Partners in Health update℠

Working together for quality health care

July 2016

Independence

Inside this edition

Administrative

- Required lead time when updating your provider information
- ► Upcoming Risk Adjustment Data Validation audit

Billing

- ► Mapping change for vaginal delivery claims
- Claim notifications and common ICD coding errors on paper and electronic claims

BlueCard®

- ► Updated information on *COB Questionnaire* for out-of-area members

NaviNet®

- ► Coming soon: New Eligibility and Benefits Inquiry transaction

Medical

- ► View up-to-date policy activity on our Medical Policy Portal
- ► Updated InterQual® guidelines for 2016
- ► Updates to policies pertaining to nerve conduction studies and needle electromyography
- ► Yervoy® being added to Dosing and Frequency Program
- ► Utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenic tests now in effect

Pharmacy

- ► Understanding prescription drug vouchers
- Reminder: Important message for providers who prescribe drugs for Medicare patients

For articles specific to your area of interest, look for the appropriate icon:

P Professional F Facility A Ancillary

► Articles designated with a blue arrow include notice of changes or clarifications to administrative policies and procedures.

*Partners in Health Update*SM 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

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).

PFA

Required lead time when updating your provider information

Independence would like to remind you that, per your Independence Professional Provider Agreement and/or Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement), you are required to notify Independence whenever key provider demographic information changes. Submitting changes in a timely manner helps to ensure prompt payment of claims, delivery of critical communications, seamless recredentialing, and accurate listings in our provider directories.

Professional providers*

Independence requires at least 30 days advanced notice to process most updates as long as the information submitted is accurate. For a complete outline of the advanced notice time frames that Independence requires to process most updates, refer to the Administrative Procedures section of the *Provider Manual for Participating Professional Providers (Provider Manual)*. Most of the changes to basic practice information can be quickly submitted using the *Provider Change Form*, available at *www.ibx.com/providerforms*.

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 at least 30 days advanced written notice to process changes to your information as long as the information submitted is accurate.

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 resulting 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.

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

ADMINISTRATIVE

Upcoming Risk Adjustment Data Validation audit

A Risk Adjustment Data Validation (RADV) audit is scheduled to begin this summer. This will be the first RADV audit for Independence commercial members. The audit is being held in accordance with the Centers for Medicare & Medicaid Services (CMS) requirements and will validate enrollment and medical information. CMS will generate a random sample of Independence members required for the audit. Independence has contracted with an independent medical record retrieval vendor that will be collecting medical charts on Independence's behalf in order to authenticate the diagnosis codes on submitted claims.

We appreciate your cooperation throughout this process. If you have any questions regarding the RADV audit, please contact Customer Service at 1-800-ASK-BLUE. ◆

BILLING

Mapping change for vaginal delivery claims

On May 29, 2016, a mapping change was implemented related to vaginal delivery claims. *Note:* This change applies only to facility providers that are on a DRG-based reimbursement method and use DRG Version 32 or earlier.

Background

Inquiries related to vaginal delivery claims with repair of perineum had been received from facility providers using DRG Version 32 or earlier. In those cases, ICD-10 procedure code 0KQM0ZZ (Repair Perineum Muscle, Open Approach) was grouping to a Non-Delivery MS-DRG, which in turn affected the payment.

For DRG Version 33, claims with this procedure code group to a Vaginal Delivery MS-DRG (i.e., MS-DRGs 774, 775).

Mapping change for ICD-10 procedure code 0KQM0ZZ

As of May 29, 2016, the DRG Grouper was updated so that these claims correctly group to the appropriate Vaginal Delivery MS-DRG (MS-DRGs 774, 775) when submitted using DRG Version 32 or earlier. This change to the mapper for ICD-10 procedure code 0KQM0ZZ is effective for dates of service on or after October 1, 2015, the ICD-10 implementation date.

Affected claims are being reprocessed and grouped to the appropriate Vaginal Delivery MS-DRG based on the updated logic. Providers should not resubmit claims.

If you have any questions about this mapping change for vaginal delivery claims, please contact your Network Coordinator. ◆

PFA

Claim notifications and common ICD coding errors on paper and electronic claims

Since the ICD-10 compliance date on October 1, 2015, Independence has noticed a number of common ICD coding errors that are affecting claims processing. Below you will find types of claim notifications and ICD-10 coding tips.

Claim notifications

Electronic claims submitters: If you submit claims electronically, you receive a Health Care Claim Acknowledgment (277CA) for notification of both accepted and rejected claims. It is important that this notification is regularly reviewed. The error description on the 277CA will aid you in correcting and resending files to ensure an expedited remittance. Providers should work with their clearinghouse/trading partner to ensure accurate claims submission.

Paper claims submitters: Providers who continue to submit paper claims will receive a claim return and cover sheet identifying the reason for claims rejection(s). Providers should respond to that notification accordingly and resubmit the corrected claim for processing.

ICD-10 coding tips

Please follow the tips below to ensure that your claims are coded correctly:

- **Do not bill ICD-9 and ICD-10 codes on the same claim.** Per guidelines from the Centers for Medicare & Medicaid Services (CMS), you cannot bill with both ICD-9 and ICD-10 codes on a single claim unless otherwise specified.
- **Use the appropriate ICD code for inpatient and outpatient claims.** For dates of discharge (inpatient) or service (outpatient) on or before September 30, 2015, you must bill with ICD-9 codes. For dates of discharge (inpatient) or service (outpatient) on or after October 1, 2015, you must bill with ICD-10 codes.
- **Code DME and home infusion claims appropriately.** Durable medical equipment (DME) and home infusion claims should be coded based on the "From" date or initial date of service. If the "From" date is on or before September 30, 2015, you must bill with ICD-9 codes. If the "From" date is on or after October 1, 2015, you must bill with ICD-10 codes.
- **Use the appropriate diagnosis qualifier:**
  - **Paper claims.** When billing with ICD-9 codes, you must use the qualifier "9". When billing with ICD-10 codes, you must use the qualifier "0" (CMS-1500, box 21; UB-04, field 66).
  - **Electronic claims.** Please refer to the most recent version of the HIPAA-mandated 5010 ASC X12 Implementation Guides for the 837I and 837P transactions.
- **Use valid codes.** Whether you are billing with ICD-9 or ICD-10 codes, please ensure that the codes you are using are valid and appropriate.

For more information, visit our dedicated ICD-10 web page at *www.ibx.com/icd10*, which includes Frequently Asked Questions. ◆

Benefits of submitting claims electronically

We encourage all providers to submit claims electronically. Submitting claims electronically can result in the following:

- increased accuracy of claims
- better tracking ability
- greater efficiency and productivity within your office

In addition, you will also benefit from error reporting, which allows you to easily correct claims before submission. You will experience fewer payer rejections and administrative concerns, resulting in faster claim payments.

Refer to the Independence *HIPAA Transaction Standard Companion Guide*, available at *https://www.highmark.com/edi-ibc/resources/index.shtml*, for more information about submitting claims electronically.

PFA

Updated information on *COB Questionnaire* for out-of-area members

Coordination of benefits (COB) refers to how Blue Plans ensure that members receive full benefits and prevents double payment for services when members have coverage from two or more sources. When providing services to out-of-area* Blue members, it is important to have them complete the *COB Questionnaire* for the following reasons:

- streamlines claims processing;
- expedites payment to providers;
- reduces the number of denials related to COB;
- enables employer groups to finalize out-of-area claims for their employees.

Please ask all out-of-area Blue members to complete this questionnaire *prior* to rendering services to ensure that each claim is paid quickly and properly.

Updated mailing address and fax number

Download the latest version of the BlueCard® *COB Questionnaire*, which contains an updated mailing address and fax number for submitting the form. You can access the updated form in the following ways:

- **Websites.** Visit our BlueCard webpage at *www.ibx.com/providers/claims_and_billing/bluecard.html* or go to our Provider News Center at *www.ibx.com/pnc* and select the *BlueCard* option at the top of the page.
- **NaviNet® web portal.** Select *Independence* from My Health Plans, and then select *BlueCard COB Questionnaire* from the BlueExchange® Out of Area option in the Workflows menu.

Instructions for completing the questionnaire

Out-of-area Blue members should complete the *COB Questionnaire* with other registration forms. Office staff should complete the first two fields of the questionnaire — provider name and NPI — and the out-of-area member should complete the remaining sections of the questionnaire before services are rendered.

Please immediately process the completed questionnaire by faxing it to 215-238-7915 or by mailing it to:

Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103

If you have any questions about this important process, please contact your Network Coordinator.

Note: The BlueCard *COB Questionnaire* should **not** be used for local Independence members or Federal Employee Program members. ◆

**Out-of-area members are members of other Blue Cross® and Blue Shield® plans who travel or live in the Independence five-county service area, which includes Philadelphia, Bucks, Montgomery, Chester, and Delaware counties.*

PFA

Coming soon: New Eligibility and Benefits Inquiry transaction

Begininning July 20, 2016, for a number of provider offices, we will introduce a new Eligibility and Benefits Inquiry transaction in the Independence Workflows menu on the NaviNet® web portal. All remaining NaviNet-enabled participating providers will be given access to the new transaction starting August 3, 2016. The member search criteria in the updated transaction will be modified, and the presentation of eligibility and benefits information will change.

The Eligibility and Benefits Inquiry transaction will continue to provide access to detailed, real-time eligibility and benefits information for Independence members, as well as information about a member's demographics, insurance, and cost-sharing (e.g., copayment, coinsurance, deductible). The Eligibility and Benefits Details screen will offer a list of benefit categories to view and will continue to include links to information about the member's capitated sites (where applicable), member ID card, and product-wide provisions associated with the member's benefit plan.

The new Eligibility and Benefits Inquiry transaction will allow you to search for a member's eligibility and benefits record for up to two years preceding the current date. However, when the new transaction is first released, you will only be able to retroactively search for dates of service on or after July 1, 2015. Eligibility and benefits information for Independence members ***will not*** be available through NaviNet for dates of service prior to July 1, 2015.

In the coming weeks, we will publish a new user guide for the updated Eligibility and Benefits Inquiry transaction in the NaviNet Resources section of our Provider News Center at *www.ibx.com/pnc/navinet*. Once available, we will make an announcement on the Provider News Center as well as on Independence NaviNet Plan Central.

If you have any questions about the upcoming changes to the Eligibility and Benefits Inquiry transaction, call the eBusiness Hotline at 215-640-7410. ◆

New Document Exchange feature postponed

The release of the new Document Exchange feature has been postponed until later in the third quarter of 2016. As a reminder, this new feature will allow Independence to share information electronically with our provider network. Your NaviNet Security Officer will control which end users, including himself or herself, associated with your NaviNet office will be given access to five unique Practice Document Categories.

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

A user guide for Document Exchange is available in the NaviNet Resources section of our Provider News Center at *www.ibx.com/pnc/navinet*.

Look for additional information about Document Exchange in future editions of *Partners in Health Update.*

PFA

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

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

News & Announcements

In addition to the information posted in our Site Activity section, articles related to our website and medical and claim payment policies are periodically posted within the News & Announcements section. Simply select the appropriate link (Commercial, Medicare Advantage, or MAPPO Host) under the News & Announcements header on the Medical Policy Portal homepage to stay informed of the latest information.

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. ◆

PFA

Updated InterQual® guidelines for 2016

McKesson Health Solutions, an independent company, has made significant changes to the InterQual Level of Care Criteria for 2016.

Beginning in August 2016, the Clinical Services – Utilization Management department at Independence (formerly known as Care Management and Coordination) will use the 2016 InterQual Level of Care criteria for review of acute inpatient, acute rehabilitation, skilled nursing facility, and long-term acute care admissions. In addition, we will transition to the 2016 home care guidelines. Changes include:

- **InterQual Acute Adult Level of Care criteria:**
  - **General Medical.** Updates were made to inpatient chemotherapy administration.
  - **Sepsis and Septic Shock.** Criteria were updated based on the current evidence, including the recently published *Third International Consensus Definitions for Sepsis and Septic Shock*.
  - **Sickle Cell Crisis.** Criteria were updated based on the new National Heart, Lung, and Blood Institute guidelines.
- **InterQual Acute Pediatric criteria:**
  - **General Medical.** Updates were made to inpatient chemotherapy administration.
  - **Hyperbilirubinemia.** Criteria were revised to align more closely with American Academy of Pediatrics guidelines.
- **InterQual Post-Acute Care criteria:** Updates were made to the Subacute/Skilled Nursing Facility, Long Term Acute Care, and Acute Rehabilitation products.

For detailed information on the 2016 InterQual guidelines, please visit the McKesson Health Solutions website at *www.mckesson.com*. ◆

Updates to policies pertaining to nerve conduction studies and needle electromyography

Independence has two interrelated medical policies for electrodiagnostic medicine (nerve conduction studies [NCS] and related electrodiagnostic studies) and electromyography (EMG) studies (needle EMG, surface EMG [SEMG]). These policies were developed in accordance with current standards of medical practice, professional organizations, and criteria presented in Local Medicare Coverage Determinations.

Effective August 1, 2016, NCS and EMG policies will be updated to include the addition of applicable diagnosis codes to clarify and support medically necessary indications. Previously, diagnosis codes were not included. However, diagnosis codes will be added to help improve the quality of patient care and to encourage appropriate utilization of the studies involved.

About NCS and needle EMG studies

Electrodiagnostic medicine is an important and useful component of the clinical evaluation of individuals with disorders of the peripheral and/or central nervous systems. Both nerve conduction and needle electromyography studies are often crucial to evaluating symptoms, arriving at a diagnosis, and evaluating a disease process and response to treatment in individuals with neuromuscular disorders.

The interrelated medical policies for electrodiagnostic medicine under NCS and EMG continue to include:

- discussion of NCS studies conducted with needle EMG;
- medically necessary indications;
- statement for the maximum allowable performance of NCS by a non-physician governed by the scope of practice defined by the state and the appropriate level of supervision described by the Federal Register;
- credentialing and certification information;
- professional and technical reimbursement;
- recommended guidelines for maximum number of NCS and EMG studies.

Policy updates

In order to communicate the criteria for these tests, we are updating our commercial and Medicare Advantage policies. The following policies are posted as Notifications and will become **effective August 1, 2016:**

- **Commercial:** #07.03.18j: Nerve Conduction Studies (NCS) and Related Electrodiagnostic Studies
- **Medicare Advantage:** #MA07.033a: Nerve Conduction Studies (NCS) and Related Electrodiagnostic Studies
- **Commercial:** #07.03.09k: Electromyography (EMG) Studies: Needle EMG, Surface EMG (SEMG)
- **Medicare Advantage:** #MA07.050a: Electromyography (EMG) Studies: Needle EMG, Surface EMG (SEMG)

To view the Notifications for these policies, visit our Medical Policy Portal at *www.ibx.com/medpolicy* and select *Accept and Go to Medical Policy Online*. Then select either *Commercial* or *Medicare Advantage* under Active Notifications.

If you have any questions about these policies, please contact your Network Coordinator. ◆

Yervoy® being added to Dosing and Frequency Program

Effective July 5, 2016, ipilimumab (Yervoy®) will be added to the Dosing and Frequency Program.

Since January 1, 2011, Independence has reviewed the dosing and frequency of administration for select drugs as part of the precertification process. With the addition of Yervoy® to this program, the drugs that will be reviewed for dosing and frequency are:

- bevacizumab (Avastin®)*
- cetuximab (Erbitux®)
- immune globulin, intravenous/subcutaneous (IVIG/SCIG)
- infliximab (Remicade®)
- ipilimumab (Yervoy®)
- onabotulinumtoxinA (Botox®)
- rituximab (Rituxan®)
- trastuzumab (Herceptin®)

Independence reserves the right to conduct a post-payment review and audit of claims submitted for any drug that is part of the Dosing and Frequency Program and may recover payments made in excess of the amount approved through the precertification process. For more information on guidelines for the Dosing and Frequency Program, please refer to the specific medical policies for each drug included in the program.

Adjuvant Patient Program for Melanoma

Providers should be aware that Bristol-Myers Squibb, an independent company and the manufacturer of Yervoy®, offers a patient assistance program called the Adjuvant Patient Program for Melanoma. This program is available for individuals, whether insured or uninsured, who are undergoing adjuvant treatment of fully resected Stage III melanoma (lymph node >1 mm).

Providers should contact Bristol-Myers Squibb to enroll their Independence patients in this program if they are requesting the 10 mg/kg dose for the adjuvant treatment of fully resected Stage III melanoma. Enrollment in this program may yield savings for these individuals. Eligible individuals may receive Yervoy® free of charge for the duration of treatment, which may be up to three years. Providers who administer Yervoy® to members enrolled in this program should ***not*** submit reimbursement claims for Yervoy®, as the drug is being supplied at no cost to the provider; however, providers should continue to submit claims for administration of the drug and for any other services rendered during the visit. Eligibility in this program is determined by the drug manufacturer. More information about the program is available from Bristol-Myers Squibb Access Support® at 1-800-861-0048 or at *www.bmsaccesssupport.com*.

Providers can also find additional information about this program in the following Independence medical policies, which will be available on July 5, 2016:

- **Commercial:** #08.01.01e: Ipilimumab (Yervoy®)
- **Medicare Advantage:** #MA08.059b: Ipilimumab (Yervoy®)

To access medical policies, visit our Medical Policy Portal at *www.ibx.com/medpolicy*. Select *Accept and Go to Medical Policy Online*, then select *Commercial* or *Medicare Advantage*, depending on which version of the policy you'd like to view, and then type the name or policy number in the Search field. To access medical policies from Independence NaviNet® Plan Central, select *Medical Policy Portal* under Provider Tools in the right hand column.

Please call 1-800-ASK-BLUE if you have any questions about the precertification process for Yervoy® or any other drugs included in the Dosing and Frequency Program. ◆

**Only oncology requests for bevacizumab (Avastin®) require precertification approval for dosing and frequency. Requests for intravitreal injection of bevacizumab (Avastin®) to treat the ophthalmologic conditions listed in this drug's medical policy do not require precertification.*

PFA

Utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenetic tests now in effect

Independence has introduced a new utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenetic tests for all commercial Independence members. We are working with CareCore National, LLC d/b/a eviCore healthcare (eviCore), an independent specialty benefit management company, to manage precertification and/or prepayment reviews.

Precertification requirements

For dates of service on or after July 1, 2016, ordering health care providers and/or laboratories must contact eviCore to obtain precertification for certain genetic/genomic tests, including, but not limited to, the following:*

- BRCA gene testing
- genetic panels and cancer gene expression tests
- genome-wide tests
- pharmacogenomic tests

Submitting requests to eviCore

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.

Prepayment review

For dates of service on or after July 1, 2016, all genetic/genomic tests, along with certain molecular analyses and cytogenetic tests, will be reviewed by eviCore. Examples of molecular analyses and cytogenetic tests include, but are not limited to, the following:*

- comparative genomic hybridization (CGH)
- flow cytometry
- fluorescent in situ hybridization (FISH)
- immunohistochemistry (IHC)
- morphometric analyses

Lab management policy and guidelines

Review Medical Policy #06.02.52: eviCore Lab Management Program for more information about the utilization management program. The policy includes a link to the *Lab Management Program Clinical Guidelines* that eviCore will use during the precertification and prepayment review processes, as well as a listing of procedure codes requiring precertification and/or prepayment review.

To view this policy, visit our Medical Policy Portal at *www.ibx.com/medpolicy*. Select *Accept and Go to Medical Policy Online*, then select the *Commercial* tab from the top of the page and type the policy name or number in the Search field.

More information

If you have questions about any of these requirements, you can contact your Network Coordinator or call Customer Service at 1-800-ASK-BLUE. ◆

**This list of services is subject to change.*

P F

Understanding prescription drug vouchers

When getting medications, Independence members may occasionally use a prescription drug voucher card to lower out-of-pocket expenses. However, these cards may not actually contribute toward long-term savings. It is important to understand what these cards are and when they can help members save money.

What is a prescription drug voucher?

A prescription drug voucher is typically offered by pharmaceutical companies that manufacture brand-name or specialty medications. These vouchers can be taken to a pharmacy and used to lower or eliminate a member's insurance copayment or out-of-pocket cost for a prescription medication. The pharmaceutical company covers the cost of reducing the copayment. Many of these vouchers are available on the Internet or at the physician's office. They prove to be especially beneficial for members in scenarios where all other prescription drug alternatives are also high cost brand-name or specialty products.

Potential issues with use

Generally, generic medications have the lowest copayment and brand-name medications have the highest copayment. Independence uses cost-sharing to direct patients to more cost-effective medications, such as when generic alternatives are available. We design formulary tiers and copayment cost-sharing to encourage price competition and reduce drug costs. These tiers are designed as an incentive for members to choose clinically appropriate medications with the lowest net cost.

Prescription drug vouchers may discourage members from choosing the least costly, most clinically appropriate medications. When pharmaceutical companies offer prescription drug vouchers, they reduce or eliminate the higher copayments associated with their brand-name or specialty medications. This narrows the copayment differential between the generics and brands and may encourage the patient to go with the brand-name medication. Despite the lower copayment, the gross cost of the drug remains unchanged because the insurance company's cost still applies.

As brand-name medication utilization increases, the insurance company's overall costs also increase. This may ultimately affect the premium insurance companies charge to offset expenses. According to the Pharmaceutical Care Management Association, the use of prescription drug vouchers will increase the prescription drug spending for commercially insured patients by $32 billion over the next ten years. This will inevitably increase health insurance premiums for all parties. It is important to understand that even though a patient's prescription may cost less that month, it may ultimately raise overall health care costs.

How you can help

It is important to understand how prescription drug vouchers work before accepting them from pharmaceutical companies and distributing to patients. It is also important to remind patients of the potential downstream effects of these vouchers when seeking savings opportunities for their prescription drugs. ◆

P

Reminder: Important message for providers who prescribe drugs for Medicare patients

As previously communicated, the Centers for Medicare & Medicaid Services (CMS) has delayed the enforcement of the Part D Prescriber Enrollment Requirements until **February 1, 2017,** to allow prescribers sufficient time to complete their enrollment activities. Once in effect, CMS Medicare Part D prescription drug benefit plans *may not* cover drugs prescribed by providers not enrolled in (or validly opted out of) Medicare, except in very limited circumstances.

CMS strongly encourages prescribers of Part D drugs (except those who meet the definition of "other authorized prescribers") to submit their Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractor (MAC) **before August 1, 2016.** This should provide MACs with sufficient time to process the prescribers' applications or opt-out affidavits and thus prevent prescription drug claims associated with their prescriptions from being rejected by Part D plans beginning February 1, 2017.

For more information, please visit CMS's website at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Prescriber-Enrollment-Information.html*. ◆

Important Resources

Anti-Fraud and Corporate Compliance	
Hotline	1-866-282-2707 or www.ibx.com/antifraud
Clinical Services	
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)
Provider Automated System User Guide	www.ibx.com/providerautomatedsystem
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	
Independence eBusiness Hotline	215-640-7410
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*

Independence

Visit our Provider News Center: www.ibx.com/pnc