Partners in Health update℠

Working together for quality health care

August 2014

Independence

Inside this edition

Announcements

- IBX Wire to include new gap-in-care messages

Business Transformation

- Stay informed during our transition to the new platform

Administrative

- Reminder: Out-of-pocket maximums for commercial HMO, POS, and PPO members
- Reminder: Change to IBC's outpatient laboratory network now in effect
- Get up-to-date news and information at our Provider News Center

Billing

- Reminder: Participating providers must submit all claims for IBC members to IBC
- ► Coding guidelines for spinal fusion procedures
- ► Ensure successful submission of CMS-1500 claim forms and an updated toolkit now available
- Reminder: 90-day grace period for APTC members
- ► Upcoming changes to IBC's post-service appeals and grievance processes

NaviNet®

- ► New Allowance Inquiry transaction coming to NaviNet® this fall
- ► Pre-service review for out-of-area members will be made available through NaviNet®

Quality Management

- Highlighting HEDIS®: Colorectal cancer screening

Products

- ► Benefit tier re-evaluation for Keystone HMO Proactive

Medical

- ► Medical and claim payment policy activity posted from June 25 – July 25, 2014
- Reminder: Upcoming changes to Medicare Advantage HMO and PPO policies and clinical relationship logic

Credentialing

- ► IBC's policy on locum tenens

BlueCard®

- Reminder: Provider financial responsibility for preapproval of inpatient facility services for out-of-area members

Health and Wellness

- Pilot programs available to select patients likely to be hospitalized
- Health Coaches: Supporting your patients, our members
- Encourage pregnant IBC members to register for Baby BluePrints®

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*SM 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:

Provider Communications
Independence Blue Cross
1901 Market Street
27th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

Models are used for illustrative purposes only. Some illustrations in this publication copyright 2014. www.dreamstime.com. All rights reserved.

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

The Blue Cross and Blue Shield names and symbols, BlueCard, BlueExchange, Blue Extra, and Baby BluePrints are registered marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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.

NaviNet® is a registered trademark of NaviNet, Inc., an independent company.

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

CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

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 65SM PPO have an accreditation status of *Commendable* from NCQA.

ANNOUNCEMENTS

P

IBX Wire to include new gap-in-care messages

IBX Wire is a free communication service for IBC commercial members. It currently focuses on preventive health screening reminders, such as flu shots and cervical and colorectal cancer screenings, as well as important news related to Health Care Reform.

Later in August, content will be expanded to include additional Healthcare Effectiveness Data and Information Set (HEDIS®) gaps in care for:

- asthma control
- breast cancer screening
- cardiovascular disease management
- chlamydia screening
- diabetes management

About IBX Wire

IBX Wire is a private, HIPAA-compliant, digital tool that leverages the accessibility of text messaging and the security of the Web to deliver practical and usable plan- and service-based information. Launched in early 2014, IBC commercial members are invited to sign up for IBX Wire when they receive their health plan ID card.

Participation in this communication channel is voluntary, and members have the ability to change their notification frequency or shut off IBX Wire at any time. IBX Wire is a free service for IBC members. Standard message and data rates may apply based on the member's mobile phone plan. IBX Wire is not available for Medicare Advantage, Medicare Supplement, Blue Extra, Medicaid, or CHIP members. They will soon be able to opt-in via the IBX App*, our free app for Apple and Android platforms.

Download the IBX App

We hope you will recommend our app and IBX Wire to your IBC commercial patients. 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.*

BUSINESS TRANSFORMATION

P F A

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. We will continue to provide comprehensive communications and tools to support our members and provider network, both during and after the transition to the new platform.

Be sure to 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*. ◆

**Behavioral health claims for HMO/POS non-migrated members should continue to be submitted to Magellan Behavioral Health, Inc. Behavioral health claims for all migrated members, including HMO/POS, should be submitted to IBC.*

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

PFA

Reminder: Out-of-pocket maximums for commercial HMO, POS, and PPO members

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 out-of-pocket limit for essential health benefits 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 for essential health benefits, providers should not collect additional cost-sharing. To verify if members have reached their out-of pocket maximum for essential health benefits, 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.

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.

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.

Learn more

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.

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

PFA

Reminder: Change to IBC's outpatient laboratory network now in effect

As previously communicated, Laboratory Corporation of America® Holdings (LabCorp) is now IBC's exclusive nationally based provider of outpatient laboratory services. This change went into effect on July 1, 2014. Also effective July 1, 2014, Quest Diagnostics is an out-of-network provider.

This change applies to all Blue-branded product lines and members (i.e., Personal Choice®, Keystone Health Plan East, and Independence Administrators), including individual, group commercial, and Medicare Advantage members, for services rendered in the Philadelphia five-county region and contiguous counties (i.e., the counties that surround the IBC five-county service area).

As a reminder, your Professional Provider Agreement with IBC requires you to direct members and/or their lab specimens to a participating outpatient laboratory provider, except in an emergency, as otherwise described in the applicable Benefit Program Requirements, or as otherwise required by law.

Establish your electronic interfaces with LabCorp

LabCorp offers a variety of test ordering and result delivery solutions that provide the flexibility to meet your needs, including several electronic options, like LabCorp Beacon®. For more information about LabCorp Beacon®, go to *www.labcorp.com/beacon*.

If you haven't already, we strongly suggest that you contact LabCorp at 1-888-295-5915 as soon as possible to establish your preferred electronic interfaces.

Re-issue of ID cards for affected members

As a result of this change in our outpatient laboratory network, many primary care physicians (PCP) who were previously capitated to Quest Diagnostics were assigned a new capitated laboratory provider. As a result, HMO and POS members whose PCP's capitated laboratory changed were issued a new member ID card. ID cards for HMO and POS members indicate the member's capitated laboratory provider through the Lab Indicator.

As they do today, physicians should check the member's ID card and use the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal to verify the capitated laboratory provider for HMO and POS members. Using NaviNet ensures that practices have the most accurate information.

For more information

We encourage you to review the information posted on the LabCorp-dedicated section of our Provider News Center at *www.ibx.com/pnc/lab*. This section contains valuable resources specific to our provider network, including:

- frequently asked questions;
- a list of LabCorp's new patient service centers in the IBC five-county service area;
- a list of other currently contracted laboratories that will remain in our network in addition to LabCorp;
- an archive of communications related to this change.

If you have any questions about this change, please email us at *provider_communications@ibx.com*. ◆

ADMINISTRATIVE

P F A

Get up-to-date news and information at our Provider News Center

The Provider News Center — a provider-dedicated website located at *www.ibx.com/pnc* — features up-to-date news and information of interest to providers and the health care community. Bookmark this site to ensure IBC news and information remain only a click away.

Finding information you need

The Provider News Center has a user-friendly interface that allows you to easily find news and information of interest to you and your office:

- **Latest News.** All provider news published within the previous month is listed conveniently on the home page.
- **Spotlight.** Promotional banners located at the top of the home page highlight important news.
- **Dedicated News.** The home page features dedicated sections for important topics (e.g., ICD-10, Business Transformation) with significant impact to our network providers.
- **Sortability & Searchability.** All news is grouped by category (e.g., Billing & Reimbursement, NaviNet®, and Products) and by provider type (Professional, Facility, or Ancillary), allowing you to easily find news that's relevant to you and your office staff. You can also conduct keyword searches to pinpoint specific content.

Additionally, the Provider News Center includes current and past editions of *Partners in Health Update* and a Quick Links section that provides easy access to our traditional IBC resources, such as bulletins, *Inside IPP* (the Inter-plan programs publication), IBC forms, the IBC Medical Policy portal, the NaviNet web portal, and our annually published provider publication indices.

We welcome your feedback. Please email us at *provider_communications@ibx.com* to share your thoughts. ◆

BILLING

P F

Reminder: Participating providers must submit all claims for IBC members to IBC

As previously communicated, if you are a participating provider with IBC submitting claims for IBC commercial HMO, POS, and PPO and Medicare Advantage HMO and PPO members, you must submit the claim directly to IBC.

***Note:* Use our payer ID grids to find the appropriate claims submission information based on the IBC member's health plan. The payer ID grids are available at *www.ibx.com/edi*.**

This requirement applies both to providers in the IBC five-county service area (i.e., Bucks, Chester, Delaware, Montgomery, and Philadelphia) and providers located in contiguous counties (i.e., counties that surround the IBC five-county service area).

Claims for IBC members may not be submitted to a local plan if the provider is contracted with IBC. For example, an IBC-participating provider located in Camden County, New Jersey (i.e., a contiguous county) should not submit a claim to Horizon Blue Cross Blue Shield of New Jersey for an IBC member. Rather, he or she should submit the claim directly to IBC.

If an IBC-participating provider attempts to submit a claim to their local plan for an IBC member, the claim will be denied. No payment will be issued by IBC until the claim is correctly submitted to IBC.

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

F

Coding guidelines for spinal fusion procedures

Spinal fusion surgery is on the rise. From 2001 to 2011, the number of spinal fusions in the United States increased 70 percent. These procedures have become even more common than hip replacements. More than 465,000 spinal fusions were performed in the United States during 2011.

With the overall increase of these procedures, it is important that providers carefully review the documentation prior to submitting the claim. To ensure proper coding, providers must determine the following:

- Is it a fusion or refusion procedure?
- What is the correct operative approach: anterior, posterior, or combined?

For example, a combined anterior posterior procedure will have two incisions. This must be documented separately. Often, there are two different surgeons involved as well. Documentation on the operative report should reflect that the patient was turned over (from his or her back to stomach, or vice versa) between the two procedures.

In the near future, our Corporate and Financial Investigations Department will be taking a closer look at the coding for these procedures to ensure that the claims are paying to the correct diagnosis related group (DRG).

Learn more

The following organizations offer additional information on current coding guidelines for spinal fusion:

- **American Hospital Association.** Visit *www.ahacentraloffice.org* and click on *Coding Clinic* on the top tool bar.
- **Centers for Disease Control and Prevention.** Visit *www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf* to access the ICD-10-CM Official Guidelines for Coding and Reporting. ◆

P A

Ensure successful submission of CMS-1500 claim forms and an updated toolkit now available

As previously communicated, IBC is now only accepting the updated version of the 1500 Health Insurance Claim Form (CMS-1500 claim form). The new claim form (02/12), which went into effect January 6, 2014, accommodates reporting needs for ICD-10 and aligns with data captured on electronic 837 transactions.

Field 24G

To ensure that claims submitted to IBC on the CMS-1500 claim form do not reject, please be sure to complete Field 24G “Days or Units”, regardless of claim type. Days or Units is the number of days that correspond to the dates entered in Field 24A or units as defined in CPT® or HCPCS coding manuals. A unit of at least “1” is required in this field.

Failure to complete Field 24G will result in a rejected claim with code P0021, as shown below:

> **Code P0021:** “Unit field is null or zero ___ for service line ___. Please correct and resubmit.”

Updated toolkit available

Our CMS-1500 toolkit has been updated to reflect details related to this requirement. Download the toolkit, titled *Claims submission toolkit for proper electronic and paper claims submissions*, from *www.ibx.com/providers/claims_and_billing/claim_requirements*.

For additional tips on proper claims submission, please review the article, *Tips for submitting claims using the new CMS-1500 (02/12) claim form*, which was published in the May 2014 edition of *Partners in Health Update*.

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

PFA

Reminder: 90-day grace period for APTC members

The Advanced Premium Tax Credit (APTC) is part of the Patient Protection and Affordable Care Act, also known as Health Care Reform. The APTC helps qualifying individuals and families obtain health insurance by reducing monthly premiums.

As previously communicated, Health Care Reform mandates a three-month grace period for APTC members who are delinquent in paying their portion of the premiums. Please note that members must first pay their initial premium payment to be eligible for the grace period.

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.

Delinquent payment indicator

To comply with the mandate, IBC has created a new field called APTC (Advanced Premium Tax Credit), which is available within the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal. This field indicates when a member is in the grace period and provides a status of the member's claims. The APTC field will only display when a member is in a delinquency status. When the member enters the grace period, the APTC field will be populated on the Eligibility and Benefits Details screen with the word "Yes." There will be a corresponding message that indicates the month of delinquency the member is in and the status of his or her claims.

If claims incurred in the second and third month are denied due to non-payment of premium by the end of the grace period, and the member's policy is terminated, providers may seek reimbursement directly from the member. However, if the premium is paid in full before the grace period ends, any pended claims will be processed in accordance with the terms of your Provider Agreement.

For more information

Please refer to the *Delinquent Payment Indicator for APTC Members* user guide for detailed information about the APTC field. This guide is available in the NaviNet Transaction Changes section of our Business Transformation site at *www.ibx.com/pnc/businesstransformation*.

If you have any questions about this mandate, 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. ◆

Upcoming changes to IBC's post-service appeals and grievance processes

Following a review of IBC's post-service professional provider appeals and grievances processes, which focused on how providers have utilized and how IBC has operationalized these processes, **effective November 1, 2014,** we will be rolling out a streamlined appeals process and offering enhanced access to the provider grievance process, as follows:

- **Billing dispute appeals.** There will be two levels of internal review for professional providers. All first-level billing disputes must be received within 180 days of your receipt of the Statement of Remittance (SOR)* or Provider Explanation of Benefits (Provider EOB).
- **Grievances.** There will be a one-level external review, as described below, by a clinically matched specialist for professional providers. IBC reserves the right to conduct a preliminary internal assessment. *Note:* Appeals not overturned during the original assessment will automatically be forwarded for an external, matched specialty review.

Billing dispute appeals process

IBC offers a two-level post-service billing dispute appeals process for professional providers. For services provided to any commercial or Medicare Advantage IBC member, providers may appeal claim denials related to general coding and the administration of claim payment policy as billing disputes.

Examples of billing disputes include:

- bundling logic (integral, incidental, mutually exclusive claim edits);
- modifier consideration and application;
- claims adjudication settlement not consistent with the law or the terms of the provider's contract;
- improper administration of an IBC claim payment policy;
- claim coding (i.e., how we processed the codes in the claim vs. the provider's use of the codes).

The provider billing dispute appeals process does *not* apply to:

- utilization management determinations (e.g., claims for services considered not medically necessary, experimental/investigational, cosmetic);
- precertification/authorization/referral requirements;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the Corporate and Financial Investigations Department;
- fee schedule concerns.

Submission of billing dispute appeals

To facilitate a first- or second-level billing dispute review, submit inquiries to:

Provider Billing Dispute Appeals
P.O. Box 7930
Philadelphia, PA 19101-7930

All first-level billing dispute appeals must be filed within 180 days of receiving the SOR or Provider EOB and should contain all applicable medical records, notes, and tests, along with a cover letter explaining the appeal. IBC will process first-level appeals within 30 days of receipt of all necessary information. A billing dispute appeal determination letter will be sent to the provider.

If a provider disputes the first-level provider billing dispute appeal determination, he or she may then submit a second-level provider billing dispute appeal by sending a written request within 60 days of receipt of the decision of the first-level provider billing dispute appeal. The appeal will be reviewed by an internal Provider Appeals Review Board (PARB) consisting of three members, including at least one Medical Director. The decision will then be communicated to the provider and will include a detailed explanation. The decision of the PARB will be the final decision of IBC.

continued on the next page

continued from the previous page

If a member appeal, or provider appealing on behalf of the member appeal with the members consent, is filed before or during an open provider appeal for the same issue, the provider appeal will be closed and addressed under the member appeal.

Provider grievance process

IBC offers a one-level post-service grievance process for professional providers. For services provided to any commercial or Medicare Advantage IBC member, providers may appeal claim denials related to services (i.e., those considered not medically necessary, experimental/investigational, or cosmetic) as grievances.

The grievance process does *not* apply to

- precertification/authorization/referral requirements;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the Corporate and Financial Investigations Department;
- fee schedule concerns;
- billing dispute appeals.

Submission of provider grievances

To facilitate a grievance review, submit to:

Provider Grievances
P.O. Box 7930
Philadelphia, PA 19101-7930

All grievances must be filed within 180 days of receiving the SOR or Provider EOB and should contain all applicable medical records, notes, and tests, along with a cover letter explaining the grievance. All grievances will be processed within 60 days of receipt of all necessary information. A preliminary review will be conducted. If the determination is to pay the claim, a claim adjustment will be processed and a determination letter will be sent to the provider. All other grievances will be sent to an Independent Review Organization (IRO) for a matched specialty review. A determination letter will be sent to the provider containing the IRO decision and detailed explanation. The decision of the IRO is final.

If a member grievance, or provider filing on behalf of the member grievance, is filed before or during an open provider grievance for the same issue, the provider grievance will be closed and addressed under the member grievance.

For more information

For claim explanation, providers may call Customer Service at 1-800-ASK-BLUE. ◆

**As of November 1, 2013, and continuing through mid-2015, IBC is in the process of migrating its membership to a new operating platform. Once a member has been migrated to the new platform, providers will no longer receive the current SOR. Professional providers will receive what will be called the Provider Explanation of Benefits (EOB). Once all members are migrated in 2015, you will only receive the new Provider EOB.*

PFA

New Allowance Inquiry transaction coming to NaviNet® this fall

In mid-October, IBC will introduce a new transaction to the NaviNet web portal – called Allowance Inquiry – to replace the retired Fee Schedule Inquiry transaction. Allowance Inquiry will be available through the Plan Transactions menu.

Allowance Inquiry will return fees for professional providers only and will indicate where primary care physician capitation is generally applicable. The fees returned via Allowance Inquiry will be associated with migrated members only and will not include results for Traditional or Comprehensive Major Medical members.

Please note that provider payment allowance information will be for informational purposes only and will not be a guarantee of payment for the amount displayed.

User guide available soon

We will publish a user guide soon in the NaviNet Transaction Changes section of our Business Transformation site at *www.ibx.com/pnc/businesstransformation*. This guide will describe the Allowance Inquiry transaction in detail. We strongly encourage you to review the user guide once it's published. An announcement will be made on IBC NaviNet Plan Central and on our Provider News Center once it is available.

If you have any questions regarding this new transaction, please call the eBusiness Hotline at 215-640-7410. ◆

Attention: NaviNet office conversion postponed until 2015

Last month we announced that we would be converting NaviNet offices to the new platform in October 2014. Please be advised that this conversion has been postponed until 2015. We will communicate more specific information, as it becomes available, in future editions of *Partners in Health Update*.

PF

Pre-service review for out-of-area members will be made available through NaviNet®

Starting in mid-August, IBC will offer the ability to use Electronic Provider Access (EPA) through the NaviNet web portal to access the provider portal of an out-of-area member's Home Plan and conduct electronic pre-service reviews.

With this added function on NaviNet, you may no longer be required to call the out-of-area member's health plan line to request preapproval. Users may still need to call the member's Home Plan to request preapproval if the Home Plan does not offer the pre-service review electronically. The new transaction, *Pre-Service Review for Out-of-Area Members*, will be available under the *Blue Exchange® Out of Area* option in the Plan Transactions menu.

The benefits of EPA include:

- more efficient pre-service review process;
- reduced administrative costs and fewer phone calls;
- improved provider and member satisfaction.

For more information

A new user guide that describes this transaction in greater detail is available in the NaviNet Transaction Changes section of our Business Transformation site at *www.ibx.com/pnc/businesstransformation*. We encourage you to review the guide prior to the transaction becoming available in mid-August.

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

Highlighting HEDIS®: Colorectal cancer screening

This article series is our monthly tool to help you maximize patient health outcomes in accordance with NCQA's[1] HEDIS®[2] measurements for high quality care on important dimensions of services.

HEDIS® definition

Colorectal cancer screening: The percentage of commercial and Medicare members ages 50 – 75 who had appropriate screening for colorectal cancer during the measurement year.

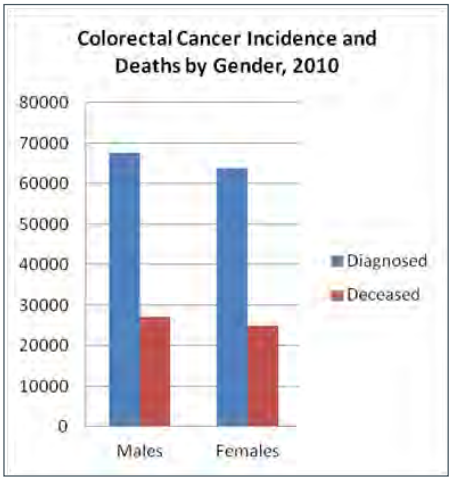
Any of the following tests meets the criteria:

- fecal occult blood test – guaiac (gFOBT) or immunochemical (iFOBT) during the measurement year;
- flexible sigmoidoscopy during the measurement year or four years prior to the measurement year;
- colonoscopy during the measurement year or nine years prior to the measurement year.

Note: Digital rectal exams do not count as evidence of colorectal cancer screening because they are not specific or comprehensive enough to screen for colorectal cancer. Additionally, members who had either colorectal cancer or a total colectomy at any time in their history are excluded.

The importance of screening

"Colorectal cancer is the second leading cause of cancer-related deaths in the U.S. It places significant economic burden on society: treatment costs over $6.5 billion per year. Unlike other screening tests that only detect disease, some methods of screening can detect premalignant polyps and guide their removal, which in theory can prevent cancer from developing." — *NCQA, HEDIS 2013 V1*



Learn more

Visit *www.ibx.com/providers/resources/hedis.html* to view previously published Highlighting HEDIS® articles.

If you have feedback about the Highlighting HEDIS® series or you have topic ideas, email us at *provider_communications@ibx.com*. ◆

QIPS[3] Alert!

Colorectal cancer screening is a performance measure in the QIPS program for measurement year 2014 for participating providers.

Stars[4] Alert!

This measure is also a Medicare Stars measure.

Register for ePASS® today and start earning!

Did you know that providers registered for ePASS® can receive financial incentives by documenting patient encounters? Documentation for colorectal cancer screening is required when submitting patient encounters.

[1] *The National Committee for Quality Assurance (NCQA) is the most widely recognized accreditation program in the U.S.*

[2] *The Healthcare Effectiveness Data and Information Set (HEDIS) is an NCQA tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care.*

[3] *The Quality Incentive Payment System (QIPS) is a reimbursement system developed by Keystone Health Plan East for participating Pennsylvania primary care physicians that offers incentives for high-quality, accessible, and cost-effective care.*

[4] *Stars is a program developed by the Centers for Medicare & Medicaid Services to measure quality health care. Ratings are published annually to help educate consumers prior to enrollment decisions.*

Benefit tier re-evaluation for Keystone HMO Proactive

In 2014, IBC introduced Keystone HMO Proactive, a lower-cost, tiered provider network plan available both on and off the Health Insurance Marketplace. For this plan, providers in IBC's HMO network were categorized into one of three benefit tiers:

- **Tier 1 – Preferred:** Members pay the lowest cost-sharing for most services.
- **Tier 2 – Enhanced:** Members pay a higher cost-sharing for most services compared to Tier 1 – Preferred.
- **Tier 3 – Standard:** Members pay the highest cost-sharing for most services.

Re-evaluation of benefit tier placements for 2015

As previously communicated, IBC will review provider benefit tier placements annually for Keystone HMO Proactive. We are currently re-evaluating the benefit tier placements for our professional providers for 2015 using more recent data.

All providers whose benefit tier is changing for 2015 will be notified by mail in the coming weeks of their new benefit tier assignment. The new benefit tier will remain in place from January 1, 2015, through December 31, 2015.

Note: If you do not receive a letter regarding your benefit tier placement, then your benefit tier will not change in 2015.

Benefit tier placement criteria

Like last year, benefit tier placements for professional providers are based upon criteria that include relative cost (i.e., contracted fee schedule), minimum quality standards (if applicable), and the tier of the facilities in which a provider's IBC patients are typically referred for hospital and outpatient surgical services.

If you have questions specific to Keystone HMO Proactive or your benefit tier placement, please email us at *provinquiry@ibx.com*. ◆

PFA

Medical and claim payment policy activity posted from June 25 – July 25, 2014

Below is a listing of the policy activity that we have posted to our website from June 25 – July 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
08.01.17	Elosulfase alfa (Vimizim™)	June 18, 2014	July 18, 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
00.01.25u	PPO Network Rules for Provision of Specialty Services for Durable Medical Equipment and Laboratory, Radiology, and Physical Medicine and Rehabilitative Services	Coverage and/or Reimbursement Position; Medical Coding	N/A	July 16, 2014
00.06.02k	Preventive Care Services	Medical Necessity Criteria; Medical Coding	June 5, 2014	September 3, 2014
02.01.01c	Home Health Care Services	Medical Necessity Criteria; Coverage and/or Reimbursement Position; General Description, Guidelines, or Informational Update	April 23, 2014, Revised June 19, 2014	July 22, 2014
05.00.14g	High-Frequency Chest Wall Oscillation Devices	Medical Necessity Criteria	June 18, 2014	July 18, 2014
05.00.38h	Negative-Pressure Wound Therapy (NPWT) Systems	Medical Coding; Medical Necessity Criteria	June 30, 2014	July 30, 2014
05.00.42f	Patient Lifts	Medical Necessity Criteria; Medical Coding	N/A	July 2, 2014
05.00.43e	Seat Lift Mechanisms	Medical Necessity Criteria	N/A	July 2, 2014
05.00.47j	Knee Braces	Medical Coding; Medical Necessity Criteria; Coverage and/or Reimbursement Position	June 30, 2014	July 30, 2014
05.00.56f	Hospital Beds and Accessories	Medical Necessity Criteria; General Description, Guidelines, or Informational Update	July 3, 2014	August 4, 2014
05.00.59g	Lower Limb Prostheses	General Description, Guidelines, or Informational Update; Medical Necessity Criteria	N/A	July 16, 2014
07.03.21g	Electromyography (EMG) (Needle and Non-Needle) of the Anal or Urethral Sphincter	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding	June 30, 2014	July 30, 2014

continued on the next page

MEDICAL

continued from the previous page

Policy #	Title	Type of policy change	Notification date	Effective date
07.07.02g	Ultraviolet Light Therapy for the Treatment of Dermatological Conditions	General Description, Guidelines, or Informational Update; Medical Necessity Criteria; Medical Coding	N/A	July 2, 2014
07.10.06a	Assisted Reproductive Technology for Infertility and Oocyte Cryopreservation	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	June 30, 2014	July 30, 2014
08.00.33j	Trastuzumab (Herceptin®)	Coverage and/or Reimbursement Position; Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	April 23, 2014	July 22, 2014
09.00.17j	Intensity Modulated Radiation Therapy (IMRT)	Medical Coding	January 3, 2014	April 2, 2014, Revised July 15, 2014
11.00.06e	Treatment of Obstructive Sleep Apnea (OSA) and Primary Snoring for Adults	Coverage and/or Reimbursement Position; Medical Coding; General Description, Guidelines, or Informational Update	April 23, 2014	July 23, 2014
11.00.14d	Treatment of Twin-Twin Transfusion Syndrome (TTTS)	Medical Necessity Criteria; Medical Coding; General Description, Guidelines, or Informational Update	N/A	July 2, 2014
12.01.01x	Experimental/ Investigational Services	Medical Coding; Coverage and/or Reimbursement Position	April 10, 2014	July 9, 2014
12.01.01y	Experimental/ Investigational Services	Coverage and/or Reimbursement Position; Medical Coding	N/A	July 10, 2014

Reissued policies

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

Policy #	Title	Reissue effective date
01.00.09b	Continuous Local Delivery of Anesthesia to Operative Sites Using an Elastomeric Infusion Pump	July 23, 2014 (Published July 24, 2014)
05.00.70a	Mechanical Stretching Devices for the Treatment of Joint Stiffness or Contractures	June 25, 2014 (Published June 25, 2014)
07.02.09b	Ambulatory Blood Pressure Monitoring (ABPM)	July 23, 2014 (Published July 24, 2014)
07.06.01b	Complete Decongestive Therapy (CDT)	July 9, 2014 (Published July 11, 2014)
07.06.03a	Bioimpedance for the Detection of Lymphedema	July 9, 2014 (Published July 11, 2014)
08.00.62e	Abatacept (Orencia®) for Injection for Intravenous Use	July 9, 2014 (Published July 11, 2014)
08.01.03c	Belatacept (Nulojix®)	July 9, 2014 (Published July 11, 2014)
09.00.02d	Electron Beam Computed Tomography (EBCT) for Screening Evaluations	June 25, 2014 (Published June 25, 2014)
09.00.24b	Full-Body Computerized Tomography (CT) Scan Screening	June 25, 2014 (Published June 26, 2014)
11.03.12j	Colorectal Cancer Screening	July 23, 2014 (Published July 24, 2014)
11.05.01c	Refractive Keratoplasty	July 9, 2014 (Published July 11, 2014)
11.05.07c	Surgical Correction of Strabismus	July 9, 2014 (Published July 11, 2014)
11.05.08c	Photocoagulation of Macular Drusen	July 9, 2014 (Published July 11, 2014)

continued on the next page

MEDICAL

continued from the previous page

Policy #	Title	Reissue effective date
11.08.14f	Removal of Breast Implants	June 25, 2014 (Published June 25, 2014)
11.11.05e	Circumcision	July 23, 2014 (Published July 24, 2014)
11.14.01f	Mentoplasty or Genioplasty	June 25, 2014 (Published June 25, 2014)
11.14.17b	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure	July 9, 2014 (Published July 11, 2014)
11.14.19g	Artificial Intervertebral Disc Insertion	June 25, 2014 (Published June 25, 2014)
11.14.23c	Surgical Treatment of Femoroacetabular Impingement	July 9, 2014 (Published July 11, 2014)
11.14.24	Manipulation Under Anesthesia	June 25, 2014 (Published June 25, 2014)
12.04.03b	Air or Sea Ambulance Transport Services	July 23, 2014 (Published July 24, 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
00.03.02q	Diagnostic Radiology Services Included in Capitation	July 1, 2014 (Published July 25, 2014)
00.03.07h	Laboratory Services for Members Enrolled in Health Maintenance Organization (HMO) or Health Maintenance Organization Point-of-Service (HMO-POS) Products	July 1, 2014 (Published July 25, 2014)
03.00.06k	Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure or Other Service	July 1, 2014 (Published July 11, 2014)
03.00.10k	Modifiers LT/RT: left Side/Right Side Procedures	July 11, 2014 (Published July 11, 2014)
03.00.15k	Modifier 24: Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period	July 1, 2014 (Published July 11, 2014)
03.00.16k	Modifier 57: Decision for Surgery	July 1, 2014 (Published July 11, 2014)
05.00.24k	Interstitial Continuous Glucose Monitoring Systems (CGMSs)	July 1, 2014 (Published July 1, 2014)
05.00.32f	Speech- and Non-Speech-Generating Devices	July 1, 2014 (Published July 1, 2014)
06.02.35g	Genetic Testing	July 1, 2014 (Published July 1, 2014)
07.05.02k	Wireless Capsule Endoscopy (WCE) as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon	July 1, 2014 (Published July 10, 2014)
08.00.57f	Complex Regional Pain Syndrome (CRPS) Parenteral Treatments	July 1, 2014 (Published July 1, 2014)
08.00.92h	Coagulation Factors for Hemophilia	July 1, 2014 (Published July 1, 2014)
09.00.10q	Brachytherapy	July 1, 2014 (Published July 10, 2014)
10.03.01d	Physical Medicine, Rehabilitation, and Habilitation Services	July 1, 2014 (Published July 2, 2014)
10.06.01h	Speech Therapy	July 1, 2014 (Published July 2, 2014)

continued on the next page

continued from the previous page

Archived policy

The following policy is deemed no longer necessary by IBC.

Policy #	Title	Notification date	Effective date
08.00.54d	Radioimmunotherapy with Tositumomab and Iodine I-131 Tositumomab (the Bexxar® Therapeutic Regimen)	July 14, 2014	August 13, 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. ◆

PFA

Reminder: Upcoming changes to Medicare Advantage HMO and PPO policies and clinical relationship logic

Effective January 1, 2015, we are introducing changes related to the application of medical and claim payment policies, as well as clinical relationship logic, for IBC's Medicare Advantage business.

Policy changes

Medical and claim payment policies that currently apply to both commercial and Medicare Advantage business will be separated into two unique policy portfolios: one for Medicare Advantage business and one for commercial business.

The new Medicare Advantage policy portfolio will become effective January 1, 2015; notifications for these policies will be available on the IBC Medical Policy Portal by October 1, 2014. This policy portfolio will be based on Medicare coverage guidance as well as additional IBC medical and claim payment policy determinations.

Note: The existing policy portfolio will continue to apply to commercial business.

Clinical relationship logic (procedure code-to-procedure code edits)

Effective January 1, 2015, the following will be applied to claims submitted on the CMS-1500 claim form or through the 837P transaction for Medicare Advantage HMO and PPO members:

- Medicare's National Correct Coding Initiative (NCCI) editing;
- other clinical relationship logic, which is based on procedure code editing standards.

For more information

Additional information about these changes will be provided in future editions of *Partners in Health Update*.

Stay up-to-date on policy activity by visiting *www.ibx.com/medpolicy* and selecting *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. ◆

IBC's policy on locum tenens

IBC requires all physicians who provide services to our members to be credentialed and contracted. However, under certain circumstances, we do allow for locum tenens arrangements.

What is a locum tenens arrangement?

Substitute physicians are generally called locum tenens physicians. According to the *Medicare Claims Processing Manual*, it is a long-standing and widespread practice for physicians to retain locum tenens physicians in their professional practices when they are absent for reasons of illness, pregnancy, vacation, or continuing medical education.

It is also acceptable for the regular physician to bill and receive payment for the locum tenens physician's services as if he performed them himself. The locum tenens physician generally has no practice of his own and moves from area to area as needed. It is customary for the regular physician to pay the locum tenens physician a fixed amount per diem.

Locum tenens status is that of independent contractor rather than an employee. In addition, locum tenens provisions apply only to physicians. Services of non-physician practitioners (e.g., Certified Registered Nurse Anesthetists, Nurse Practitioners, and Physician Assistants) may not be billed under the locum tenens guidelines from the Centers for Medicare & Medicaid Services. These provisions apply only to physicians.

Duration of a locum tenens arrangement

If a regular physician is absent longer than 60 days without returning to work, the locum tenens must be credentialed and enrolled as if he or she were joining your practice as a new physician.

The 60 days is a "consecutive" 60-day period. For example, a locum tenens physician providing coverage three days a week beginning on September 1 can still only provide services for the same absentee physician through October 30. This also applies even if several different locum tenens physicians are used to provide coverage during the 60-day period, because the limitation is tied to the billing of the Q6 modifier, not to the number of days that any particular locum tenens physician provides coverage.

Therefore, a new 60-day period for billing the services of a locums tenens physician does not commence as a result of a break in service of the locum tenens physician. Instead, a new 60-day period commences only by a break in the absence of the physician for whom a locum tenens physician is necessary. After the regular physician returns to work and provides services for at least one day, then a locum tenens physician can provide services as a substitute for that regular physician again at some point in the future, if necessary, for up to 60 consecutive days. ◆

F

Reminder: Provider financial responsibility for preapproval of inpatient facility services for out-of-area members

As previously communicated, effective July 1, 2014, participating providers became responsible for obtaining preapproval for inpatient facility services for out-of-area members. Dates of admission on or after July 1, 2014, are subject to this requirement, and the out-of-area member is held harmless.

While most providers currently obtain preapproval for inpatient facility services, this new requirement moved financial responsibility for lack of preapproval from the member to the provider. Failure to obtain preapproval for inpatient facility services for out-of-area members will result in a denied claim. To avoid claim denials, it is important to preapprove the inpatient stay and check that additional days are authorized before an out-of-area member is discharged.

Inpatient stay extensions for DRG/case rate facilities

In diagnosis related group (DRG)/case rate situations, when the length of an inpatient stay extends beyond the preapproved length of stay, any additional days should be approved by the last day of the originally approved days. For example, if five days are approved by the Home Plan and the patient has not been discharged by the fifth day, the provider should contact the Home Plan and ask to have the authorization updated. Please ensure that you seek approval of additional days to avoid payment issues.

Denied days within an approved inpatient stay for non-DRG/case rate facilities

In non-DRG/case rate situations, if there are denied days within an approved inpatient stay, the provider will be financially liable for the denied days and the member will be held harmless.

Getting preapproval for out-of-area members

Providers can obtain preapproval of inpatient facility services for an out-of-area member through one of the following:

- **Telephone.** Providers can call the BlueCard Eligibility® line at 1-800-676-BLUE and ask to be transferred to the utilization review area.
- **NaviNet® web portal.** Starting in mid-August, IBC providers will be able to submit electronic preapproval requests for out-of-area members through NaviNet. Please refer to the article titled *Pre-service review for out-of-area members will be made available through NaviNet* in the NaviNet section of this edition.

Please note that providers must notify the member's Home Plan within 48 hours when a change or modification to the original pre-service review occurs. Providers must also notify the member's Home Plan within 72 hours for emergency/urgent pre-service review. ◆

Pilot programs available to select patients likely to be hospitalized

In the March 2014 edition of *Partners in Health Update*, we introduced a new initiative to help physicians target care for their IBC patients who had a likelihood of acute hospitalization within the next six months, based on conditions such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Select providers received a mailing in February 2014, as well as in May 2014, with a list of their at-risk patients.

New pilot programs

We are pleased to introduce two new pilot programs to further assist you in caring for your patients who are at risk for acute hospitalization. These pilot programs are available for select IBC members who qualify for participation:

- **Remote Monitoring Pilot Program.** IBC is working with Valued Relations Inc. (VRI), an independent company, to provide 24-hour remote home monitoring services to qualified commercial members with a likelihood of acute hospitalization in the next six months based on indicators of escalated clinical situations. VRI utilizes wireless technology that will apprise you of significant changes such as weight gain for CHF patients and oxygen desaturation for COPD patients. The goal of the program is to prevent acute admission and reduce acute readmissions. The program is expected to launch in 2014.
- **Community Health Worker (CHW) Pilot Program.** IBC and the Visiting Nurse Association of Greater Philadelphia, an independent company, are connecting CHWs with the highest-risk members within a targeted geographic location. The goal of the program is to provide non-clinical services to help select members with a variety of social and environmental challenges that may affect their ability to access health care and social resources. The CHW Program launched in early July and will run for six months.

If you have any questions about these new pilot programs, please contact your Network Coordinator. ◆

Health Coaches: Supporting your patients, our members

Health Coaches are available 24/7/365 through the following programs to enhance your ability to provide coordinated care for your patients and promote integration of care among members and their families, physicians, and community resources:

- **Condition management.** Condition management is available to eligible members for common chronic conditions such as asthma, diabetes, COPD, and hypertension.
- **Case management.** Case management provides support to members who are experiencing complex health issues or challenges in meeting their health care goals.

For additional information about our condition management and case management programs, visit our website at *www.ibx.com/providers/resources*. Members can reach their Health Coach by calling 1-800-ASK-BLUE. ◆

Refer a patient to an IBC Health Coach today by completing the online physician referral form at **www.ibx.com/providerforms** or by calling **1-800-ASK-BLUE**.

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 eligible for condition management will be given the name and contact information for a 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.

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

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 to prescribe contraception, if necessary. These visits should be scheduled before members are discharged from the hospital.

Important Resources

Anti-Fraud and Corporate Compliance	
Hotline	1-866-282-2707 or www.ibx.com/antifraud
Care Management and Coordination	
Baby BluePrints®	215-241-2198 / 1-800-598-BABY (2229)*
Case Management	1-800-ASK-BLUE
Condition Management Program	1-800-ASK-BLUE
Credentialing	
Credentialing Violation Hotline	215-988-1413 or 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
Electronic Data Interchange (EDI)	
Highmark EDI Operations	1-800-992-0246
FutureScripts® (commercial pharmacy benefits)	
Pharmacy benefits	1-888-678-7012
Pharmacy website (formulary updates, prior authorization)	www.ibx.com/rx
FutureScripts® Secure (Medicare Part D pharmacy benefits)	
FutureScripts Secure Customer Service	1-888-678-7015
Formulary updates	www.ibxmedicare.com
NaviNet® web portal	
IBC eBusiness Hotline	215-640-7410
Registration	www.navinet.net
Other frequently used phone numbers and websites	
IBC Direct Ship Injectables Program (medical benefits)	www.ibx.com/directship
Medical Policy	www.ibx.com/medpolicy
Provider Supply Line	1-800-858-4728 or www.ibx.com/providersupplyline

**Outside 215 area code*

†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 Provider News Center: www.ibx.com/pnc