Partners in Health update℠

Working together for quality health care

February 2014

Independence

Inside this edition

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

(P) Professional (F) Facility (A) Ancillary

▶ Articles designated with a blue arrow include notice of changes or clarifications to administrative policies and procedures.

Partners in Health Update℠ is a publication of Independence Blue Cross and its affiliates (IBC), created to provide valuable information to the IBC-participating provider community. This publication may include notice of changes or clarifications to administrative policies and procedures that are related to the covered services you provide in accordance with your participating professional provider, hospital, or ancillary provider/ancillary facility contract with IBC. This publication is the primary method for communicating such general changes. Suggestions are welcome.

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

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

BUSINESS TRANSFORMATION

PFA

Stay informed during our transition to the new platform

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

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

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

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

We are committed to working closely with you and our entire provider network as we work to complete our Business Transformation. We will continue to provide comprehensive communications and tools to support our members and provider network.

PFA

Reminder: Out-of-pocket maximums for commercial HMO, POS, and PPO members beginning January 1, 2014

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

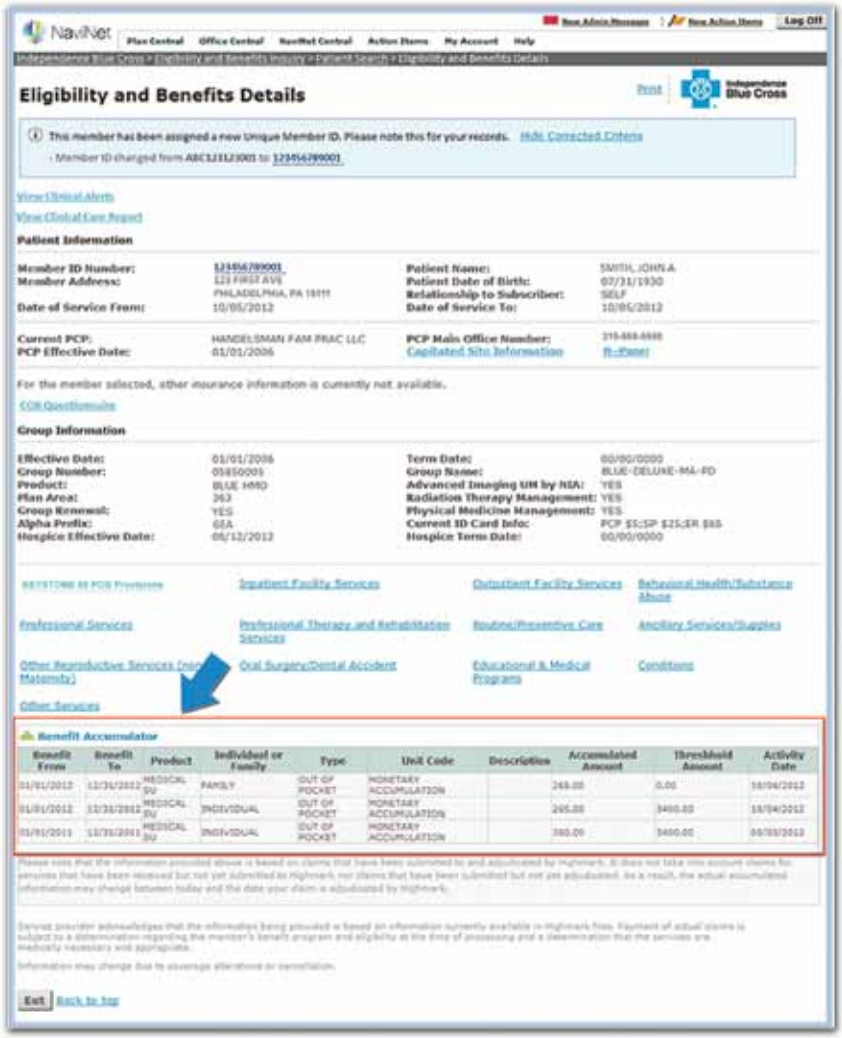
- **Individual:** $6,350
- **Family:** $12,700

Once members have reached their out-of-pocket maximum, providers should not collect additional cost-sharing.

To verify if members have reached their out-of-pocket maximum, providers should use the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal. However, due to our transition to a new operating platform, the process differs depending on whether the member has been migrated. The steps are outlined below.

For migrated members

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



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For non-migrated members

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

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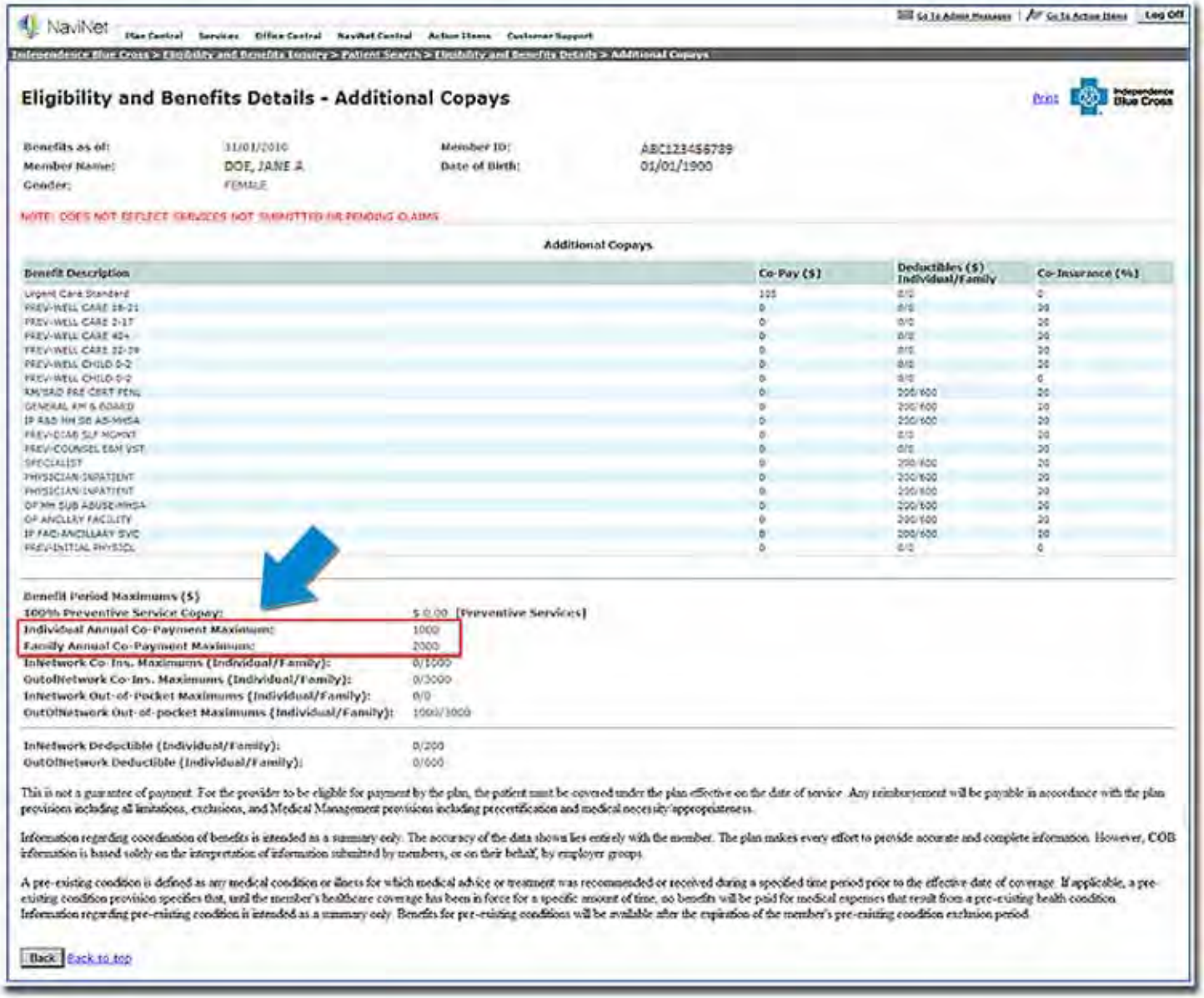

NaviNet

Plan Central | Services | Office Central | NaviNet Central | Action Items | Customer Support

Go To Admin Messages | Go To Action Items | Log Off

Independence Blue Cross > Eligibility and Benefits Enquiry > Patient Search > Eligibility and Benefits Details > Additional Copays

Eligibility and Benefits Details - Additional Copays

Print

Independence Blue Cross

Benefits as of:	11/01/2010	Member ID:	ABC123456789
Member Name:	DOE, JANE A	Date of Birth:	01/01/1900
Gender:	FEMALE		

NOTE: DOES NOT REFLECT SERVICES NOT SUBMITTED OR PENDING CLAIMS

Additional Copays

Benefit Description	Co-Pay ($)	Deductibles ($) Individual/Family	Co-Insurance (%)
Urgent Care Standard	105	0/0	0
PREV-WELL CARE 18-21	0	0/0	20
PREV-WELL CARE 1-17	0	0/0	20
PREV-WELL CARE 40+	0	0/0	20
PREV-WELL CARE 22-39	0	0/0	20
PREV-WELL CHILD 0-2	0	0/0	20
PREV-WELL CHILD 0-2	0	0/0	0
RM/BRD PRE CERT PEN	0	200/600	20
GENERAL RM & BOARD	0	200/600	20
IP R&B RM SB AD-MHSA	0	200/600	20
PREV-DCAB SLP MGMNT	0	0/0	20
PREV-COUNSEL E&M VST	0	0/0	20
SPECIALIST	0	200/600	20
PHYSICIAN INPATIENT	0	200/600	20
PHYSICIAN INPATIENT	0	200/600	20
OP RM SUB ABUSE-MHSA	0	200/600	20
OP ANCLLRY FACILITY	0	200/600	20
IP FAC-ANCILLARY SVC	0	200/600	20
PREV-INITIAL PHYSCL	0	0/0	0

Benefit Period Maximums ($)	
100% Preventive Service Copay:	$ 0.00 [Preventive Services]
Individual Annual Co-Payment Maximum:	1000
Family Annual Co-Payment Maximum:	2000
InNetwork Co-Ins. Maximums (Individual/Family):	0/1000
OutOfNetwork Co-Ins. Maximums (Individual/Family):	0/3000
InNetwork Out-of-Pocket Maximums (Individual/Family):	0/0
OutOfNetwork Out-of-pocket Maximums (Individual/Family):	1000/3000
InNetwork Deductible (Individual/Family):	0/200
OutOfNetwork Deductible (Individual/Family):	0/600

This is not a guarantee of payment. For the provider to be eligible for payment by the plan, the patient must be covered under the plan effective on the date of service. Any reimbursement will be payable in accordance with the plan provisions including all limitations, exclusions, and Medical Management provisions including precertification and medical necessity/appropriateness.

Information regarding coordination of benefits is intended as a summary only. The accuracy of the data shown lies entirely with the member. The plan makes every effort to provide accurate and complete information. However, COB information is based solely on the interpretation of information submitted by members, or on their behalf, by employer groups.

A pre-existing condition is defined as any medical condition or illness for which medical advice or treatment was recommended or received during a specified time period prior to the effective date of coverage. If applicable, a pre-existing condition provision specifies that, until the member's healthcare coverage has been in force for a specific amount of time, no benefits will be paid for medical expenses that result from a pre-existing health condition. Information regarding pre-existing condition is intended as a summary only. Benefits for pre-existing conditions will be available after the expiration of the member's pre-existing condition exclusion period.

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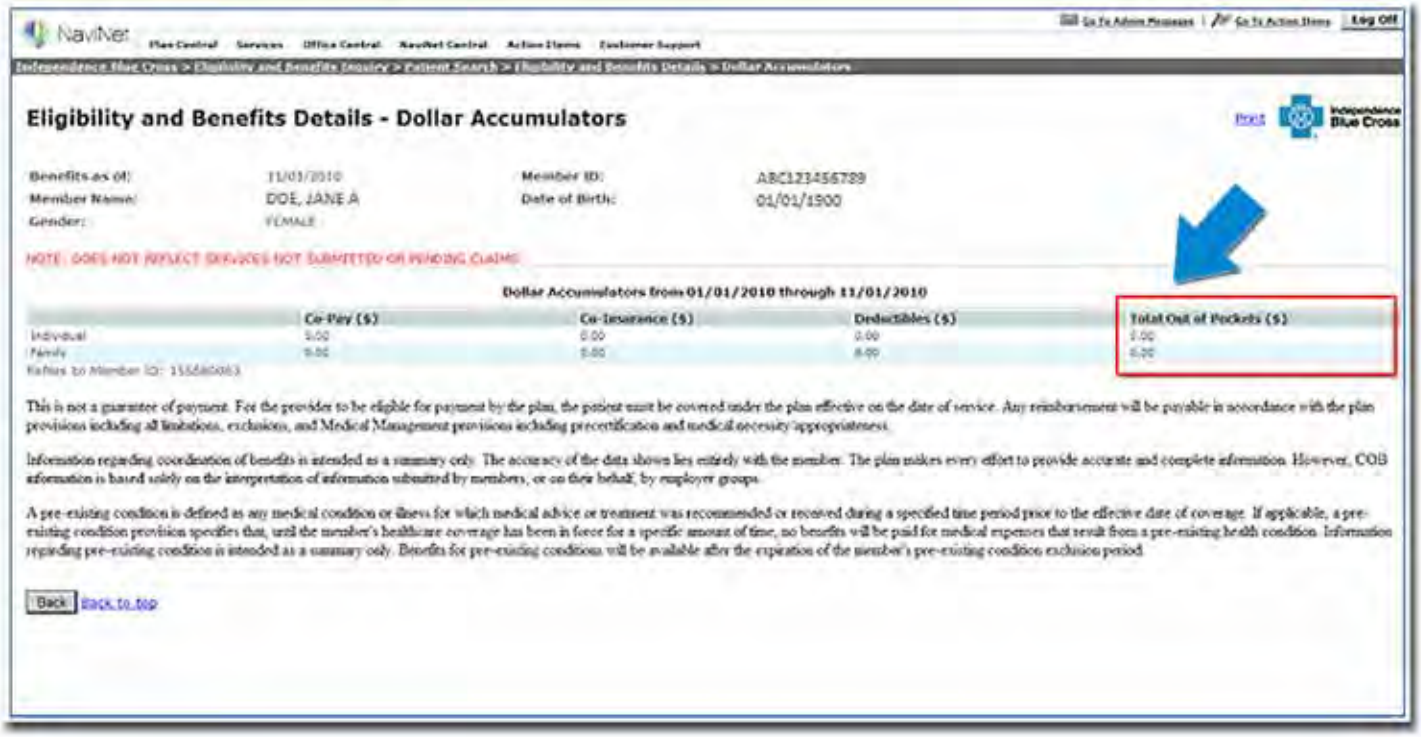

If your office is not yet NaviNet-enabled, you can sign up by going to *www.navinet.net* and selecting *Sign Up* at the top right.

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

Look for additional information about this requirement in future editions of *Partners in Health Update*.

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

PF

Risk adjustment: Why improving coding accuracy matters more now

Under the Patient Protection and Affordable Care Act, also known as Health Care Reform, the process of risk adjustment is being expanded to include commercial members in an individual or small group plan offered both on and off the Health Insurance Marketplace. This process currently exists for our Medicare Advantage HMO and PPO plans.

Under Health Care Reform, everyone has access to health insurance regardless of their health status. In order to try to create a system in which payers and their provider network are compensated for the risk associated with the members they treat (i.e., risk-adjusted payments), complete and accurate information of each individual's health status through claims and encounter data is critical.

Risk adjustment

This risk adjustment process uses demographics and illness burden (measured by diagnosis code information), to assign members' risk scores. It also requires proper documentation of conditions for each member/provider encounter to accurately assess risk scores. The overall objective is to stabilize risk and prevent adverse selection by insurers.

However, there are some key differences between the risk adjustment models used for commercial and Medicare Advantage members. The commercial model is designed to redistribute money from insurers with healthier patient populations to those that have a sicker patient population, and either the state or federal government is responsible for operating the commercial model. The Medicare model is set up to determine the payment to Medicare Advantage organizations and is operated by the federal government.

How does this impact my practice?

In risk adjustment, there is an increased dependence on accurate coding practices. By having precise coding, it will provide better insight on the true risk associated with members and allows for a more accurate projection of medical cost, enabling practices to obtain greater financial stability. It also allows practices to analyze and evaluate the effectiveness of care management programs, reduce practice variation, and help drive better quality outcomes for members.

Practices can use these steps to make sure they achieve the best results:

- standardize the medical documentation and coding process consistent with billing procedures;
- adopt electronic health records and other technologies that support greater coding accuracy and efficiencies;
- engage office staff and coders to ensure the best coding practices are being used.

Support from IBC

IBC contracts with Inovalon, Inc., an independent company, to provide support services for risk adjustment. These services ensure that members with targeted diagnosis gaps are identified for follow-up care and that practices have access to the necessary tools to accurately capture and report diagnostic code information. Through Inovalon, the following programs are designed to help your practice attain the best results:

- **Personal Health Visits.** Identified members are offered supplemental care management services such as Personal Health Visits at their home or other location where IBC has contracted for these services (i.e., Walgreens).

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- **ePASS®.** Providers can use the ePASS® system to ensure that diagnosis gaps for Medicare Advantage HMO and PPO members and certain commercial members are being reported back to IBC. Providers who submit information to ensure quality and consistent coding through ePASS® for Medicare Advantage HMO and PPO members and certain commercial members are eligible to receive a financial incentive.
- **Medical record review.** An Inovalon representative will contact certain providers to determine the most appropriate method of retrieving medical charts for select members from your practice. Certified coders or nurse practitioners will either come on-site to providers' offices to retrieve the charts or providers may be asked to fax the charts to Inovalon. Providers will receive compensation for each medical chart retrieved. Integration with select electronic medical record systems is also available to provide greater efficiencies and to minimize provider disruption when obtaining necessary medical records.

If you have any questions regarding risk adjustment, please contact Customer Service at 1-800-ASK-BLUE. ◆

In risk adjustment, there is an increased dependence on accurate coding practices. By having precise coding, it will provide better insight on the the true risk associated with members and allows for a more accurate projection of medical cost, enabling practices to obtain greater financial stability. It also allows practices to analyze and evaluate the effectiveness of care management programs, reduce practice variation, and help drive better quality outcomes for members.

PFA

90-day Grace Period now in effect

The Patient Protection and Affordable Care Act, also known as Health Care Reform, mandates a three-month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of the premiums. Under this mandate, insurers are required to pay medical claims received during the first 30 days of the grace period, but may pend medical claims for services rendered to those members and their eligible dependents during the second and third months of the grace period. Insurers are also required to notify affected providers when one of these members enters the grace period. If payment is not received by the end of the grace period, the pended claims will be denied and the member's policy will be terminated.

To comply with the mandate, IBC will notify affected providers by mail upon receipt of a claim for services rendered for a member who is within the second or third month of the grace period. In addition, a new field called Advanced Premium Tax Credit will display within the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal to show providers when a member is in the grace period and provide a status of the member's claims.

Look for additional information regarding the 90-day Grace Period in future editions of *Partners in Health Update*. ◆

PFA

Medical and claim payment policy activity posted as of January 25, 2014

Below is a listing of the policy activity that we have posted to our website as of January 25, 2014.

New policies

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

Policy #	Title	Notification date	Effective date
08.01.10	Octreotide acetate (Sandostatin® LAR Depot)	December 4, 2013	March 4, 2014
11.00.18	Robotic-Assisted Surgery	n/a	January 6, 2014
11.14.24	Manipulation Under Anesthesia	October 3, 2013	January 1, 2014

Updated policies

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

Policy #	Title	Type of policy change	Notification date	Effective date
00.06.02i	Preventive Care Services	Coverage and/or Reimbursement Position; Medical Coding	n/a	January 1, 2014
05.00.24j	Interstitial Continuous Glucose Monitoring Systems (CGMSs)	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	October 3, 2013 (Revised: November 25, 2013)	January 1, 2014
05.00.37e	Compression Garments	Medical Necessity Criteria; Medical Coding	December 2, 2013	January 1, 2014
05.00.39i	Ankle-Foot/Knee-Ankle-Foot Orthoses	Coverage and/or Reimbursement Position; Medical Coding	October 3, 2013	January 1, 2014
05.00.42e	Patient Lifts	Medical Necessity Criteria; Medical Coding	November 6, 2013	February 5, 2014
06.02.39a	Measurement of Serum Antibodies to and Measurement of Serum Levels of Infliximab and Adalimumab	Coverage and/or Reimbursement Position; General Description, Guidelines, or Informational Update	January 3, 2014	February 3, 2014
07.00.02g	Intravenous Chelation Therapy	Coverage and/or Reimbursement Position; Medical Necessity Criteria; General Description, Guidelines, or Informational Update	November 7, 2013	February 5, 2014
07.00.03k	Full-Body Monoplace or Multiplace Chamber Hyperbaric Oxygen Therapy	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	October 3, 2013 (Revised: November 20, 2013)	January 1, 2014
07.00.20e	Routine Costs Associated with Qualifying Clinical Trials	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	October 3, 2013	January 1, 2014

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Policy #	Title	Type of policy change	Notification date	Effective date
07.02.03g	Implantable Cardiac Loop Monitor	Coverage and/or Reimbursement Position; Medical Necessity Criteria	November 20, 2013	February 18, 2014
07.02.05i	External Counterpulsation (ECP)	Medical Coding; General Description, Guidelines, or Informational Update	December 4, 2013	January 3, 2014
07.03.05p	Sleep Disorder Testing	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	October 3, 2013	January 1, 2014
07.03.08d	Neuropsychological Evaluation/Testing	Medical Necessity Criteria	October 9, 2013	January 7, 2014
07.05.02j	Wireless Capsule Endoscopy (WCE) as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	October 3, 2013	January 1, 2014
07.06.01b	Complete Decongestive Therapy (CDT)	Coverage and/or Reimbursement Position	n/a	January 1, 2014
07.10.05b	Noncontraceptive Use of the Levonorgestrel-Releasing Intrauterine System	Coverage and/or Reimbursement Position	November 21, 2013	January 1, 2014 (policy will be published on February 19, 2014)
07.13.01f	Orthoptic/Pleoptic Training	Coverage and/or Reimbursement Position	n/a	January 1, 2014
07.13.05g	Photodynamic Therapy (PDT) Using Verteporfin (Visudyne®)	General Description, Guidelines, or Informational Update; Medical Coding	n/a	January 2, 2014
07.13.11e	Contact Lenses for the Treatment of Persistent (Corneal) Epithelial Defects	Medical Necessity Criteria; Medical Coding	n/a	January 8, 2014
08.00.13o	Immune Globulin Intravenous (IVIG), Subcutaneous (SCIG)	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding	October 3, 2013	January 1, 2014
08.00.57e	Complex Regional Pain Syndrome (CRPS) Parenteral Treatments	Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	December 11, 2013	January 10, 2014
08.00.73e	Bortezomib (Velcade®)	Medical Necessity Criteria; Medical Coding	January 2, 2014	April 2, 2014
08.00.74g	Intravitreal Injection of Vascular Endothelial Growth Factor (VEGF) Antagonists (e.g., ranibizumab [Lucentis®], pegaptanib sodium [Macugen®], aflibercept [Eylea®])	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	January 2, 2014	April 2, 2014

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Policy #	Title	Type of policy change	Notification date	Effective date
08.00.78j	Self-Administered Drugs	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	October 3, 2013 (Revised: October 11, November 8, and December 20, 2013)	January 1, 2014
08.00.92e	Coagulation Factors for Hemophilia	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	October 3, 2013	January 1, 2014
09.00.10p	Brachytherapy	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	December 19, 2013	March 19, 2014
09.00.17j	Intensity Modulated Radiation Therapy (IMRT)	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	January 3, 2014	April 2, 2014
09.00.49e	Proton Beam Radiation Therapy	Medical Necessity Criteria; Medical Coding	January 2, 2014	April 2, 2014
10.03.01c	Physical Medicine, Rehabilitation, and Habilitation Services	General Description, Guidelines, or Informational Update	October 3, 2013	January 1, 2014
11.01.07b	Cataract Surgery	Medical Necessity Criteria	n/a	January 2, 2014
11.02.01j	Treatment of Varicose Veins of the Lower Extremities and Perforator Vein Incompetence	Medical Necessity Criteria	n/a	January 2, 2014
11.02.12e	Percutaneous Transluminal Angioplasty (PTA) Concurrent with or without Stenting of the Extracranial Carotid Artery or Intracranial Artery	Medical Necessity Criteria; Medical Coding	November 20, 2013 (Revised: January 23, 2014)	February 19, 2014
11.03.01d	Repair of Cleft Lip, Cleft Nose, and/or Cleft Palate	Medical Necessity Criteria; Medical Coding	n/a	January 1, 2014
11.07.01l	Hematopoietic Stem Cell Transplantation (Bone Marrow Transplant)	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding	October 3, 2013	January 1, 2014
11.08.02f	Reduction Mammaplasty	Coverage and/or Reimbursement Position; Medical Coding	November 6, 2013 (Revised: December 2, 2013)	February 4, 2014
11.08.06g	Abdominoplasty and/or Panniculectomy	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding	January 3, 2014	February 3, 2014
11.08.10f	Excision of Redundant Skin	Medical Necessity Criteria; Medical Coding	January 3, 2014	February 3, 2014
11.08.25j	Scar Revision	Coverage and/or Reimbursement Position; Medical Coding	January 2, 2014	April 2, 2014

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Policy #	Title	Type of policy change	Notification date	Effective date
11.11.01f	Evaluation and Treatment of Erectile Dysfunction (ED)	Medical Coding	November 21, 2013	February 19, 2014
11.14.10k	Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty	Medical Coding	November 6, 2013	February 5, 2014
11.16.01g	Septoplasty, Rhinoplasty, and Septorhinoplasty	Medical Necessity Criteria; General Description, Guidelines, or Informational Update	December 19, 2013	March 19, 2014
11.17.04m	Sacral Nerve Stimulation (SNS) and Posterior Tibial Nerve Stimulation (PTNS) for the Control of Incontinence	Coverage and/or Reimbursement Position; Medical Coding	December 9, 2013	January 8, 2014
12.04.03a	Air or Sea Ambulance Transport Services	Coverage and/or Reimbursement Position; General Description, Guidelines, or Informational Update	December 2, 2013	January 1, 2014

Reissued policies

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

Policy #	Title	Reissue effective date
07.00.10f	Photodynamic Therapy (PDT) using Porfimer Sodium (Photofrin®)	December 26, 2013
07.13.07e	Corneal Pachymetry Using Ultrasound	December 26, 2013
11.00.13d	Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	December 26, 2013
11.05.16	Aqueous Shunts, Viscocanalostomy, and Canaloplasty for the Treatment of Glaucoma	December 26, 2013
11.07.02f	Sentinel Lymph Node Biopsy	December 26, 2013

Archived policies

The following are policies that IBC has determined are no longer necessary to remain active.

Policy #	Title	Notification date	Archive effective date
07.03.16b	Electrosleep Therapy using a Cranial Electrical Stimulation Device	January 16, 2014	February 17, 2014

Coding updates

The following policies have been reviewed and updated to add new and revised medical codes (e.g., ICD-9 and ICD-10 diagnosis codes; CPT® and HCPCS codes; revenue codes) and/or remove terminated medical codes.

Policy #	Title	Effective date
00.06.02j	Preventive Care Services	January 2, 2014
00.10.35f	Remote Patient Management: Telemedicine and Telehealth	January 1, 2014

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Policy #	Title	Effective date
05.00.21l	Durable Medical Equipment (DME)	January 1, 2014
05.00.30h	Noninvasive Respiratory Assist Devices (RADs): Continuous Positive Airway Pressure (CPAP) Devices and Bi-level Devices	January 1, 2014
05.00.38g	Negative-Pressure Wound Therapy (NPWT) Systems	January 1, 2014
05.00.39j	Ankle-Foot/Knee-Ankle-Foot Orthoses	January 2, 2014
05.00.47i	Knee Braces	January 1, 2014
05.00.50i	Ostomy Supplies	January 1, 2014
05.00.58g	Home Oxygen Therapy	January 1, 2014
05.00.62f	Injectable Dermal Fillers	January 1, 2014
05.00.67j	Wheelchair Options and Accessories	January 1, 2014
06.02.10l	Genetic Testing for Inherited Susceptibility to Colon Cancer and Microsatellite Instability Testing (Familial Adenomatous Polyposis and Lynch Syndrome)	January 1, 2014
06.02.35f	Genetic Testing	January 1, 2014
06.03.04i	Apheresis Therapy	January 1, 2014
07.00.10g	Photodynamic Therapy (PDT) using Porfimer Sodium (Photofrin®)	January 1, 2014
07.03.07j	Evaluation and Management of Autism Spectrum Disorders (ASD)	January 1, 2014
07.05.06e	Transcatheter Arterial Chemoembolization (TACE) of Hepatic Malignancies	January 1, 2014
07.05.07b	Drug-Eluting Beads and Bland Embolization for the Treatment of Hepatic Malignancies	January 1, 2014
08.00.44n	Zoledronic Acid (Zometa®, Reclast®)	January 1, 2014
08.00.51g	Enzyme Replacement for the Treatment of Gaucher's Disease	January 1, 2014
08.00.57d	Complex Regional Pain Syndrome (CRPS) Parenteral Treatments	January 1, 2014
08.00.78k	Self-Administered Drugs	January 2, 2014
08.00.92f	Coagulation Factors for Hemophilia	January 2, 2014
08.01.04f	Preventive Immunization	January 1, 2014
08.01.05a	Carfilzomib (Kyprolis™)	January 1, 2014
08.01.07b	Pertuzumab (Perjeta®)	January 1, 2014
08.01.09b	Omacetaxine mepesuccinate (Synribo®)	January 1, 2014
08.01.11b	Ado-trastuzumab emtansine (Kadcyla®)	January 1, 2014
08.01.15a	Golimumab (Simponi® Aria™) Intravenous (IV) Injection	January 1, 2014
08.09.11r	Medicare Part B vs. Part D Crossover Drugs	January 1, 2014
09.00.10o	Brachytherapy	January 1, 2014
09.00.17i	Intensity Modulated Radiation Therapy (IMRT)	January 1, 2014
09.00.48c	Radioembolization for Primary and Metastatic Tumors of the Liver	January 1, 2014
09.00.49d	Proton Beam Radiation Therapy	January 1, 2014

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Policy #	Title	Effective date
10.06.01g	Speech Therapy	January 1, 2014
11.00.16d	Radiofrequency Ablation and Cryosurgical Ablation of Lung Tumors	January 1, 2014
11.01.01i	Otoplasty	January 1, 2014
11.02.06i	Catheter Ablation of Cardiac Arrhythmias	January 1, 2014
11.02.10i	Endovascular Grafts for Abdominal Aortic Aneurysms (AAA), Aortic-Iliac Aneurysms, and Infrarenal Aortic Aneurysms	January 1, 2014
11.02.13e	Transcoronary Ablation of Septal Hypertrophy (TASH)	January 1, 2014
11.02.25c	Transcatheter Aortic-Valve Replacement (TAVR)	January 1, 2014
11.03.11i	Procedures for the Treatment of Gastroesophageal Reflux Disease (GERD)	January 1, 2014
11.03.11j	Procedures for the Treatment of Gastroesophageal Reflux Disease (GERD)	January 2, 2014
11.05.16a	Aqueous Shunts, Viscocanalostomy, and Canaloplasty for the Treatment of Glaucoma	January 1, 2014
11.06.04h	Uterine Artery Embolization	January 1, 2014
11.06.07b	Ovarian and Internal Iliac Vein Embolization as Treatment for Pelvic Congestion Syndrome	January 1, 2014
11.08.15p	Reconstructive Breast Surgery	January 1, 2014
11.08.15q	Reconstructive Breast Surgery	January 2, 2014
11.08.20l	Wound Care: Bioengineered Skin Substitutes	January 1, 2014
11.08.23g	Mohs' Micrographic Surgery	January 1, 2014
11.08.25i	Scar Revision	January 1, 2014
11.11.06e	Saturation Needle Biopsy of the Prostate	January 1, 2014
11.14.21d	Microprocessor-Controlled Prostheses for Lower-Extremity Amputees	January 1, 2014
11.15.01k	Spinal Cord Stimulation (Dorsal Column Stimulation)	January 1, 2014
11.15.20i	Deep Brain Stimulation (DBS)	January 1, 2014
11.17.04l	Sacral Nerve Stimulation (SNS) and Posterior Tibial Nerve Stimulation (PTNS) for the Control of Incontinence	January 1, 2014
12.04.02e	Nonemergency Ambulance Transport Services	January 1, 2014
12.04.03b	Air or Sea Ambulance Transport Services	January 2, 2014

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

Specialists needed to assist in developing medical policies

IBC is currently recruiting physicians from a number of medical specialties to provide us with expert clinical input during the development and maintenance of our medical coverage policies. Medical policies are research-based documents that communicate coverage of medical services for our members, including medical devices, injectable and infusible drugs and biologics, and medical and surgical procedures. In addition, medical policies provide guidelines for obtaining benefits and reimbursement in accordance with the member's benefits plan.

As a consultant, you would be responsible for evaluating and providing feedback on the scientific evidence and local standards of care addressed in our medical policies. You would evaluate proposed medical policies based on your areas of expertise and be paid a consulting fee. Your contributions could significantly impact the medical policies that IBC establishes, which in turn affect the delivery of health care in our region.

At this time, IBC is seeking physician consultants in the following specialties:

- medical oncology
- ophthalmology
- orthopedic surgery
- pain management
- radiation oncology

Qualifications

To qualify as a consultant, you must:

- maintain board certification in each specialty for which you wish to consult;
- maintain an active clinical practice in each specialty for which you wish to consult;
- understand and agree to our conflict of interest statement, which is available upon request prior to participation and is reviewed and reaffirmed annually;
- understand and agree to our confidentiality statement;
- maintain a high ethical standard, evidenced by the absence of any IBC investigation into personal or group claims practices.

Become a consultant

If you meet these criteria and are interested in sharing your expertise as a consultant, please submit your curriculum vitae by email to *IBCMedicalPolicy@ibx.com* or by mail to:

George S. Fenimore, DNP, RN
Director, Medical & Claim Payment Policy
Independence Blue Cross
1901 Market Street, 29th floor
Philadelphia, PA 19103 ◆

We are seeking physician consultants to evaluate and provide feedback on the scientific evidence and local standards of care addressed in our medical policies.

P F

Upcoming changes to our precertification process for outpatient echocardiography services

Effective for commercial HMO, POS, and PPO members for dates of service on or after May 1, 2014, providers will need to obtain precertification for outpatient echocardiography services, which include:

- stress echocardiography
- resting transthoracic echocardiography
- transesophageal echocardiography

The CPT® codes to which the precertification applies are listed in the table below.

Precertification for outpatient echocardiography services can be obtained through the NaviNet® web portal using the AIM Specialty Health® (AIM) ProviderPortal℠. To do so, select *AIM* from the Authorizations option in the Plan Transactions menu.

It is very important that providers use NaviNet to verify member-specific requirements or refer to the precertification list on our website at *www.ibx.com/preapproval*. Failure to obtain precertification for any of the services or drugs that require it may result in a reduction in payment or nonpayment for the services not authorized.

Please call 1-800-ASK BLUE if you have any questions about this upcoming change.

Note: These changes will go into effect for Medicare Advantage HMO and PPO members on January 1, 2015. ◆

AIM is an independent company contracted with Independence Blue Cross to perform precertification for select diagnostic imaging services for most managed care members.

Echocardiography service	CPT® code	Description
Stress echocardiography (SE)	93350	Transthoracic stress echo, complete
	93351	Transthoracic stress echo, complete w/cont EKG
Resting transthoracic echocardiography (TTE)	93303	Transthoracic echo cardiac anomalies
	93304	Transthoracic echo cardiac anomalies, limited
	93306	Transthoracic echo complete w/color & spectral
	93307	Transthoracic echo complete w/o color & spectral
	93308	Transthoracic echo limited
Transesophageal echocardiography (TEE)	93312	Transesophageal echo
	93313	Transesophageal echo probe only
	93314	Transesophageal echo interpretation
	93315	Transesophageal echo congenital
	93316	Transesophageal echo congenital, probe only
	93317	Transesophageal echo congenital interpretation
Add-on codes	93320*	Doppler echo complete
	93321*	Doppler echo limited
	93325*	Doppler echo flow velocity
	93352*	Echo contrast agent (SE only)

**Denotes a CPT code that is an add-on/secondary code to the primary code and does not require precertification.*

PFA

Recent NaviNet changes and new user guides/webinars available

Starting in 2013, IBC began to implement changes to the NaviNet web portal that were intended to streamline processes to make doing business with IBC more efficient. Participating providers likely have noticed a difference in the look and functionality of the provider portal.

Recap of transaction changes

Some functions that saw significant changes in 2013 include:

- referrals and authorizations
- eligibility and benefits
- encounters
- claims inquiry/investigation (formerly claims INFO)
- capitation and QIPS rosters
- BlueExchange® transactions

New transactions were also introduced in 2013, including:

- EOB and Remittance
- Network Provider/Facility Inquiry

More changes are scheduled for 2014, and we will communicate more about them in future editions of *Partners in Health Update* as information becomes available.

Resources available to providers

Given the significant number of changes implemented, we have published more than a dozen detailed user guides and instructional webinars to the NaviNet Transaction Changes section of our Business Transformation site at *www.ibx.com/pnc/businesstransformation*. We strongly encourage you to review these resources to become familiar with new and updated transactions.

The NaviNet Transaction Changes section also contains a communication archive of all information published about recent NaviNet changes.

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

User guides and instructional webinars have been published to the NaviNet Transaction Changes section of our Business Transformation site at www.ibx.com/pnc/businesstransformation.

Encourage pregnant IBC members to register for Baby BluePrints®

The Baby BluePrints program promotes early outreach to members who have been identified as having risk factors within their first trimester of pregnancy. We ask that you inform pregnant IBC members about the Baby BluePrints program at their first prenatal visit and encourage them to self-enroll by calling our toll-free number, 1-800-598-BABY. Upon calling, a Health Coach will explain the program to the member and ask her a series of questions to complete the enrollment process.

Once enrolled in the program, members will receive a welcome letter that includes information on how to access educational materials on our secure member website, ibxpress.com, and the 1-800-598-BABY phone number for questions and support during pregnancy. In addition, high-risk members will be given the name and contact information for their Health Coach.

Resources available

A flyer is available upon request to place in the member's chart and distribute at the first prenatal visit to encourage her to enroll in Baby BluePrints. To order flyers, please submit an online request at *www.ibx.com/providersupplyline* or call the Provider Supply Line at 1-800-858-4728.

Postpartum office visits

As a reminder, postpartum visits should be scheduled 21 to 56 days after delivery. Adhering to this time frame provides the best opportunity to assess the physical healing for new mothers and safely prescribe contraception, if necessary.

These visits should be scheduled before members are discharged from the hospital.

If you have any questions, please call Customer Service at 1-800-ASK-BLUE. ◆

Encourage members to self-enroll in Baby BluePrints by calling our toll-free number, 1-800-598-BABY.

Improving lead testing among CHIP members

Some of our Pennsylvania's Children's Health Insurance Program (CHIP) population may reside in homes that place them at risk for Elevated Blood Lead Levels (EBLL); therefore, we would like to take this opportunity to remind your practice how to identify our CHIP members so you can evaluate the need for testing.

During 2013, the Pennsylvania Insurance Department reiterated to health plans the importance of increasing rates for lead testing among CHIP members. IBC shared with practitioners the Centers for Disease Control and Prevention's (CDC) updated recommendation for prevention of lead poisoning and a new reference level of 5µg/dL to identify children and environments associated with lead-exposure hazards.

In accordance with the Pennsylvania Insurance Department and Healthcare Effectiveness Data and Information Set (HEDIS®) specification, all children currently enrolled in the CHIP program should receive a test for EBLL. Children who are enrolled in CHIP follow the same guidelines for lead testing as children who are enrolled in the Medicaid program; therefore, they should receive at least one lead capillary or venous blood test on or before their second birthday.

Identifying CHIP members

All CHIP members are issued an IBC member ID card with the words "PA KIDS" written on the front. See the sample CHIP ID card below.

What practices can do: Lead testing vs. screening

Lead testing is described as one or more lead capillary or venous blood test for lead poisoning administered by a child's second birthday. Lead screening is described as an assessment or questionnaire regarding a child's health or living environment. While the terminologies are sometimes used interchangeably, lead screening is not the same as lead testing.

Practitioners are asked to test children enrolled in the CHIP program between ages 9 to 12 months and again at 24 months and thereafter based on risk. All CHIP members should be tested for EBLL regardless of risk level. A risk assessment should be performed starting at 6 months, then again at 9 and 18 months, then annually from ages 3 – 6 with testing as appropriate.

Your personal recommendation has tremendous influence on the parents/guardians of your pediatric patients and their decision to seek lead testing information for their children. Therefore, we respectfully ask for your practice's participation in ensuring that all CHIP members receive lead testing as appropriate.

The following resources provide additional information regarding lead testing recommendations:

- **CDC:** *www.cdc.gov/nceh/lead/nlppw.htm*.
- **Philadelphia Department of Public Health:** 215-685-2788 (Philadelphia residents).
- **National Lead Information Center:** 1-800-424-LEAD (non-Philadelphia residents). ◆

New High Value Care website available from the American College of Physicians

Approximately 30 percent of health care costs (more than $750 billion annually) are spent on wasted care, according to the American College of Physicians (ACP). The ACP is committed to reducing unsustainable financial burdens to our health care system and believes that it is the responsibility of medical professionals to become cost-conscious and decrease unnecessary care that does not benefit patients.

To help physicians provide the best possible care to their patients while reducing unnecessary health care costs, the ACP has developed the High Value Care (HVC) initiative, which implements high value care principles.

The ACP recently launched an HVC website for physicians, which focuses on optimal diagnostic and treatment strategies designed to prevent wasted care. The website includes ACP Guidelines and Clinical Recommendations designed to help physicians understand the benefits, harms, and costs of interventions and to determine whether services provide good value. The goal is to help physicians determine whether their patients' quality of care would be negatively affected if certain tests and care options were eliminated.

Through the site, physicians can access curriculum, interactive case studies, medical news, public policy recommendations, and an ethics manual. There is also a Patient Resources page, designed to help patients understand the benefits, harms, and costs of tests and treatments for common clinical issues.

The HVC curriculum covers relevant and timely topics such as eliminating health care waste, over-ordering of tests, overcoming barriers to high value care, and high value medication prescribing. It was jointly developed by the ACP and the Alliance for Academic Internal Medicine in an effort to train physicians to be good stewards of limited health care resources. The curriculum can be completed in six hours and includes audio/video content. It is available at http://hvc.acponline.org/curriculum.html.

For more information, please visit the HCV website at hvc.acponline.org. ◆

The ACP recently launched the High Value Care website at http://hvc.acponline.org/curriculum.html, which focuses on optimal diagnostic and treatment strategies designed to prevent wasted care.

Important Resources

Anti-Fraud and Corporate Compliance	
Hotline	1-866-282-2707 www.ibx.com/antifraud
Care Management and Coordination	
Baby BluePrints®	215-241-2198 / 1-800-598-BABY (2229)*
Case Management	1-800-ASK-BLUE
Condition Management Program	1-800-ASK-BLUE
Credentialing	
Credentialing Violation Hotline	215-988-1413 www.ibx.com/credentials
Customer Service/Provider Services	
Provider Automated System† (eligibility/claims status/precertification)	1-800-ASK-BLUE
Provider Services user guide	www.ibx.com/providerautomatedsystem
eBusiness	
Help Desk	215-241-2305
FutureScripts® (commercial pharmacy benefits)	
FutureScripts Customer Service	1-888-678-7012
Fax	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 pharmacy benefits)	
FutureScripts Secure Customer Service	1-888-678-7015
Formulary updates	www.ibxmedicare.com
Mail order program toll-free fax	1-877-344-1318
Other frequently used phone numbers and websites	
IBC Direct Ship Injectables Program (medical benefits)	www.ibx.com/directship
Medical Policy	www.ibx.com/medpolicy
NaviNet® portal registration	www.navinet.net
Provider Supply Line	1-800-858-4728 www.ibx.com/providersupplyline

**Outside 215 area code*

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

Independence

Visit our website: www.ibx.com/pnc