Partners in Health update℠

Working together for quality health care

June 2014

Independence

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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℠ is a publication of Independence Blue Cross and its affiliates (IBC), created to provide valuable information to the IBC-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 IBC. This publication is the primary method for communicating such general changes. Suggestions are welcome.

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Keystone 65 HMO has an accreditation status of *Excellent* from the National Committee for Quality Assurance (NCQA).

Keystone Health Plan East, Personal Choice®, and Personal Choice 65℠ PPO have an accreditation status of *Commendable* from NCQA.

Establishing your electronic interfaces with LabCorp

As previously communicated, effective July 1, 2014, Laboratory Corporation of America® Holdings (LabCorp) will be IBC's exclusive, nationally based provider of outpatient laboratory services. IBC's contract with Quest Diagnostics® laboratories will end for IBC health plans effective July 1, 2014.

This change covers all Blue-branded product lines and members (i.e., Personal Choice®, Keystone Health Plan East, and Independence Administrators), including individual, group commercial, and Medicare Advantage members, **for services rendered in the Philadelphia five-county region and contiguous counties** (i.e., the counties that surround the IBC service area).

Establish your electronic interfaces with LabCorp

LabCorp offers a variety of test ordering and result delivery solutions that provide the flexibility to meet your needs, including several electronic options:

- **Web-based or Windows®-based electronic solutions.** Go to *www.labcorp.com/beacon* for more information.
- **Bi-directional and uni-directional interfaces.** LabCorp has established interface capabilities with more than 600 EMR (electronic medical record) and PMS (practice management software) systems.

In light of this upcoming change, we strongly suggest that you contact LabCorp at 1-888-295-5915 as soon as possible to establish your preferred electronic interfaces. These interfaces must be established prior to July 1, 2014. ◆

In light of this upcoming change, we strongly suggest that you contact LabCorp at 1-888-295-5915 as soon as possible to establish your preferred electronic interfaces.

Patient access for laboratory services

IBC's laboratory network will provide access that is generally equivalent to or better than the access members have with IBC's current laboratory network (including Quest Diagnostics).

Prior to July 1, 2014, LabCorp will significantly expand the number of patient service centers (PSC) in the IBC service area to provide convenient member access. With the addition of newly built PSCs, LabCorp will have approximately 169 access points, including an estimated 50 new sites, in the IBC service area.

Additional resources available

Search for currently open and "coming soon" LabCorp PSCs by going to *www.labcorp.com* and selecting *Find a Lab*.

Find other (non-LabCorp) participating local and regional laboratories by using the Find a Doctor tool at *www.ibx.com*.

We encourage providers and their office staff to visit the LabCorp-dedicated section of our Provider News Center at *www.ibx.com/pnc/lab* for additional resources, including frequently asked questions and a list of other currently contracted laboratories that will remain in the IBC network in addition to LabCorp.

If your office does not already have an account with LabCorp or you would like a local LabCorp representative to help you set up your account, please email *NENewaccounts@labcorp.com* or call 1-888-295-5915.

PF

Urgent care centers and retail health clinics are alternatives to the ER when physicians are unavailable

We would like to remind you of the urgent care benefit available for most IBC members. This benefit allows members to receive services for urgent medical issues that do not require the advanced medical services of the emergency room/department (ER) when their physician is unavailable. Generally, urgent care is categorized as medically necessary treatment for a sudden illness or accidental injury that requires prompt medical attention, but is not life-threatening and is not an emergency medical condition, when a member's primary physician is unavailable.

Eligible members can receive urgent care in the following places:

- **Urgent care centers.** Urgent care centers are staffed by board-certified physicians who can provide medically necessary treatment for a sudden illness or injury that is not life-threatening.
- **Retail health clinics.** Retail health clinics are staffed by certified registered nurse practitioners trained to diagnose, treat, and write prescriptions (when clinically appropriate) for common illnesses and medical conditions. Local supervising physicians are on call during clinic hours of operation to provide guidance and direction when necessary.

Approved urgent care centers and retail health clinics can be found by using the Find a Doctor tool on our website. Go to *www.ibx.com* and select *Search* under Find a Doctor. Then select *Urgent Care Center & Retail Clinic* from the first drop-down menu and enter your additional search criteria. These approved providers may treat members without a referral or authorization.

You may want to print out a list of the approved urgent care centers and retail health clinics in your area to keep on hand and share with the staff who handle after-hours calls. This list may be instrumental in cases when a member requires urgent medical attention, but your office is closed and ER care is not necessary.

Note: Not all members are eligible for the urgent care benefit. As always, continue to check the NaviNet® web portal for member eligibility and cost-sharing amounts.

If you have any questions about the urgent care or retail health clinic network, please call Customer Service at 1-800-ASK-BLUE. ◆

Coverage for CHIP members

All CHIP members are enrolled in the Keystone Health Plan East (KHPE) HMO program with coverage for urgent care and retail clinic visits.

CHIP members are issued an IBC member ID card with the words "PA KIDS" written on the front, as shown on the sample CHIP ID card below:

PFA

Reminder: Out-of-pocket maximums for commercial HMO, POS, and PPO members

Under the Patient Protection and Affordable Care Act, also known as Health Care Reform, members should not be charged any cost-sharing (i.e., copayments, coinsurance, and deductibles) once their annual out-of-pocket limit for essential health benefits has been met. These limits are based on the member's benefit plan. While individual and group benefit limits may be lower, they cannot exceed the following amounts:

- **Individual:** $6,350
- **Family:** $12,700

Once members have reached their out-of-pocket maximum for essential health benefits, providers should not collect additional cost-sharing. To verify if members have reached their out-of pocket maximum for essential health benefits, providers should use the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal. However, due to our transition to a new operating platform, the process differs depending on whether the member has been migrated. The steps are outlined below.

For migrated members

Once on the Eligibility and Benefits Details screen, the member's current out-of-pocket expense (Accumulated Amount) and the maximum dollar limit (Threshold Amount) will be displayed at the bottom of the screen in the Benefit Accumulator section.

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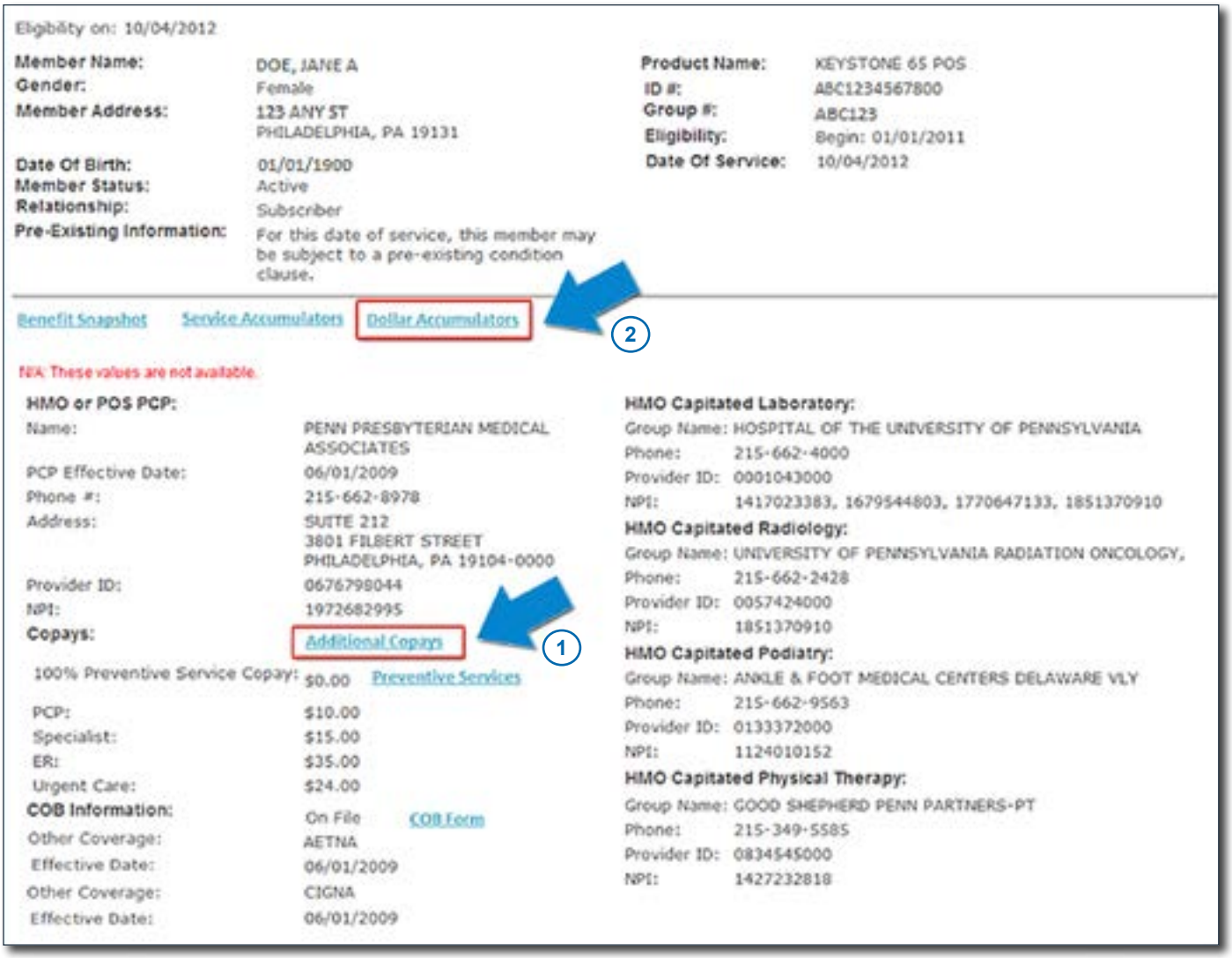
For non-migrated members

Once on the Eligibility and Benefits Details screen, providers will first need to select the *Additional Copays* link to verify the copayment maximums and secondly select the *Dollar Accumulators* link to view the total out-of-pocket amount accumulated to date.



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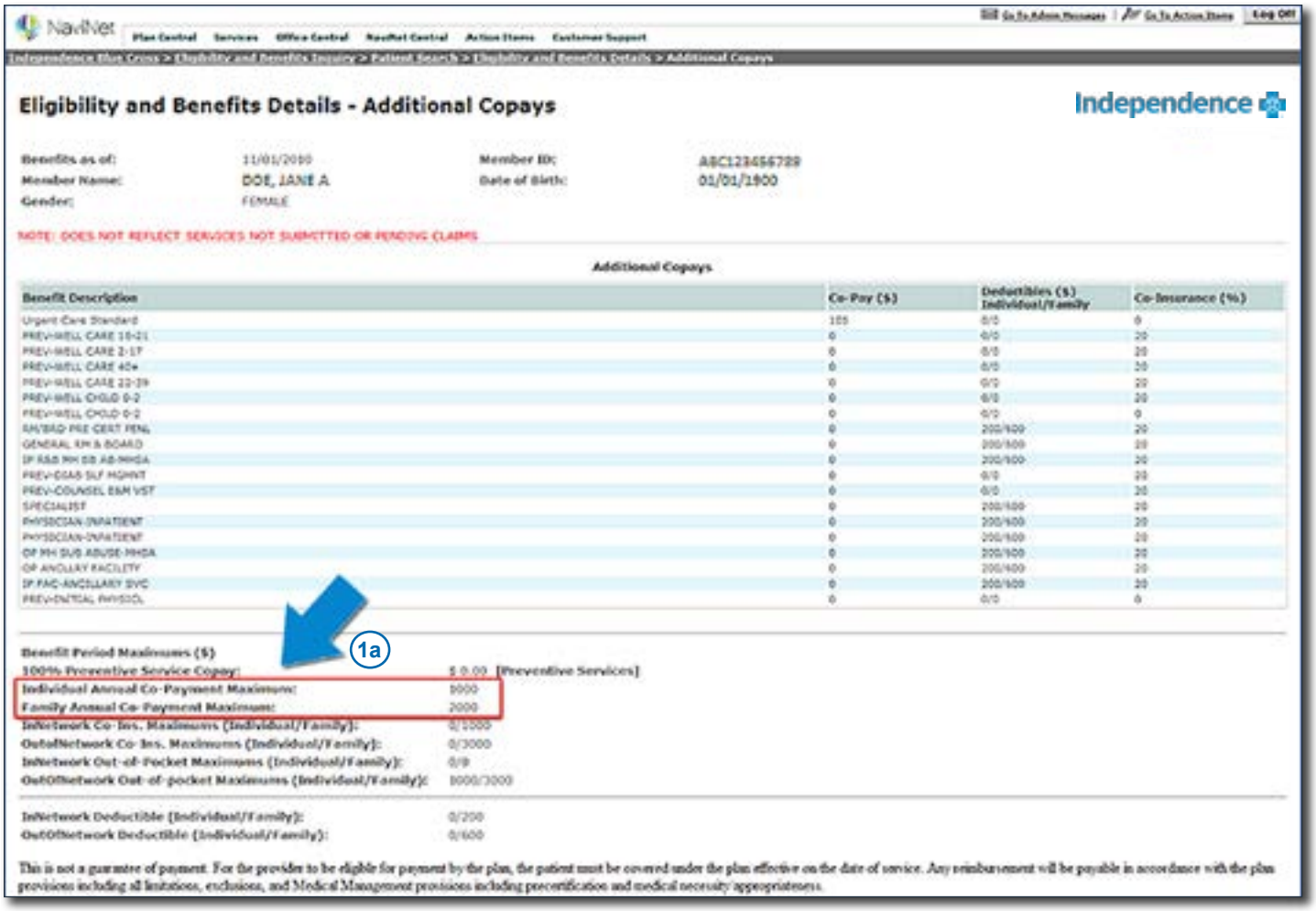

If your office is not yet NaviNet-enabled, you can sign up by going to *www.navinet.net* and selecting *Sign Up* at the top right.

If you have any questions about this change, please call Customer Service at 1-800-ASK-BLUE. If you have questions regarding NaviNet transactions, please call the eBusiness Hotline at 215-640-7410.

Note: Cost-sharing amounts are available to members through their benefit materials or by logging on to our secure member website, ibxpress.com. ◆

ADMINISTRATIVE

P F A

Sign up to receive IBC news and announcements via email

Do you want to be notified directly about breaking news, publication releases and updates, and changes to our processes and procedures? If so, sign up to receive our provider email.

Email sign-up: *www.ibx.com/providers/email*

All requests are processed within 48 hours. To prevent your firewall from marking our email messages as spam, please add IBC (*provider_communications@ibx.com*) to your email address book and provide your information services or information technology contacts with the domains and IP addresses listed on our website.

For professional providers only

Additionally, the IBC Network Medical Directors offer a physician-to-physician email platform, which provides direct and succinct messaging intended to assist physicians in providing quality care to our members. Email topics include the Quality Performance Measure (QPM) score program, announcements of new initiatives, fee schedule reminders, and more.

Participating professional providers are encouraged to join the Network Medical Directors Physician-to-Physician email list.

Physician-to-Physician email sign-up: *www.ibx.com/providers/physician_email*

We respect your privacy and will not make your email address available to third parties. For more information about our privacy policy, go to *www.ibx.com/privacy*. ◆

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New NCQA 2014 PCMH Guidelines

On March 24, 2014, NCQA (National Committee for Quality Assurance) launched the 2014 version of the Patient-Centered Medical Home (PCMH) program with new standards. Additional information about the new version of the PCMH recognition program will be available in the coming months. Please visit NCQA's website, *www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/NewVersionofPCMH.aspx*, for information on purchasing the new version.

For practices that choose to use the PCMH 2011 survey tools, please keep in mind that the last day they will available for purchase is June 30, 2014. The deadline to submit PCMH 2011 survey tools is March 31, 2015. ◆

PFA

Reminder: 90-day grace period for APTC members

The Advanced Premium Tax Credit (APTC) is part of the Patient Protection and Affordable Care Act, also known as Health Care Reform. The APTC helps qualifying individuals and families obtain health insurance by reducing monthly premiums.

As previously communicated, Health Care Reform mandates a three-month grace period for APTC members who are delinquent in paying their portion of the premiums. Please note that members must first pay their initial premium payment to be eligible for the grace period.

Under this mandate, insurers are required to pay medical claims received during the first 30 days of the grace period, but may pend medical claims for services rendered to those members and their eligible dependents during the second and third months of the grace period. Insurers are also required to notify affected providers when one of these members enters the grace period. If payment is not received by the end of the grace period, the pended claims will be denied and the member's policy will be terminated.

Delinquent payment indicator

To comply with the mandate, IBC has created a new field called APTC (Advanced Premium Tax Credit), which is available within the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal. This field indicates when a member is in the grace period and provides a status of the member's claims. The APTC field will only display when a member is in a delinquency status. When the member enters the grace period, the APTC field will be populated on the Eligibility and Benefits Details screen with the word "Yes." There will be a corresponding message that indicates the month of delinquency the member is in and the status of his or her claims.

If claims incurred in the second and third month are denied due to non-payment of premium and the member's policy is terminated, providers may seek reimbursement directly from the member. However, if the premium is paid in full before the grace period ends, any pended claims will be processed in accordance with the terms of your Provider Agreement.

For more information

Please refer to the *Delinquent Payment Indicator for APTC Members* user guide for detailed information about the APTC field. This guide is available in the NaviNet Transaction Changes section of our Business Transformation site at *www.ibx.com/pnc/businesstransformation*.

If you have any questions about this mandate, please call Customer Service at 1-800-ASK-BLUE. If you have questions regarding NaviNet transactions, please call the eBusiness Hotline at 215-640-7410. ◆

PFA

Professional Injectable and Vaccine Fee Schedule updates effective July 1, 2014

Effective July 1, 2014, 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.

If you have any questions about the updates or where to view them, please contact your Network Coordinator. ◆

P F A

Electronic claim resubmission requirements

As a reminder, there are specific guidelines in the *IBC HIPAA Transaction Standard Companion Guide* that providers must follow when resubmitting a claim for an adjustment. In order for the adjustment to occur, the following Loop ID/Reference segments must be populated accordingly:

- Loop 2300, Reference CLM05-3 (Claim Frequency Type Code);
- If CLM05-3 contains 5, 7, or 8, prior claim information is required in Loop 2300 because it indicates that a claim is a replacement or void to a previously adjudicated claim.

Claims resubmission

Claim Frequency Type Codes that tie to a "prior claim" or "finalized claim" refer to a previous claim that has completed processing in the payer's system and has produced a final paper/electronic Provider Remittance or Explanation of Benefits (EOB)*.

Please note the following:

- Previous claims that are pending due to a request from the payer for additional information are not considered a "prior claim" or "finalized claim."
- An 837 professional claim transaction is not an appropriate response to a payer's request for additional information. Rather, providers must follow the instructions within the request for returning the additional information. At this time, there is not an EDI transaction available to return the requested information.

For more information

For more information about electronic claim submission guidelines, refer to the *IBC HIPAA Transaction Standard Companion Guide*, available on the IBC Trading Partner Business Center at *www.highmark.com/edi-ibc*.

If you have questions about the requirements for resubmitting electronic claims, please contact your Network Coordinator. ◆

**For migrated member claims, providers will receive a Provider Remittance/EOB. For non-migrated member claims, providers will receive a Statement of Remittance.*

P F A

Upcoming changes to billing requirements

Effective August 1, 2014, all hospital, ancillary, and professional participating providers are required to bill Usual, Customary, and Reasonable charges for covered services provided to IBC members.

Updates reflecting this new billing requirement will be made to the *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers* and the *Provider Manual for Participating Professional Providers* in the sections listed below.

For hospital and ancillary providers:

- Billing & Reimbursement for Hospital Services
- Billing & Reimbursement for Ancillary Services

For professional providers:

- Billing

Updated manuals will be available through the NaviNet® web portal after August 1, 2014. ◆

PFA

Guidelines for billing with taxonomy codes

As previously communicated, IBC is in the process of transitioning its membership to a new operating platform. During this transition, which began in November 2013 and will continue through mid-2015, we will be working with you in a dual claims-processing environment. As part of this transition, the use of taxonomy codes is required to ensure proper claims processing.

Using taxonomy codes

If your group National Provider Identifier (NPI) is associated with more than one IBC specialty, you must include the appropriate provider taxonomy code in addition to the NPI on all claims. This allows the accurate application of the provider's contractual business arrangements with IBC. Failure to submit claims with the applicable NPI and correct correlating taxonomy code may result in incorrect claims processing and/or payment delays.

The examples below illustrate how to correctly submit your taxonomy code:

Example 1

Incorrect billing practice

Billing NPI	Specialty description	Taxonomy code	Taxonomy description
12345XXXXX	Durable medical equipment	332B00000X	Durable medical equipment
Rendering NPI	**Specialty description**	**Taxonomy code**	**Taxonomy description**
11223XXXXX	Durable medical equipment	333600000X	Pharmacy

Correct billing practice

Billing NPI	Specialty description	Taxonomy code	Taxonomy description
12345XXXXX	Durable medical equipment	332B00000X	Durable medical equipment
Rendering NPI	**Specialty description**	**Taxonomy code**	**Taxonomy description**
11223XXXXX	Durable medical equipment	332B00000X	Durable medical equipment

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BILLING

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Example 2

Incorrect billing practice			
Billing NPI	**Specialty description**	**Taxonomy code**	**Taxonomy description**
12345XXXXX	Home infusion/Durable medical equipment	3336H0001X	Home infusion/Durable medical equipment
Rendering NPI	**Specialty description**	**Taxonomy code**	**Taxonomy description**
11223XXXXX	Home infusion/Durable medical equipment	333600000X	Pharmacy

Correct billing practice			
Billing NPI	**Specialty description**	**Taxonomy code**	**Taxonomy description**
12345XXXXX	Home infusion/Durable medical equipment	3336H0001X	Home infusion/Durable medical equipment
Rendering NPI	**Specialty description**	**Taxonomy code**	**Taxonomy description**
11223XXXXX	Home infusion/Durable medical equipment	3336H0001X	Home infusion/Durable medical equipment

For more information about our Business Transformation, please visit our dedicated site at *www.ibx.com/pnc/businesstransformation.* On this site, you will find a communication archive and frequently asked questions. ◆

Interpreting your PCP payments via EFT

As of November 2013 and continuing through mid-2015, IBC is migrating membership to a new operating platform. Until all of our business is on the new platform, we will be working with you in a dual claims-processing environment.

Primary care physicians (PCP) will receive two different forms of payment from IBC: electronic funds transfer (EFT) for migrated members and EFT-enabled providers and paper checks for non-migrated members and nonEFT-enabled providers. The following information was developed to assist our PCPs in understanding Capitation (CAP) and/or the Quality Incentive Payment System (QIPS) program payments for migrated and non-migrated members using the NaviNet® web portal. **Please note, this process only applies to provider offices set up to receive EFT payments.**

Note: Only those practices that are eligible to participate in the QIPS program can receive QIPS payments.

Distribution of your CAP and QIPS payments

The process flows below outline how CAP and QIPS payments are distributed and how to access the payment information through NaviNet.

CAP payments

- Providers receive paper checks for CAP payments specific to non-migrated members.
- Providers can access the PCP CAP Rosters transaction located under ePayment on NaviNet by office location (if applicable).
- Note the total CAP payment amount – this represents your payment for both non-migrated and migrated members.
- Subtract the paper check amount from the total CAP payment amount to obtain the total EFT CAP payment amount for migrated members.

QIPS payments

- Providers receive paper checks for QIPS payments specific to non-migrated members.
- QIPS-eligible providers can access the QIPS Rosters transaction located under ePayment on NaviNet by office location (if applicable).
- Note the total QIPS payment amount – this represents your QIPS payment for migrated members.
- Add the total QIPS payment to the EFT CAP payment to obtain the total amount of your EFT payment.

Calculating your EFT payment

Total CAP Payment Amount (NaviNet)	$ 13,066.27
Paper Check Amount for non-migrated members	- $ 789.25
EFT CAP Payment for Migrated Members	= $ 12,277.02
Total QIPS Payment Amount (NaviNet)	+ $ 1,148.40
Total EFT Payment	**= $ 13,425.42**

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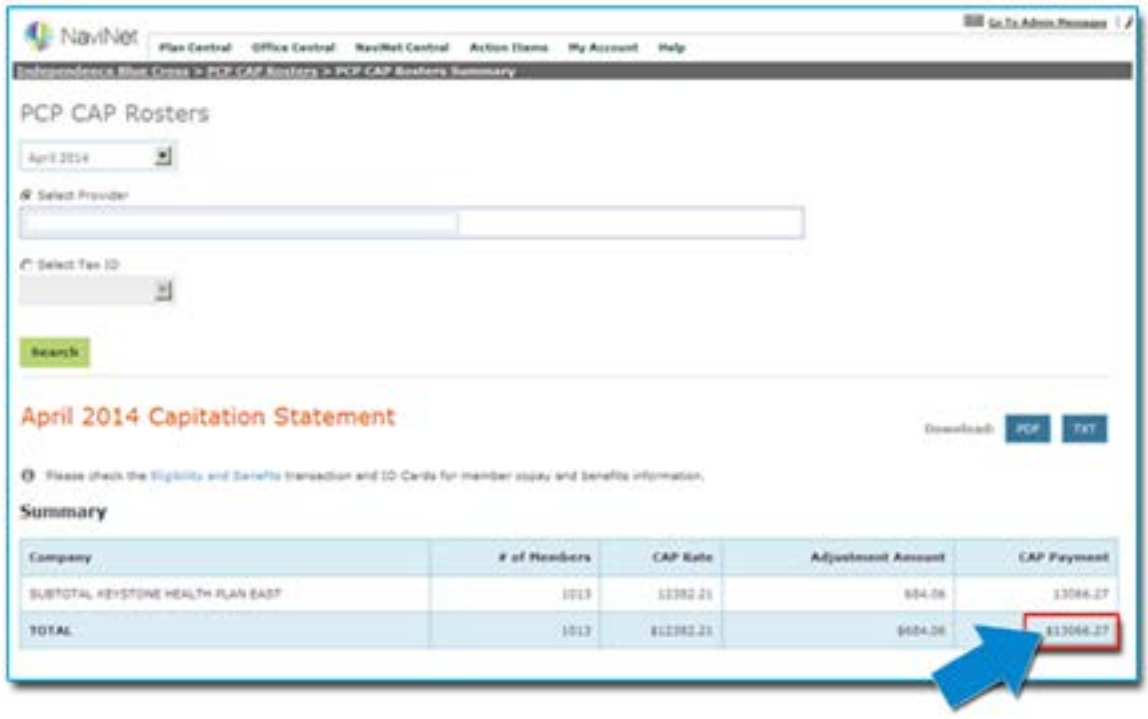
Accessing CAP/QIPS rosters and payments

The following are brief instructions to help you navigate the PCP CAP and PCP QIPS Rosters transactions through NaviNet. Please use the online roster to obtain the most up-to-date information.

CAP Roster — Contains both migrated and non-migrated members

From the Plan Transactions menu, select *ePayment*, then *PCP CAP Rosters*.

Next, you will see a screen that allows you to search by month, provider (office location), or tax ID number. Once the appropriate information is entered, select *Search.*



The results that appear reflect member-level detail of your CAP payment for all members – both migrated and non-migrated. The total CAP payment amount is displayed within the Capitation Statement summary.

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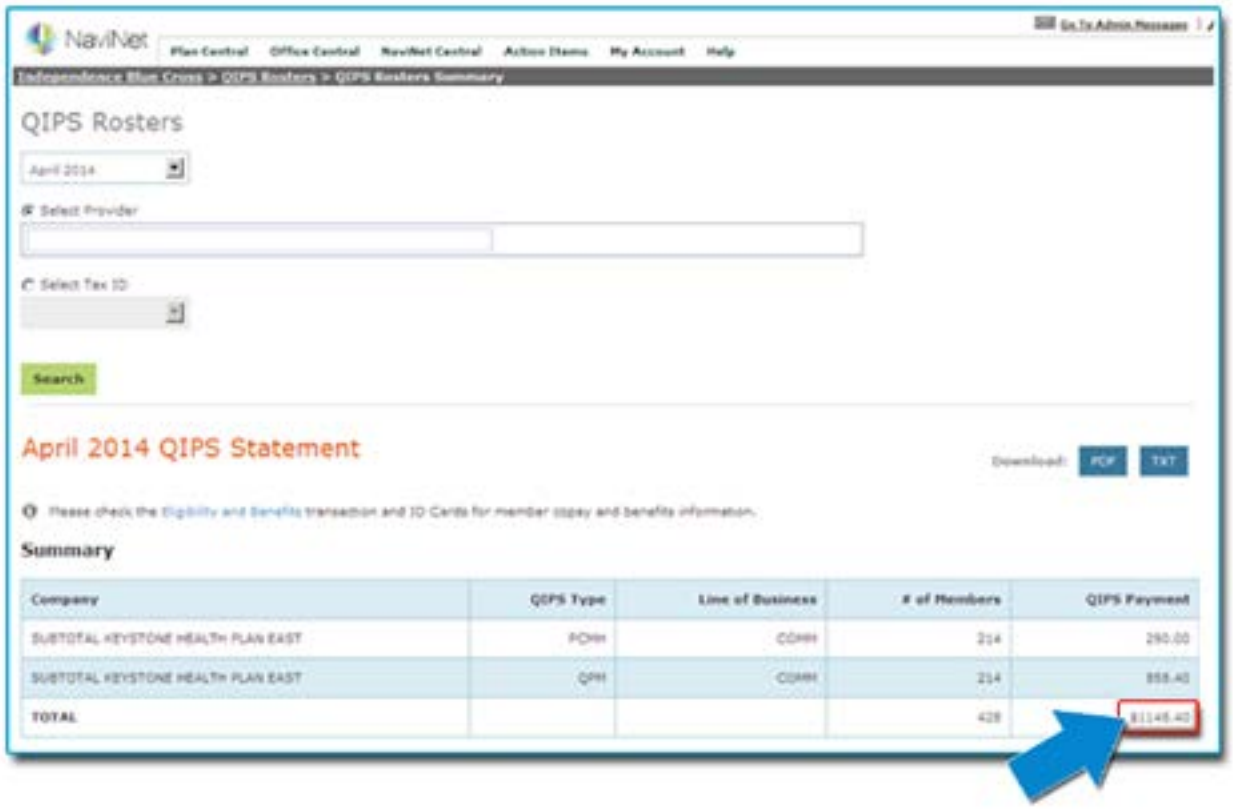
QIPS Roster — Contains only migrated members

From the Plan Transactions menu, select *ePayment*, and then *QIPS Rosters.*

Next, you will see a screen that allows you to search by month, provider (office location), or tax ID number. Once the appropriate information is entered, select *Search*.



The results that appear reflect member-level detail of your QIPS payment for migrated members only. The EFT QIPS payment amount is displayed within the QIPS Statement summary. To obtain your total QIPS payment amount, add the NaviNet roster payment amount (EFT) to the paper check amount.

For more information

User guides that describe these transactions in greater detail are available in the NaviNet Transaction Changes section of our Business Transformation site at *www.ibx.com/pnc/businesstransformation*. We encourage you to review the guides and check back for any updates.

If you have any questions regarding NaviNet transaction changes, call the eBusiness Hotline at 215-640-7410. ◆

PFA

Medical and claim payment policy activity posted from April 26 – May 25, 2014

Below is a listing of the policy activity that we have posted to our website from April 26 – May 25, 2014.

New policy

The following policy has been newly developed to communicate coverage and/or reimbursement positions, reporting requirements, and other processes and procedures for doing business with IBC.

Policy #	Title	Notification date	Effective date
00.01.56	National Correct Coding Initiative (NCCI) Modifier Indicator 0 (Zero) Procedure Code Pairs	February 12, 2014	May 13, 2014

Updated policies

The following policies have been reviewed and updated to communicate current coverage and/or reimbursement positions, reporting requirements, and other processes and procedures for doing business with IBC.

Policy #	Title	Type of policy change	Notification date	Effective date
00.01.19c	Facility Reporting of Observation Services	Coverage and/or Reimbursement Position	N/A	May 7, 2014
00.01.24e	Obsolete or Unreliable Diagnostic Tests and Medical Services	Medical Necessity Criteria; Medical Coding; Guidelines	March 26, 2014	May 7, 2014
02.01.01c	Home Health Care Services	Medical Necessity Criteria; Coverage and/or Reimbursement Position; General Description, Guidelines, or Informational Update	April 23, 2014	July 22, 2014
05.00.26c	Prothrombin Time Monitor for Home Anticoagulation Management	Medical Necessity Criteria; Medical Coding; Guidelines	May 5, 2014	June 4, 2014
05.00.30i	Noninvasive Respiratory Assist Devices (RADs): Continuous Positive Airway Pressure (CPAP) Devices and Bi-Level Devices	Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	May 5, 2014	June 4, 2014
05.00.54f	Power Wheelchairs (PWCs), Power-Operated Vehicles (POVs), and Push-Rim Activated Power-Assist Devices	Medical Necessity Criteria	April 9, 2014	May 9, 2014
05.00.55h	Wheelchair Cushions and Seating	Medical Coding; Medical Necessity Criteria	April 9, 2014	May 9, 2014
05.00.67k	Wheelchair Options and Accessories	Medical Coding; Medical Necessity Criteria	April 21, 2014	May 21, 2014
07.03.09j	Electromyography (EMG) Studies: Needle EMG, Surface EMG (SEMG)	Medical Coding	N/A	May 7, 2014
08.00.33j	Trastuzumab (Herceptin®)	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	April 23, 2014	July 22, 2014

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Policy #	Title	Type of policy change	Notification date	Effective date
08.00.34g	Infliximab (Remicade®)	Coverage and/or Reimbursement Position; Medical Necessity Criteria Medical Coding; General Description, Guidelines, or Informational Update	May 22, 2014	June 23, 2014
08.00.50l	Rituximab (Rituxan®)	Medical Coding	March 5, 2014	June 3, 2014
08.00.62e	Abatacept (Orencia®) for Injection for Intravenous Use	Coverage Position; Medical Necessity Criteria; General Description	March 5, 2014	June 3, 2014
08.00.81c	Bendamustine Hydrochloride (Treanda®)	Medical Necessity Criteria	February 12, 2014	May 13, 2014
08.00.85d	Tocilizumab (Actemra®) for Intravenous Infusion	Medical Necessity Criteria; General Description	March 5, 2014	June 3, 2014
08.00.94f	Denosumab (Prolia™, Xgeva™)	Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	April 23, 2014	May 23, 2014
08.01.05b	Carfilzomib (Kyprolis™)	Medical Necessity Criteria	N/A	May 7, 2014
09.00.46l	High-Technology Radiology Services	Coverage and/or Reimbursement Position; Medical Coding	January 31, 2014 (notification revised February 12, 2014)	May 1, 2014
11.00.06e	Treatment of Obstructive Sleep Apnea (OSA) and Primary Snoring for Adults	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	April 23, 2014	July 23, 2014
11.02.10j	Endovascular Grafts for Abdominal Aortic Aneurysms (AAA), Aortic-Iliac Aneurysms, and Infrarenal Aortic Aneurysms	General Description; Coverage Position; Medical Necessity Criteria; Medical Coding	March 26, 2014	June 24, 2014
11.15.19e	Nucleoplasty	General Description, Guidelines, or Informational Update	N/A	May 7, 2014
12.01.01x	Experimental/ Investigational Services	Medical Coding; Coverage Position	April 10, 2014	July 9, 2014

Reissued policies

The following policies have been reviewed, and no substantive changes were made.

Policy #	Title	Reissue effective date
05.00.45g	Repair or Replacement of an External Prosthetic Device	May 14, 2014 (published May 16, 2014)
05.00.69	Home-Use Light Box for the Treatment of Seasonal Affective Disorder (SAD)	May 14, 2014 (published May 16, 2014)
06.02.01e	Lyme Disease: Diagnosis and Intravenous (IV) Antibiotic Treatment	May 14, 2014 (published May 15, 2014)
06.02.26b	In Vitro Allergy Testing	May 14, 2014 (published May 16, 2014)
08.01.00c	Hydroxyprogesterone Caproate Injection as a Technique to Reduce the Risk of Preterm Birth in High-Risk Pregnancies	May 14, 2014 (published May 15, 2014)
08.01.01c	Ipilimumab (Yervoy®)	May 14, 2014 (published May 15, 2014)

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MEDICAL

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Policy #	Title	Reissue effective date
08.01.08	Coverage of Prescription Oral Anticancer Drugs and Biologics as Provided Under the Company's Medical Benefit	May 14, 2014 (published May 15, 2014)
09.00.04f	Bone Mineral Density (BMD) Testing	May 14, 2014 (published May 15, 2014)
09.00.40b	Screening for Vertebral Fracture with Dual-Energy X-ray Absorptiometry (DEXA/DXA)	May 14, 2014 (published May 15, 2014)
09.00.42b	Computer-Aided Detection (CAD) System for use with Chest Radiographs	May 14, 2014 (published May 15, 2014)
11.06.02f	Elective Abortion	May 14, 2014 (published May 15, 2014)
11.06.09a	Labiaplasty	May 14, 2014 (published May 15, 2014)
11.08.05g	Application and Removal of Tattoos	May 14, 2014 (published May 16, 2014)
11.14.03e	Meniscal Allograft Transplantation	May 14, 2014 (published May 15, 2014)
11.14.06f	Autologous Chondrocyte Implantation (ACI)/Carticel® and Other Cell-based Treatments of Focal Articular Cartilage Lesions	May 14, 2014 (published May 15, 2014)
11.14.09e	Osteochondral Autograft Transplantation (OAT) Procedure	May 14, 2014 (published May 15, 2014)
11.14.12c	Osteochondral Allograft Transplantation	May 14, 2014 (published May 15, 2014)
11.14.13e	Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions	May 14, 2014 (published May 16, 2014)
11.14.25a	Total Ankle Arthroplasty/Replacement	May 14, 2014 (published May 15, 2014)
11.15.22b	Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis	May 14, 2014 (published May 15, 2014)

To view policy activity, go to *www.ibx.com/medpolicy* and select *Accept and Go to Medical Policy Online*. You can also view policy activity using the NaviNet® web portal by selecting *Reference Tools* from the Plan Transactions menu, then *Medical Policy.* Be sure to check back often, as the site is updated frequently. ◆

BUSINESS TRANSFORMATION

PFA

Stay informed during our transition to the new platform

As of November 2013 and continuing through mid-2015, IBC is in the process of transitioning its membership to a new operating platform, generally based on when the customer/member's contract renews.

During this transition, we will be working with you in a dual claims-processing environment until all of our membership is migrated to the new platform. In other words, as members are migrated, their claims will be processed on the new platform; however, we will continue to process claims on the current IBC platform for members who have not yet been migrated.*

We are committed to working closely with our entire provider network as we complete this Business Transformation. We will continue to provide comprehensive communications and tools to support our members and provider network, both during and after the transition to the new platform.

Be sure to visit our dedicated Business Transformation site at *www.ibx.com/pnc/businesstransformation*. On this site you will find a communication archive as well as a frequently asked questions (FAQ) document. If you still have questions after reviewing the FAQ, email us at *provider_communications@ibx.com*. ◆

**Behavioral health claims for HMO/POS non-migrated members should continue to be submitted to Magellan Behavioral Health, Inc. Behavioral health claims for all migrated members, including HMO/POS, should be submitted to IBC.*

Magellan Behavioral Health, Inc., an independent company, manages mental health and substance abuse benefits for most IBC members.

Visit our dedicated Business Transformation site for a communication archive and FAQ. Go to **www.ibx.com/pnc/businesstransformation**.

PFA

Select Drug Program® Formulary updates

The Select Drug Program Formulary is a list for commercial members 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:

Generic drug	Brand drug	Formulary chapter	Effective date
abacavir/lamivudine/zidovudine	Trizivir®	1. Antibiotics & Other Drugs Used for Infection	December 23, 2013
dexmethylphenidate hcl xr	Focalin™ XR	3. Pain, Nervous System, & Psych	November 25, 2013
diclofenac sodium	Solaraze®	9. Bone, Joint, & Muscle	December 2, 2013
duloxetine	Cymbalta®	3. Pain, Nervous System, & Psych	December 16, 2013
fluocinonide	Vanos®	5. Skin Medications	January 20, 2014
hydrocod-cpm-pseudoephedrine	Zutripro™	12. Allergy, Cough & Cold, Lung Meds	January 20, 2014
lamivudine	Epivir HBV®	1. Antibiotics & Other Drugs Used for Infection	January 13, 2014
lomedia 24 fe	Not available	10. Female, Hormone Replacement, & Birth Control	January 6, 2014
moderiba*	Ribapak®	1. Antibiotics & Other Drugs Used for Infection	January 13, 2014
mycophenolic acid	Myfortic®	2. Cancer & Organ Transplant Drugs	January 13, 2014
Not available	Klor-Con® 25 meq Packets	14. Vitamins & Electrolytes	May 1, 2014
potassium citrate er	Urocit®-K	13. Urinary & Prostate Meds	January 13, 2014
rabeprazole	Aciphex®	8. Stomach, Ulcer, & Bowel Meds	November 18, 2013
sirolimus	Rapamune®	2. Cancer & Organ Transplant Drugs	January 20, 2014
telmisartan	Micardis®	4. Heart, Blood Pressure, & Cholesterol	January 13, 2014
telmisartan-amlodipine	Twynsta®	4. Heart, Blood Pressure, & Cholesterol	January 13, 2014
tobramycin	Tobi®	1. Antibiotics & Other Drugs Used for Infection	November 25, 2013
tolterodine tartrate er	Detrol® LA	13. Urinary & Prostate Meds	January 13, 2014

**Generic drug requires prior authorization.*

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Brand additions

Effective May 1, 2014, these brand drugs were added to the formulary and are covered at the appropriate brand formulary level of cost-sharing:

Brand drug	Formulary chapter
Asmanex®	12. Allergy, Cough & Cold, Lung Meds
Ciprodex®	6. Ear, Nose, Throat Medications
Estring®	10. Female, Hormone Replacement, & Birth Control
Tecfidera®	3. Pain, Nervous System, & Psych

Brand deletions

Effective July 1, 2014, these brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

Brand drug	Generic drug	Formulary chapter
Cymbalta®	duloxetine	3. Pain, Nervous System, & Psych
Epivir HBV®	lamivudine	1. Antibiotics & Other Drugs Used for Infection
Rapamune® 0.5 mg tab	sirolimus	2. Cancer & Organ Transplant Drugs
Tobi®	tobramycin	1. Antibiotics & Other Drugs Used for Infection
Trizivir®	abacavir/lamivudine/zidovudine	1. Antibiotics & Other Drugs Used for Infection

The generic drugs for the above brand drugs are available at the generic formulary level of cost-sharing.

Brand deletions

Effective July 1, 2014, these brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

Brand drug	Formulary therapeutic alternatives	Formulary chapter
Advair®	Dulera®, Symbicort®	12. Allergy, Cough & Cold, Lung Meds
Ciloxan®	Vigamox™, ciprofloxacin	11. Eye Medications
Cipro® HC	Ciprodex®	6. Ear, Nose, Throat Medications
Flovent®	Qvar®, Asmanex®	12. Allergy, Cough & Cold, Lung Meds
Pulmicort Flexhaler®	Qvar®, Asmanex®	12. Allergy, Cough & Cold, Lung Meds

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. ◆

PFA

Prescription drug updates

For commercial members enrolled in an IBC 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 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:

Brand drug	Generic drug	Drug category	Effective date
Farxiga™	Not available	Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones	January 27, 2014
Imbruvica™	Not available	Cancer & Organ Transplant Drugs	November 18, 2013
Olysio™	Not available	Antibiotics & Other Drugs Used for Infection	December 2, 2013
Otrexup™	Not available	Bone, Joint, & Muscle	December 30, 2013
Sovaldi™	Not available	Antibiotics & Other Drugs Used for Infection	December 16, 2013
Stendra™	Not available	Urinary & Prostate Meds	January 13, 2014

The following drugs have been added to the list of drugs requiring prior authorization:

Brand drug	Generic drug	Drug category	Effective date
Adasuave®	Not available	Pain, Nervous System, & Psych	July 1, 2014
Advair®	Not available	Allergy, Cough & Cold, Lung Meds	July 1, 2014
Aerospan™	Not available	Allergy, Cough & Cold, Lung Meds	July 1, 2014
Alvesco®	Not available	Allergy, Cough & Cold, Lung Meds	July 1, 2014
Exalgo™	Not available	Pain, Nervous System, & Psych	July 1, 2014
Fetzima™	Not available	Pain, Nervous System, & Psych	July 1, 2014
Flovent®	Not available	Allergy, Cough & Cold, Lung Meds	July 1, 2014
Pulmicort Flexhaler®	Not available	Allergy, Cough & Cold, Lung Meds	July 1, 2014

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Drugs with quantity limits

Quantity limits will be added for the following drugs:

Brand drug	Generic drug	Quantity limit	Effective date
Aciphex®	rabeprazole*	30 tabs per 30 days	November 18, 2013
Focalin™ XR	dexmethylphenidate hcl*	30 tabs per 30 days	November 25, 2013
Stendra™	Not available	8 tabs per 30 days	January 13, 2014
Zomig® Spray 2.5 mg	Not available	9 bottles per 30 days	July 1, 2014

**Quantity limits currently exist for brand drugs and will apply to generics at the dates indicated above.*

Drug no longer requiring prior authorization

Prior authorization was removed for the following drug:

Brand drug	Generic drug	Formulary chapter	Effective date
Tecfidera®	Not available	Pain, Nervous System, & Psych	May 1, 2014

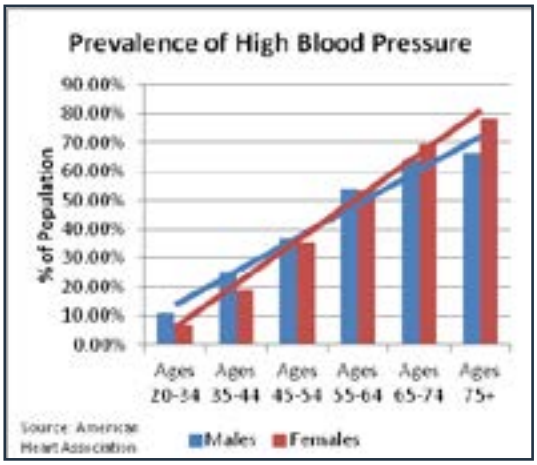
For additional information on pharmacy policies and programs, please visit *www.ibx.com/rx*. ◆

Highlighting HEDIS®: Controlling high blood pressure

This article series is our monthly tool to help you maximize patient health outcomes in accordance with NCQA's[1] HEDIS®[2] measurements for high-quality care on important dimensions of services.

HEDIS® definition

Controlling High Blood Pressure (CBP): The percentage of commercial and Medicare members ages 18 – 85 who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90) during the measurement year.



Quick tips for improvement

- ✓ Measure a patient's blood pressure at the beginning and end of each visit, making sure to record the lower value.
- ✓ Leverage the Hypertension Program offered through IBC Health Coaches.
- ✓ Provide patients with educational resources from the Centers for Disease Control and Prevention: *www.cdc.gov/bloodpressure/materials_for_patients.htm*.

Support from IBC

IBC Health Coaches can collaborate with you to support and guide your patients through an acute or chronic episode to help achieve the medical treatment goals you establish. IBC Health Coaches are available 24/7/365 and can support your patients as they make important decisions about their health. Ask your IBC patients to call an IBC Health Coach at 1-800-ASK-BLUE and say "Health Coach" when prompted.

Send us your feedback

If you have feedback about the Highlighting HEDIS® series or you have topic ideas, email us at *provider_communications@ibx.com*. ◆

Stars Alert!

Controlling High Blood Pressure is also a Medicare Stars[3] measure.

Did you know that providers registered for ePASS® can receive financial incentives by documenting certain patient encounters, including CBP documentation? Register for ePASS® at *https://epass.inovalon.com* and enter your registration code (ePASS2012) to sign up.

Learn More

Visit *www.ibx.com/providers/resources/hedis.html* to view previously published Highlighting HEDIS® articles.

[1] *The National Committee for Quality Assurance (NCQA) is the most widely recognized accreditation program in the U.S.*

[2] *The Healthcare Effectiveness Data and Information Set (HEDIS) is an NCQA tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care.*

[3] *Stars is a program developed by the Centers for Medicare & Medicaid Services to measure quality health care. Ratings are published annually to help educate consumers prior to enrollment decisions.*

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 Management	1-800-ASK-BLUE
Condition Management Program	1-800-ASK-BLUE
Credentialing	
Credentialing Violation Hotline	215-988-1413 or www.ibx.com/credentials
Customer Service/Provider Services	
Provider Automated System† (eligibility/claims status/precertification)	1-800-ASK-BLUE
Provider Services user guide	www.ibx.com/providerautomatedsystem
eBusiness	
Help Desk	215-241-2305
FutureScripts® (commercial pharmacy benefits)	
Prescription drug prior authorization	1-888-678-7012
Fax	1-888-671-5285
Blood Glucose Meter Hotline	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
Prescription drug prior authorization toll-free fax	1-888-671-5285
Other frequently used phone numbers and websites	
IBC Direct Ship Injectables Program (medical benefits)	www.ibx.com/directship
Medical Policy	www.ibx.com/medpolicy
NaviNet® portal registration	www.navinet.net
Provider Supply Line	1-800-858-4728 or www.ibx.com/providersupplyline

**Outside 215 area code*

†The Provider Automated System will be phased out as members are migrated to the new operating platform. For more information go to www.ibx.com/pnc/businesstransformation.

Independence

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