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PARTNERS IN HEALTH UPDATE

July 2008

Working Together For Quality Health Care

Updated QIPS manual now available

An updated version of the QIPS (Quality Incentive Payment System) Program Manual is now available on NaviNet®. QIPS is a reimbursement system developed by Keystone Health Plan East for participating Pennsylvania primary care physicians.

Visit NaviNet Plan Central to view and/or download the updated 2008 QIPS Manual. Paper copies are also available by calling the Provider Supply Line at 1-800-858-4728.

For additional information regarding QIPS, please contact your Network Coordinator.

NaviNet® is a registered trademark of NaviMedix, Inc.

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

- Professional
- Facility
- Ancillary

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Claims submitted without a valid, registered NPI will reject

NPIs must be registered with IBC

As of **May 23, 2008,** in accordance with the CMS mandate, providers must use the NPI as the primary identifier on claims submitted to IBC. Claims began rejecting if NPIs were not registered with us. To avoid claims rejections you can register your NPI with IBC if you have not already done so. NPIs can be registered online by submitting an NPI provider registration web form at *www.ibx.com/providers/npi/provider_registration.html.*

Claims submitted with invalid NPIs will reject

Each claim must pass an NPI check-digit validation to ensure that it has a valid NPI. To date, many claims are not passing this check-digit validation. The most common reasons why claims are not passing the NPI check-digit validation are:

- The wrong provider identifier is entered in an NPI field.
- The NPI is entered incorrectly.
- The number entered is not a valid NPI.

Processing of claims

For purposes of processing a claim in accordance with the reimbursement terms of your IBC provider contract, you may continue to provide your 10-digit legacy number in addition to your valid, registered NPI. The sole purpose for providing the 10-digit legacy number is to facilitate accurate claims payment — not to identify the claim for acceptance into IBC's system. Only a valid NPI will be accepted by IBC as the primary identifier on the claim.

If you require further information regarding NPI claims submission, please refer to IBC's *National Provider Identifier (NPI) Toolkit: Tips for Proper Electronic and Paper Claims Submission*, located at *www.ibx.com/pdfs/providers/npi/toolkit.pdf.*

Learn more about NPIs. Our previous communications, FAQs, and additional resources, are available at *www.ibx.com/providers/npi.*

**IBC will receive contracted behavioral health providers' NPI information directly from Magellan Behavioral Health, Inc., an independent company. For further information, please contact Magellan National Provider Services Center at 1-800-788-4005, or visit Magellan at www.magellanhealth.com.*

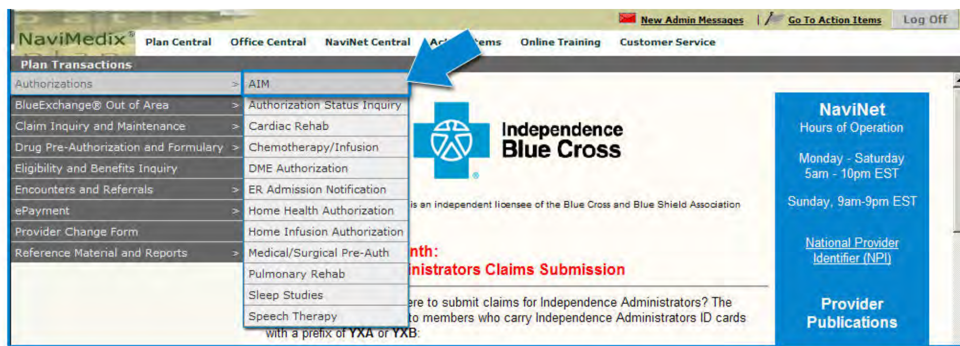
Benefits of submitting precertification requests through the AIM portal

IBC requires precertification requests for outpatient, non-emergent diagnostic imaging (e.g., CT/CTA, MRI/MRA, nuclear cardiology studies, and PET scans), and encourages participating providers to submit requests online to American Imaging Management (AIM) via AIM's provider portal.

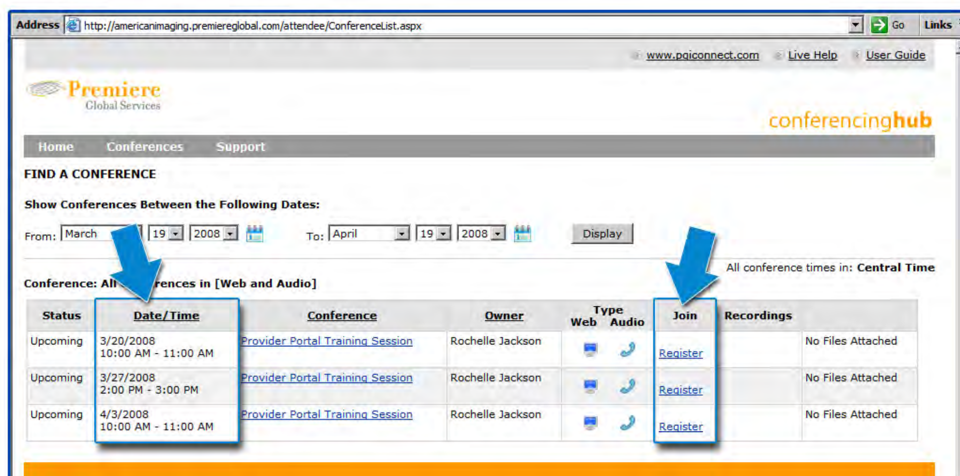
Submitting precertification requests through the AIM portal offers benefits, such as:

- seven-days-a-week availability;
- an easy-to-use interface for efficient submission of precertification requests;
- printable precertification summary information sheet for completed requests;
- online tracking of previous precertification requests and status of open requests.

To access AIM's portal, select the link available through the NaviNet provider portal.



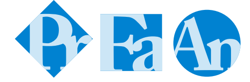
If you need assistance, AIM offers online instruction for providers. To register for a session, simply enter the following web address in your web browser: *http://americanimaging.premiereglobal.com/attendee/ConferenceList.aspx.*



View upcoming sessions (listed by date and time), and select *Register* to initiate the registration process. AIM will send a registration email with additional information.

If you have questions about the registration process or the online sessions, please contact AIM's Customer Service department at 1-800-252-2021.

Keystone Direct Point-of-Service (POS): offering members more direct access to participating specialists



The Keystone Direct POS benefits plan allows members to see most providers directly, *without a referral*. However, Direct POS requires primary care physician (PCP) referrals for routine radiology, physical/occupational therapy, spinal manipulations, and podiatry services. Obtaining a referral for these services ensures that the member receives the highest level of benefits. For laboratory services, members must obtain a laboratory requisition form from their PCP or specialist. For all other services, members may visit any Keystone network provider directly, *without a referral.* Utilizing providers who participate in the Keystone network ensures that members will receive the highest level of benefits and the lowest out-of-pocket costs.

Keystone's capitated program remains in effect for Direct POS. Similar to our Keystone HMO and POS benefits, PCPs must refer Direct POS members to capitated providers for capitated services (i.e., routine radiology, physical/occupational therapy, laboratory, and podiatry) for members to receive the highest level of benefits.

How the plan works:

- A Direct POS member selects a participating PCP from the Keystone Health Plan East network.
- No referrals are required for members to see participating specialists.
- Referrals are required for routine radiology, podiatry, spinal manipulation, and physical/occupational therapy services.
- A requisition form is required for laboratory services.
- The member is responsible for applicable cost-sharing.
- The member does not need to file claim forms when services are provided by participating specialists.

Note: For services requiring precertification through AIM (CT/CT scans, MRI/MRA, nuclear cardiology services, and PET scans), a separate PCP referral is not required. Additionally, referrals are never required for mammography.

BLUECARD®

Inside IPP — a newsletter for Inter-Plan Programs providers

A new quarterly publication called *Inside IPP* was recently introduced in the May 2008 issue of *Partners in Health Update*. This publication is an IBC initiative geared towards facility and ancillary providers to increase provider awareness of and satisfaction with the BlueCard Program, as well as highlight plans for improvement.

The upcoming issue of *Inside IPP* includes articles relating to the following topics:

- changes in COB administration
- Blue Plan validation of eligibility and benefits
- BlueCard online resources
- Provider Satisfaction Survey
- Delaware Valley Healthcare Council and IBC collaboration

The summer edition of *Inside IPP* is available online at *www.ibx.com/providers/blue_card,* along with past issues. Paper copies of *Inside IPP* are available via the Provider Supply Line upon request.

How fraud investigations help keep health care costs down

Each year, three to five percent of our nation's health care expenses are lost to fraud, according to the National Health Care Anti-Fraud Association. With a $2 trillion national health care price tag, the loss is a staggering $60 to $100 billion a year.

Although IBC's Corporate and Financial Investigations Department (CFID) continues to have success in identifying, investigating, and recovering money from fraudulently paid claims, and referring cases to law enforcement authorities for criminal prosecution, your help is needed.

The initiation of investigations of suspected fraud or abuse has increased from 213 in 2006 to 227 in 2007. During 2007, 88 cases of suspected fraud or abusive practices were referred to law enforcement and/or regulatory authorities. Nineteen indictments or criminal informations were filed in 2007 with 17 individuals being sentenced because of guilty pleas or trials resulting from their fraudulent activity. Some of these individuals were sentenced to 12 to 24 months in prison. Convictions or guilty pleas received include:

- submitting false medical claims;
- billing for services not rendered;
- up-coding services to receive higher reimbursement;
- prescription fraud;
- billing for experimental services not covered.

In addition to CFID's role in combating fraudulent practices against IBC, the department is responsible for conducting audits of facility and professional providers, ancillary service providers, and pharmaceutical-related audits. In 2007, more than 30,000 facility claims were audited. Audits were initiated on 80 professional and ancillary service providers. The pharmaceutical mail-order program was audited last year, as were 386 retail pharmacy sites.

Because of fraud, waste, and abuse investigations and audits in 2007, CFID has increased recoveries of overpaid claims for fraudelently/falsely billed claims from $35.5 million in 2006 to $37.5 million in 2007. Additionally, in 2007, CFID has identified more than $30 million plus in overpaid claims that are currently being pursued for recovery.

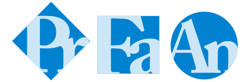
Examples of false claims procedures include:

- **Unbundling of claims** — billing separately for procedures that normally are covered by a single fee;
- **Double billing** — charging more than once for the same service;
- **Up-coding** — charging for a more complex service than was performed;
- **Miscoding** — using a code number that does not apply to the particular procedure performed;
- **Falsifying medical diagnoses or procedures** to maximize payments;
- **Billing for services not performed.**

Unfortunately, a few providers taint the profession of the vast majority of providers who render appropriate care and bill accordingly. CFID utilizes sophisticated software data-mining tools to analyze all claims submitted by medical providers, facilities, and pharmacies and compares them against member enrollment data and overall provider information. Any trends, patterns, or aberrant billing practices are selected for an in-depth audit or investigation.

Although CFID's ongoing efforts to ensure health care insurance payments are valid and appropriate, we need your help. There is no substitute for our health care providers' own vigilance. An easy-to-use process exists for reporting suspected fraud and abuse. This awareness can lead to prevention because providers may become aware of suspicious practices of other providers, subscribers/patients, or billing companies. If you are suspicious of any health care-related activity, please call our toll-free Corporate Compliance and Fraud Hotline at 1-866-282-2707, or visit *www.ibx.com/anti-fraud.* These tips can, and usually do, lead to audits, fraud investigations, and money recoveries, which will help keep health care costs down.

Transition to all-electronic authorization inquiry and submission—Part II*

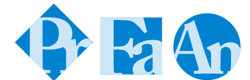


The provider interactive voice response (IVR) system is being enhanced to allow providers to submit an authorization or precertification request for outpatient and office medical and/or surgical procedures. This feature will be available in the near future as part of our phased approach toward the electronic authorization mandate project.

Additional information will be available in future editions of *Partners in Health Update*.

**Behavioral health authorizations are not included in this process. For further authorization/precertification informatino, please contact Magellan Behavioral Health at 1-800-688-1911.*

Policy notifications available online



To better communicate updates to our medical and claim payment policies, we will be posting notifications online prior to the policy's effective date. The notifications will be listed by the intended effective date, and we will provide the policy in its entirety for you to become familiar with it in advance. To read these notifications, please follow these instructions:

1. Visit *www.ibx.com/medpolicy.*
2. Select *Accept and Go to Medical Policy Online*.
3. Select the *Commercial and Other Medicare Advantage policies* link.
4. Select *Policy Notifications* from the Medical Policy column on the left sidebar.
5. Select the date under Policy Effective Date for the policy notification you wish to view.

Notifications will be posted frequently, so please check the site often.

Contact Us | Provider Home | Med Policy Home

Medical Policy.

Welcome to the Medical Policy Home Page

Medical Policy

> Policy Notifications

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Policy Notifications

Welcome to the Policy Notification page. The notifications below are listed by the policy's intended effective date and the policy can be viewed in its entirety for you to become familiar with in advance. Please check back frequently as notifications are posted often.

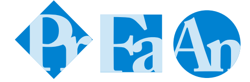
Note: The documents below are strictly notifications and the positions within are not enforced until they become active policy on their intended effective date. To view active company policies go to the Policy Bulletins section of this site or click here.

NEXT | PREVIOUS | EXPAND | COLLAPSE

Policy Effective Date	Notification Title	Notification Issue Date
06/02/2008		
	Diagnostic and Therapeutic Radiopharmaceutical Agents	05/01/2008
07/29/2008		

POLICY

Coverage change regarding wheelchairs



Effective August 1, 2008, in order for durable medical equipment (DME) suppliers to provide members with a Group 2 single power option or multiple power option power wheelchair, any Group 3 or Group 4 power wheelchair, or a push rim activated power assist device for a manual wheelchair, the DME supplier must employ a RESNA-certified assistive technology supplier (ATS) or assistive technology practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

For more information, please contact your Network Coordinator.

PHARMACY

Starting July 1, 2008, *Rx for Better Health* waives copays

The *Rx for Better Health* program will waive copays and coinsurance for IBC members for generic drugs used to treat common chronic conditions from July 1, 2008, through December 31, 2008.

The *Rx for Better Health* program waives copays on 75 generic drugs that are commonly used to treat the following chronic conditions:

- high blood pressure
- high cholesterol
- diabetes
- depression
- acid reflux
- heart failure
- heart disease

These conditions affect a significant number of IBC members.

Clinical studies have proven that consistent drug therapy can help members effectively manage their chronic conditions, but cost often precludes members from keeping up with their regimens. The program will help members to adhere to their therapies, avoiding costly complications and resulting in long-term cost savings.

With your patients' best interests in mind, we encourage you to discuss the benefits of generic drug alternatives for these conditions with them and to consider prescribing generics where appropriate to help them save money. We also encourage you to consider generics when treating patients even after the *Rx for Better Health* program concludes, to assit members in keeping up with their drug regimens.

For the complete list of generic drugs included in this member incentive program, please visit *www.ibx.com.*

Rx for Better Health *program specifics: No enrollment necessary. Available for in-store pickup at participating pharmacies or mail-order fulfillment. Members with Medicare Part D drug plans; Personal Choice® HSA-qualified High-Deductible Health Plans with integrated drug coverage; and HMO members who belong to the Federal Employee Health Benefits Program are not eligible. Other exclusions may apply.*

Note: Members who have integrated drug plans are eligible for refunds for their out-of-pocket costs for these 75 drugs. They will not have copays or coinsurance waived in the store.

Factors that may affect members receiving cancer-prevention screenings

The benefits of cancer screening in terms of quality of care, longevity, and quality of life are well documented. There is strong evidence supporting the premise that quality of life improves when certain cancers are detected earlier.

Breast and cervical cancer

According to the March 24, 2008, issue of the journal *Cancer*, a study found that obese women, especially obese Caucasian women, are less likely to be screened for breast and cervical cancer. There is speculation that the lower screening rates are due to patient embarrassment, fear of being weighed, and physician bias directed at obese women. Researchers recommended that efforts to increase breast and cervical cancer screenings should target obese woman.

Colorectal cancer

According to the March 28, 2008, issue of the *Archives of Internal Medicine*, African Americans with a family history of colon cancer are less likely than Caucasians to undergo colonoscopy. The most common reason patients stated that they did not undergo this screening was not having a recommendation from their physician. The authors recommended that physicians elicit family histories for all patients. Physicians should follow up with patients with family histories of colon cancer to ensure they receive colon cancer screening. For complete screening recommendations, see the policy, colorectal cancer screening #11.03.12e, at *www.ibx.com/medpolicy.*

Encourage your patients to seek the recommended screenings. It is especially important to remind those who may be reluctant to be screened, as noted in the above journals articles.

IBC partners with Quest Diagnostics® to improve colorectal cancer screening compliance

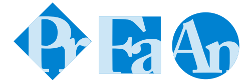
IBC and Quest Diagnostics will be conducting an innovative quality improvement initiative in an effort to improve compliance with colorectal cancer screening. Despite increasing promotion of colorectal cancer screening (e.g., colonoscopy), many members still remain unscreened according to our claims data. We plan to reach out to HMO members age 52 and older associated with primary care physician (PCP) practices who use a Quest laboratory. These will be members without a diagnosis of colorectal cancer and who have no evidence of a colorectal cancer screening according to the following parameters in our claims data:

- fecal occult blood test (FOBT) within the last 12 months;
- fecal immunochemical test (FIT) within the last 12 months;
- flexible sigmoidoscopy within the last five years;
- double contrast barium enema within the last five years;
- colonoscopy within the last ten years.

During the outreach, the members will be sent a mailer with health information on the importance of colorectal cancer screening. The mailer will contain a business reply card that the member can return to request a FIT kit (Insure®Fit™). The participant will then receive a letter with a colorectal cancer screening kit and instructions on how to do the home testing. Test results are completed in one to three days after receipt at Quest lab. The results will be communicated to both the participant and their PCP. We are encouraging participants to discuss their results with their PCPs.

Reminders will be sent to those members who have requested a screening kit but have not completed the test.

To find additional information on the InsureFit test, please visit *www.insuretest.com.*



ConnectionsSM Health Management Programs: supporting our members, your patients

ConnectionsSM Health Management Program

Call the Provider Support Line at 1-866-866-4694 to refer a patient for Health Coaching with any of the following conditions:

- asthma
- diabetes
- heart failure
- COPD
- coronary heart disease
- migraine
- hypertension

Health Coaches provide disease management and decision support for numerous health-related issues.

ConnectionsSM AccordantCare™ Program

Call the ConnectionsSM AccordantCare™ Program at 1-866-398-8761 to refer a patient with any of the following diseases:

- seizure disorders
- rheumatoid arthritis
- multiple sclerosis
- Crohn's disease
- Parkinson's disease
- systemic lupus erythematosus (SLE)
- myasthenia gravis
- sickle cell disease
- cystic fibrosis
- hemophilia
- scleroderma
- polymyosositis
- dermatomyositis
- chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- amyotrophic lateral sclerosis (ALS)
- Gaucher disease

Call our Care Management and Coordination department at 1-800-313-8628 to refer a patient with end-stage renal disease on outpatient dialysis.

Drug Utilization Review results

The Member Safety Program has teamed up with Informatics and our pharmacy benefits manager, FutureScripts®, to conduct a Drug Utilization Review (DUR). The DUR identifies members who are receiving improper doses or combinations of products, who are potential abusers of narcotics, and who are high users of medication. An automated check of drug claims data is performed to identify potentially inappropriate prescriptions for individual members. The targeted DUR programs currently in effect include: antidepressant therapy, potentially inappropriate medication in the elderly, and controlled substances.

Antidepressant therapy

This initiative identifies members who, based on a lapse in their prescription fill schedule, may not be complying with their antidepressant therapy. Identification of antidepressant compliance issues may reduce the risk of relapse or recurrence of depression.

The basic criterion for this initiative identifies members who are at least 16 years old and have been prescribed antidepressants but have gaps of time in their expected refills.

In the first quarter of 2007, 3,851 letters were mailed to practitioners in Pennsylvania and Delaware regarding 12,391 members identified as having a gap in their antidepressant refills. Included in the mailing were the current depression treatment guidelines from the American Psychiatric Association.

During the fourth quarter of 2007, we looked at the same members to see if there was an improvement in their refill rates. We found that only 7,885 of these same members were identified as having a potential gap — *a 36 percent improvement*.

Potentially inappropriate medication for the elderly

This initiative enhances member safety by increasing provider awareness of medications that are potentially unsuitable for use for the elderly.

The basic criterion for this initiative identifies members age 65 and older who are receiving a medication that should generally be avoided for the elderly.

In the first quarter of 2007, there were 8,016 Pennsylvania and Delaware members age 65 and older who had filled potentially inappropriate prescriptions. Letters were sent to 2,860 network physicians listing the member and the medication for their consideration. Included in this mailing was an inclusive list of medications to be avoided in people age 65 and older.

We reviewed the same members in the fourth quarter of 2007. The number of members still receiving potentially inappropriate medications was down to 3,886 — *a 52 percent improvement*.

Controlled substances

This DUR identifies members who may be overusing controlled substances. Prescribers are encouraged to review the prescription patterns of identified members for potential controlled substance issues.

The basic criterion for this initiative identifies those members with more than ten controlled substance prescriptions within three months, from at least three different providers. The program makes every effort to exclude members with cancer and other medical conditions where the use of these medications is indicated.

The providers were sent a letter detailing the prescriptions their patients were currently taking and when the prescription was filled. Included in the mailing was educational material on maximum recommended daily doses of opoid analgesics containing acetaminophen or aspirin.

Based on data from the first quarter of 2007, 553 members in Pennsylvania and Delaware were identified as having issues of potential overuse of prescriptions. We looked at the same 553 members in the fourth quarter of 2007 and found that only 179 of them still met the criteria — *a 68 percent improvement*.

One member was initially receiving prescriptions from 12 different providers. In the follow-up period, it was determined that a single provider is now managing the member for these medications.

These initiatives will continue in 2008 in order to promote appropriate medication management for improved health outcomes.

Partners in Health Update is a publication of the Provider Communications department for the exchange of information and ideas among the IBC provider community. Suggestions are welcome.

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

Not all benefit plans use Magellan Behavioral Health, Inc. to administer behavioral health benefits. Please check the back of the member's ID card for the telephone number to contact for behavioral health services, if applicable.

The third-party websites mentioned in this publication are maintained by organizations over which IBC exercises no control, and accordingly, IBC 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 presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefit plans. Members should refer to their benefit contract for complete details of the terms, limitations, and exclusions of their coverage.

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FutureScripts and FutureScripts Secure are independent companies that provide pharmacy benefit management services.

IMPORTANT RESOURCES

View our online provider directories on www.ibx.com

CARE MANAGEMENT AND COORDINATION Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
CONNECTIONS℠ HEALTH MANAGEMENT PROGRAMS Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ AccordantCare™ Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/anti-fraud
CREDENTIALING Credentialing Hotline Credentialing Violation Hotline	www.ibx.com/credentials 215-988-6534 215-988-1413
eBUSINESS Help Desk	215-241-2305
FutureScripts® Prescription Drug Authorization Toll Free Fax	 1-888-678-7012 1-888-671-5285
Direct Ship Injectable Fax	1-888-678-7012 215-761-9165
Blood Glucose Meter Hotline	1-888-678-7012
FutureScripts® Secure Medicare Part D	1-888-678-7015
HEALTH RESOURCE CENTER Healthy Lifestyles℠	215-241-3367 1-800-275-2583*
Precertification	215-241-2100 1-800-227-3116*
PROVIDER MEDICAL POLICY WEB PAGE	www.ibx.com/medpolicy
PROVIDER NETWORK eSERVICES NaviNet® Portal Registration EDI Claim Registration	www.ibx.com/providers/navinet/index.html 215-640-7410
PROVIDER PHARMACY WEB PAGE	www.ibx.com/provider_rx
PROVIDER SERVICES (Policies/Procedures/Claims) HMO	215-567-3590 1-800-227-3119*
PPO	215-567-3694 1-800-332-2566*
PROVIDER SUPPLY LINE	1-800-858-4728

* Outside 215 area code

Visit our website: *www.ibx.com/providers/communications*