ DME/Supply Vendor                __ Freestanding Dialysis Center
__ Certified/Licensed Home Health Agency     __ Hearing Aid Dealer           __ Ambulance
__ Skilled Nursing Facility          __ Vision (Optician) Center       __ Outpatient Mental Health/OASAS
__ Infusion Therapy                  __ Freestanding Ambulatory Surgery Center
__ Other (specify): __________________________

OFFICE CONTACT: ___________________________ PHONE NUMBER: _______________________

Note: We will use this form to update our provider file repository containing your practice-specific information. We do not issue NPI numbers. You must obtain your NPI from the enumerator, Fox Systems, Inc. For additional information, visit www.FOXsys.com or apply for your NPI online at nppes.cms.hhs.gov.
Managing Diabetes – Some Key Points

As you manage your patients with diabetes, here are some key points from our community practice guidelines (based on recommendations from American Diabetes Association and the Association of Clinical Endocrinologists). You can access the complete document on our Web site at excellusbcbs.com.

Hemoglobin A1C
The goal should be to keep the A1C under 6.5 percent, as this has been associated with a reduction in microvascular, neuropathic, and cardiovascular complications.

A1C testing is recommended:
- At least twice per year in patients who are meeting treatment goals
- Quarterly in patients whose therapy has changed or who are not meeting glycemic goals.

Fasting Lipid Profile
A fasting profile including total cholesterol, LDL and triglyceride levels should be done annually. Tests resulting in abnormal values requiring therapy should be repeated. Diabetic individuals require an intensive CHD prevention strategy aiming for an LDL cholesterol <100 mg/dl.

For people with diabetes, aggressive lipid-lowering therapy has great impact on reducing morbidity and mortality rates. ADA guidelines now recommend that statins be considered for people with diabetes over the age of 40 who have a total cholesterol level that is greater than or equal to 135.

Microalbuminuria Screening
Screening for nephropathy at an early stage is important for identifying those patients affected, and for provision of appropriate management. The earliest clinically detectable sign of nephropathy is microalbuminuria. Annual screening is recommended, even for those patients who are already on an ACE or ARB.

There are three methods for screening for microalbuminuria: measurement of spot urinary albumin to creatinine ratio, 24-hour urine collection with albumin and creatinine, and a timed 8-hour or overnight urine collection to measure the albumin to creatinine ratio. Microalbuminuria is present if urinary albumin excretion is equal to or greater than 30 mg/24 hour (equivalent to 20 µg/min on a timed specimen or 30 mg/g creatinine on a random sample).

Retinopathy Screening
The prevalence of diabetic retinopathy is strongly related to the duration of diabetes and is the most frequent cause of new cases of blindness among adults. Glaucoma, cataracts, and other disorders of the eye may occur earlier in people with diabetes.

Patients with diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist (Type 1 within 5 years after the onset of diabetes, type 2 shortly after the diagnosis of diabetes). Subsequent exams for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist.