Required lead time when updating your provider information page 3

Prescription drug updates page 14

Positive results in Independence’s 2015 Provider Satisfaction Survey page 16
Inside this edition

Administrative
- Required lead time when updating your provider information
- Reminder: Concierge medical practices prohibited as a participating provider

Billing
- Professional Injectable and Vaccine Fee Schedule updates effective July 1, 2016
- Changes in reimbursement display
- Important billing reminders for hospitals

NaviNet®
- Document Exchange coming soon to NaviNet®

BlueCard®
- BlueCard® PPO Professional Host claim submissions

Medical
- Recent updates to Direct Ship Drug Program
- View up-to-date policy activity on our Medical Policy Portal
- Upcoming training for precertification of certain genetic/genomic tests through eviCore

Pharmacy
- Select Drug Program® Formulary updates
- Prescription drug updates

Quality Management
- Positive results in Independence’s 2015 Provider Satisfaction Survey

Health and Wellness
- Health Coaches: Supporting your patients, our members
- Coming soon: Healthy Families and Kids

Partners in Health Update® is a publication of Independence Blue Cross and its affiliates (Independence), created to provide valuable information to the Independence-participating provider community. This publication may include notice of changes or clarifications to administrative policies and procedures that are related to the covered services you provide in accordance with your participating professional provider, hospital, or ancillary provider/ancillary facility contract with Independence. This publication is the primary method for communicating such general changes. Suggestions are welcome.

Contact information:
Provider Communications
Independence Blue Cross
1901 Market Street
27th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

Models are used for illustrative purposes only. Some illustrations in this publication copyright 2016 www.dreamstime.com. All rights reserved.

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Program (HMO, PPO, etc.), and/or employer groups. Providers should call Provider Services for the member’s applicable benefits information. Members should be instructed to call the Customer Service telephone number on their ID card.

The third-party websites mentioned in this publication are maintained by organizations over which Independence exercises no control, and accordingly, Independence disclaims any responsibility for the content, the accuracy of the information, and/or quality of the products or services provided by or advertised in these third-party sites. URLs are presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefits plans. Members should refer to their benefits contract for complete details of the terms, limitations, and exclusions of their coverage.

NaviNet is a registered trademark of NaviNet, Inc., an independent company.
FutureScripts and FutureScripts Secure are independent companies that provide pharmacy benefits management services.

CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Keystone Health Plan East, Personal Choice®, Keystone 65 HMO, and Personal Choice 65SM PPO have an accreditation status of Commendable from the National Committee for Quality Assurance (NCQA).
Required lead time when updating your provider information

Independence would like to remind you about the importance of submitting changes to your provider information in a timely manner. Keeping your provider information current and up-to-date helps to ensure prompt payment of claims, delivery of critical communications, seamless recredentialing, and accurate listings in our provider directories. Per your Independence Professional Provider Agreement and/or Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement), you are required to notify Independence whenever key practice information changes.

Professional providers

As outlined in the Administrative Procedures section of the Provider Manual for Participating Professional Providers (Provider Manual), Independence requires 30 days advanced notice to process most updates, with the exceptions noted below:

- **30-day notice.** Independence requires 30 days advanced notice for the following changes/updates to your practice information:
  - updates to address, office hours, total hours, phone number, or fax number;
  - changes in selection of capitated providers (HMO primary care physicians [PCP] only);
  - addition of new providers to your group (either newly credentialed or participating);
  - changes to hospital affiliation;
  - changes that affect availability to patients (e.g., opening your panel to new patients).

- **60-day notice.** Independence requires 60 days advanced written notice for closure of a PCP practice or panel to additional patients.

- **90-day notice.** Independence requires 90 days advanced written notice for resignation and/or termination from our network.

*Note:* Independence will not be responsible for changes not processed due to lack of proper notice.

Submitting updates and/or changes*

Professional providers can use the Provider Change Form, available at www.ibx.com/providerforms, to quickly and easily submit most of the changes to their basic practice information. Please be sure to print clearly, provide complete information, and attach additional documentation as necessary. Mail your completed Provider Change Form to:

Independence Blue Cross  
Attn: Network Administration  
P.O. Box 41431  
Philadelphia, PA 19101-1431

You can also fax the completed form to Network Administration at 215-988-6080. Please be sure to keep a confirmation of your fax.

*Note:* The Provider Change Form cannot be used if you are closing your practice or terminating from the network. Refer to “Resignation/termination from the Independence network” in the Administrative Procedures section of the Provider Manual for more information regarding policies and procedures for resigning or terminating from the network.

Facility and ancillary providers

As outlined in the Administrative Procedures section of the Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers, Independence requires 30 days advanced written notice to process updates to address, phone number, or fax number, as well as change in ownership.

*Note:* Independence will not be responsible for changes not processed due to lack of proper notice.

continued on the next page
Submitting updates and/or changes
Per your Agreement, all changes must be submitted in writing to our contracting and legal departments at the following addresses:

Independence Blue Cross
Attn: Senior Vice President, Provider Networks and Value-Based Solutions
1901 Market Street, 27th Floor
Philadelphia, PA 19103

Independence Blue Cross
Attn: Deputy General Counsel, Managed Care
1901 Market Street, 43rd Floor
Philadelphia, PA 19103

Authorizing signature and W-9 Forms
Updates that result in a change on your W-9 Form (e.g., changes to a provider’s name, tax ID number, billing vendor or “pay to” address, or ownership) require the following signatures:

- **For professional providers**: A signature from a legally authorized representative (e.g., head physician of the practice, practice administrator) is required.
- **For facility and ancillary providers**: Written notification on company letterhead is required.

An updated copy of your W-9 Form reflecting these changes must also be included to ensure that we provide you with a correct 1099 Form for your tax purposes. If you do not submit a copy of your new W-9 Form, your change will not be processed.

If you have any questions about updating your provider information, please contact your Network Coordinator.

*To ensure appropriate setup in Independence systems, the timelines outlined above also apply to behavioral health providers contracted with Magellan Healthcare, Inc., an independent company, but they must submit any changes to their practice information to Magellan via their online Provider Data Change form at www.MagellanHealth.com/provider by selecting the “Display/Edit Practice Info” link or by contacting their Network Management Specialist at 1-800-866-4108 for assistance.*
Reminder: Concierge medical practices prohibited as a participating provider

Concierge medicine, also referred to as retainer medicine, is a relationship between a patient and a physician in which the patient pays an annual fee or retainer. Please be advised that the practice of charging Independence members a mandatory annual payment violates the terms of your Independence Professional Provider Agreement (Agreement).

Physicians who participate with Independence are required to comply with the terms and conditions of their Agreement, which requires participating providers to accept Independence’s payment as payment in full for Covered Services. Covered Services are considered to include:

- well-patient visits
- emergency telephone consultation available 24 hours a day, seven days a week
- treatment of acute conditions
- coordination of medically necessary care
- referrals to appropriate specialists for treatment

In addition, extending the length of a visit, coordinating medically necessary care, and/or providing wellness-type services are integral to the provision of Covered Services and are consistent with a standard of care Independence expects from participating providers.

Participating providers are required to provide Covered Services during normal business hours, but they must also be available to Independence members by telephone 24 hours a day, seven days a week, for consultation on medical concerns and emergencies.

Please be advised that Independence-participating providers who elect to open a concierge practice that requires members to pay a designated fee for Covered Services to remain in their practice are in violation of their Agreement and are subject to termination from the Independence network.

If you have any questions, please contact your Network Coordinator.

Professional Injectable and Vaccine Fee Schedule updates effective July 1, 2016

Effective July 1, 2016, we will implement a quarterly update to our Professional Injectable and Vaccine Fee Schedule for all contracted providers. These updates reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables.

Allowance Inquiry transaction

To look up the rate for a specific code, use the Allowance Inquiry transaction on the NaviNet® web portal. To do so, go to Independence NaviNet Plan Central, select Claim Inquiry and Maintenance from the Independence Workflows menu, and then select Allowance Inquiry. For step-by-step instructions on how to use this transaction, refer to the user guide available in the NaviNet Resources section of our Provider News Center at www.ibx.com/pnc/navinet.

Note: The Allowance Inquiry transaction returns current rates for professional providers only. The reimbursement rates that go into effect July 1, 2016, will be available through this transaction on or after this effective date. Provider payment allowances are for informational purposes only and are not a guarantee of payment.

If you have any questions about the updates, please contact your Network Coordinator.
Changes in reimbursement display

As previously communicated, during the transition to our new claims processing platform, there was a change in the display of reimbursement for multiple outpatient surgeries for Indemnity/Traditional, Federal Employee Program (FEP), and Host BlueCard® claims. In addition, there was a change in display for inpatient stays for commercial and Medicare Advantage claims (excludes Host BlueCard claims). Please note that regardless of payment methodology (i.e., per diem or diagnosis related group [DRG]), the reimbursement for services is displayed across all claim lines.

### Outpatient surgeries

- **Claims processed on the previous platform.** Reimbursement for multiple outpatient surgical procedures were rolled up and displayed on *one payment line*, as shown below.

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Claim line</th>
<th>Rev code</th>
<th>Procedure code</th>
<th>Contracted rate</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234</td>
<td>1</td>
<td>0360</td>
<td>23130</td>
<td>$100 x 2.5 = $250</td>
<td>$375.00</td>
</tr>
<tr>
<td>1234</td>
<td>2</td>
<td>0369</td>
<td>23156</td>
<td>$50 x 2.5 = $125</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

- **Claims processed on the new platform.** Reimbursement for multiple outpatient surgical procedures are displayed on *two or more separate payment lines*, as shown below.

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Claim line</th>
<th>Rev code</th>
<th>Procedure code</th>
<th>Contracted rate</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234</td>
<td>1</td>
<td>0360</td>
<td>23130</td>
<td>$100 x 2.5 = $250</td>
<td>$250.00</td>
</tr>
<tr>
<td>1234</td>
<td>2</td>
<td>0369</td>
<td>23156</td>
<td>$50 x 2.5 = $125</td>
<td>$125.00</td>
</tr>
</tbody>
</table>

### Inpatient stays

- **Claims processed on the previous platform.** Reimbursement for an inpatient stay was rolled up and displayed on *one payment line*, as shown below.

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Claim line</th>
<th>Rev code</th>
<th>Units of service</th>
<th>Charges</th>
<th>Contracted rate</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0011</td>
<td>1</td>
<td>171</td>
<td>1</td>
<td>$3,000</td>
<td>$47 per diem</td>
<td>$47.00</td>
</tr>
<tr>
<td>0011</td>
<td>2</td>
<td>174</td>
<td>1</td>
<td>$6,000</td>
<td>$3,489 per diem</td>
<td>$3,489.00</td>
</tr>
<tr>
<td>0011</td>
<td>3</td>
<td>300</td>
<td>5</td>
<td>$1,000</td>
<td>–</td>
<td>$0.00</td>
</tr>
<tr>
<td>0011</td>
<td>4</td>
<td>636</td>
<td>10</td>
<td>$2,000</td>
<td>–</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Total:** $12,000 $3,536.00 $3,536.00

- **Claims processed on the new platform.** Reimbursement for an inpatient stay is displayed on *two or more separate payment lines*, as shown below.

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Claim line</th>
<th>Rev code</th>
<th>Units of service</th>
<th>Charges</th>
<th>Contracted rate</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0011</td>
<td>1</td>
<td>171</td>
<td>1</td>
<td>$3,000</td>
<td>$47 per diem</td>
<td>$884.00</td>
</tr>
<tr>
<td>0011</td>
<td>2</td>
<td>174</td>
<td>1</td>
<td>$6,000</td>
<td>$3,489 per diem</td>
<td>$1,768.00</td>
</tr>
<tr>
<td>0011</td>
<td>3</td>
<td>300</td>
<td>5</td>
<td>$1,000</td>
<td>–</td>
<td>$294.67</td>
</tr>
<tr>
<td>0011</td>
<td>4</td>
<td>636</td>
<td>10</td>
<td>$2,000</td>
<td>–</td>
<td>$589.33</td>
</tr>
</tbody>
</table>

**Total:** $12,000 $3,536.00 $3,536.00

For more information about changes in the display of reimbursement, please contact your Network Coordinator.
Important billing reminders for hospitals

Please note the following billing reminders for hospitals.

Quarterly fee schedule updates for all hospitals
As outlined in your Hospital Agreement (Agreement), due to changes in clinical practice and/or modifications to standard coding systems, we may add, delete, and/or re-categorize the fee schedule for outpatient procedures. Independence provides a 30-day written advance notice to facilities of such changes. It is imperative that these changes are reviewed to ensure accurate billing and claims reimbursement.

If a particular outpatient procedure is not listed on the applicable fee schedule, but we agree that it is a covered service, the following pricing rules will apply:

- **Surgical services**: Independence will establish a fee for the procedure in question, based on the current fees for similar services.
- **Non-surgical services**: Payment will be made based on the applicable "Percentage of Charges" until a fee is established.

Independence or its authorized representative has the right to review, within reason and with timely notice to the hospital, medical records pertaining to an outpatient service provided to members subject to the terms and conditions within your Agreement. In some instances, this may be necessary in establishing a fee for services rendered.

For hospitals contracted under APC:

Proper billing practices
On January 1, 2012, Ambulatory Payment Classifications (APC) reimbursement was added to your Agreement for certain Independence products. According to that Agreement, the APC Grouper/Pricer and Fee Schedules published and distributed by the Centers for Medicare & Medicaid Services (CMS) are used to determine reimbursement. The reimbursement amount is the product of the CMS APC Pricer amount (or fee schedule amount) and the CMS Pricer Adjustment Factor.

Reimbursement
As of January 2016, CMS implemented updates to the Hospital Outpatient Prospective Payment System, OPPS (APC Pricer). It is important that you have the most current version of the pricing application to ensure compliant billing practices. Use of the inappropriate version may result in inaccurate reimbursement.

**Claim submission**
For services applicable to APC reimbursement, when a provider has more than one National Provider Identifier (NPI) based on the specialty of service(s) they provide, he or she must use the NPI and coordinating taxonomy code that is specific to acute-care services. This enables the accurate application of the provider’s contractual business arrangements with Independence. Failure to submit claims with the applicable NPI and correct correlating taxonomy code may result in incorrect claim processing and/or payment delays.

Please review the following examples and share this information with your billing staff/vendor.

<table>
<thead>
<tr>
<th>Incorrect billing practice</th>
<th>Correct billing practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue/ procedure code billed</strong></td>
<td></td>
</tr>
<tr>
<td>0324/71023 (Radiology – Diagnostic/ Diagnostic Radiology)</td>
<td>0324/71023 (Radiology – Diagnostic/ Diagnostic Radiology)</td>
</tr>
<tr>
<td><strong>Billing NPI</strong></td>
<td></td>
</tr>
<tr>
<td>12345XXXXX</td>
<td>11223XXXXX</td>
</tr>
<tr>
<td><strong>Specialty description</strong></td>
<td></td>
</tr>
<tr>
<td>Psychology, Clinical</td>
<td>Hospital – Acute Care</td>
</tr>
<tr>
<td><strong>Taxonomy code</strong></td>
<td></td>
</tr>
<tr>
<td>103T00000X</td>
<td>282N00000X</td>
</tr>
<tr>
<td><strong>Taxonomy description</strong></td>
<td></td>
</tr>
<tr>
<td>Psychology, Clinical</td>
<td>Hospital – Acute Care</td>
</tr>
</tbody>
</table>

For hospitals **not** contracted under APC:

Modifier pricing
If you are a facility that is contracted according to the outpatient fee schedule, meaning **non-APC reimbursement**, Independence does not acknowledge modifiers. The application of modifier pricing is administered on APC-based outpatient contracts only.

If you have any questions about these important billing reminders, please contact your Network Coordinator.

---

**For hospitals not contracted under APC:**

Modifier pricing
If you are a facility that is contracted according to the outpatient fee schedule, meaning **non-APC reimbursement**, Independence does not acknowledge modifiers. The application of modifier pricing is administered on APC-based outpatient contracts only.

If you have any questions about these important billing reminders, please contact your Network Coordinator.
Document Exchange coming soon to NaviNet®

As previously communicated, Document Exchange will soon be introduced to providers on the NaviNet web portal. This new feature will allow us to share more information electronically with our provider network.

When Document Exchange is first released, your designated NaviNet Security Officer will control which end users, including himself or herself, associated with your NaviNet office will be given access to the following five unique Practice Document Categories:

- Billing/Financial Report
- Patient Roster Report
- Patient Transition Report
- Pharmacy Report
- Program Enrollment Report

Once end users are granted permission to access a specific Practice Document Category, they will be able to view and download any documents associated with that category. For example, if a NaviNet Security Officer grants permission to an associate to access the Billing/Financial Reports category, all reports made available by Independence under that category will be available to the associate to view or download.

It is important for your NaviNet Security Officer to manage permissions appropriately for each document category to ensure reports are accessed in a manner that is compliant with role-based access requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Note: Third-party vendors that have access to NaviNet will not have the ability to access Document Exchange.

Initial report

The High Risk Hospitalization Predictor report from February 2016 will be the first report made available for targeted primary care physician practices under Document Exchange. Based on a predictive model, this report identifies members you have treated who are at high risk of acute hospitalization in the next six months and who have one or more of the following chronic conditions:

- chronic obstructive pulmonary disease (COPD)
- congestive heart failure (CHF)
- coronary artery disease (CAD)
- diabetes

If you have questions or suggestions that relate to the High Risk Hospitalization Predictor report, please contact your network medical director.

For more information

A new user guide for Document Exchange is now available in the NaviNet Resources section of our Provider News Center at www.ibx.com/pnc/navinet. It provides detailed instructions on how to use this new feature.

If you have any questions about Document Exchange, call the eBusiness Hotline at 215-640-7410.
**BlueCard® PPO Professional Host claim submissions**

Through the BlueCard Program, providers can render services to patients who (1) are enrolled in a Blue Cross® and Blue Shield® plan other than one offered by Independence and (2) present to physicians in the Independence five-county service area (i.e., Bucks, Chester, Delaware, Montgomery, and Philadelphia counties) for treatment.

There are two BlueCard PPO professional networks within the Independence five-county service area:

- **Personal Choice®** (Independence’s PPO network)
- **Premier Blue** (Highmark Blue Shield’s PPO network)

Professional providers who are contracted with both of these PPO networks may submit claims to either Independence or Highmark Blue Shield, except for the following:

- Providers who hold a professional contract with Independence and not Highmark Blue Shield should submit professional claims to Independence directly.
- Providers should continue to submit professional claims to Highmark Blue Shield for Traditional Indemnity members and HMO members (for urgent/emergent situations) enrolled in a Blue Cross and Blue Shield plan other than one offered by Independence.
- Professional providers who are contracted with other area health plans (e.g., Highmark Blue Shield, Highmark Blue Cross Blue Shield of Delaware, Capital Blue Cross, Horizon Blue Cross Blue Shield of New Jersey) must submit claims to the applicable contracted health plan when treating members from those plans.

All members who present for service are subject to eligibility verification and the applicable precertification requirements of their Home Plan.

If you have any questions related to this article, please contact your Network Coordinator.

---

**Updated Payer ID grids available soon**

The Payer ID grids will be updated in early June based on the information in this article. You will be able to download the latest versions at www.ibx.com/edi under EDI Resources to ensure that your office is using the most up-to-date information for claim submissions. Announcements will be made on Independence NaviNet® Plan Central and on our Provider News Center once the updated Payer ID grids are available.
Recent updates to Direct Ship Drug Program

Throughout 2015 and 2016, Independence has been updating various aspects of our Direct Ship Drug Program. This program is a value-added service that allows our network providers to order select office-based drugs covered under the medical benefit without incurring cost. Independence works directly with our vendors to handle processing, payment, and delivery.

As previously communicated, Walgreens and PerformSpecialty, independent companies, are the preferred vendors for the Direct Ship Drug Program as of March 1, 2016. All requests for direct ship drugs are now fulfilled by these vendors, with the exception of Synagis®, which continues to be fulfilled by ACRO Pharmaceutical Services, an independent company.

Submitting a new request

Providers who have been receiving direct ship drugs from other vendors need to submit a new request to Independence. Once the new request is approved by Independence, the provider will be notified and Independence will forward the request to a preferred vendor for fulfillment. Providers should not contact the vendors to order a drug through the Direct Ship Drug Program. The only exception to this rule is for providers who request Synagis®; those requests should go directly to ACRO Pharmaceutical Services.

Request forms are available on our Direct Ship Drug Program webpage at www.ibx.com/directship. These forms were recently updated with ICD-10 coding requirements, a new fax number, and, in some cases, new coverage questions. Providers should always download direct ship request forms from this page to ensure they are using the most up-to-date versions. This webpage also provides more information about the program and the list of medical benefit drugs available through direct ship.

Note: Precertification requirements may apply to drugs available through the Direct Ship Drug Program, in accordance with the terms of Independence medical policies. Member cost-sharing may also apply to select drugs available through this program, based on the terms of the member’s benefit contract. ♦

View up-to-date policy activity on our Medical Policy Portal

Changes to Independence medical and claim payment policies for our commercial and Medicare Advantage Benefits Programs occur frequently in response to industry, medical, and regulatory changes. We encourage you to view the Site Activity section of our Medical Policy Portal in order to keep up to date with changes to our policies.

The Site Activity section is updated in real time as changes are made to the medical and claim payment policies. Topics include:

- Notifications
- Reissued Policies
- New Policies
- Coding Updates
- Updated Policies
- Archived Policies

For your convenience, the information provided in Site Activity can be printed to keep a copy on hand as a reference.

To access the Site Activity section, go to our Medical Policy Portal at www.ibx.com/medpolicy and select Accept and Go to Medical Policy Online. From here you can select Commercial or Medicare Advantage under Site Activity to view the monthly changes. To search for active policies, select either the Commercial or Medicare Advantage tab from the top of the page. To access medical policies from Independence NaviNet® Plan Central, select Medical Policy Portal under Provider Tools in the right hand column. ♦
Upcoming training for precertification of certain genetic/genomic tests through eviCore

Effective July 1, 2016, Independence will implement a new utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenetic tests for all commercial Independence members. Independence is working with CareCore National, LLC d/b/a eviCore healthcare (eviCore), an independent specialty benefit management company, to manage precertification and/or prepayment reviews.

This utilization management program will encompass precertification and/or prepayment review as follows:
- Precertification will be required for certain genetic/genomic tests.
- All genetic/genomic tests, along with certain molecular analyses and cytogenetic tests, will be reviewed prior to claim payment.

Submitting requests to eviCore

Starting June 27, 2016, you can request precertification for genetic/genomic tests for dates of service on or after July 1, 2016, by calling eviCore directly at 1-866-686-2649 or submitting requests via the NaviNet® web portal.

To submit a request on NaviNet, select CareCore from the Authorizations option in the Workflows menu, and a new window will open that sends providers directly to eviCore’s provider portal to initiate the precertification process. Once on eviCore’s portal, you will be required to create a login and password, which will be used every time you request precertification through eviCore. If you have already established credentials for eviCore’s portal, please use your current login information.

Tutorial webinars

To assist you in using their provider portal, eviCore will host the following tutorial webinars called “Independence Blue Cross Laboratory Management Program Provider Orientation Session”:
- June 27, 2016, 2 – 3 p.m.
- June 28, 2016, 10 – 11 a.m.

If you are interested in participating, visit medssolutions.webex.com, select the Training Center tab, and then choose your preferred session from the Upcoming tab. If you have any questions about signing up for these training sessions, please send an email to provider_communications@ibx.com.

More information

For more information on the new utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenetic tests, please refer to the May 2016 edition of Partners in Health Update.

If you have questions about this program, you can contact your Network Coordinator or call Customer Service at 1-800-ASK-BLUE.
Select Drug Program® Formulary updates

The Select Drug Program Formulary, which is available for commercial members, is a list of medications approved by the U.S. Food and Drug Administration that were chosen for formulary coverage based on their medical effectiveness, safety, and value. The list changes periodically as the Pharmacy and Therapeutics Committee reviews the formulary to ensure its continued effectiveness. The most recent changes are listed below.

Generic additions
These generic drugs recently became available in the marketplace. When these generic drugs became available, we began covering them at the appropriate generic formulary level of cost-sharing:

<table>
<thead>
<tr>
<th>Generic drug</th>
<th>Brand drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>linezolid susp*</td>
<td>Zyvox® susp</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
<td>November 23, 2015</td>
</tr>
<tr>
<td>metoclopramide odt</td>
<td>Metozolv® ODT</td>
<td>8. Stomach, Ulcer, &amp; Bowel Meds</td>
<td>November 2, 2015</td>
</tr>
<tr>
<td>nevirapine er</td>
<td>Viramune® XR</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
<td>November 16, 2015</td>
</tr>
<tr>
<td>olopatadine hcl 0.1%</td>
<td>Patanol® 0.1%</td>
<td>11. Eye Medications</td>
<td>December 14, 2015</td>
</tr>
<tr>
<td>pramipexole er 2.25 mg</td>
<td>Mirapex® ER 2.25 mg</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>November 30, 2015</td>
</tr>
<tr>
<td>repaglinide-metformin hcl</td>
<td>Prandimet™</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other Miscellaneous Hormones</td>
<td>November 23, 2015</td>
</tr>
<tr>
<td>tobramycin/nebulizer</td>
<td>Kitabis® Pak</td>
<td>12. Allergy, Cough &amp; Cold, Lung Meds</td>
<td>November 9, 2015</td>
</tr>
</tbody>
</table>

*Generic requires prior authorization.

Brand additions
Effective July 1, 2016, this brand drug will be added to the formulary and covered at the appropriate brand formulary level of cost-sharing:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cimzia®</td>
<td>Not available</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
</tbody>
</table>

Brand deletions
Effective July 1, 2016, these brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gleevec®</td>
<td>imatinib mesylate</td>
<td>2. Cancer &amp; Organ Transplant Drugs</td>
</tr>
<tr>
<td>Mirapex® ER 2.25 mg</td>
<td>pramipexole er 2.25 mg</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
</tbody>
</table>

continued on the next page
The generic drugs for the listed brand drugs are on our formulary and available at the generic formulary level of cost-sharing.

**Effective July 1, 2016**, these brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Formulary therapeutic alternative</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ortho Tri-Cyclen Lo®</td>
<td>norgestimate-ethinyl estradiol</td>
<td>10. Female, Hormone Replacement, &amp; Birth Control</td>
</tr>
<tr>
<td>Patanol® 0.1%</td>
<td>olopatadine hcl 0.1%</td>
<td>11. Eye Medications</td>
</tr>
<tr>
<td>Acanya®</td>
<td>clindamycin phos-benzoyl perox 1%-5% gel</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Enbrel®†</td>
<td>Cimzia®, Humira®</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
</tbody>
</table>

†Our preferred formulary tumor necrosis factor inhibitor will change from Enbrel® to Cimzia® effective July 1, 2016. Please note that your Independence patients who are currently receiving Enbrel® will not need a new prior authorization; however, they may be subject to a higher level of cost-sharing.

There are no generic equivalents for the above brand drugs; however, there are formulary therapeutic alternative drugs. These therapeutic alternative drugs are available at the appropriate formulary level of cost-sharing. We encourage you to discuss formulary alternatives with your patients. 🟢
Prescription drug updates

For commercial members enrolled in an Independence prescription drug program, prior authorization and quantity limit requirements will be applied to certain drugs. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. Quantity limits are designed to allow a sufficient supply of medication based upon the maximum daily dose and length of therapy approved by the U.S. Food and Drug Administration (FDA) for a particular drug. The most recent updates are reflected below.

Drugs requiring prior authorization

The prior authorization requirement for the following non-formulary drugs was effective at the time the drugs became available in the marketplace:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alecensa®</td>
<td>Not available</td>
<td>2. Cancer &amp; Organ Transplant Drugs</td>
<td>December 21, 2015</td>
</tr>
<tr>
<td>Cotelic™</td>
<td>Not available</td>
<td>2. Cancer &amp; Organ Transplant Drugs</td>
<td>November 16, 2015</td>
</tr>
<tr>
<td>Enstilar® 0.005–0.064 foam</td>
<td>Not available</td>
<td>5. Skin Medications</td>
<td>January 11, 2016</td>
</tr>
<tr>
<td>Ferriprox® 100 mg/ml solution</td>
<td>Not available</td>
<td>15. Diagnostics &amp; Miscellaneous Agents</td>
<td>December 7, 2015</td>
</tr>
<tr>
<td>Ninlaro®</td>
<td>Not available</td>
<td>2. Cancer &amp; Organ Transplant Drugs</td>
<td>November 30, 2015</td>
</tr>
<tr>
<td>Nuwiq®</td>
<td>Not available</td>
<td>4. Heart, Blood Pressure, &amp; Cholesterol</td>
<td>November 2, 2015</td>
</tr>
<tr>
<td>Riastap®</td>
<td>Not available</td>
<td>4. Heart, Blood Pressure, &amp; Cholesterol</td>
<td>June 1, 2016</td>
</tr>
<tr>
<td>Strensiq™</td>
<td>Not available</td>
<td>15. Diagnostics &amp; Miscellaneous Agents</td>
<td>November 2, 2015</td>
</tr>
<tr>
<td>Tagrisso™</td>
<td>Not available</td>
<td>2. Cancer &amp; Organ Transplant Drugs</td>
<td>November 23, 2015</td>
</tr>
<tr>
<td>Utibron™ Neohaler</td>
<td>Not available</td>
<td>12. Allergy, Cough &amp; Cold, Lung Meds</td>
<td>November 16, 2015</td>
</tr>
<tr>
<td>Zepatier™</td>
<td>Not available</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
<td>February 8, 2016</td>
</tr>
</tbody>
</table>

Effective July 1, 2016, the following non-formulary drugs will be added to the list of drugs requiring prior authorization:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acanya®</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Adderall®</td>
<td>dextroamphetamine-amphetamine</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Brand prenatal vitamins</td>
<td>various</td>
<td>14. Vitamins &amp; Electrolytes</td>
</tr>
</tbody>
</table>

continued on the next page
continued from the previous page

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerta®</td>
<td>methylphenidate er</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Desoxyn®</td>
<td>methamphetamine hcl</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Dextedrine®</td>
<td>dextroamphetamine sulfate</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Focalin® XR 5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg</td>
<td>dexamethasone hcl er</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Metadate® CD</td>
<td>methylphenidate hcl cd</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Ritalin® LA 20 mg, 30 mg, 40 mg</td>
<td>methylphenidate er</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Zegerid® 40 mg/1.1 g cap</td>
<td>omeprazole/sodium bicarbonate 40 mg/1.1 g cap*</td>
<td>8. Stomach, Ulcer, &amp; Bowel Meds</td>
</tr>
</tbody>
</table>

*Generic requires prior authorization.

According to the FDA, “A generic drug is the same as a brand-name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use.” Before approving a generic drug product, the FDA requires many rigorous tests and procedures to assure that the generic drug can be substituted for the brand-name drug. The FDA bases evaluations of substitutability, or “therapeutic equivalence,” of generic drugs on scientific evaluations. By law, a generic drug product must contain identical amounts of the same active ingredient(s) as the brand-name product. Drug products evaluated as “therapeutically equivalent” can be expected to have equal effect with no difference when substituted for the brand-name product. Generic equivalents are required to demonstrate bioequivalence, which evaluates the rate and extent of absorption of the drug.

Clinically, it is reasonable to interchange the generic equivalents, which are generally less costly to your patients, for the above-listed brand-name drugs, including ADHD medications (Adderall®, Concerta®, Desoxyn®, Dextedrine®, Focalin® XR, Metadate® CD, Ritalin® LA).

**Drugs with quantity limits**

Quantity limits were added or updated for the following drugs as of the date indicated below:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Quantity limit</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belbuca™</td>
<td>Not available</td>
<td>30 films per 30 days</td>
<td>November 30, 2015</td>
</tr>
<tr>
<td>Dyanavel® XR</td>
<td>Not available</td>
<td>240 ml per 30 days</td>
<td>January 25, 2016</td>
</tr>
<tr>
<td>Narcan® 4 mg/actuation spray</td>
<td>Not available</td>
<td>4 units per 30 days</td>
<td>December 7, 2015</td>
</tr>
</tbody>
</table>

For additional information on pharmacy policies and programs, please visit www.ibx.com/rx.

**Upcoming transition of pharmacy claims**

Independence will be transitioning its pharmacy claims to a new platform in an effort to streamline claims processes and business operations, while saving on administrative costs. The transition will occur in stages, which are set to begin on July 1, 2016, and be completed by October 1, 2016. Please note that this is not a change in our pharmacy benefits manager, just the platform on which claims are processed. The transition of claims should be seamless to Independence members and should not affect their access to care.
Positive results in Independence’s 2015 Provider Satisfaction Survey

In the 2015 Provider Satisfaction Survey, physicians and administrators rated their level of satisfaction with Independence on a five-point scale (5 = Very satisfied; 1 = Not at all satisfied). The following topics were specifically addressed on the survey: claims processing, utilization management, communications, and peer-to-peer review. In total, 154 physicians and 207 administrators completed the survey.

We are pleased to report that 78.4 percent of respondents provided a positive overall satisfaction rating, giving Independence a rating of either 4 (Satisfied) or 5 (Very satisfied). In comparison to the 2014 Provider Satisfaction Survey, the overall average satisfaction rating increased by a mean of 0.36 points to 4.18 from providers and by a mean of 0.19 to 4.08 from administrators.

The following were common drivers to satisfaction:

- how claims were finalized
- communications received from Independence

In addition, physicians included Independence’s reimbursement package, and administrators included Independence’s precertification and utilization management process and the reliability of the NaviNet® web portal as drivers to satisfaction.

Independence’s peer-to-peer review process was also rated positively by 69.9 percent of physicians, as driven by the medical appropriateness of the review.

Continuing efforts

Independence utilizes provider feedback to improve services and achieve optimal outcomes. Based on the 2015 survey, increasing provider satisfaction may be accomplished by:

- ensuring claims are processed consistently and paid in a timely fashion;
- ensuring that providers and administrators clearly understand which procedures require authorization;
- further enhancing the usefulness of information available on ibx.com;
- improving the clarity of medical policy updates.

Thank you to those who participated in the 2015 survey. ☻
Health Coaches: Supporting your patients, our members

Independence recognizes that the physician-patient relationship is at the heart of patient care. Through health coaching from our Registered Nurse Health Coaches, the following programs are offered to enhance your ability to provide coordinated care for your patients and promote integration of care among members and their families, physicians, and community resources:

- **24/7 Health Information Line.** Your Independence patients can call 1-800-ASK-BLUE anytime to speak with a Registered Nurse Health Coach about general health questions and concerns.
- **Case management.** Case management provides support to members who are experiencing complex health issues or challenges in meeting their health care goals.
- **Condition management.** Condition management is available to eligible members for specific chronic conditions such as asthma, diabetes, COPD, hypertension, and congestive heart failure.
- **Baby BluePrints® maternity program.** Your expecting Independence patients can self-enroll in this free program to receive support from an experienced Registered Nurse Health Coach throughout their pregnancy. Please encourage your expecting Independence patients to enroll by calling 1-800-598-BABY (1-800-598-2229). Independence also offers obstetrical Registered Nurse Health Coach support to expecting Independence patients who have been identified as high-risk to facilitate the best possible outcome.

If you would like to refer an Independence patient to one of the programs listed above, complete the online physician referral form, available at www.ibx.com/providerforms, or call 1-800-313-8628.

Coming soon: Healthy Families and Kids

Later this month, we will retire the Good 2B Me website and launch a new resource on our member portal that contains important health-related information for families about the physical, emotional, and social issues that can affect their children. This new resource, Healthy Families and Kids, will include information on the following:

- childhood and adolescent immunizations and the crucial role they play in protecting kids’ health;
- BMI and weight categories, exercise, nutrition, eating disorders, and substance abuse;
- other important health conditions, such as asthma;
- tips and articles for parents on a wide range of adolescent health topics.

Children can learn how to gain the confidence they need to make smart choices for their health and parents can learn about preteen and adolescent health issues by visiting the site frequently. We ask that you encourage your patients — parents and kids alike — to take full advantage of this new resource, which will be available on our member portal, ibxpress.com.
### Important Resources

**Anti-Fraud and Corporate Compliance**
- Hotline: 1-866-282-2707 or www.ibx.com/antifraud

**Care Management and Coordination**
- Baby BluePrints®: 215-241-2198 / 1-800-598-BABY (2229)*
- Case and Condition Management: 1-800-313-8628

**Credentialing**
- Credentialing Violation Hotline: 215-988-1413 or www.ibx.com/credentials

**Customer Service**
- Provider Services (prompt 1): 1-800-ASK-BLUE (1-800-275-2583)

**Electronic Data Interchange (EDI)**
- Highmark EDI Operations: 1-800-992-0246

**FutureScripts® (commercial pharmacy benefits)**
- Prescription drug prior authorization: 1-888-678-7012
- Pharmacy website (formulary updates, prior authorization): www.ibx.com/rx

**FutureScripts® Secure (Medicare Part D pharmacy benefits)**
- FutureScripts Secure Customer Service: 1-888-678-7015
- Formulary updates: www.ibxmedicare.com

**Mental Health/Substance Abuse Precertification**
- Independence: 1-800-688-1911
- Independence Administrators: 1-800-634-5334
- CHIP: 1-800-294-0800

**NaviNet® web portal**
- Registration: www.navinet.net

**Other frequently used phone numbers and websites**
- Independence Direct Ship Drug Program (medical benefits): www.ibx.com/directship
- Medical Policy: www.ibx.com/medpolicy
- Provider Supply Line: 1-800-858-4728 or www.ibx.com/providersupplyline

*Outside 215 area code*