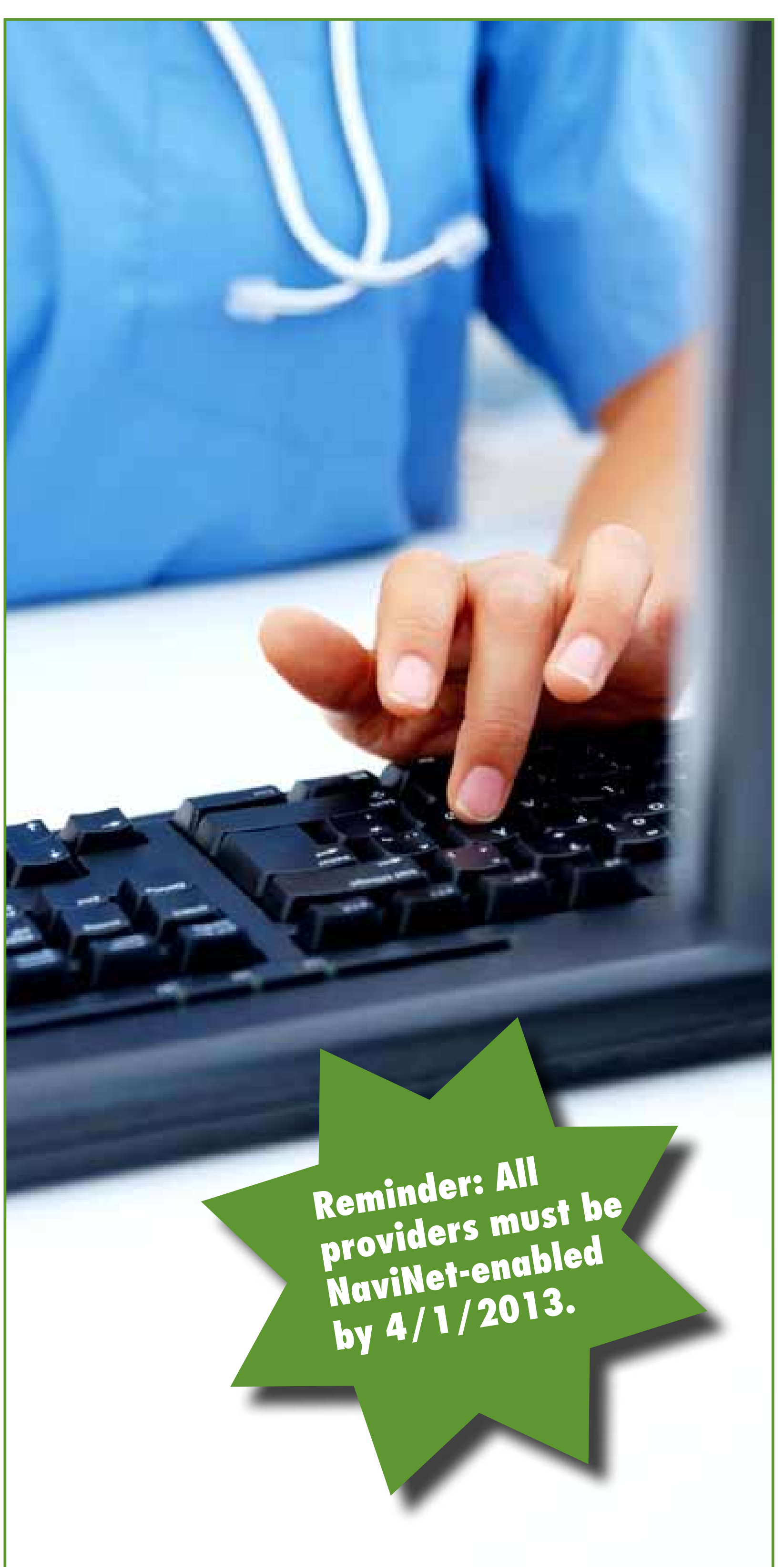
Independence

Partners in Health UPDATE[SM]



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An updated *Provider Manual* coming soon

The latest revision of the *Provider Manual for Participating Professional Providers (Provider Manual)* will be available soon through the NaviNet® web portal. The manuals are located in the Current Publications section of IBC Plan Central. Please note that going forward, the *Provider Manual* will be updated monthly, as needed, to reflect changes to important information regarding our policies, procedures, and programs previously communicated through *Partners in Health Update*.

The *Provider Manual* is available as easy-to-navigate PDFs that are organized into color-coded sections. Within each section are links to important information, such as forms and reference material, with a simple click of your mouse.

If you do not have access to NaviNet, you may request a print version of the *Provider Manual* through the Provider Supply Line order form at www.ibx.com/providersupplyline or by calling 1-800-858-4728.

Reminder: All providers must be NaviNet-enabled by 4/1/2013.

Personal Choice®, Keystone 65 HMO, and Personal Choice 65℠ PPO have an accreditation status of *Excellent* from the National Committee for Quality Assurance (NCQA).

Keystone Health Plan East has an accreditation status of *Commendable* from NCQA.

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

Professional

Facility

Ancillary

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.

Contact information:

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

The third-party websites mentioned in this publication are maintained by organizations over which 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 are presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefits plans. Members should refer to their benefits contract for complete details of the terms, limitations, and exclusions of their coverage.

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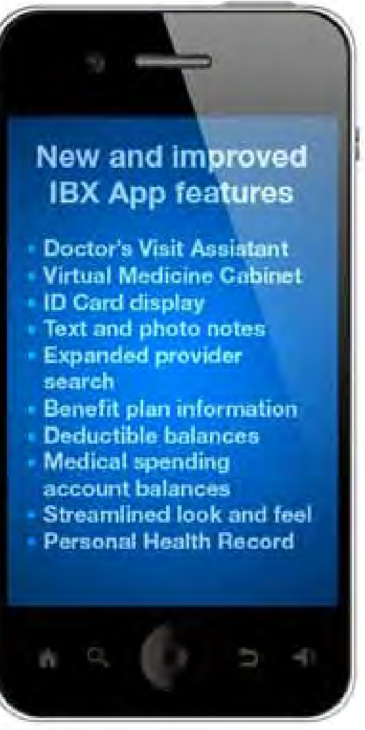
Enhanced IBX App offers Doctor's Visit Assistant

We recently released an enhanced version of our IBX App* for iPhone and Android-powered phones and devices. It features new and improved tools, including the new Doctor's Visit Assistant, that will help members manage their health more effectively.



Doctor's Visit Assistant

Our new Doctor's Visit Assistant tool allows members to view open referrals, track their prescribed medications, fax or email a copy of their ID card to your office (if they've lost or forgotten theirs), and more.

The Notes feature of this tool enables members to write down questions and upload photos in preparation for an appointment in order to maximize their interaction with you. Members can also record reminders during their appointment that can aid them in following your instructions and recommendations.

Other enhancements

The IBX App now features expanded provider search capabilities and now includes participating Patient-Centered Medical Homes, urgent care providers, hospitals, and pharmacies. The app also features access to benefits information, deductible and medical spending account balances, contact information, improved login/password management, and an updated user interface that makes it easier for members to manage their health on the go.

Download the IBX App

We hope you will recommend this app to your IBC patients, especially those who may need assistance in taking notes on conditions or managing their prescriptions. The IBX App works with both iPhone and Android-powered phones and devices. To download the IBX App, members can visit *www.ibx.com/mobile* or search for "IBX" in the Apple or Android store.

**To access this mobile application, users must read and accept IBC's and third-party vendors' respective Privacy Policy/Terms and Conditions of Access.*

ANNOUNCEMENTS

New network of vision care providers available for IBC members

Visionworks®, an independent company, is a leading provider of eye care services with more than 570 optical retail stores nationwide. Members who have IBC vision coverage or other vision insurance benefits can take advantage of Visionworks as an addition to the Davis Vision® network of 35,000 access point, including doctors of optometry, ophthalmology, and retail chains.

Supporting IBC's commitment to customer choice, Visionworks enhances the existing blended network of private practitioners and optical retail chains to meet the diverse health and vision needs of both employers and employees.

Visionworks stores offer members a one-stop shopping experience to help meet their vision care needs for items like designer and exclusive brand name frames, lenses, contacts, sunglasses, and accessories at competitive prices, along with the leading technology in vision correction. In addition, Visionworks can have most prescription lenses ready in about an hour in their in-store labs.

Visionworks also serves our community by providing preventive health services like free vision screenings. Keep an eye out for new Visionworks stores throughout the Greater Philadelphia and Southern New Jersey regions.

Administered by Davis Vision, an independent company.

An affiliate of Independence Blue Cross has a financial interest in Visionworks.

ADMINISTRATIVE

Complete your compliance training for Medicare programs

IBC is committed to compliance with the Medicare Advantage Program, as required by the Centers for Medicare & Medicaid Services (CMS).

As a provider of health care services for IBC Medicare Advantage HMO and PPO members, you and your staff are expected to comply with CMS requirements by completing Medicare compliance training on an annual basis.

IBC is providing you and your staff with access to training materials, which are available on our website at *www.ibx.com/compliance_training*.

We recognize that many providers may have already completed compliance training through another organization. You and your staff must complete the training provided by IBC, or a similar Medicare compliance training that meets CMS requirements, within 90 days of hire and then annually thereafter. We suggest that you and your staff maintain records of completion.

If you have questions about Medicare compliance training, please contact your Network Coordinator.

Investigations and audits help reduce health care fraud, waste, and abuse

The Corporate and Financial Investigations Department (CFID) at IBC continues to address the rising cost of health care by identifying, investigating, and reporting suspicious cases of fraudulent and abusive practices to law enforcement authorities. In addition, CFID is responsible for conducting audits of billing activity for facility, professional, and ancillary service providers.

During 2012, CFID received over 1,000 allegations of fraud, waste, abuse, or aberrant billing practices. More than 75 investigations were initiated. Audits were conducted on 148,266 hospital claims, 349 professional providers, 2,791 pharmacy drug utilization desk audits, and 377 pharmacy retail sites.

Evidence gathered through these investigations resulted in 38 referrals to law enforcement or regulatory authorities. Grand Jury indictments and the filing of criminal information charges were brought against eight individuals. In addition, 16 guilty pleas or convictions resulted in sentences ranging from probation to 72 months incarceration.

The fraud schemes most often used were:

- billing for services not rendered;
- up-coding procedure codes in order to receive higher reimbursement;
- submission of false claims;
- prescription fraud.

The investigations and audits performed or facilitated by CFID in 2012 resulted in approximately $69 million in recoveries of overpaid claims, with an additional $4.2 million identified but not yet recovered. Over the last ten years, CFID has recovered more than $476 million in overpaid claims.

Based partially on the positive national reputation achieved by CFID, IBC was one of four Blue Cross® Blue Shield® Plans asked to participate in a joint federal government, state agency, and private sector Health Care Fraud Prevention Partnership to help address the rising cost of health care in America.

Questionable billing and coding practices and trends identified during 2012 will result in increased audits in 2013 in the following areas:

Facility provider audits

- Credit balance audits correct overpayments that can adversely affect balance sheets of both IBC and its hospital providers.
- DRG audits focus on the correct coding of documented medical information by analysis of medical records for inpatient claims.
- IBC medical policy audits ensure that facilities are aware of and follow IBC medical and claim payment policies as they pertain to our members.
- Outpatient fee schedule audits select claims for review based on either government edits or on those procedure codes that have been identified as frequently miscoded and incorrectly billed.
- Readmission audits pertain to an unplanned inpatient hospital admission within three days of discharge from a previous inpatient hospital stay and for a condition directly related to the original inpatient hospital stay.

Professional provider audits

- New patient evaluation and management (E&M) code audits verify that a member has not received a new patient E&M service within the past three years from multiple physicians of the same specialty in the same group.
- Single- versus multiple-unit audits ensure that the correct units are billed, as defined for CPT® codes.
- High-dollar medication audits focus on high-dollar medications that are administered in a physician's office to ensure the accuracy of claims billed.
- Duplicate billing audits ensure that duplicate claims are denied appropriately.

continued on the next page

Investigations and audits help reduce health care fraud, waste, and abuse (continued)

- Split-billing audits look at claims for the same member, from the same provider, for the same date of service and visit.
- Modifier 25 audits look at E&M codes billed with modifier 25 on the same day as preventive medicine codes were billed. This process ensures that the E&M service was for a significant and separately identifiable service from the preventive medicine service.
- Inpatient and outpatient E&M service audits ensure that appropriate levels are billed and paid, including consultation codes and the use of modifiers 24 and 25 with E&M claims submissions.
- Office site-of-service audits ensure that services receiving a site-of-service differential were rendered and billed in the office where the service took place.

Although CFID's ongoing efforts are effective, we still need your help. The sophisticated software data-mining tools used and our toll-free hotline provide valuable leads, but there is no substitute for your vigilance. Allegations received from our provider community are extremely valuable; therefore, we ask you to continue to contact CFID if you are suspicious of any questionable health care activity.

You can contact us by calling our toll-free Corporate Compliance and Fraud Hotline at 1-866-282-2707 or by going to *www.ibx.com/antifraud* and filing an electronic report.

2013 medical chart reviews

As part of our efforts for Health Care Reform, IBC recently launched the 2013 Medical Chart Review Program for our commercial and Medicare Advantage HMO and PPO benefit plans. The purpose of this program is to validate our claims coding and submission processes with the objective of better understanding the health status of members. We have contracted with Inovalon, Inc., an independent company, to gather records for these reviews.

As both a commercial health insurer and Medicare Advantage Managed Care Organization, IBC is required to meet standards set forth by the Centers for Medicare & Medicaid Services and the U.S. Department of Health and Human Services.

If you are selected to participate, an Inovalon representative will contact you to share details about these reviews and to determine the most appropriate method of retrieving charts from your practice.

The methods of retrieving the charts from your practice include the following options:

- Inovalon can schedule the most appropriate time for providers for an onsite chart retrieval.
- You can send a secure fax of the medical records to 1-877-221-0604.
- You can mail copies of the medical records to the address listed in the letter you may receive.

We appreciate your assistance in this important program. If you have any questions about this initiative, please call Customer Service at 1-800-ASK-BLUE.

Upcoming process change for the review of emergency admissions

Effective April 1, 2013, IBC's Care Management and Coordination (CMC) department is changing the process for the review of emergency admissions following notification through the NaviNet® web portal.

CMC will no longer remind hospitals to provide clinical information to complete the medical necessity review for authorization and payment. Hospitals will need to provide the clinical information to CMC within two business days of notice to complete authorization. Failure to provide clinical information to CMC in a timely fashion may delay reimbursement.

Upon completing the notice of the emergency admission, hospitals will receive a modified NaviNet message as a reminder to submit clinical information to complete authorizations. Hospitals may also refer to NaviNet to confirm the status of any authorization. To do so, select *ER Admission Notification* from the *Authorizations* option in the Plan Transactions menu.

If you have any questions about this change in procedure, please contact Marianne Brown, Manager of Utilization Management at 215-241-4655.

New Independence Administrators mailing address

Independence Administrators' mailing address has changed. As we transition to the new address, some plan member ID cards may still show the old address. Please update your records and send paper claims and correspondence to the new address listed below.

Independence Administrators
P.O. Box 21974
Eagan, MN 55121

This change does not affect electronically submitted claims.

Reminder: Provider self-service requirements

As previously communicated, providers must use the NaviNet® web portal or the Provider Automated System when requesting member eligibility.

In addition, providers must use NaviNet or call the Provider Automated System to check claims status information. The claim detail provided through either system includes specific information, such as check date, check number, service codes, paid amount, and member responsibility.

Reminder: All providers must be NaviNet-enabled by 4/1/2013.

Providers can view a webinar at *www.navinet.net/intro_pss_ibc* for more information on these requirements. The presentation offers guidance on where to obtain member eligibility and claims status information through NaviNet. If your office is currently NaviNet-enabled but would like assistance with accessing member or claims information, please call the eBusiness Provider Hotline at 215-640-7410.

Providers without access to NaviNet must obtain eligibility and claims status information through the Provider Automated System by calling 1-800-ASK-BLUE and following the voice prompts. *Note:* Per upcoming NaviNet requirements, you must register by April 1, 2013. To register, please visit *www.navinet.net* and select *Sign Up* from the top right.

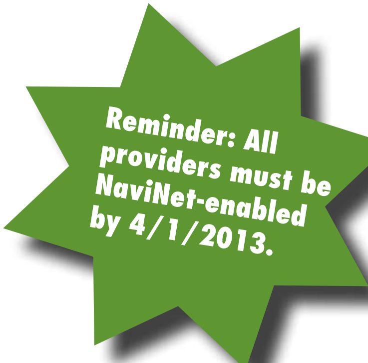
Administrative

Reminder: Upcoming NaviNet® requirements

In the past few years we have instituted a number of provider self-service requirements, where providers must use the NaviNet web portal or the Provider Automated System to obtain certain information, such as member eligibility. Over the next several months, we will be introducing a series of new initiatives and announcing changes to existing initiatives that will require providers to solely use NaviNet.

In preparation for these upcoming initiatives, providers who are not yet NaviNet-enabled *must* register no later than **April 1, 2013.** To register, go to *www.navinet.net* and select *Sign Up* from the top right. If you have questions regarding the registration process or the NaviNet requirement in general, please call the eBusiness Provider Hotline at 215-640-7410.

Look for additional information about these upcoming initiatives in future editions of *Partners in Health Update*.



Billing

Updated payer ID grids now available

The professional and facility payer ID grids were recently updated with the following changes:

- A new alpha prefix was added for account-specific National BlueCard® PPO members.
- The mailing address for Independence Administrators has been changed.
- Several new prefixes for Independence Administrators were added.

Please be sure to use the most current version of the payer ID grids, which are available on our website at *www.ibx.com/edi*.

Changes to billing procedures for nutrition counseling are now in effect

As previously communicated, most commercial managed care members are eligible for up to six fully covered one-on-one nutrition counseling sessions with a registered dietitian or primary care provider per benefit contract year. In the original communication about this benefit in the June 2007 edition of *Partners in Health Update,* group counseling sessions were mistakenly included in the eligible list of codes. This benefit, however, was intended only to be provided in an individual setting — not in a group setting.

Therefore, nutrition counseling in a group setting is no longer eligible for payment for dates of service on or after March 1, 2013. Providers should no longer bill for medical nutrition therapy in a group setting with the following codes: 97804, G0271. Only diabetic education services are eligible for payment in a group setting with these codes.

Note: Members do not need to obtain a referral for nutrition counseling services.

Prescription drug updates

For 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
Aubagio®	Not available	Pain, Nervous System, & Psych	September 28, 2012
Qsymia™	Not available	Diagnostics & Miscellaneous	September 7, 2012
Stivarga®	Not available	Cancer & Organ Transplant Drugs	September 28, 2012

The following prior authorization requirements for the following non-formulary drugs are effective at the time indicated below:

Brand drug	Generic drug	Drug category	Effective date
Solodyn®	Not available	Antibiotics & Other Drugs Used for Infection	April 1, 2013
Xyrem®	Not available	Pain, Nervous System, & Psych	April 1, 2013

Drug with quantity limits

Quantity limits will be added for the following drug:

Effective April 1, 2013.

Brand drug	Generic drug	Drug category	Quantity limit (per 30 days)
Xyrem®	Not available	Pain, Nervous System, & Psych	540ml

Select Drug Program® Formulary updates

The Select Drug Program Formulary is a list 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
cevimeline hcl	Evoxac®	16. Diagnostics & Miscellaneous Agents	October 12, 2012
entacapone	Comtan®	3. Pain, Nervous System, & Psych	September 28, 2012
mb hydrogel	Aurstat™	5. Skin Medications	October 12, 2012
methylphenidate hcl	Metadate CD®	3. Pain, Nervous System, & Psych	September 28, 2012
tiagabine hcl	Gabitril®	3. Pain, Nervous System, & Psych	October 26, 2012
trospium chloride	Sanctura XR®	14. Urinary & Prostate Meds	October 19, 2012
valsartan/hydrochlorothiazide	Diovan HCT®	4. Heart, Blood Pressure, & Cholesterol	September 28, 2012

Brand additions

These brand drugs were added to the formulary and are covered at the appropriate brand formulary level of cost-sharing:

Brand drug	Formulary chapter	Effective date
Stribild™	1. Antibiotics & Other Drugs Used for Infection	August 30, 2012
Vytorin®	4. Heart, Blood Pressure, & Cholesterol	January 1, 2013

Brand deletions

These brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

Effective April 1, 2013.

Brand drug	Generic drug	Formulary chapter
Diovan HCT®	valsartan/hydrochlorothiazide	4. Heart, Blood Pressure, & Cholesterol
Levaquin®	levofloxacin	1. Antibiotics & Other Drugs Used for Infection
Nardil®	phenelzine sulfate	3. Pain, Nervous System, & Psych
Neurontin Solution®	gabapentin solution	3. Pain, Nervous System, & Psych
Vfend®	voriconazole	1. Antibiotics & Other Drugs Used for Infection
Xalatan®	latanoprost	12. Eye Medications

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

Upcoming changes to our home oxygen therapy policy

Home oxygen therapy is most commonly used to treat chronic, stable medical conditions that cause significant hypoxemia, such as severe lung disease (e.g., chronic obstructive pulmonary disease [COPD], interstitial fibrosis, cystic fibrosis, pulmonary neoplasm), pulmonary hypertension, and congestive heart failure related to cor pulmonale. Appropriate evidence of significant hypoxemia includes arterial blood gas studies, pulse oximetry, and certain clinical signs, such as elevated pulmonary artery pressure, dependent edema, and polycythemia vera.

Home oxygen therapy may be delivered via nasal cannula, face mask, or transtracheal catheter. Supply sources include a stationary or portable compressed gas tank, stationary or portable liquid oxygen tank, or stationary oxygen concentrator.

Our current Medical Policy #05.00.58e: Home Oxygen Therapy will be updated as outlined below, and revised Medical Policy #05.0058f will become **effective April 1, 2013.**

The following policy criteria have been **revised:**

Group 1 Criteria

Current policy	Revised policy (effective April 1, 2013)
The individual demonstrates a decrease in arterial PO_2 more than 10 mmHg or a decrease in arterial oxygen saturation more than 5 percent for at least five* minutes during sleep associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, P-pulmonale on electrocardiogram [P-wave greater than 3 mm in standard leads II, III, or AVF], documented pulmonary hypertension, polycythemia vera).	The individual demonstrates a decrease in arterial PO_2 greater than 10 mmHg or a decrease in arterial oxygen saturation greater than 5 percent from baseline for at least five* minutes during sleep that is associated with any of the following signs and symptoms attributable to hypoxemia: • Nocturnal restlessness • Insomnia • Cor pulmonale • “P” pulmonale on electrocardiogram (EKG) • Documented pulmonary hypertension • Erythrocytosis

**For all the sleep oximetry criteria described above, the five minutes do not have to be continuous.*

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Upcoming changes to our home oxygen therapy policy (continued)

Prescription renewal

Current policy	Revised policy (effective April 1, 2013)
A revised prescription for home oxygen therapy is required in any of the following situations: • When the prescribed maximum flow rate changes from one of the following categories to another: – Less than 1 LPM – 1 – 4 LPM – Greater than 4 LPM – If the change is from less than 4 LPM to greater than 4 LPM, a repeat blood gas study with the individual on 4 LPM must be performed. • If the physician specified less than lifetime length of need on the most recent CMN, and this length of need has expired. • When a portable oxygen system is added subsequent to the initial certification of a stationary system. • When a stationary system is added subsequent to the initial certification of a portable system. • When there is a new treating physician but the oxygen order is the same. • A change in a DME provider who does not have the prior prescription.	A revised prescription for home oxygen therapy is required in any of the following situations: • When the prescribed maximum flow rate changes from one of the following categories to another: – Less than 1 LPM – 1 – 4 LPM – Greater than 4 LPM – If the change is from less than 4 LPM to greater than 4 LPM, a repeat blood gas study with the individual on 4 LPM must be performed. A blood gas study must be the most recent study obtained within 30 days prior to the initial date. • If the physician specified less than lifetime length of need on the most recent CMN, and this length of need has expired. A blood gas study must be the most recent study obtained within 30 days prior to the initial date. • When a portable oxygen system is added subsequent to the initial certification of a stationary system. There is no requirement for a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the beneficiary is at rest (awake) or during exercise within 30 days prior to the revised date. • When a stationary system is added subsequent to the initial certification of a portable system. • When there is a new treating physician but the oxygen order is the same. • A change in a DME provider who does not have the prior prescription.

The following policy criteria have been **added:**

- **Recertification in other scenarios:**
  - For replacement equipment, repeat testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the initial date. It can be the test reported on the most recent certification.
  - There is no requirement for a physician visit related to the certification for replacement of equipment.

To view our medical policies, go to *www.ibx.com/medpolicy*. For questions or additional information related to our home oxygen therapy policy, please contact your Network Coordinator.

Policy notifications posted as of February 28, 2013

All policies are posted prior to their effective date. Below is a listing of the policy notifications that we have posted to our website as of February 28, 2013.

Policy effective date	Policy No.	Notification title	Notification issue date
February 25, 2013	07.08.03	Medical and Surgical Treatment of Temporomandibular Joint Disorder	November 27, 2012
March 5, 2013	11.14.26	Surgical Treatments of Athletic Pubalgia	December 5, 2012
March 29, 2013	08.01.05	Carfilzomib (Kyprolis™)	February 27, 2013
March 29, 2013	08.01.09	Omacetaxine mepesuccinate (Synribo®)	February 27, 2013
April 1, 2013	05.00.58f	Home Oxygen Therapy	February 28, 2013
April 2, 2013	11.14.08c	Orthognathic Surgery	January 2, 2013
April 2, 2013	08.00.81b	Bendamustine Hydrochloride (Treanda®)	January 2, 2013
April 2, 2013	11.14.03e	Meniscal Allograft Transplantation	January 2, 2013
April 4, 2013	08.00.25g	Treatment of Pulmonary Artery Hypertension with Intravenous, Subcutaneous and Inhaled Pharmacologic Agents Intended for Home Use	January 4, 2013
April 16, 2013	07.02.07g	Ambulatory, Real-Time Cardia Surveillance System	January 16, 2013
April 16, 2013	11.05.02g	Blepharoplasty, Repair of Blepharoptosis, Repair of Brow Ptosis, and Canthoplasty/Canthopexy	January 16, 2013
April 17, 2013	11.15.09d	Denervation of the Spinal Nerves for Chronic Facet Pain	January 17, 2013

To view the policy notifications, go to www.ibx.com/medpolicy, select *Accept and Go to Medical Policy Online,* and click on the *Policy Notifications* box. You can also view policy notifications using the NaviNet® web portal by selecting *Reference Tools* from the Plan Transactions menu, then *Medical Policy.* Once these policies are in effect, they will be available by using the Search box on the Medical Policy homepage. Be sure to check back often, as the site is updated frequently.

Putting ICD-10 into Practice: Coding exercises and scenarios

ICD | 10

More codes • More detail • Improved accuracy℠

In preparation for the transition to ICD-10, each month IBC will include an article called *Putting ICD-10 into Practice: Coding exercises and scenarios* in *Partners in Health Update*. This feature will help you put the new guidelines and conventions you learned about last year into practice. If needed, use the *ICD-10 Spotlight: Know the codes* booklet for assistance with these exercises. An answer key is provided below so you can verify if your answers are correct. In addition, a list of code narratives is included to describe each ICD-10 code.

Coding exercises

Code the following conditions according to ICD-10 coding conventions and guidelines:

1. Routine infant or child health check
2. Acquired loss of teeth due to trauma, partial
3. Influenzal myocarditis
4. Elevated fasting triglycerides
5. Hungry bone syndrome
6. Primary open-angle glaucoma, moderate stage in left eye and mild stage in right eye
7. Dorsal somatic dysfunction
8. Invasive ductular carcinoma of breast, completely excised
9. Decompensated COPD with (acute) exacerbation
10. Concussion without loss of consciousness, initial encounter with neck pain

Coding scenario

Code the following scenario according to ICD-10 coding conventions and guidelines:

A 16-year-old student was at the gymnasium participating in a dancing contest to raise money for her class. She slipped on the gym floor and fell, injuring her left ankle. After she visited the emergency room, it was determined that she did not fracture her ankle. However, she did suffer a sprain to that ankle.

Answers to coding exercises:

1) Z00.129 2) K08.419 3) J10.89 4) E78.1 5) E83.81 6) H40.11x2, H40.11x1 7) M99.01 8) C50.412 9) J44.1 10) S06.0x0A, M54.2

Answer to coding scenario:

S93.402A, W01.0xxA, Y92.39, Y93.41, Y99.2

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Putting ICD-10 into Practice: Coding exercises and scenarios

ICD | 10
More codes • More detail • Improved accuracy™

Narratives

The following are the corresponding code narratives for each of the ICD-10 codes in the answer key for the coding exercises and coding scenarios:

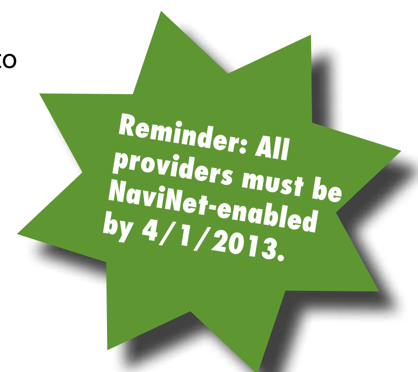
ICD-10 code	Code narrative
Z00.129	Encounter for routine child health examination without abnormal findings
K08.419	Partial loss of teeth due to trauma, unspecified class
J10.89	Influenza due to other identified influenza virus with other manifestations
E78.1	Pure hyperglyceridemia
E83.81	Hungry bone syndrome
H40.11x2	Primary open-angle glaucoma, moderate stage
H40.11x1	Primary open-angle glaucoma, mild stage
M99.01	Segmental and somatic dysfunction of cervical region
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
S06.0x0A	Concussion without loss of consciousness, initial encounter
M54.2	Cervicalgia
S93.402A	Sprain of unspecified ligament of left ankle, initial encounter
W01.0xxA	Fall on same level from slipping, tripping, and stumbling without subsequent striking against object, initial encounter
Y92.39	Other specified sports and athletic area as the place of occurrence of the external cause
Y93.41	Activity, dancing
Y99.2	Volunteer activity

For additional information related to the IBC transition to ICD-10, please visit *www.ibx.com/icd10*. On this site you will find examples of how ICD-9 codes will translate to ICD-10 codes in the *ICD-10 Spotlight: Know the codes* booklet. In addition, you will find examples of ICD-10 coding exercises and scenarios in the *Putting ICD-10 into Practice: Coding exercises and scenarios* booklet.

Coming soon: The Comparative Procedure Costs tool on the NaviNet web portal

IBC recognizes the increasing demand and interest to understand the cost of health care services, along with the importance of a shared collaboration between members and providers in helping members better understand their health care options. We are excited to announce a new tool designed to offer an interactive environment where IBC-participating primary care physicians (PCPs) in the Pennsylvania five-county service area can review cost information and become better informed about facility cost ranges for select outpatient services. This tool will also assist participating PCPs in maximizing their performance under IBC's Quality Incentive Payment System (QIPS) program. We will later expand this tool to include participating specialists and hospitals in support of IBC's accountable care payment model — the Integrated Provider Performance Incentive Plan (IPPIP).

A new transaction — called Population Management Tools — will soon be added to NaviNet. It allows IBC-participating PCPs in the Pennsylvania five-county service area to access the new Comparative Procedure Costs tool. This tool will provide network cost ranges and provider-specific relative cost rankings for a menu of treatment categories. These rankings, which will be displayed at the facility level, are based on the historical total cost of each encounter based on the contracted facility and professional costs. Future enhancements to this tool will include additional treatment categories.



Look for instructions on how to access and use the new tool in future editions of *Partners in Health Update*.

NaviNet Claim INFO Adjustment requirement

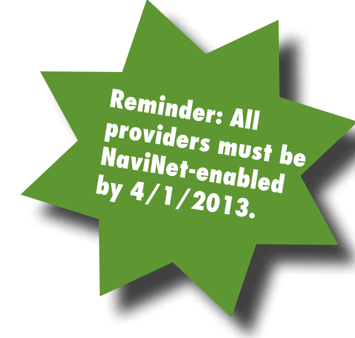
In 2011 we introduced our provider self-service initiative, which requires providers to use our automated tools for member eligibility and claim status inquiries. We are now expanding the provider self-service requirements to include questioning of claim payment or to request a claim adjustment. This requirement is already in place for primary care physicians who participate in the Quality Incentive Payment System (QIPS) program and will apply to all participating providers including those contracted with Magellan Behavioral Health, Inc. for PPO business.

Effective May 1, 2013, providers who call Customer Service to question claim payment or to request a claim adjustment will be directed to submit the request via the NaviNet web portal. NaviNet offers the Claim INFO Adjustment transactions to ensure your claim adjustment requests are addressed in the most efficient manner available.

The Claim INFO Adjustment Submission transaction allows ancillary, facility, and professional providers to submit adjustment requests or question claim payment for paid or denied claims for a period of up to 18 months after adjudication of the original claim or as required by law. Each submission is assigned a unique adjustment identification (ID) number. You will be able to access IBC's response within ten business days through the Claim INFO Adjustment Inquiry transaction. You may call Customer Service if you do not receive a response within ten business days of the submission. Please have your adjustment ID number available as this information will be required when you call.

To access the Claim INFO Adjustment Submission transaction, select *Claim Inquiry and Maintenance* from the Plan Transactions menu. Detailed user guides for this transaction are available on our Plan Central page under Administrative Tools & Resources.

If your office location is not yet registered for NaviNet, you must do so by April 1, 2013. To register, please visit *www.navinet.net* and select *Sign Up* from the top right. If your office is currently NaviNet-enabled, but would like training on how to submit a claim adjustment or retrieve a response to a submitted request through NaviNet, please contact our eBusiness Provider Hotline at 215-640-7410.



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

Reminder: Authorization submission requirements through NaviNet

As previously communicated, providers must use the NaviNet® web portal in order to initiate the following authorization types:

- medical/surgical procedures
- chemotherapy/infusion therapy
- durable medical equipment
- emergency hospital admission notification
- home health (dietitian, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy)
- home infusion
- outpatient speech therapy

Please note that the representatives at the Health Resource Center are no longer able to initiate the authorizations listed above.

Tips for submitting authorizations

NaviNet submissions that result in a pended status can take up to two business days to be completed. These may include requests for additional clinical information as well as requests that may result in a duplication of services. If the authorization remains pended beyond two business days, or if the authorization request is urgent, providers should call 1-800-ASK-BLUE for assistance.

Requests for medical/surgical procedures can be made up to six months in advance on NaviNet, and in most cases, requests for medically necessary care are authorized immediately.

In some instances, providers can modify the date of service previously approved by selecting *Authorizations* from the Plan Transactions menu, and then *Authorization Status Inquiry*.

About NaviNet

For your convenience, NaviNet is available to all participating providers Monday through Saturday, 5 a.m. to 10 p.m., and Sunday, 9 a.m. to 9 p.m. If your office location has not yet registered for NaviNet, you must do so by April 1, 2013. To register, please visit *www.navinet.net* and select *Sign Up* from the top right. If your office is currently NaviNet-enabled and would like training on how to submit authorizations, please call the eBusiness Provider Hotline at 215-640-7410.

Note: This information does not apply to providers contracted with Magellan Behavioral Health, Inc. Magellan-contracted providers should contact their Magellan Network Coordinator at 1-800-866-4108 for authorizations.

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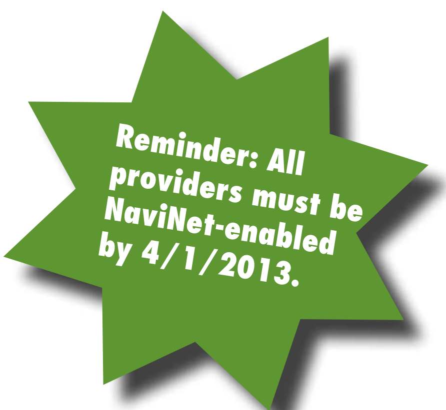

Encourage members to receive colorectal cancer screenings

March is Colorectal Cancer Awareness Month. IBC encourages you to reach out to all of your patients meeting the colon cancer screening criteria to ensure they receive the necessary colon cancer screenings.

Your personal recommendation has a tremendous influence on patients' decisions to seek recommended preventive health screenings, and adherence to the colorectal cancer screening guidelines may lead to improved patient outcomes.

Colorectal cancer is the second leading cause of cancer-related deaths for men and women in the United States. Colon cancer is a highly treatable and possibly curable disease if found in its early stages. We urge you to encourage your patients approaching age 50 (age 45 for African Americans) to be screened for colorectal cancer. Those patients with certain risk factors or family history should be screened earlier, starting at age 40, or ten years younger than the youngest relative diagnosed with colon cancer. New guidelines also recommend that patients with a history of irritable bowel disease, ulcerative colitis, or Crohn's disease be screened ten years after symptoms begin.

Screening options

Screening does not necessarily mean colonoscopy. Although this is the most specific diagnostic screening and should be the screening of choice for high-risk patients, alternative methods such as fecal occult blood test (FOBT) or fecal immunochemical test (FIT) can be used for patients with average risk. Please discuss all screening options with your patients. Individual clinical decisions should be tailored to specific patient medical and psychosocial needs.

To view our plan-adopted guidelines, see Medical Policy #11.03.12j: Colorectal Cancer Screening, available at *www.ibx.com/medpolicy*. The information contained within this policy is adapted from national sources and may evolve rapidly. As changes occur, please update your recommendations accordingly.

Important Resources

Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/antifraud
Care Management and Coordination Case Management	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℠ Complex Care Management Program	1-800-313-8628
Connections℠ Provider Portal	www.hdproviderportal.com/ibc
Credentialing Credentialing Violation Hotline	215-988-1413 www.ibx.com/credentials
Customer Service/Provider Services • Provider Automated System (eligibility/claims status/referrals) • Connections Health Management Programs • Precertification/maternity requests — Imaging services (CT, MRI/MRA, PET, and nuclear cardiology) — Authorizations	1-800-ASK-BLUE (275-2583)
Provider Services user guide	www.ibx.com/providerautomatedsystem
eBusiness Help Desk	215-241-2305
FutureScripts® (pharmacy benefits) Prescription drug prior authorization Fax	1-888-678-7012 1-888-671-5285
Direct Ship Specialty Pharmacy Program Fax	1-888-678-7012 1-888-671-5285
Mail order program toll-free fax	1-877-228-6162
Blood Glucose Meter Hotline	1-888-678-7012
Pharmacy website (formulary updates, prior authorization)	www.ibx.com/rx
FutureScripts® Secure (Medicare Part D)	1-888-678-7015
Formulary updates	www.ibxmedicare.com
Mail order program toll-free fax	1-877-344-1318
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 www.ibx.com/providersupplyline

** Outside 215 area code*

Visit our website:
www.ibx.com/pnc