Partners in Health update℠

Working together for quality health care

January 2016

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Independence

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(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 NCQA.

ADMINISTRATIVE

PFA

New Provider Automated System is now live

During December, Independence launched a new Provider Automated System to help providers obtain critical information.

When you call 1-800-ASK-BLUE, be sure to say “Provider” or press 2 when prompted.

Once in the Provider Automated System, you will need to have your National Provider Identifier (NPI) or tax ID number, as well as the member’s information (member ID number and date of birth), ready in order to access the information below.

The Provider Automated System enables providers to retrieve the following information by following a series of self-service voice prompts and questions specific to your inquiry:

- **Eligibility.** Check coverage status, effective dates, and group name information.
- **Benefits.** Verify copayment, coinsurance, and deductible information.
- **Claims.** Obtain paid status, claim denial reasons, paid amount, and member responsibility information.

For authorizations you should enter and retrieve information through the NaviNet® web portal.

User guide

A user guide for the new Provider Automated System is available at *www.ibx.com/providerautomatedsystem*. Look for additional information in future editions of *Partners in Health Update*. ◆

F

Importance of providing timely clinical information on emergency admissions

In order to efficiently conduct admission reviews of inpatient emergency admissions, clinical information regarding the member’s medical condition and treatment is required. Clinical information should be provided within a short time frame after notification of emergency admissions. Ideally, this information should be sent to Independence **within two business days.** Failure to provide the required information within 30 days of notification of admission will result in case closure with a denial due to lack of information.

Should the hospital receive a denial due to lack of information, the request for an admission review can be resubmitted when the clinical information is available. To submit the new request, call 1-800-ASK-BLUE and follow the prompts for authorizations. Please note that the submission of complete medical records is not required and could delay the admission review process.

For questions regarding this information, please contact Alfreda Earp, administrative assistant, at 215-241-3065, and she will direct your inquiry to the appropriate area. ◆

ADMINISTRATIVE

P

Concierge medical practices prohibited as a participating provider

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

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

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

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

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

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

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

P F A

2015 Cumulative Index now available

The *2015 Provider Publication Cumulative Index (2015 Cumulative Index)* is included with this edition of *Partners in Health Update*. This index lists all of the 2015 articles that were published in *Partners in Health Update*, the edition in which they can be found, and the provider audience type for which the article was intended.

A complete archive of all cumulative indexes is also available by selecting *Cumulative Index* in the Quick Links section of our Provider News Center at *www.ibx.com/pnc*.

Printed copies of the *2015 Cumulative Index* can be ordered by submitting an online request at *www.ibx.com/providersuppplyline* or by calling the Provider Supply Line at 1-800-858-4728. ◆

ADMINISTRATIVE

PFA

Update your provider information with us

Have you made any changes to your key provider information? It is important that you notify us of any changes to the following:

- your mailing address
- your phone number
- your office hours
- name of your practice
- your acceptance of new patients
- your plan to dissolve your practice

We value your help in keeping our data files current. Accurate data files allow us to provide you with important information on billing, claims, changes or additions to policies, and announcements of administrative processes.

Professional providers

Please contact your Network Coordinator and notify them of any changes to your information.

Facility and ancillary providers

Per your contract, you are required to submit any changes to your information in writing. This request should be sent directly to the Senior Vice President of Contracting and the Legal Department at the addresses below:

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: Legal Department
1901 Market Street, 43rd Floor
Philadelphia, PA 19103

Sixty days' advance notice is required for processing.

Note: This information does not apply to providers contracted with Magellan Healthcare, Inc., an independent company. Please contact your Magellan Network Coordinator, if you have any questions. ◆

F

Confirmation of precertified procedures

Approvals for inpatient elective admissions are based on procedures that require an inpatient level of care. There are times when procedures are precertified but never performed due to various reasons. In such cases, Independence is responsible for assessing whether the inpatient admission is still medically appropriate. Therefore, we are required to confirm if the precertified procedures were actually performed, and if not, to validate the medical necessity of the admission.

If we are unable to confirm the procedures, the original authorization request will remain open and payment will not be made. The *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers*, which is available in the Current Publications section of Independence NaviNet® Plan Central, is being updated to reflect this process. ◆

BILLING

P F A

Updated payer ID grids now available

The professional and facility payer ID grids contain valuable information to assist you in claims submission, including alpha prefixes, payer information, and claims mailing addresses by product.

The grids have recently been updated to reflect new products for 2016. Please be sure to download the most current versions, which are available on our Electronic Data Interchange (EDI) web page at *www.ibx.com/edi* under EDI Resources. ◆

P F A

Upcoming changes to claims reporting requirements for home infusion providers

Effective March 1, 2016, Independence will adopt new claims reporting requirements for drugs obtained from in-network home infusion providers. The following information will be required when submitting all home infusion drug claims:

- **NDC.** The specific National Drug Code (NDC) that corresponds to the drug formulation administered to the member must be reported.
- **HCPCS or CPT® codes.** The specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code for the drug must be reported. *Exception:* For drugs without a specific HCPCS or CPT code, report the J3490 or J3590 not otherwise classified (NOC) code, as appropriate.
- **Units of drug administered.** Drug units must be reported in multiples of the dosage unit specified in the HCPCS/CPT code narrative. *Exception:* For drugs without a specific HCPCS or CPT code, report the units in multiples of the drug units specified in the NDC.

Failure to include these components in a claim may result in delayed processing and reimbursement.

Note: Precertification requests submitted through the NaviNet® web portal will continue to follow the same submission process that is in effect today.

For more information

The following claim payment policies are being updated to address these new billing requirements and provide specific claims examples:

- **Commercial:** #00.01.49b: Reporting Requirements for Drugs and Biologics
- **Medicare Advantage:** #MA00.024a: Reporting Requirements for Drugs and Biologics

View the Notifications for these policies by visiting our Medical Policy Portal at *www.ibx.com/medpolicy*. Select *Accept and Go to Medical Policy Online*, and then select *Commercial* or *Medicare Advantage* under Active Notifications.

We ask that you review these policies in their entirety and share them with your staff so they can become familiar with the new requirements prior to March 1, 2016. ◆

P F

Reminder: Changes to precertification requirements for 2016

As a reminder, in 2016 new precertification requirements will apply to our commercial and Medicare Advantage HMO and PPO members for the following service and drugs.

Service

Bronchial thermoplasty will require precertification approval from Independence in 2016 as follows:

- **Effective January 1, 2016,** precertification will be required for members enrolled in Medicare Advantage plans.
- **Effective March 1, 2016,** precertification will be required for members enrolled in commercial plans.

Drugs

As of January 1, 2016, the medical benefit drugs listed below will require precertification approval from Independence:

- Adagen® (pegademase bovine)
- Blincyto® (blinatumomab)
- Cyramza® (ramucirumab)
- Gel-Syn™ (sodium hyaluronate)
- GenVisc 850® (sodium hyaluronate)
- Imlygic™ (talimogene laherparepvec)
- Kanuma™ (sebelipase alfa)
- Lemtrada® (alemtuzumab)
- Nucala® (mepolizumab)
- VISCO-3™ (sodium hyaluronate)
- Zevalin® (ibritumomab tiuxetan)*

These changes are reflected in an updated precertification requirement list, which is available at *www.ibx.com/preapproval*. ◆

**Precertification review for this drug is currently provided by CareCore National, LLC d/b/a eviCore healthcare (eviCore), an independent company.*

P F

Precertification changes for non-emergent outpatient radiation therapy services

As previously communicated, providers are required to obtain precertification through CareCore National, LLC d/b/a eviCore healthcare (eviCore), an independent company, for non-emergent outpatient radiation therapy services for all commercial and Medicare Advantage HMO, POS, and PPO members.

Effective January 1, 2016, the list of radiation therapy procedure codes that require precertification has been updated. The following medical policies include an updated list of procedure codes that require precertification as well as a link to the criteria that eviCore will use to determine medical necessity for radiation therapy services:

- **Commercial:** #09.00.56b: Radiation Therapy Services;
- **Medicare Advantage:** #MA09.020b: Radiation Therapy Services.

To view these policies, visit our Medical Policy Portal at *www.ibx.com/medpolicy*. Select *Accept and Go to Medical Policy Online*, and then select the *Commercial* or *Medicare Advantage* tab from the top of the page, depending on the version of the policy you'd like to view. Type the policy name or number in the Search field.

Requesting precertification

You can initiate precertification for non-emergent outpatient radiation therapy in one of the following ways:

- **NaviNet® web portal.** Select *eviCore/CareCore* from the Authorizations option in the Independence Workflows menu.
- **Telephone.** Call eviCore directly at 1-866-686-2649. ◆

MEDICAL

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.

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. You can also get to our Medical Policy Portal through the NaviNet® web portal by selecting the *Reference Tools* transaction, then *Medical Policy*. ◆

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.

NAVINET®

PFA

Reminder: NaviNet® resources available

As previously communicated, Independence has instituted a number of provider self-service requirements under which providers must use the NaviNet web portal to obtain certain information. Therefore, all participating providers, facilities, Magellan-contracted providers, and billing agencies that support provider organizations are required to have NaviNet access.

Over the past several years, we have been making updates and enhancing Independence NaviNet Plan Central to provide the best tool possible for our provider network. Given the significant number of changes, we created a repository on our Provider News Center to house all NaviNet-related information we publish. The NaviNet Resources page is available at *www.ibx.com/pnc/navinet* and includes dozens of transaction-specific user guides and instructional webinars, as well as a communication archive of articles published in *Partners in Health Update* about NaviNet changes.

If you have any questions about NaviNet transactions or you would like training for your office, please call the eBusiness Hotline at 215-640-7410. If you are not yet NaviNet-enabled, go to the NaviNet website at *www.navinet.net* to sign up. ◆

P

Tips to promote antimicrobial stewardship in our community

The Infectious Diseases Society of America (IDSA) defines antimicrobial stewardship as the "coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration."[1] These efforts seek to improve clinical outcomes, reduce health care costs, and slow bacterial resistance rates.

The following tips can help to promote antimicrobial stewardship:

- Consider practicing "watchful waiting" for upper respiratory infections in children and acute bronchitis in adults. Examples include:
  - **The 3-Day Rule:** Follow up with patients three days after the initial visit to discuss treatment options if symptom relief has not occurred.
  - **The Poster Board Pledge:** Display a poster-sized commitment letter in exam rooms to avoid inappropriate antibiotic prescribing. Recent studies show this as a simple, low-cost, and effective method for improvement.[2]
- Order group A streptococcus tests in children with pharyngitis prior to ordering antibiotics as "only about 30 percent of all cases of pharyngitis in children are caused by bacteria. Be sure to follow the pediatric guidelines for appropriate treatment."[3]
- Minimize the use of broad-spectrum antibiotics when narrow-spectrum antibiotics are indicated and recommended.

To learn more about the IDSA's efforts to promote antimicrobial stewardship in human medicine, visit their website at *www.idsociety.org/Stewardship_Policy*. ◆

[1] *http://www.idsociety.org/Stewardship_Policy/ and http://www.who.int/mediacentre/factsheets/antibiotic-resistance/en/*

[2] *Meeker D, et al. "Nudging guideline-concordant antibiotic prescribing: A randomized clinical trial,"* JAMA Intern Med. *2014;174(3):425-31.*

[3] *National Committee for Quality Assurance (NCQA).* The State of Health Care Quality 2014. *Washington (DC): National Committee for Quality Assurance (NCQA); Final Edition 2014; p. 70.*

P F

Prescribing high-risk medications for your older adult patients

In the December 2015 edition of *Partners in Health Update*, we provided information about high-risk medications (HRM) and the increased potential for side effects in adults ages 65 and older. In this edition, we want to remind you that prior authorization may be required for some HRMs.

Initially derived from the American Geriatric Society's "Beer's Criteria," HRMs have been proven to put older patients at a higher risk for adverse drug events. For example, medications such as zolpidem, amitriptyline, estrogens, and glyburide place patients at a higher risk for drug-related toxicities and increased risk for falls and fractures.

The National Committee for Quality Assurance and the Centers for Medicare & Medicaid Services continue to monitor utilization of medications considered to be high-risk in older adults. Careful and appropriate use of drugs in the senior population is a critical quality-of-care issue. For these reasons, we suggest that you use caution when prescribing one or more drugs on the HRM list to patients ages 65 and older.

Go to *www.pqaalliance.org/images/uploads/files/HRM2015.pdf* to view the complete list of HRMs.

Prior authorization requirement

Based on the risks of some HRMs, you may encounter the need to obtain prior authorization. Review the FutureScripts® Select Drug Formulary Guide at *www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/prior_auth_commercial.html* to determine which HRMs require prior authorization (i.e., those with "PA" indicated in the Additional Requirements column).

If the medication requires prior authorization, you can obtain the proper form at *www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization*. ◆

Medication Therapy Management program available for your patients

Independence is working with FutureScripts®, an independent company, to offer a Medication Therapy Management (MTM) program to patients enrolled in a Medicare Advantage plan. This program ensures that they are receiving the safest, most effective medications while helping to reduce out-of-pocket costs.

Program details

A patient is eligible for participation in the MTM program if he or she has three or more chronic diseases, including:

- bone/joint disease (i.e., osteoporosis or rheumatoid arthritis)
- chronic heart failure
- diabetes
- high cholesterol
- high blood pressure
- mental health issues (i.e., depression)
- respiratory diseases (i.e., asthma or chronic obstruction pulmonary disease)

Independence patients who qualify will be automatically enrolled in the MTM program and will receive the following:

- an introduction letter describing the MTM program;
- a full medication review by a specially trained pharmacist, including:
  - high-risk medications (for members taking certain medications that have a high risk of serious adverse effects when there may be safer drug alternatives);
  - medication adherence (for members who are not taking certain diabetes, high blood pressure, or high cholesterol medicines as prescribed);
- a summary medication review package that contains a medication action plan;
- telephonic outreach and review at least every three months and an updated action plan if any changes are necessary.

Medication reviews are offered once a year but may occur more frequently if a patient is diagnosed with new conditions or prescribed new medications. Medicare requires that MTM programs automatically enroll anyone who qualifies during the calendar year; however, participation is voluntary and enrollees have the opportunity to opt-out at any time. If your patient is automatically enrolled, they will remain in the program throughout the calendar year unless they opt-out or change their plan.

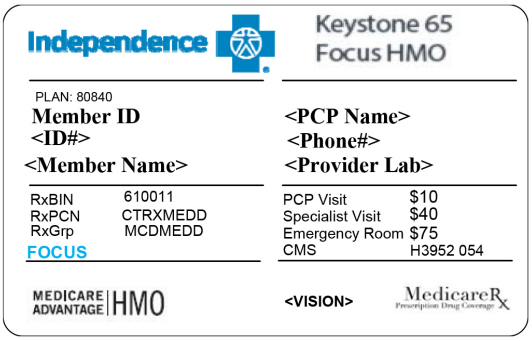
If you have any questions regarding this program, please contact the FutureScripts MTM Department at 1-855-380-1228. ◆

PFA

Keystone 65 Focus coverage starts in 2016

As of January 1, 2016, you may begin to see patients who are covered under Keystone 65 Focus Rx HMO (Keystone 65 Focus), a new Independence Medicare Advantage benefit product for 2016.

As a reminder, Keystone 65 Focus is a defined-network benefit product. Keystone 65 Focus members enjoy similar benefits as with broader-network Medicare Advantage HMO benefit products, while taking advantage of lower premiums and out-of-pocket costs resulting from the defined network of providers.



What you need to know

The following hospitals are participating in the Keystone 65 Focus network. Please note that if a hospital does not appear on this list, it means the hospital is not participating in the Keystone 65 Focus network. Keystone 65 Focus members should only be referred to the hospitals listed below for non-emergency services:

- Abington Health
  - Abington Memorial Hospital
  - Lansdale Hospital
- Aria Health
- Community Health Systems
  - Brandywine Hospital
  - Chestnut Hill Hospital
  - Jennersville Regional Hospital
  - Phoenixville Hospital
  - Pottstown Memorial Medical Center
- Doylestown Hospital
- Grand View Hospital
- Holy Redeemer Hospital and Medical Center
- Main Line Hospitals, Inc.
  - Bryn Mawr Hospital
  - Lankenau Medical Center
  - Paoli Hospital
  - Riddle Hospital
- St. Luke's Health System
- Thomas Jefferson University Hospital, Inc.
  - Methodist Hospital
  - Thomas Jefferson University Hospital

When treating Keystone 65 Focus members, also keep in mind the following:

- **Defined provider network.** Members who choose Keystone 65 Focus for their health care coverage should only be referred to providers who are participating in the Keystone 65 Focus defined network. Find Keystone 65 Focus participating providers using the online provider directory at *www.ibxmedicare.com/focusfinder*.
- **Capitation for radiology and physical therapy services.** Primary care physicians are not required to select capitated sites for radiology and physical therapy services for Keystone 65 Focus members. However, Keystone 65 Focus members must be issued a referral to a participating radiology or physical therapy provider in the Keystone 65 Focus network to receive these services. Reimbursement is made on a fee-for-service basis for the Keystone 65 Focus benefit product when these services are performed by a participating radiology or physical therapy provider in the Keystone 65 Focus network. *Note:* Capitation requirements continue to apply for laboratory services.
- **Existing referrals and authorizations.** You may have Independence Medicare Advantage patients who chose to enroll in Keystone 65 Focus for 2016. If those patients have referrals or authorizations on file under their former Independence Medicare Advantage plan, you may need to issue a new referral or authorization for a Keystone 65 Focus-participating provider.

For more information

Refer to the article titled *Keystone 65 Focus Rx HMO, our new Medicare Advantage benefit product* in the October 2015 edition of *Partners in Health Update* for detailed information about benefits and services covered under Keystone 65 Focus.

If you have any questions about Keystone 65 Focus, refer to the frequently asked questions on our Keystone 65 Focus Rx HMO web page at *www.ibx.com/providers/focus*. If you still have questions after reviewing this information, please contact your Network Coordinator. ◆

Ensure patients know how to access care after office hours

Primary and specialty care physicians make it a practice to provide coverage after office hours and on weekends. In fact, it is a requirement for all network providers to maintain this coverage. However, are your patients aware of this service, or are they simply going to the emergency room/department (ER) for care?

Recent findings

According to the 2014 Accessibility of Services Report, the number of members who call their physicians after office hours over the last four years has steadily decreased. In addition, members enrolled in Keystone Health Plan East HMO identified a decreased response rate (i.e., return call within 30 minutes) from physicians when they call after hours. Members enrolled in Personal Choice® PPO did not identify any significant change from previous years.

Another recent study of a targeted member population showed that members were utilizing the ER for urgent medical care, including otitis media, upper respiratory infection, and acute pharyngitis. Thirty four percent of these ER visits occurred on the weekend, when most primary care practices are closed. Although some providers have voicemail or answering services that answer calls after hours, this may not prevent an ER visit if:

- the patient does not call;
- there is a delay in physician response;
- the member/caregiver does not understand the difference between an emergency and urgent medical care need.

Visits to the ER can interrupt continuity of care and may affect quality of care as well — especially if the patient's physician is unaware of the ER visit and needed follow-up care is absent.

Educate your patients

Independence encourages all physicians to discuss after-hours and weekend coverage, as well as the availability of urgent care centers and retail health clinics with their patients. Physicians can communicate this message by:

- placing a notification in the office that explains how to contact you when the office is closed;
- providing a listing of the nearest urgent care centers and retail health clinics;
- discussing coverage individually with patients.

Remind patients to contact their primary physician or specialist after a visit to the ER, urgent care center, or retail health clinic for assessment of appropriate follow-up care. This is especially important for pediatric patients, elderly patients, and those patients with chronic conditions. Explain that calling will allow the physician office to coordinate services with the facility for the best patient outcome.

All patients want to receive the best possible care, so if they understand the rationale behind the request, they may be more apt to communicate more openly with your office to coordinate care after hours and after visits to the ER, urgent care center, or retail health clinic. ◆

Important Resources

Anti-Fraud and Corporate Compliance	
Hotline	1-866-282-2707 or www.ibx.com/antifraud
Care Management and Coordination	
Baby BluePrints®	215-241-2198 / 1-800-598-BABY (2229)*
Case and Condition Management	1-800-313-8628
Credentialing	
Credentialing Violation Hotline	215-988-1413 or www.ibx.com/credentials
Customer Service	
Provider Services	1-800-ASK-BLUE (1-800-275-2583)
Electronic Data Interchange (EDI)	
Highmark EDI Operations	1-800-992-0246
FutureScripts® (commercial pharmacy benefits)	
Prescription drug prior authorization	1-888-678-7012
Pharmacy website (formulary updates, prior authorization)	www.ibx.com/rx
FutureScripts® Secure (Medicare Part D pharmacy benefits)	
FutureScripts Secure Customer Service	1-888-678-7015
Formulary updates	www.ibxmedicare.com
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

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