# Partners in Health update℠

Working together for quality health care

## February 2019 Recap

**This publication contains articles previously published on our Provider News Center.**


Independence

TABLE OF CONTENTS

# Inside this edition



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

P Professional  F Facility  A Ancillary

PFA

## 2019 out-of-pocket maximums for commercial HMO, POS, and PPO members

**Published February 11, 2019**

Under the Patient Protection and Affordable Care Act (ACA), providers should ***not*** charge a member any cost-sharing (i.e., copayments, coinsurance, and deductibles) once the member's annual limit for essential health benefits has been met. Essential health benefits, as defined by the ACA, fall into ten categories including medical benefits, prescriptions, pediatric dental services, and pediatric vision services for those members whose benefits include these services.

Annual limits are based on the member's benefit plan. While some member benefit plan limits may be lower, **as of January 1, 2019,** for most members the annual limits were changed to the following amounts:

- **Individual:** $7,900
- **Family:** $15,800

Once a member has reached his or her out-of-pocket maximum, providers should ***not*** collect additional cost-sharing for essential health benefits.

To verify if a member has reached his or her out-of-pocket maximum, providers should use the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal. Once on the Eligibility and Benefits Details screen, the member's current out-of-pocket expense will be displayed. ◆

*NaviNet is a registered trademark of NaviNet, Inc., an independent company.*

---

PFA

## Important deadline: Register before July 1, 2019, for a PROMISe™ ID to receive payment for services provided to your Independence CHIP members!

**Published February 19, 2019**

Over the past several months, we have published articles in *Partners in Health Update*℠ informing you that the Pennsylvania Department of Human Services (Department) requires all providers in the Children's Health Insurance Program (CHIP) network to have a PROMISe ID for **each location** at which they treat CHIP members. A PROMISe ID is a Department-issued Provider Reimbursement and Operations Management Information System identification number. It is required for you to receive payment for services rendered to CHIP members.

### Act now!

If you have not yet enrolled with the Department for your PROMISe ID, there is still time to register. Please visit the *Pennsylvania Department of Human Services* website to access the application, requirements, and step-by-step instructions related to the enrollment process. **Providers are encouraged to enroll electronically.**

### Deadline approaching

Please be aware that beginning July 1, 2019, all claims submitted for Independence CHIP members for dates of service **on or after July 1, 2019,** will be ***denied*** if you do not have a PROMISe ID for your location.

If you have a PROMISe ID, we encourage you to confirm that your office information, including address, is up-to-date. ◆

PFA

# Required lead time when updating your provider information

**Published February 21, 2018**

In accordance with your Provider Agreement (Agreement), the *Provider Manual for Participating Professional Providers (Provider Manual)*, and/or *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers (Hospital Manual)*, as applicable, you are required to notify Independence whenever key provider demographic information changes. Independence would like to remind you that 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 advance written notice to process most updates. For a complete outline of the advance written notice time frames that Independence requires to process most updates, refer to the Administrative Procedures section of the *Provider Manual*. *Note:* If the information submitted is not accurate or complete, it may extend the time frame needed to process the request.

Most changes to basic practice information can be quickly submitted using the Provider File Management transaction on the NaviNet® web portal. Professional providers may perform the following functions as they relate to their practice:

- Add/Delete a participating practitioner to/from an existing practice
- Add/Delete an address (i.e., doing business as [DBA], check, mailing, main, or practice)
- Add/Delete contact name, title, or communication device type/number
- Add/Delete office hours
- Update “Walk-in” acceptance status
- Update Patient and Appointment Options (i.e., accepting new patients)
- Update General Practice Availability (i.e., Urgent, Routine Visits, etc.)
- Update Member Access number (i.e., the telephone number that appears on the member’s identification card – which must be the location-specific telephone number for a patient to make an appointment)
- Update Electronic Medical Records (EMR) status
- Update the availability of other clinical staff (i.e., midwife, nurse practitioner, etc.)
- Update office accessibility and services (i.e., handicapped, parking, and communication and language services)

### Important information on updating your provider record

Providers are strongly encouraged to use the Provider File Management transaction to update provider records. If Independence receives provider record updates that can be submitted using the Provider File Management transaction, a member of our eBusiness team may contact that provider to assist them in using the transaction to make the necessary updates. This will allow our team to receive user feedback on the transaction and help improve the overall user experience for our network.

A *Provider File Management Guide* is available to assist you in navigating this transaction and ensure accurate submissions. The guide is available in the *NaviNet Resources* section. If you have any further questions on this transaction, please contact the eBusiness Hotline at **215-640-7410.**

For more information on how to use the Provider File Management transaction, please review the user guide, which is available in the *NaviNet Resources* section.

The Provider File Management transaction is not intended for use by facilities, skilled nursing facilities, ancillary providers, or providers contracted with Magellan Healthcare, Inc. (Magellan), an independent company.

*continued on the next page*

*continued from the previous page*

If you are unable to process your request through the Provider File Management transaction, please submit a *Provider Change Form*. 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 215-238-2275. 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 leaving the network. Refer to "Resignation/termination from the Independence network" in the Administrative Procedures section of the *Provider Manual* for more information regarding these policies and procedures.

## Facility and ancillary providers

As outlined in the Administrative Procedures section of the *Hospital Manual*, Independence requires at least 30 days advance written notice to process changes to your information. *Note:* If the information submitted is not accurate or complete, it may extend the time frame needed to process the request.

Notification of all changes must be submitted in writing to both our contracting and legal departments at the following addresses, or as provided in your Agreement:

Independence Blue Cross
Attn: Vice President, Total Value Contracting and Reimbursement
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:**
  - **Group practices:** A signature from a legally authorized representative (e.g., physician or other person who signed the Agreement or one who is legally authorized to bind the group practice) of the practice is required.
  - **Solo practitioners:** A signature from the individual practitioner 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. Failure to provide proper advance written notice to Independence may delay or otherwise affect provider payment.**

If you have questions related to updating your provider information, please email us at *provider_communications@ibx.com*. ◆

**To ensure appropriate setup in Independence systems, the same time frames also apply to behavioral health providers contracted with Magellan. Behavioral health providers must submit any changes to their practice information to Magellan via their online* Provider Data Change *form by selecting the "Display/Edit Practice Info" link.*



*Magellan Healthcare, Inc. manages mental health and substance abuse benefits for most Independence members.*

PFA

# Check member ID card and verify eligibility with every visit

**Published February 12, 2019**

Some of your Independence patients may have received a new member ID card for coverage effective in 2019. It is important that providers confirm the member's coverage and eligibility at each visit, prior to rendering services.


For our Independence and out-of-area Blue Plan members, providers should:

1. **Make a copy.** Make a copy of the member,s current ID card to ensure that the most up-to-date information is submitted on the claim. Refer to the *Quick guide to Blue member ID cards* for information on the various ID cards that could be presented by out-of-area Blue Plan members.
2. **Verify eligibility and benefits.** Verify eligibility and benefits on the NaviNet® web portal through the Eligibility and Benefits Inquiry transaction. For out-of-area Blue Plan members, use the BlueExchange® Out of Area transaction.
3. **Complete COB, as applicable.** For out-of-area Blue Plan members, have them complete the *Coordination of Benefits (COB) Questionnaire for Out-of-Area Members*, if applicable.

## Medical Policy/PreCertification for out-of-area Blue Plan members

The Medical Policy/Precertification Router allows an Independence network provider access to information about the out-of-area Blue members Home Plan this through NaviNet. For more detailed information about NaviNet and for access to our NaviNet transaction user guides, visit the *NaviNet Resources* section.

There may be occasions when a member's health insurance goes into effect before he or she receives a member ID card in the mail. In these situations, you have options:

- You may ask members to print a temporary ID card by logging on to our secure member portal, *ibxpress.com*.
- You may access real time, detailed eligibility and benefits information for Independence members through NaviNet using the Eligibility and Benefits Inquiry transaction. There you will find information about a member's demographics, insurance, and cost-sharing information (i.e., copayment, deductible, and coinsurance).

For your convenience, NaviNet and *ibxpress.com* are available seven days a week. ◆

*NaviNet is a registered trademark of NaviNet, Inc., an independent company.*



P

# Resolved: Overpayment impacting January 2019 capitation and PCP quality incentive payments for panels with Keystone 65 Focus Rx membership only

**Published February 13, 2019**

Last month Independence identified errors impacting January 2019 capitation and PCP quality incentive payments with panels containing Keystone 65 Focus Rx membership. We shared details of the issue in a *Partners in Health Update℠ article*.

The issue has been resolved. Overpayments to the affected practices were adjusted in providers' February capitation payments.

If you have questions about how your practice's capitation payments were affected, please contact Independence by emailing *pcprequests@ibx.com* or *specialistsrequests@ibx.com*, as appropriate. ◆

PFA

# BlueCard® Program roles and responsibilities

**Published February 22, 2019**

As we service new enrollees, it is important to remember that Independence, as your local Blue Cross® and/or Blue Shield® Plan (Host Plan), has roles and responsibilities when you render services to an out-of-area member (i.e., member enrolled in another Blue Cross and/or Blue Shield Plan), including provider-related functions such as:

- being the single contact for all claims payment, customer service issues, provider education, adjustments, and appeals;
- pricing claims and applying pricing and reimbursement rules consistent with provider contractual agreements;
- forwarding all clean claims received to the member's Blue Cross and/or Blue Shield Plan (Home Plan) to adjudicate based on eligibility and contractual benefits;
- conducting appropriate provider reviews and/or audits;
- confirming that providers are performing services and filing claims appropriately within their scope of practice and according to their Provider Agreement with Independence;
- conducting HIPAA-standard transactions;
- training providers about the BlueCard Program.

## Home Plan roles and responsibilities to Independence network providers

The Home Plan has roles and responsibilities when you, the local Independence network provider, render services to an out-of-area member, including the following functions:

- adjudicate claims based on member eligibility and contractual benefits;
- respond to prior authorization and precertification requests/inquiries;
- request medical records through the Host Plan when required (e.g., for review of medical necessity, determination of a pre-existing condition, high-cost/utilization).

## Roles and responsibilities of Independence network providers

You, the local Independence network provider, have the following roles and responsibilities when you render services to an out-of-area member:

- obtaining benefits and eligibility information, including covered services, copayments, and deductible requirements;
- filing claims with the correct Host Plan and including, at minimum, the required elements to ensure timely and correct processing, such as:
  - current member ID card number;
  - all Other Party Liability information;
  - all member payments (i.e., copayments, coinsurance, or deductibles);
- submitting medical records in a timely manner when requested by the Host or Home Plan.

For more information about the BlueCard Program, visit the *BlueCard* section. If you have additional questions, please email us at *provider_communications@ibx.com*. ◆

PFA

# Updates to the list of specialty drugs that require precertification

**Published February 15, 2019**

Independence recently made several updates to the list of specialty drugs that require precertification, which are eligible for coverage under the medical benefit for Independence commercial and Medicare Advantage HMO and PPO members.

## Additions for biosimilars

All biosimilars to originator products on the precertification list require precertification approval from Independence as soon as the biosimilar receives approval from the U.S. Food and Drug Administration (FDA). The following biosimilars were recently approved by the FDA and are now included on the precertification list:

- Herzuma® (trastuzumab-pkrb) – Antineoplastic Agents
- Ontruzant® (trastuzumab-dttb) – Antineoplastic Agents
- Truxima™ (rituximab-abbs) – Antineoplastic Agents
- Udenyca™ (pegfilgrastim-cbqv) – Colony-Stimulating Factors

## Newly approved drugs from the FDA

The following drugs were added to the precertification list, as of January 1, 2019, using their clinical (non-brand) name. The precertification list is now updated to reflect the FDA-approved brand names for these drugs:

- Gamifant® (emapalumab-lzsg) – Miscellaneous Therapeutic Agents
- Ultomiris™ (ravulizumab-cwvz) – Miscellaneous Therapeutic Agents

## Gene therapy

As of January 1, 2019, ***all*** drugs that are classified by Independence as gene therapy require precertification.

The following gene therapy drug is expected to receive FDA approval in the coming months for the treatment of spinal muscular atrophy: Zolgensma* (onasemnogene abeparvovec-xxxx).

Zolgensma will require precertification by Independence once it receives FDA approval.

## For more information

Medical policies for these drugs are currently in development. In lieu of a published medical policy, requests for these drugs will be subject to precertification review using the FDA-approved guidelines.

These changes are reflected in an updated precertification requirement list, which has been posted to our *website*. ◆

**This brand name is subject to change, pending final FDA approval.*

PFA

# New drugs to be added to the Dosage and Frequency Program

**Published February 18, 2019**

**Effective June 3, 2019,** the Independence Dosage and Frequency Program will be expanded to include 16 additional drugs that are eligible for coverage under the medical benefit. Most of these drugs are enzyme replacement drugs and biosimilars to originator products that are already part of this program.

The following is the comprehensive list of drugs that will be reviewed for dosage and frequency:

- Adagen® (pegademase bovine) – **New for June 3, 2019**
- Aldurazyme® (laronidase) – **New for June 3, 2019**
- Avastin® (bevacizumab)*†
- Bivigam® (immune globulin intravenous [human])
- Blincyto® (blinatumomab)
- Brineura™ (cerliponase alfa) – **New for June 3, 2019**
- Carimune® NF (immune globulin intravenous [human])
- Cerezyme® (imiglucerase) – **New for June 3, 2019**
- Cutaquig® (immune globulin subcutaneous [human])
- Cuvitru™ (immune globulin subcutaneous [human])
- Elaprase® (idursulfase) – **New for June 3, 2019**
- Elelyso® (taliglucerase alfa) – **New for June 3, 2019**
- Entyvio® (vedolizumab)
- Erbitux® (cetuximab)
- Fabrazyme® (agalsidase beta) – **New for June 3, 2019**
- Flebogamma® (immune globulin intravenous [human])
- Flebogamma® DIF (immune globulin intravenous [human])
- Gamastan® S/D (immune globulin [human])
- Gamifant® (emapalumab-lzsg)
- Gammagard® Liquid (immune globulin infusion [human])
- Gammagard® S/D (immune globulin intravenous [human])
- Gammaked™ (immune globulin [human])
- Gammaplex® (immune globulin intravenous [human])
- Gamunex®-C (immune globulin injection [human])
- Herceptin® (trastuzumab)†
- Herzuma® (trastuzumab-pkrb) – **New for June 3, 2019**
- Hizentra® (immune globulin subcutaneous [human])
- HyQvia® (immune globulin infusion [human])
- Ilaris® (canakinumab)
- Inflectra® (infliximab-dyyb)
- Ixifi™ (infliximab-qbtx)
- Kanuma® (sebelipase alfa)
- Lumizyme™ (alglucosidase alfa) – **New for June 3, 2019**
- Mepsevii™ (vestronidase alfa-vjbk) – **New for June 3, 2019**
- Mvasi™ (bevacizumab-awwb)*
- Naglazyme® (galsulfase) – **New for June 3, 2019**
- Octagam® (immune globulin intravenous [human])
- Ogivri™(trastuzumab-dkst)
- Onpattro™ (patisiran)
- Ontruzant® (trastuzumab-dttb) – **New for June 3, 2019**
- Panzyga® (immunoglobulin intravenous)
- Privigen® (immune globulin intravenous)

*continued on the next page*

*continued from the previous page*

- Remicade® (infliximab)†
- Renflexis® (infliximab-abda)
- Revcovi™ (elapegademase-lvlr) – **New for June 3, 2019**
- Rituxan® (rituximab)†
- Rituxan Hycela™ (rituximab/hyaluronidase human for subcutaneous injection)
- Sandostatin® LAR Depot (octreotide acetate)
- Spinraza® (nusinersen)
- Stelara® (ustekinumab)
- Truxima® (rituximab-abbs) – **New for June 3, 2019**
- Ultomiris™ (ravulizumab-cwvz)
- Vimizim® (elosulfase alfa) – **New for June 3, 2019**
- VPRIV® (velaglucerase alfa) – **New for June 3, 2019**
- Xolair® (omalizumab)
- Yervoy® (ipilimumab)

## About the Dosage and Frequency Program

Since January 1, 2011, Independence has reviewed the requested dosage and frequency of administration for select drugs as part of the precertification process. Coverage of the drugs included in this program is contingent upon review by Independence for appropriate dosage and frequency. Providers who request coverage above the dosage and frequency requirements listed in the medical policies for each drug will be required to submit documentation (i.e., published peer-reviewed literature) to Independence to support the request. Members who are currently receiving any drug on this program are subject to Dosage and Frequency review at every renewal of precertification.

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

If you have any questions about the precertification process for drugs included in the Dosage and Frequency Program, please call the Independence Clinical Services department at 1-800-ASK-BLUE.

## Updated policies

Medical policies for the newly added drugs are currently in development. In lieu of published policies, Independence will follow the dosage and frequency guidelines listed in the prescribing information for each drug, as approved by the U.S. Food and Drug Administration (FDA).

To access medical policies, visit our *Medical Policy Portal*. Select *Accept and Go to Medical Policy Online*, then select *Commercial* or *Medicare Advantage*, depending on which version of the policy you would like to view, and then type the policy name or number in the Search field. ◆

**Bevacizumab (Avastin®, Mvasi™) only requires precertification approval for dosage and frequency for oncologic indications. Coverage requests for intravitreal injection of bevacizumab (Avastin®, Mvasi™) to treat the ophthalmologic conditions listed in this drug's policies do not require precertification.*

*†Dosage and frequency requirements apply to all FDA-approved biosimilars to this originator product.*

PFA

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

**Published February 22, 2019**

Changes to Independence medical and claim payment policies for our commercial and Medicare Advantage benefit programs occur for a variety of reasons, including in response to industry, medical, and regulatory changes. We encourage you to view the Site Activity section of our Medical Policy Portal to stay 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

## Medical codes for services that require precertification

A list of services that require preapproval/precertification from Independence prior to being performed for our members is available for providers on our Medical Policy Portal. This list, *Services that require precertification*, includes the CPT® and HCPCS codes, where applicable, that correlate with the services and injectable drugs that are included on our Preapproval/Precertification List.

To access *Services that require precertification*, visit our *Medical Policy Portal* and select *Accept and Go to Medical Policy Online*. Choose the *Commercial* or *Medicare Advantage* tab from the top of the page, then select *Services Requiring Precertification* from the left-hand menu.

Links to *Services that require precertification* have also been added to the Quick Links section on the right-hand side of the Provider News Center.

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* and select *Accept and Go to Medical Policy Online*. From there 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 policies from Independence NaviNet® Plan Central, select *Medical Policy Portal* under Quick Links in the right hand column. ◆

# NaviNet® Authorization Log and Authorization Inquiry: Know the difference

**Published February 26, 2019**

There are two different ways to search for authorizations through the Authorizations transaction on the NaviNet web portal. Both the Authorization Log and Authorization Inquiry allow you to search for authorization requests, but each has different capabilities.

## Authorization Log

The Authorization Log is a repository of all authorization requests associated with your facility or professional office for Independence members that originated through the Authorizations transaction. In the Authorization Log, you can:

- view the status of previously submitted requests;
- create new authorizations;
- amend authorizations;
- delete incomplete authorization requests;
- view historic authorization details.

*Note:* Please select the *Refresh Status* icon to view the most current status.


**The Authorization Log *does not include* original prior authorization requests submitted to Independence by means other than NaviNet, such as those called into Independence Clinical Services or requests submitted through AIM Specialty Health® (AIM) and CareCore National, LLC d/b/a eviCore healthcare (eviCore), independent companies.**

## Authorization Inquiry

Authorization Inquiry allows you to search for ***all*** prior authorization requests associated with your Independence members, including original requests called into Independence and finalized AIM and eviCore requests.

## More information

We encourage you to review the *Authorization Submission and Inquiry Guide* and the *Authorization Log Guide*, which are available under “Authorizations transaction resources” in the *NaviNet Resources* section.

If you have any questions, please contact the eBusiness Hotline at 215-640-7410. ◆

*NaviNet is a registered trademark of NaviNet, Inc., an independent company.*

# Thorough completion of prescription drug prior authorization forms linked to improved member satisfaction

**Published February 14, 2019**

Independence actively studies member satisfaction to enhance the health and well-being of the people and communities we serve. Analyses related to the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey along with other member experience metrics show a positive correlation between member satisfaction and efficient processing of prescription drug prior authorization requests. Members report frustration with delays in decisions caused by incomplete coverage determination forms.

## Our findings

Through our analyses, we have found that members calling to inquire about the status of their coverage determination would often find that the process was delayed due to missing information.

Examples of missing information include: diagnosis codes, lab values, and medication history details (e.g., trial and failure of formulary medications).

## Steps to take

Independence will make several attempts to contact the provider to obtain missing information. There are scenarios where the provider's office is unavailable such as weekends and holidays, which may result in a denied coverage determination, member inconvenience, and the potential need to initiate an appeal.

We strongly encourage providers to:

- Empower their office staff and on-call services to support health plan outreach.
- Complete all coverage determination forms carefully and thoroughly to minimize the need for follow-up from Independence.
- Use our electronic prior authorization (ePA) platform through *CoverMyMeds®* or *SureScripts™*.

Using ePA enables providers to receive real-time prior authorization decisions. The decisions are based on an algorithm created for approximately 100 of the most-requested medications from all drug classes that require prior authorization under an Independence formulary.

## For more information

A more detailed article on the annual CAHPS survey will be published next month.

If you have questions about registering or using the portal, call CoverMyMeds at 1-866-452-5017 or SureScripts at 1-866-797-3239. If you have any questions about ePA, call FutureScripts®, our independent pharmacy benefits manager, at 1-888-678-7012. ◆

*FutureScripts is an independent company that provides pharmacy benefits management services.*

# Reminder: Prior authorization update regarding low-dose opioid therapy

**Published February 1, 2019**

As of July 1, 2017, Independence placed a five-day supply limit on all low-dose opioids. Members who, at that time, already had a prescription for greater than a five-day supply of low-dose opioids were temporarily exempted from this limit.

As a reminder, beginning March 1, 2019, all members, **including those previously exempt,** will require a prior authorization when continuing low-dose opioid therapy beyond five days, if they have not already received prior authorization approval from Independence. Providers will receive a letter with a list of their Independence patients who are affected by this change.

For more details regarding opioid and non-opioid therapy options, please refer to the CDC's *Checklist for prescribing opioids for chronic pain*.

If you have any questions concerning the prior authorization process, please contact FutureScripts®, our pharmacy benefits manager, at 1-888-678-7012. ◆

*FutureScripts is an independent company that provides pharmacy benefits management services.*



# Improving lead testing and developmental screening among CHIP members

**Published February 26, 2019**

The Pennsylvania Department of Human Services (DHS) and Healthcare Effectiveness Data and Information Set (HEDIS®) specifications state that all children enrolled in Pennsylvania's Children's Health Insurance Program (CHIP) should receive testing for elevated blood lead levels (EBLL) and developmental screening as recommended below.

## Lead testing and developmental screening recommendations

Practitioners are encouraged to follow the Medicaid and Bright Futures™ guidelines for lead testing and developmental screening. A lead blood test should be completed at ages 9 to 12 months and again before age 24 months. Formal screening for developmental disorders using a standardized tool, such as the Ages and Stages questionnaire (CPT® 96110), should be completed for children who turn 1, 2, or 3 years of age or when surveillance yields concern. This is especially important for children enrolled in CHIP because of the higher incidence of developmental delay among certain pediatric populations enrolled in government sponsored programs when compared to children enrolled in privately insured plans.

CHIP members should meet the Medicaid guidelines for lead testing and developmental screening regardless of risk level. We know many provider practices have already performed these tests, and we thank you and your staff for the care you provide to our pediatric and CHIP members.

## What your practice can do

To help ensure your members receive the required testing, your practice can do the following:

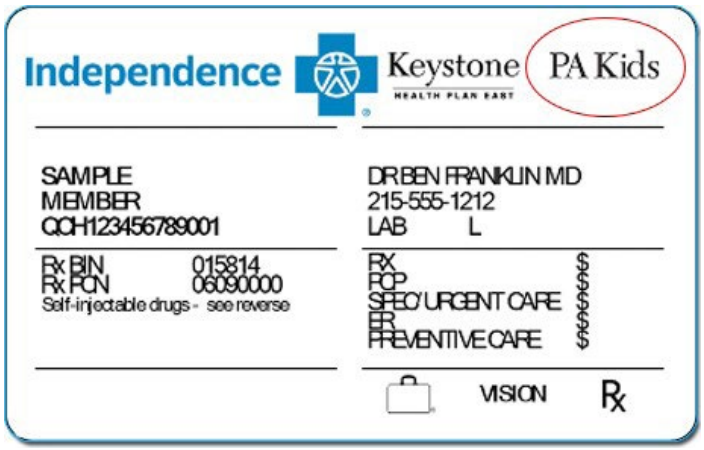
- Screen children for EBLL by performing a risk assessment at 6 months, 9 months, 18 months, and then annually from ages 3 – 6 with testing as appropriate.
- Perform developmental surveillance at each well-child visit and document the use of a standardized developmental screening tool for children who turn 1, 2, or 3 years of age or when surveillance yields concern.
- Discuss recommendations for lead testing and developmental screening with the parents/guardians of your CHIP patients.

*continued on the next page*

*continued from the previous page*

## Identifying CHIP members

To help your practice easily identify CHIP members, we include the identifying words "PA Kids" on the front of Independence ID cards, as shown in the sample CHIP ID card below.




## Reminder: PROMISe™ ID required to render services to CHIP members

The state of Pennsylvania requires a Provider Reimbursement and Operations Management Information System (PROMISe) ID for all providers who render services to CHIP members. There are a few important things about PROMISe IDs to keep in mind:

- DHS implemented the Affordable Care Act provision that requires all providers who render services to CHIP members be enrolled with DHS as a CHIP provider.
- Upon enrollment, DHS will issue providers a PROMISe identification number.
- The deadline for CHIP providers to enroll with DHS is **July 1, 2019.**
- Remember, registering as a CHIP-only provider does **not** mean providers must accept Medical Assistance beneficiaries.
- Beginning July 1, 2019, a PROMISe ID will be required to receive payment from Independence for services rendered to CHIP members.
- As of July 1, 2019, claims submitted to Keystone Health Plan East by a non-enrolled provider (i.e., one without a PROMISe ID) will not receive payment.
- Visit the DHS *website* to access the application, requirements, and step-by-step instructions related to the enrollment process.

## Resources

The following resources provide additional information regarding lead testing recommendations:

- Centers for Disease Control and Prevention (CDC): *Childhood Lead Poisoning Prevention Program*
- Philadelphia Department of Public Health: 215-685-2788 (Philadelphia residents)
- National Lead Information Center: 1-800-424-LEAD (non-Philadelphia residents)
- American Academy of Pediatrics: "Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening." *Pediatrics*. 2006; 405-420. Available from: *http://pediatrics.aappublications.org/content/118/1/405*
- *CDC's Child Developmental Screening*
- *Independence website* ◆

# Contact numbers

Please visit the *Contact Information* section of the Providers section of our website for a complete list of important telephone numbers.

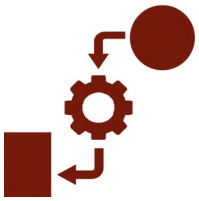
# Websites

## NaviNet Resources

NaviNet is our secure, online provider portal that gives you and office staff access to critical administrative and clinical data. To help you navigate the portal and various transactions, we have created a central location for a variety of NaviNet resources, including user guides, webinars, and a communications archive.

*NaviNet Resources*

## Utilization Management



Certain utilization review activities are delegated to different entities. Here you will find detailed information on our utilization management programs and common resources used among them.

*Utilization Management*

## Opioid Awareness

We have created a repository of tools and resources to assist you in managing your patients who are prescribed opioid medications.

*Opioid Awareness Resources*

## Quick Links

- *Bulletins*
- *Forms*
- *Frequently Asked Questions*
- *Medical Policy*
- *NaviNet Login*
- *Provider Home*
- *Services that require precertification*
  - *Commercial*
  - *Medicare Advantage*

## Archives

- *Partners in Health Update past edition PDFs*
- *Cumulative Index*
- *ICD-10 Transition*

## Email sign up

- *Sign up for email from Provider Communications*

# Provider Communications

Independence Blue Cross
1901 Market Street
28th Floor
Philadelphia, PA 19103

*provider_communications@ibx.com*

*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 that provides Covered Services to Independence members. 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. Refer to the Provider News Center to stay up to date on news and information from Independence.



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 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.