Physician Issue List for BCBSNC Joint Advisory Group (JAG)
Items Received in Response to 7/13/09 Blast Email to NCMS Physician Members

Background: The Physician Advisory Committee (BCBSNC changed the name to the Joint Advisory Group or" JAG") was formed to discuss issues arising from or related to the relationships and interactions between and among Physicians, their patients, and BCBSNC. These issues may include, but are not limited to: (a) improvement of health care and clinical quality, (b) improvement of communications, relations and cooperation between Physicians and Blue Cross, and/or (c) matters of a clinical or administrative nature that impact the interaction between Physicians and Blue Cross. In July, 2009 the JAG members asked members of the NCMS to submit their issues to the members of the JAG. The list was compiled and categorized and is presented below.

I. NEW PRIMARY CARE CONTRACT

- Multiple concerns re: BCBSNC slashing of lab fees-- this constitutes a major fee cut to practices.
- Most physicians spend at least one hour/day reviewing and managing care based on lab results—they will no longer be paid by BCBSNC for this service.
- Pediatric academic practice is considering closing its genetics lab.
- Pediatrics labs are all "STAT"- bilirubins to prevent kernicterus- in office labs prevent 3-day-old infant & postpartum mom from returning to the hospital for lab.
- Many labs are recommended by AAP as screening labs at well care visits—we can't afford to provide them!
- "After BCBSNC decided we couldn't do labs—I talked to my provider rep, who said all labs need to be sent to a reference lab. We need CBC, Strep test, urinalysis *during* the visit, not one-two days later. This shows that the provider reps have no idea about the practice of medicine in an office setting. Someone in a decision making position needs to explain to us how we should make a correct diagnosis without the STAT labs."
- "Totally impossible to operate an in-house lab without incurring an enormous loss. No one can afford to operate a lab at [a fraction of] of Medicare [rates]. It saves Blue Cross money for us to be able to run a diagnostic test in-house and prescribe the right treatment for the child in one visit. If we are unable to afford in-house labs the alternative is to send the patient out to a draw station like LabCorp then have the mom return with the child the next day for diagnosis and treatment. That will cost BCBSNC two office visits and the mom two co-pays."
- Large entities such as CMC/Presbyterian/Novant that have their own labs can still bill for the labs thus giving them a competitive advantage over smaller family practices.

- BCBSNC says it wants frequent Hgb_{A1C}s for diabetic patients, but payment makes this non-viable.

- Midlevel Practitioners Limited Payment to 85% of Doctor Rate:
  - MD still holds all the liability- NPs work for MD- NP farm with 1 doc, 10 NPs is different than an on-site MD with 1:1 NP or PA.
  - Workforce dynamic is that fewer doctors in primary care (and work fewer hours) will force increase in midlevels.

- Full Fee Schedule: Complaints re: only partial fee schedule sent, unable to obtain additional fees.

- BCBSNC "Pricing Policy", which is referenced by contract is unintelligible—is this optional? Does it supersede our contract fee schedule?

- BCBSNC "Pricing Policy" contains most favored nations clause: when application of BCBSNC's reimbursement procedures results in payment of a given claim based on your charge or a percentage of your charge, you are obligated to ensure that: (1) all charges billed to BCBSNC are reasonable, (2) all charges are consistent with your fiduciary duty to your patient and BCBSNC, (3) no charges are excessive in any respect, and (4) all charges are no greater than the amount regularly charged to the general public, including those persons without health insurance.

- Final reimbursement total [under the new Primary Care Contract] is less than what BCBSNC was paying us before.

- After hours charges – contract specifies a % of charges, which means there is no real number in the contract.

- Vaccines and other drugs are below the physician's cost of procurement. No margin for drug/vaccine handling or procurement.

II. PAYMENT POLICY

- Secondary Benefits/Payments:
  - When patients have a secondary policy, the copayments from the primary payor are frequently not reimbursed. This is particularly true when both the primary and secondary policies are Blue Cross plans. This means that the

patient does not realize the benefits of having the secondary policy and the provider is denied payment.

- Physician Office Labs:

    - "As a family physician, we are struggling to make ends meet. Currently, BCBSNC reimburses my practice at a rate that is [a fraction of] of Medicare. Also-when I bill BCBSNC for an E&M code and a surgical code on the same day, my patient is charged two copays for the same visit. I don't know how we are supposed to make a go of it."
    - Blue Cross has begun to systematically deny my lab claims without notice. The provider rep said no notice was needed because of the "Pricing Development and Maintenance Policy."

- Payment Directly to Patient/Assignment:

    - Since I am not participating, they send payments directly to the patient, without even letting me know how much, and the patient may or may not then pay me. However, if they send me a patient's money by their error, they refuse to help correct the mistake.
    - A pediatric critical care group—Blue Cross refuses to assign member benefits to out of network providers, resulting in unnecessary cost, chasing the patient down for reimbursement, etc.

- Physician Assistant Surgeons for Total Joint Replacements: Question re: whether this was resolved, and whether the affected practices were ever told about the resolution.

- Optical Establishments: Why do are ophthalmologists required to have their optical establishments for participate in the BCBSNC, isn't this a violation of the lawsuit "all products" clause? BCBSNC refuses to permit the ophthalmologists to participate for professional services unless they provide a 30% discount for BCBSNC members in their optical shops. This is an excessive exercise of market power by BCBSNC.

- CPT/Payment: Blue Cross picks and chooses what definition of CPT to use when paying for a particular procedure. Fraud and abuse unit gets involved over even minor CPT-related matters when Blue Cross changes its mind re: how to pay a code. All of this is especially problematic for new technologies.

- Colonoscopy Centers:
    - Patients are referred to "Blue Cross Certified Centers" for screening—which does not include the certified, JACO-

accredited Ambulatory Surgery Centers. This is seems paradoxical and in contrast to quality standards.
  - Despite a state law requiring coverage, Blue Cross consistently denies colonoscopy reimbursement for patients.

- Retroactive Recoupment: Blue Cross retroactively reduced payment for a "secondary" procedure to 50% even though it was a separate procedure and the procedures were not performed on the same day!

- Renumbered/New Codes:
  - Monthly Dialysis Codes: Blue Cross reduced payment for dialysis codes without notice despite a rate that was line-itemed in the contract. The practice was told that they were new codes—but these codes do not reflect the procedure that we are performing. My question then is why have a contract at all?
  - Dialysis Codes: Renumbered Codes: In 2009, codes were renumbered, with no changes to the descriptions, RVU structure, etc. For example, 90772 is now 96372. Even worse, G-codes were assigned permanent codes. BCBSNC unilaterally decided to reduce fees. They retained the multiplier and pay the current year Medicare rate for the "new" code. Then they tell you that your only choice is to renegotiate your entire fee schedule if you protest. These are for the exact same services—the only difference is the five digit number we bill. This shows that BCBSNC will take advantage of any circumstance that results in reducing their payments to physicians, no one in their right mind would consider this to be a fair business practice.
  - Bone Density Exams: Renumbered Codes resulted in a considerable reduction in bone dialysis payments; BCBSNC completely refused to consider this even when they were promoting bone dialysis to their patients.

- Lab Same Day as Admission: Patient had blood work in our office, and then was admitted to the hospital the same day. Now BCBSNC says they won't pay for the in-office blood work. They said this was "their policy."

- Two Surgeries/Same Day: OB/GYN performed vaginal delivery; several hours later performed a bilateral tubal ligation. BCBSNC paid for both—then two years later came back for a refund, calling it the BTL a "secondary procedure" which they say should have been paid at 50%. They said they would have paid it if we brought the patient back on another day. Even though BCBSNC says that BLT do not require preauthorization—the BTL is denied for "failure to obtain preauthorization." So we have been forced to appeal every one of these.

- Ear Wax Removal: Blue Cross is the only payor that refuses to pay for ear wax removal and an office visit on the same day. Ear wax removal is necessary to make a correct diagnosis. Codes= 99213 with a -25 modifier and 69210.

- Asthma: The high copays for many state-of-the-art asthma medications makes it very difficult to fulfill the asthma therapy recommendations of using combination therapy rather than increasing steroids to control symptoms. This does not line up with their "quality" programs and causes increased hospitalizations.

- Psychiatry/Mental Health:

  - Access to Mental Health is reaching critical levels - low payment is driving the "thermodynamics".
  - Psychiatrists are limited to medication management code 90862—and cannot bill other E&M codes. The lack of E/M coding is eroding the ability of psychiatrists to appropriately treat complicated BCBSNC patients.
  - Medicare and Medicaid will reimburse psychiatrists for E/M codes, BCBSNC will not. This is in violation of the NC mental health parity Act as will as the Wellstone-Domenici Mental Health Parity Act of 2008. The North Carolina statute required insurance companies to cover major psychiatric conditions in the same manner as medical conditions. The federal bill states that treatment limitations applicable to mental health or substance abuse disorder benefits should be no more restrictive than all medical and surgical benefits covered by the health plan. Thus, not reimbursing psychiatrists for E/M coding is a violation of parity.
  - Not reimbursing for E&M codes impairs our ability to evaluate side effects of medications—these medications affect multiple systems and require frequent physical assessment. Primary care physicians may not be in a position to evaluate these patient impacts—even if we are able to refer these patients to a PCP.
  - I recently saw a man who was floridly psychotic who had been admitted to a hospital after a high speed chase and was discharged still psychotic. I interviewed him, talked to the family and involuntarily committed to him. The only code available was 90807.
  - BCBSNC has refused to talk to psychiatrists or Psychiatric Association about these issues.
  - Payments have declined by over 30% in the past 10 years.

III. OPERATIONS/ADMINISTRATIVE COSTS/HASSLE FACTOR

- Imaging Preauthorization/Administrative Complexity:

  - "The preauthorization requirement for imaging is still a pain; when it becomes too onerous, we just refer to a specialist who can do the evaluation and administrative work."
  - This program is anti-medical home.

- It is not uncommon to be tied up on the phone for 20-30 minutes.
- I end up bringing the patient back in the office (after a denial) to discuss their choices, so that costs BCBSNC and the patient extra money.
- Preauthorization for imaging is required for both primary and secondary payors. This is true even when we are not initially aware that Blue Cross is secondary. Appeals are not heard when the preauthorization is not obtained.
- Dx Imaging Precert is time consuming and an added administrative burden without compensation.
- Problem with nuclear stress tests being denied due to lack of preauthorization of the primary care physician. BCBSNC now even prohibits appeals of these situations—even though they are completely outside of the control of the cardiologist. Appeals should be permitted due to simple administrative errors!

- Out-of-State BCBS/Blue Card Program:

  - Blue Card Eligibility: "BCBSNC requires that we accept all BCBS insureds (from any state) but we cannot verify eligibility. If BCBS wants us to continue this, then they need to get some system in place (like Blue-e) that allows us to verify online in a timely fashion. Some BCBS cards have numbers for providers to call, but you can be on hold for inordinate amounts of time waiting for someone to help you.
  - "I'm sure everyone has problems with the Blue Card policies."
  - "It costs twice as much to deal with a Blue Card patient because of the administrative hassles."
  - I am switched back and forth for inquiries between the out-of-state plan and the home plan. When I am sent back to the home plan, I am told to wait 15 days for a response. The majority of the time we never hear back from either plan.

- Prior Approval Required for Cosmetic Procedures that are Consistently Denied:

  - "BCBSNC is the only plan that requires that we go through them to seek prior approval (if the procedure is on their prior approval list) even if we know the medical necessity will not be met. They also expect us to accept their fee schedule of what we deem cosmetic and the patient understand is cosmetic. Medicare allows us to charge our fee schedule to patients for procedures that we either deem cosmetic or procedures that we know do not meet their medical necessity guidelines as long as we inform the patient upfront and have them sign the proper waiver.
  - With other health plans, when we determine that a service procedure is likely not to be covered, the patient signs a waiver and we charge them up-front based on our fee schedule. Blue Cross requires us to seek prior approval/denial—even when we are certain it will not be covered. Then they expect us to charge based on their fee schedule for a non-covered service. Even Medicare does not do this.

- Pharmacy Preauthorizations: The drug pre-authorization process through Merck-Medco is a constant problem. They will usually not permit phone authorization, requiring a fax-back form—you don't hear from them for days, they lose the form. They repeatedly verify your address, phone and fax even though you just talked with them. Numerous forms sent in.

- Identification Cards: Members do not receive cards in a timely fashion resulting in misunderstandings regarding coverage and particularly co-pays. This is especially true of the State Employee Health Plan.

- New Direct Deposit Program: Program is confusing—cannot obtain information on how to receive old EOBs.

- Copays/Consistency: Lack of consistency regarding whether a copay is required—specifically when some plans require a copay for both the office visit and a procedure and others require only one copay for both. It is not possible to discern this from the patient's ID card.

- E-Prescribe Program:

  - E-Prescribe Bonus Program: Appeal documentation is "lost" despite having a stamped and dated return receipt. No one will help me.

  - E-Prescribe Program: We were supposed to receive the incentive around the end of the 1st quarter. The ePrescribe team will not provide a contact person to speak with about when it will be received. This does not reflect well on BCBSNC.

  - E-Prescribe Software: Didn't get paid at the end because we were suddenly informed our system was certified. The e-prescribe system is part of our EMR!

  - There are many unresolved issues: pharmacies not participating (CVS in Burlington), unable to submit narcotics electronically, prescriptions "not received" by pharmacy. BCBSNC must address these fundamental problems before it penalizes physicians for not using the program.

- Recoupment: Payments are continuing to be recouped from an ERA, without any request for a refund. These are being recouped without a request for a refund in advance. This is not in compliance with the settlement agreement.

- Medicare Crossover Claims: Medicare Crossover Claims, documented by Medicare EOBs, are not being processed for payment. BCBSNC says they never received from Medicare which necessitates the practice filing a paper claim with a copy of the Medicare EOB.

- Paper Claims: For small rural practitioners, BCBSNC should have a toll free fax number to send paper claims.

- Claims Timeliness: OB/GYN practice concerned about claims timeliness by the state employee health plan. "More recently we have not been paid at all."

- Medical Records:
  - We repeatedly send records, then Blue Cross requests it again. We have time/date stamped documentation that they received it the first time.
  - We have continuing g issues with Blue Cross regarding medical records. They are frequently lost, we send them again, then claim is denied, we appeal—then the claim is denied for claims timeliness despite the fact that the delay was due to Blue Cross repeatedly losing the medical records. This seems intentional to us—Blue Cross could fix this.
  - EOB states that payment is denied because Blue Cross needs medical records-but 90% of the time they have never contacted us for medical records. So we have to contact them!

IV. MEDICAL POLICIES/AUTHORIZATION/BENEFIT DESIGN/APPEAL ISSUES

Pediatric Surgery Issues:

- Preop Authorizations for Gynecomastia Surgery.
  "The generally-accepted management of these teenage boys, in the pediatric surgery literature, includes observation for about a year or so (since the problem typically resolves spontaneously without surgery). If it doesn't resolve, and if the patient has pain/tenderness, then we typically offer a surgical procedure (subcutaneous mastectomy) as long as the hormonal "workup" (testosterone levels, LH, FSH, etc) is normal and as long as the BMI is reasonable (this shows that the breast tissue isn't just fat in an obese kid). Occasionally, insurance companies want us to show that the excess tissue is primarily "glandular" or "dense" which I don't mind doing with an ultrasound or mammogram. However... we often get denials with comments such as "has not documented failure of alternate therapies" or "not a covered service until age 18 years" (or one of many other reasons). Seems to me that BCBSNC should clarify their "policies" and make

them consistent with what is currently accepted practice in mainstream pediatric surgery."
Recommendation→Clarify policy to be consistent with mainstream clinical practice.

- Payment for Gastrostomy Tube Placement during Nissen Fundoplication.
  "BCBSNC pays us for the Nissen but not for the G-tube, which is really ridiculous since placing the G-tube adds plenty of time to the procedure and the perioperative management of the G-tube (teaching, cleaning, care, etc) can be very, very time-consuming. Why will BCBSNC pay for the Nissen and not the G-tube, if done at the same operation? (Seems to me that this would save the company LOTS of money since some surgeons might be tempted to do the Nissen and "see how it goes" without the G-tube and then come back at a later date and do the G-tube, if needed, and this then costs BCBSNC LOTS more money...)
  Recommendation→Pay for both procedures

- Pectus Carinatum Brace.
  This brace, which costs about $500, works about 70% of the time to correct the deformity and PREVENT the need for the $40,000 operation (hospital fee/charge and anesthesia, etc). Why does BCBSNC authorize the operation and not the brace? There are now multiple series of brace patients in the literature from Cincinnati Children's, Canada, Massachusetts, California, and other institutions documenting success of the procedure.
  Recommendation→Pay for brace

- Denial of Hospital Admit for New Onset Pediatric Diabetes:

  "BCBSNC has repeatedly attempted to deny coverage of hospital admission for pediatric new onset diabetes. They use clinical criteria which don't account for standard of care or guidelines from the American Diabetes Association. Standard of care across the country for pediatric endocrinology is admission of children with new onset diabetes, whether or not they are in DKA, for initiation of insulin therapy and for intensive diabetes education. The ADA has hospital admission guidelines for diabetes that are published (most recent version is attached) and which clearly lists pediatric patients as a sub-category of patients who are appropriate for admission."
  Recommendation→Pay for admission for new onset diabetes

- Vascular Surgery: Concerns about limitations on payment re: venous insufficiently. There are multiple delays in paying for venous stasis ulcers caused by bad venous insufficiency. Waiting 3-6 months or taking anti-inflammatories or most of the other two pages of requirements do not cure this disease, which can cause limb loss. This is not cosmetic.
  Recommendation→*Pay for brace*

- Dermatology:

  - Patch testing policy (several comments): BCBSNC has changed their medical policy (MED1030) regarding Patch Testing—resulting in major disruption in services and payments. BCBSNC will not even pay for the preferred 82 patch tests, and will not pay for even the 32 patch tests indicated in their policy.
  - BCBSNC specialty reviewer has no clue about dermatology. All appeals are denied, even for the worst conditions.

- Ophthalmology- endothelial keratoplasty surgery:

  - "I am in the middle of a lengthy appeals process with BCBSNC regarding their policy to deny coverage for endothelial keratoplasty surgery. They claim that this surgery is investigational, and therefore not medically necessary. The truth is that for appropriate diagnoses, this procedure has been adopted by corneal surgeons nation-wide (actually world-wide) due to its well-documented clinical benefits over nutritional corneal transplant surgery. For these diagnoses, it is WRONG not to offer this surgery to patients. EK surgery received its own Category 1 CPT code (65756) by CMS in January, '09. I have supplied BCBSNC with multiple authoritative references documenting EK's significant advantages, and its widespread support in the ophthalmology community, but they still denied coverage. I also referenced BCBS of Georgia's policy of coverage. They still denied coverage. I am now waiting for the results of their Level II Grievance process. This is the same organization that still denies coverage for corneal topography, despite over a decade of widespread acceptance of this service nationwide by just about every other insurance carrier."

DSEK (SUTURELESS CORNEAL TRANSPLANT SURGERY TECHNIQUES):

  - "DSEK is NOT "experimental" and has rapidly become the surgical standard of care for bullous keratopathy. It's advantages over PKP for many conditions is obvious and now well documented. Corneal topography is, historically, a bit tougher nut to crack. I did my research on topography at LSU with Steve Klyce, PhD. I've never understood why (except as a means to deny payment) corneal topography has been the poor little red headed step child of ophthalmic testing as it is as useful as any other test we do. It is standard in many diseases and malpractice NOT to use in some instances. And given my advancing age, I can say, topography has been widely accepted for over two decades. Both SHOULD be covered. "

- Orthopedic Surgery: Patients with osteochondral defect in ankle—recommended a mosaicplasty. Considered experimental by BCBSNC despite use in U.S. for ten years with high rate of success, and has a CPT code approved by

CMS (CPT 28446). BCBSNC approves similar procedure for the knee, which makes no sense. All documentation has been provided to BCBSNC, to no avail.

- Pain Management:

  - Blue Cross considers many procedures to be experimental and refuses to reimburse for them even when they have shown excellent success for years and despite the fact that Medicare and Medicaid pay for them.
  - Examples include: epidural lysis of adhesions, percutaneous discectomy and all intradiscal electrothermal procedures. These procedures are effective in an office setting and potentially save patients from having major orthopedic surgery.

- Sleep Studies: Denials of medically necessary equipment and requirements to send medical records, letters, etc. (even if all the information is sent initially) is wasteful of physician/nursing time and increases cost. If a patient has a sleep study indicating the need for a CPAP, the study shows titration of the CPAP—despite that BCBSNC requires extra letters.

- Benefit Plan: Patients who see specialists at an outpatient client or have outpatient labs/x-rays are charged like they have had an inpatient hospital stay.

- Radiofrequency Turbinate Reductions:

  - Blue Cross refused to cover despite clinical evidence to the contrary.
  - Controversy re: use of the CPT code 30140 vs. 30802.
  - Practice conducted its own outcomes research prospective study which was not considered persuasive by BCBSNC. Procedure has been conducted for 12+ years and 10 prospective studies have been published.
  - Despite contract negotiations listing the codes, practice was hit with a very large refund demand from BCBSNC without any appeal process or other recourse.
  - No documentation re: investigational nature of the procedure; academy's recommendations were used selectively. Policy only published after the practice asked for it to be put in writing.
  - Reference: CPT Assistant provides clarification on the appropriate code to be used—30140 is appropriate, radiofrequency turbinate reduction is mentioned under clinical indications section.

V. PROVIDER RELATIONS/COMMUNICATIONS/POLICY ISSUES

- Numerous Comments: [Note: These emails are "on-fire.] "BCBSNC bullies, coerces, refuses to negotiate fees," etc. Take or leave it attitude. "Provider reps not responsive or powerless." Examples:

  - I recently tried to "negotiate" a proper fee schedule with BCBSNC rep. She came to the office; I spent over an hour educating her about my services. The result was that despite multiple phone calls, I heard back from BCBSNC three months later (I never heard from the particular rep again) and the fee schedule proposed was lower than my existing schedule which was set up in 1997 (12 years ago). There is clearly no desire to "communicate" or "work together" with BCBSNC.
  - Very serious relationship issues re: BCBSNC provider rep/contractor in [specific city cited]. "The most condescending person I have ever met."
  - Some comments re: "our provider reps seem embarrassed about [their organization's policy], they have no power."
  - Provider Reps: Reps always have to call "corporate"—this process takes weeks.
  - Blue Cross "consistently intimidates both physicians and hospitals for purposes that serve their bottom line and not patient care. I have observed this pattern for over 30 years."
  - I don't know how BCBSNC can condone this rude behavior, especially in the South.
  - "They always bring five people to intimidate us. Then they never get back with us."
  - Reps/consultants have made statements to us like "they don't trust physicians." Is this behavior considered to be ok with their supervisors/BCBSNC?
  - Closing multiple provider offices will just enhance the bad relationships—why don't they fix these offices instead?
  - Emails suggesting that closing provider offices was "retaliation" against the providers.
  - When there is a glitch or a problem (such as lost checks, new group number, etc.)—the issues drag on for months. The first line person takes the message, assures us that it will be passed on or resolved, but most of the time we never hear back or get paid. Only one out of six calls is returned, often the response is ridiculous or unrelated to the question.

- BCBSNC Ads/Campaigns re: Public Option:
  - Multiple emails complaining unprofessional and inappropriate use of premium dollars.
  - Ads are inconsistent with the views of physicians, plan members and many others.
  - This money should be spent for patient care, not promoting BCBSNC self interest.

➢ Termination from BCBSNC Network Due to Customized Practice: Physicians developed practice limiting patients to 600 patients/physician and charging patients a fee. Prevention oriented. BCBSNC terminated the practice from their network. Program has 300 physicians in 27 states and is accepted by Medicare and other payors. Services include those not covered by BCBSNC. BCBSNC asserts that charging the patient is a violation of its standard contract.
➢ Liability Reform: Why can't BCBSNC support North Carolina physicians on liability reform? In their best interests too.
➢ Credentialing: Specific complaint about BCBSNC—physician was deactivated due to problem on "line attestations". They were told three separate times that we had successfully been reinstated. Eventually told that even though it was all a mistake, it was necessary to re-contract with both BCBSNC and Partners. This took several months to correct, payments denied during this time, patients were notified by BCBSNC that I was not participating. BCBSNC refused to provide me with a list of these patients so I could correct the error. All this time the physician was listed as participating. Overall, this was financially devastating for my practice.
➢ Electrodiagnostic Studies being performed/paid with unsigned reports: Neurologists then asked to make a diagnosis or render treatment based on studies performed by unknown entities. Legal risk, especially re: Workers' Comp patients. Would also like to differentiate between "medical interpretation" and "physical therapy interpretation".
➢ Provider EOBs/Remittance: ➢ When BCBSNC stopped mailing provider EOBs and instead posted on their website—they made no effort to insure that physicians could match the checks they were receiving with the patient accounts. Initially, the Blue Cross website was apparently so overwhelmed that it continually crashed. No one bothered to communicate with physicians about the problem.
➢ HSA Eligibility: Physician attempted to obtain HSA coverage through BCBSNC, was turned down twice, despite submission of extensive medical documentation. Appeal was turned down quickly—does not believe the medical documentation was reviewed by a qualified person or that there is medical competence in BCBSNC underwriting criteria.
➢ Spectrum Lab Denials: Claims denied without 90 advance notice of material adverse change.