Independence Blue Cross

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PARTNERS IN HEALTH UPDATE

May 2008

Working Together For Quality Health Care

Medicare claims address changes for paper claims submissions

A change was made recently to the claims mailing addresses for Keystone 65, Personal Choice 65℠, and Select Advantage. The new claims mailing addresses are as follows:

Keystone 65
P.O. Box 69353
Harrisburg, PA 17106-9353

Personal Choice 65
P.O. Box 69352
Harrisburg, PA 17106-9352

Select Advantage
P.O. Box 69350
Harrisburg, PA 17106-9350

Please begin to use these new addresses for all your future paper claims submissions, and share this information with the person who handles billing for your office.

Contact your Network Coordinator with questions.

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

- Professional
- Facility
- Ancillary

INSIDE THIS ISSUE

NATIONAL PROVIDER IDENTIFIER (NPI)

Beginning May 23, 2008, claims submitted without a valid, registered NPI will reject

NPIs must be registered with IBC

You must register your National Provider Identifier (NPI) with IBC prior to submitting claims.* Beginning **May 23, 2008,** claims will reject if you have not registered your NPI with us. You can register your NPI with IBC 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.

If you are currently submitting claims with an NPI *and* a 10-digit legacy identifier, we have been able to accept your claims into our system consistent with our contingency plan. However, as of May 23, 2008, in accordance with the CMS mandate, providers must use the NPI as the primary identifier on the claim, and IBC will reject claims with invalid NPIs on or after this date.

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.*

More information regarding NPI, including IBC's NPI contingency plan, previous communications, FAQs, and additional resources, is 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.*

BILLING

IBC rejecting paper claims submitted on forms CMS-1500 (12/90) and UB-92

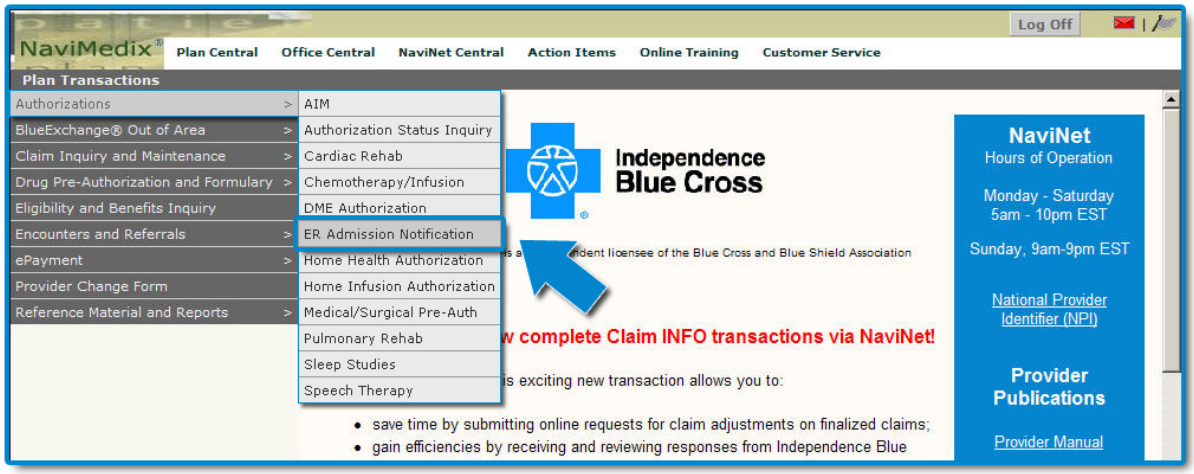
IBC no longer accepts paper claims submitted on forms CMS-1500 (12/90) and UB-92. All paper claims received after December 17, 2007, must be submitted on revised forms CMS-1500 (08/05) and UB-04. Paper claims submitted on forms CMS-1500 (12/90) and UB-92 will reject.

Use NaviNet® ER Admission Notification transaction for emergent admission notification

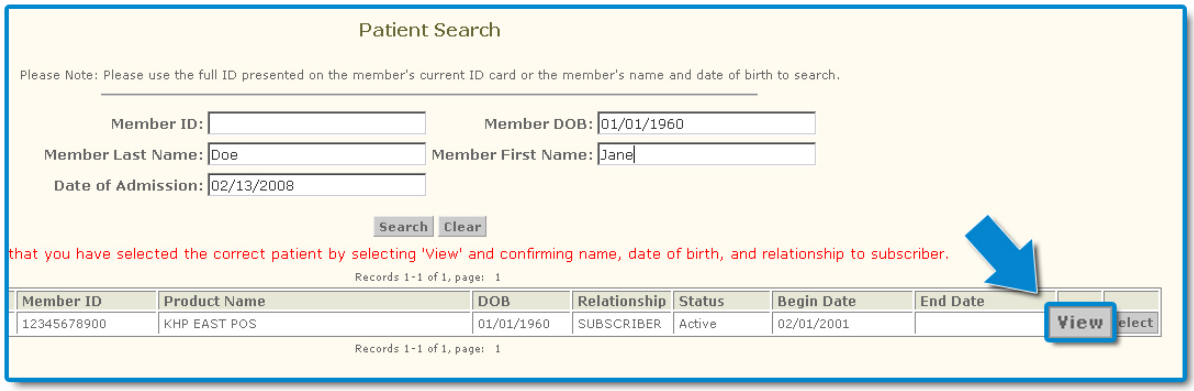
The *ER Admission Notification* transaction allows facility providers to submit emergent admission notifications to our Care Management and Coordination (CMC) department. Facility providers are asked to submit this notification within 48 hours of the member's admission to the hospital. Immediately upon submission, the information entered is downloaded to the authorization system and is available to the CMC team.

Please follow these steps to use the feature:

1. Select *Authorizations* (under Plan Transactions) from the left navigation menu.
2. Select *ER Admission Notification* to initiate the transaction.



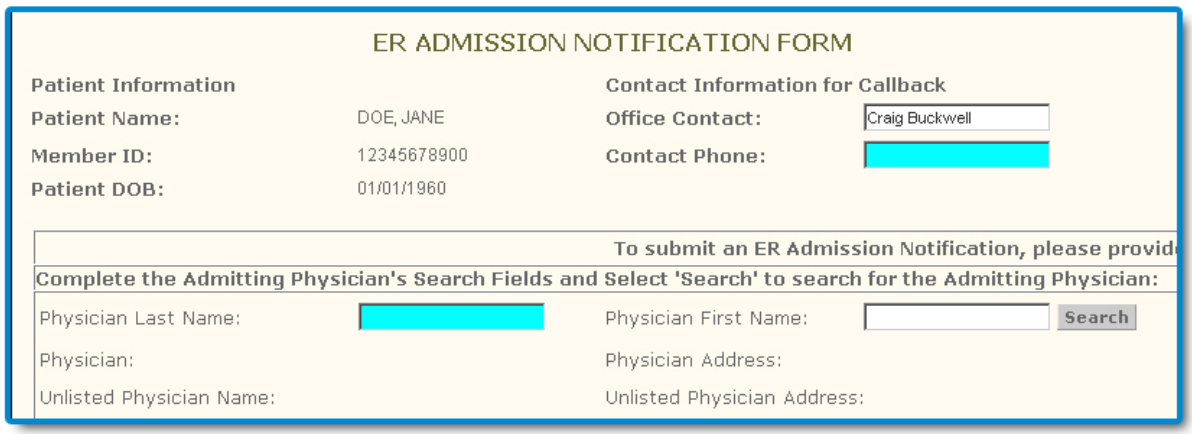
Selecting the appropriate member record is critical when submitting an ER Admission Notification and will allow CMC to process requests more efficiently. NaviNet users can review a more detailed view of the member's record by selecting *View* on the *Patient Search* screen. By verifying key pieces of information (i.e., name, date of birth, and address), HIPAA violations can be avoided and claims can be paid correctly.



continued on page 4

Use NaviNet® ER Admission Notification transaction for emergent admission notification (continued)

After the user verifies that the correct member record has been chosen, simply click *Select Member for Submission* to begin completing the ER Admission Notification form. If a different member record is needed, click *Go To Previous Screen* to initiate a new search.



PRODUCTS

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

The Keystone Direct POS program allows members to see most providers directly *without a referral.* Direct POS requires primary care physician (PCP) referrals only for radiology, physical/occupational therapy, spinal manipulations, and podiatry services. Obtaining a referral for these services ensures that the member receives the highest level of benefit. For laboratory services, members must obtain a laboratory requisition form from their PCP or specialist. Members will be directed to their designated capitated laboratory site for laboratory services. 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 benefit and the lowest out-of-pocket costs.

Keystone's capitated program remains in effect for Direct POS. Similar to our Keystone HMO and POS programs, PCPs must refer Direct POS members to capitated providers for capitated services (i.e., 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 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.
- There are no claim forms for the member to file 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®

Introducing *Inside IPP* — a newsletter for Inter-Plan Program providers

We are pleased to introduce a new quarterly publication, *Inside IPP,* for our facility and ancillary providers. The creation of this newsletter is an IBC initiative to improve provider satisfaction with the BlueCard® Program. Our goal is to improve your awareness of the BlueCard Program and to highlight improvement initiatives.

The publication will contain topics about claims processing and resolution, coordination of benefits, and other valuable information to assist you in providing quality health care services to Blue Plan members.

Inside IPP will be posted at *www.ibx.com/providers/blue_card* each quarter. A new link from the welcome page will contain this new publication, as well as forms and other information specific to the BlueCard Program. Paper copies of *Inside IPP* will be available via the Provider Supply Line upon request.

Please look for more information about this new online publication in future issues of *Partners in Health Update*.

ClaimCheck® offers automated claim evaluation

As of April 14, 2008, ClaimCheck was upgraded from Version 8.5.40 to Version 8.5.41.1. ClaimCheck is a comprehensive code-auditing tool utilized by IBC that provides automated claims evaluation with regard to procedure code editing on CMS-1500 claims. Edits are sourced to nationally accepted authorities, including the American Medical Association, Current Procedural Terminology (CPT®), the Centers for Medicare & Medicaid Services (CMS), and national specialty society recommendations.

In an effort to maintain an enhanced level of transparency, the ClaimCheck notification is being issued to all contracted providers who deliver professional services to IBC members by way of a CMS-1500 or equivalent electronic format. This type of notice is scheduled to be issued twice a year to notify providers of a ClaimCheck upgrade and to familiarize providers with the use of Clear Claim Connection™.

Easy access to a detailed disclosure of ClaimCheck code edits is provided through Clear Claim Connection, which is available 24 hours a day, seven days a week through the NaviNet® provider portal.

For more information, contact your Network Coordinator.

Two new article series now available online: hospice care and teratogenic medications

We are pleased to introduce an online series of articles on two important topics: hospice care and teratogenic medications. These featured articles can be found on our website at *www.ibx.com/providers/communications/featured_articles.*

The first hospice care article in the series, *Offering hope in the face of apparent hopelessness: Hospice enhances end-of-life care,* is a general introduction to hospice services geared toward professional, facility, and ancillary providers. The article, which identifies patient types that may benefit from hospice care, contains information on issues such as:

- When is it too early for hospice?
- How can I best manage pain and other physical symptoms for patients with advanced illness?
- What hospice services are available at home?
- How can I help families struggling with terminal illness?
- How does hospice work with individual cultural and religious beliefs and values?

Read more about hospice care at *www.ibx.com/pdfs/providers/communications/featured_articles/IBC_HospiceCare.pdf.*

The first article in the teratogenic medications series, *Safely prescribing potentially teratogenic medications to women,* provides professional providers with information and resources to assist in decision making about prescriptions for reproductive-age women. This important message is for all physicians, not just OB/GYNs. The article includes topics such as:

- understanding the impact of teratogenic drugs on pregnancy;
- providing education to your patients;
- addressing concerns with your patients.

Read more about issues to consider when prescribing for women this age at *www.ibx.com/pdfs/providers/communications/featured_articles/IBC_TeratogenicMeds.pdf.*

We hope the content will be a valuable tool in helping you to provide the best possible care for our members. *Partners in Health Update* will keep you abreast when each article in the series is available on our website. The information is applicable to both commercial and Medicare products.

MEDICAL

Precertification required for services performed by mobile radiology sites

Skilled nursing facilities (SNFs) are required to obtain precertification for members requiring a mobile radiology site to come to the SNF to perform X-rays and other radiology services. If precertification is not obtained by the SNF, the claim will be denied and the SNF may be financially responsible for services provided to the member.

Contact your Network Coordinator with any questions.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services or via NaviNet®.

POLICY

Septoplasty, rhinoplasty, and septorhinoplasty medical policy #11.16.01d

The medical policy for rhinoplasty and septorhinoplasty #11.16.01c has been revised. **Effective for claims processed on or after August 1, 2008,** we are expanding the scope of the policy to include **septoplasty** as a standalone procedure and clarifying medically necessary indications of nasal and/or septal obstruction for rhinoplasty and septorhinoplasty. We are also modifying the types of documentation required in the individual's medical records to support the need for these procedures. The updated version of this policy now includes the following:

Septoplasty as a standalone procedure

Septoplasty as a standalone procedure is considered medically necessary, and therefore, covered when used to treat any of the following conditions:

- continuous nasal airway obstruction related to septal deformity when both of the following criteria are met:
  - the space between the inferior turbinate and the septum is decreased by a clinical estimate of greater than 50 percent;
  - a three-month minimum trial of conservative medical therapy (e.g., decongestants, nasal spray, corticosteroids) has been ineffective in treating obstruction.
- recurrent sinusitis related to septal deformity
  - documented continued infection after a three-week minimum trial of antibiotics;
- recurrent epistaxis related to septal deformity;
- when performed in association with cleft lip or cleft palate repair.

Rhinoplasty and Septorhinoplasty

Rhinoplasty and septorhinoplasty are now considered medically necessary procedures to correct significant impairment of nasal function caused by continuous nasal and/or septal obstruction when both of the following criteria are met:

- the space between inferior turbinate and septum decreased by a clinical estimate of greater than 50 percent;
- a three-month minimum trial of conservative medical therapy (e.g., decongestants, nasal spray, corticosteroids) has been ineffective in treating the obstruction.

Documentation requirements

Supporting medically necessary documentation criteria for septoplasty, rhinoplasty, and septorhinoplasty are expanded to include results of CT scan, X-ray, endoscopy, or any other appropriate imaging modality to document deformity and/or obstruction.

For more information, please contact your Network Coordinator.

Medicare Part D formulary updates

Generic additions

These generic drugs recently became available in the marketplace. When these generic drugs become available, we began covering them at the appropriate generic formulary copayment:

Generic Drug	Brand Drug	Formulary Chapter
alendronate plus D tabs	Fosamax Plus D®	43. Metabolic Bone Disease Agents
alendronate tabs	Fosamax®	43. Metabolic Bone Disease Agents
amlodipine/benazepril caps	Lotrel®	25. Cardiovascular Agents
carvedilol tabs	Coreg®	25. Cardiovascular Agents
cefuroxime axetil susp recon	Ceftin®	3. Antibacterials
ciclopirox cr gel, topical soln, shampoo	Loprox®	9. Antifungals
colestipol HCl 1gm tab	Colestid®	25. Cardiovascular Agents
diclofenac 0.1% opth soln	Voltaren®	45. Opthalmic Agents
granisetron tabs, IV soln	Kytril®	8. Antiemetics
hydrocortisone butyrate oint	Locoid®	32. Hormonal Agents, Stimulant/Replacement/ Modifying (Adrenal)
hydrocortisone tabs	Cortef®	32. Hormonal Agents, Stimulant/Replacement/ Modifying (Adrenal)
metoprolol succinate ER tabs 50, 100, 200mg	Toprol XL®	25. Cardiovascular Agents
nimodipine cap	Nimotop®	25. Cardiovascular Agents
ofloxacin otic drops	Floxin® Otic	46. Otic Agents
ramipril tabs, caps	Altace®	25. Cardiovascular Agents

Brand deletions

These brand drugs will be covered at the appropriate non-preferred formulary copayment. The generic drugs for all of these brand drugs are on our formulary and are available at the generic formulary copayment:

Effective July 1, 2008

Brand Drug	Generic Drug
Altace®	ramipril tabs, caps
Ceftin®	cefuroxime axetil susp recon
Colestid®	colestipol HCl 1gm tab
Coreg®	carvedilol tabs
Cortef®	hydrocortisone tabs
Floxin® Otic	ofloxacin otic drops
Fosamax®	alendronate tabs
Fosamax Plus D®	alendronate plus D tabs
Kytril®	granisetron tabs, IV soln
Locoid®	hydrocortisone butyrate oint
Loprox®	ciclopirox cr gel, topical soln, shampoo
Lotrel®	amlodipine/benazepril caps
Nimotop®	nimodipine cap
Toprol XL®	metoprolol succinate ER tabs 50, 100, 200mg
Voltaren®	diclofenac 0.1% opth soln

continued on page 9

Medicare Part D formulary updates (continued)

These brand drugs will be covered at the appropriate non-preferred formulary copayment. There is no generic equivalent available for these brand drugs.

Effective July 1, 2008

Brand Drug	Generic Drug
Balacet® 325/100mg	Not available
Kytril® Oral Soln	Not available
Pangestyme CN 10®	Not available
Provigil®	Not available
Yasmin® 28	Not available

Drugs requiring prior authorization

The prior authorization requirements for the following non-preferred drugs were effective at the time the drugs became available in the marketplace:

Effective July 1, 2008

Brand Drug	Generic Drug
Altabax™	Not available
Luvox® CR	Not available
Magnacet™	Not available
Qualaquin®	Not available
Taclonex®	Not available
Zegerid®	Not available

Change in quantity limit

A quantity limit will be added for the following drugs:

Effective July 1, 2008

Brand Drug	Generic Drug	Quantity Limit
Dilaudid® tabs	hydromorphone hcl	240 tablets per 30 days
Endocet® tabs	oxycodone with acetaminophen	240 tablets per 30 days
Ondansetron 4mg tabs	ondansetron	12 tablets per 30 days
Ondansetron 24mg tabs	ondansetron	2 tablets per 30 days
Ondansetron Soln 4mg per 5ml	ondansetron	50 millileters per 30 days
Ondansetron ODT 4mg tabs	ondansetron odt	12 tablets per 30 days
Ondansetron ODT 8mg tabs	ondansetron odt	6 tablets per 30 days
Percocet® tabs	oxycodone with acetaminophen	240 tablets per 30 days

SMART® Registry release for June 2008

The next release of the SMART Registry will be mailed to IBC providers in June 2008. The SMART Registry provides information to doctors on their patients with one or more of the chronic conditions managed by the Connections℠ Health Management Program.

This release includes a new report on medication persistence. This medication monitoring tool will help doctors manage their patients with diabetes and cardiac conditions who are using ACE inhibitors, angiotensin II receptor blockers, beta blockers, and lipid-lowering drugs. The persistence rates will show if patients have ever filled a prescription for the recommended medication and if they are getting refills.

Also new this year, all doctors with more than 11 patients in the Connections Program will now receive the Registry on CD rather than in binder format. The CD includes a read-only PDF file of the entire SMART Registry as well as all supplemental materials; an Excel file of the Group Registry Reports with information that can be sorted; and diabetes and asthma template letters to alert members of a missing test or treatment or the need for an office visit. A Registry binder can be delivered upon request.

If you have any questions about the SMART Registry CD, please contact a Provider Service Specialist (PSS) by calling the Connections Program Provider Support Line at 1-866-866-4694. A PSS can work with you and your clinical office staff to sort the CD to provide the most important information for you.

PSSs can also meet with you and your staff to review the SMART Registry reports and to help with making referrals to the Connections Health Management Program. PSSs can provide new asthma education tools, including an asthma symptom response plan, information about asthma triggers, and brochures on the use of quick-relief medications.

To speak with a PSS about the SMART Registry or any other aspect of the Connections Program, call the Provider Support Line at 1-866-866-4694.

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Connections℠ Health Management Programs: Supporting our members, your patients

Call the Provider Support Line at 1-866-866-4694 to refer a patient to the Connections℠ Health Management Program for Health Coaching. Health Coaches provide disease management for asthma, diabetes, COPD, HF, and CHD, as well as decision support for numerous health-related issues.

Call 1-866-398-8761 to refer patients with any of the following diseases to the Connections℠ AccordantCare™ Program:

- 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
- polymyositis
- 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 member with end-stage renal disease on outpatient dialysis.

2007 General medical record review, clinical appropriateness, and continuity-of-care assessment

Well-maintained medical records are critical for facilitating communication, continuity, coordination, and an effective plan of care. Accordingly, we have established standards to ensure that medical records are maintained in a manner that is current, detailed, and organized. A performance goal of 90 percent compliance with our medical record standards has been established. These standards are routinely distributed to primary care physicians (PCPs) via the *Provider Manual* or *Partners in Health Update*.

Compliance with the standards is assessed annually. We monitor the processes and procedures used by physician's offices to facilitate the delivery of continuous and coordinated medical care.

Specific findings

The 2007 General Medical Record Review Study was based on an analysis of data abstracted from medical records and obtained during office staff interviews. Study findings were assessed in the following three categories:

1. General medical record review

General medical record review indicator scores met the 90 percent performance goal with the following exceptions. All three of these indicators were also below goal in 2006 and continue to represent opportunities for improvement in medical record documentation:

- a separate problem list completed for each member (76.1 percent);
- documentation of history of substance abuse (80.7 percent);
- separate immunization record for both children and adults in the chart (86.6 percent).

Please make every effort to add pertinent information to all of your patient charts during 2008 to improve your conformance to nationally-endorsed standards of care.

While meeting the performance goal, significant declines were noted in the following areas:

- documentation on all pages of member name and ID number (90.1 percent);
- documentation of the presence or absence of allergies to medication prominently displayed (96.6 percent);
- documentation of biographical/personal data in the chart (99.1 percent);
- notation for every visit of the date for return visit or "return prn" for each member (92.6 percent).

2. Clinical appropriateness review

Eight of the nine indicators were 100 percent compliant with medical record standards. However, evidence of discharge summaries on the chart for patients with a hospitalization in the previous year (for members discharged the previous year) was below the performance goal at 75 percent. As a patient's care moves from one provider to another, discharge summaries play an important role in the coordination of care. Please arrange to receive discharge summaries from physicians and hospitals to which you refer patients.

3. Continuity-of-care review

A compliance rate of 90 percent or higher was observed in four of the nine continuity- and coordination-of-care indicators. One clinical indicator did not meet the established performance goal, namely provision of routine GYN services in the PCP office (77.7 percent).

Four indicators that reflect the presence of a tickler system to remind patients about preventive visits were also below the goal:

- reminder system — database (computerized);
- reminder system — manual;
- reminder system — reactive (individual identified at time of PCP visit);
- reminder system — proactive (population based, patients identified by PCP's database).

Please note: This annual compliance assessment is based on a random sampling of medical records reviewed across the network.

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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Independence Blue Cross

IMPORTANT RESOURCES

View our online provider directories on www.ibx.com

CARE MANAGEMENT AND COORDINATION	215-567-3570
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℠ AccordantCare™ Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT	1-866-282-2707
Anti-Fraud and Corporate Compliance Hotline	www.ibx.com/anti-fraud
CREDENTIALING	www.ibx.com/credentials
Credentialing Hotline	215-988-6534
Credentialing Violation Hotline	215-988-1413
eBUSINESS	
Help Desk	215-241-2305
FutureScripts®	
Prescription Drug Authorization	1-888-678-7012
Toll Free Fax	1-888-671-5285
Direct Ship Injectable	1-888-678-7012
Fax	215-761-9165
Blood Glucose Meter Hotline	1-888-494-8213 (option 2)
FutureScripts® Secure	
Medicare Part D	1-888-678-7015
HEALTH RESOURCE CENTER	215-241-3367
Healthy Lifestyles℠	1-800-275-2583*
Precertification	215-241-2100 1-800-227-3116*
PROVIDER MEDICAL POLICY WEB PAGE	www.ibx.com/medpolicy
PROVIDER NETWORK eSERVICES	www.ibx.com/providers/navinet/index.html
NaviNet® Portal Registration	
EDI Claim Registration	215-640-7410
PROVIDER PHARMACY WEB PAGE	www.ibx.com/provider_rx
PROVIDER SERVICES (Policies/Procedures/Claims)	215-567-3590
HMO	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*