



U P D A T E

PROVIDER SERVICES

Policies/Procedures/Claims

HMO

215/567-3590

800/227-3119*

PPO

800/332-2566

PHARMACY SERVICES

Prescription Drug

Authorization

888/671-5280

Toll-Free Fax

888/671-5285

Blood Glucose Meter

Hot Line (option 2)

888/494-8213 (option 2)

HEALTH RESOURCE
CENTER

215/241-3367

800/275-2583*

PRECERTIFICATION/
PATIENT CARE
MANAGEMENT

HMO Commercial

215/567-3070

800/227-3116*

Medicare

215/241-2160

800/313-8564*

PPO

215/567-3694

800/332-2566*

Medicaid

800/521-6622

THE SUPPLY LINE

800/858-4728

VISIT OUR WEB SITE
AT
WWW.IBX.COM

August 2002

Important Important HMO Billing and Referral Update: New 10-Digit HMO Provider ID Numbers

As part of the continuing conversion of our HMO products to a new managed care information system, PowerMHS™ (MHS), we are required to change to 10-digit HMO provider ID numbers. This change is also required to meet upcoming HIPAA regulations. We encourage you to prepare for the upcoming changes as outlined below.

New 10-Digit HMO Provider ID Numbers

This month, we will advise you of new 10-digit HMO provider ID numbers for your group and for the individual participating practitioners within your group at each office location. Only your HMO provider ID number is changing – **your PPO provider ID number is not changing at this time.** We will provide an *HMO Provider ID Number Reference Guide* that cross-references your new 10-digit and former 6-digit HMO provider ID numbers. As part of the conversion, we will also release new provider directories, station plates, and encounter/referral forms.

Preparing Your Practice

You should begin using the new 10-digit HMO provider ID numbers effective November 1, 2002 for HMO (and referred POS) encounters, claims, and referrals. **Please note, our claims processing system will not accept the new 10-digit HMO provider ID number prior to the November 1 start date.** We have established a transition period of November 1, 2002 to December 31, 2002 to facilitate this change. It is very important that you adjust your system/processes to accommodate the 10-digit number during the transition period.

The provider ID numbers that you currently use for Personal Choice®, BlueChoice®, and non-referred POS services are not affected and continue to be valid for Personal Choice, BlueChoice, and non-referred POS claims and related correspondence.

Unless your system already accommodates a 10-digit field, please contact your software vendor, billing office, or any other necessary party to adjust the HMO provider ID number field of your claims submission system to ensure that it is 10-digit compliant. Please do not delay in adjusting your claims submission system to accommodate the new 10-digit number.

* Outside 215 area code

The Independence Blue Cross (IBC) *Partners in Health Monthly Update* is a publication of the Provider Communications department for the exchange of information and ideas among the IBC Provider community. Suggestions and contributions are welcome.

To submit or suggest an article, contact:

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Certain services/treatments referred to in third-party sites may not be covered by all benefit plans. Members should refer to their benefit contract for complete details of the terms, limitations, and exclusions of their coverage.

Billing Reminders: Performing Provider ID Number

As previously communicated, the *Performing Provider ID Number* must be recorded on any CMS 1500 claims submitted. This is a required data element in conjunction with upcoming HIPAA compliance and other requirements.

Effective October 1, 2002, HMO, POS, and PPO claims submitted without the identification number of the physician or other professional provider performing the procedure or service will be rejected and returned as non-clean claims.

The performing provider ID number should be reported in section 33 of the CMS 1500 claim form in the "PIN #" field. **Note:** Physical therapists and labs which have not been assigned a specific performing provider ID number should submit their group provider ID number in both the "Grp #" and "PIN #" fields of box 33. Effective October 1, 2002, claims submitted without information in both of these fields will be rejected.

When submitting electronic claims, the performing provider ID number should be entered in the rendering provider ID number field (FA023). The applicable group ID number should continue to be reported in the group ID number field (CA028).

As always, the provider ID numbers entered on electronic and paper-based claims should directly reflect the member's benefit plan. Please enter your HMO provider ID number on all HMO/POS referred claims, encounters, referrals, and related correspondence. Enter your PPO provider ID number on all PPO, BlueChoice[®], and POS non-referred claims and related correspondence.

NAIC Codes for Electronic Billing

When submitting HMO/POS and PPO claims and encounters electronically through NaviNet ClaimsSM or Datastream, the appropriate National Association of Insurance Commissioners (NAIC) code must be used to identify the applicable line of business. The following are the codes assigned by NAIC:

- 95056 - Keystone Health Plan East
- 54704 - Personal Choice[®]
- 54771 - Highmark (Pennsylvania Blue Shield)

It is critical that you use the product-specific NAIC code listed above when submitting claims and encounters electronically. Using an incorrect number could delay processing and payment.

For more information, including how to get NaviNet ClaimsSM installed in your office, contact NaviMedixTM at (800) 526-7276 ext. 18

Electronic Referral Submission through NaviNetSM

Using the Referral Submission functionality within NaviNetSM, PCPs are electronically submitting referral notifications to Independence Blue Cross (IBC) when referring HMO patients to specialists and facilities. PCPs and patients alike are realizing the benefits of the auto-fax feature, which affords PCPs the opportunity to simultaneously fax HMO referrals to specialists and facilities upon submission of the referrals to IBC. Specialists and facilities must accept the printed form as a valid referral. If requested, PCPs may provide patients with a printed copy of the completed referral form to present to specialists and facilities.

NaviNetSM Frequently Asked Questions

Are the referral procedures for electronic submissions the same as the referral rules for paper submissions?

Yes, the same procedures apply for referrals submitted electronically as they do for referrals submitted on paper. To help providers supply all required information with electronic referral submissions, mandatory fields are highlighted in blue to alert the user when information must be supplied in order for the submission to be considered complete. For example, referrals must indicate the services requested; therefore, this field within the referral form is highlighted in blue. Procedure codes and diagnosis codes, on the other hand, are not required; therefore, these fields within the referral form are not highlighted in blue. We do suggest, however, that procedure codes and diagnosis codes be included.

How does NaviNetSM work?

NaviNetSM is a complete online application that uses the power of the Internet to connect to our back-end systems, allowing administrative transactions to be processed in real time. NaviNetSM reduces errors and simplifies daily administrative transactions with IBC.

How can our office get started?

All you need is a PC with Internet access and you are ready to begin realizing the benefits of NaviNetSM. The NaviNetSM application, training, and telephone support are provided by IBC and NaviMedixTM.

For access to NaviNetSM, contact the IBC eCommerce Provider Inquiry Line at (215) 640-7410 and leave a detailed message. A member of the eCommerce staff will return your call.

New Addition to HMO Capitated Laboratory Network: Mercy Health Labs

We are pleased to announce the addition of Mercy Health Labs to our network of participating HMO capitated laboratory providers. This latest addition continues our effort to increase HMO capitated laboratory availability and convenience to our physicians and HMO members. PCPs have the option to select Mercy Health Labs as a capitated site by contacting their Network Coordinator. Your office can arrange an HMO laboratory account with Mercy Health Labs by calling (610) 237-4852.

Along with Mercy Health Labs, Laboratory Corporation of America and Health Network Laboratories are HMO capitated network laboratory providers.

New Addition to HMO Capitated Laboratory Network: Mercy Health Labs (continued)

Specialists that draw or collect specimens should establish accounts with our capitated laboratories since they are required to send HMO members' specimens to their PCP's capitated laboratory. Maintaining an account with a participating capitated laboratory improves record keeping, promotes effective communication between the laboratory and the physician, and facilitates timely receipt of laboratory supplies. The Client Services Department at Laboratory Corporation of America can be reached at (800) 633-5221 and the Sales and Marketing Department at Health Network Laboratories can be reached at (610) 336-6640, extension 200.

New Benefits for University of Pennsylvania Employees

Patients who are employees of the University of Pennsylvania have a new PENNCare identification card, which they will present when receiving medical care. These patients are covered by a new benefit design, effective July 1, 2002, which provides three levels of coverage. The three benefit levels are shown below:

	PENNCare Network* Benefits	Personal Choice® Network Benefits	Out-of-Network Benefits
PCP Office Visit	\$10 copayment	\$20 copayment	70% of the IBC allowance after \$300 deductible
Specialist Visit	\$10 copayment	\$20 copayment	70% of the IBC allowance after \$300 deductible
Laboratory Services	100%	100%	70% of the IBC allowance after \$300 deductible
Pediatric and Adult Preventive Care	\$10 copayment	\$20 copayment	70% of the IBC allowance after \$300 deductible
Pediatric Immunizations	100%	100%	70% of the IBC allowance, NO deductible
Radiology Services	100%	\$20 copayment	70% of the IBC allowance after \$300 deductible

*PENNCare providers must also participate with Personal Choice

University of Pennsylvania employees receive the highest level of benefits and have the least amount of out-of-pocket costs when they use PENNCare providers. They also have access to the entire Personal Choice network with slightly higher out-of-pocket costs. If you have any questions concerning the new University of Pennsylvania benefit program, please contact Provider Services.

New Personal Choice® Options

Effective July 1, 2002, *Personal Choice High Deductible Series* options were introduced to Pennsylvania group customers. The series offers four new Personal Choice options: Personal Choice 520/80/50, Personal Choice 1020/80/50, Personal Choice 2020/80/50, and Personal Choice 2520/80/50.

The new option names refer to the amount of program deductible, primary care copayment, and in-network and out-of-network coinsurance, as illustrated below.

	Deductible <i>combined for in-network and out-of-network</i>	Primary Care Copay	In-Network Coinsurance	Out-of- Network Coinsurance
Personal Choice 520/80/50	\$500	\$20	80%	50%
Personal Choice 1020/80/50	\$1,000	\$20	80%	50%
Personal Choice 2020/80/50	\$2,000	\$20	80%	50%
Personal Choice 2520/80/50	\$2,500	\$20	80%	50%

The new plans use existing Personal Choice options as a basis for design, but incorporate a higher level of member cost sharing. Standard features of these designs are in-network and out-of-network coinsurance and a single, combined deductible.

If you have any questions concerning the new *Personal Choice High Deductible Series* plans, please contact Provider Services.

Payment Information Concerning Patients in Long-Term Care Facilities

Keystone Health Plan East (KHPE) is pleased to announce a change in the payment methodology to PCPs for care rendered to Keystone 65 patients assigned to the PCP's long-term care (LTC) panel.

Effective August 1, 2002, KHPE eliminated the LTC-enhanced capitation payment methodology and began reimbursing PCPs who render eligible services to Keystone 65 members in LTC facilities on a fee-for-service basis. This includes all covered services and is based on the applicable Keystone 65 fee schedule.

Members eligible for this panel are restricted to Keystone 65 members residing in LTC facilities. This policy does not apply to patients residing in personal care or assisted living facilities. Such members remain on your office-based panel and will be paid under capitation.

Please note that eligibility for fee-for-service reimbursement requires you to report to KHPE any member of your panel who is residing in an LTC facility. On a monthly basis, please fax a list of members from your panel residing in LTC facilities to Joseph Duda, Government Programs Network Coordinator, at (215) 632-5962. This notification should include the PCP's name, the name and ID number of the patient, and the name of the LTC facility.

If you have any questions concerning this change in reimbursement policy, please contact your Network Coordinator.

CMS 1500 Claim Form Update for Providers who Perform Outpatient Radiology and Lab Services at Participating Hospitals

IBC and KHPE recently reminded providers who perform diagnostic radiology or laboratory services in the outpatient setting of a participating hospital that they are required to include, in Field Locator 32 of the CMS 1500 form, the Medicare provider number of the hospital where the services are rendered. The name and address of the hospital continues to be required in Field Locator 32.

These are the electronic records and fields that are required:

Description	Record	Field
Facility ID Number	EA1	4
Facility Address	EA1	6
Facility Address 2	EA1	7
Facility City	EA1	8
Facility State	EA1	9
Facility Zip	EA1	10

Please note that any claim received on or after December 1, 2002 that does not include the Medicare provider number of the facility where the diagnostic radiology or laboratory service was rendered will not be adjudicated and will be returned to the provider as a non-clean claim.

Please submit the facility name, address, city/state/zip code and the Medicare provider number (10 digits, zero filled) within the lines of Box 32 (left justified). Please contact your Network Coordinator if you or your vendor have any questions about populating Box 32.

Reporting Survey Results

Included in the August Edition of *Update* is a special section highlighting the results of our recent research efforts. We are reporting survey results in the following areas:

- Member satisfaction with KHPE PCPs.
- Assessment of continuity and coordination of care between organizational providers and physicians.
- After-hours access results for KHPE PCPs and Personal Choice[®] family practitioners, pediatricians, internal medicine practitioners and OB/GYNs.

The information gathered by Independence Blue Cross and its managed care affiliates is used to assess network effectiveness, identify program successes, and target areas for improvement. The survey results reported are considered proprietary and confidential and should not be shared.

For current information about IBC's general operations, programs and services, please visit www.ibx.com.

Quality Management Update: Survey Results

Independence Blue Cross and its managed care affiliates (IBC) regularly conduct research about our provider and member communities to assess network effectiveness, identify program successes, and target areas for improvement. Periodically, when appropriate, we will share the results of our research with our provider network. The following section is devoted to reporting the results of recent research efforts. All information in this section is considered proprietary and confidential.

Member Satisfaction with PCPs

Keystone Health Plan East (KHPE) has conducted a yearly survey to assess members' satisfaction with their PCP's performance in areas such as accessibility, referrals, and preventive care counseling. Listed below are some of the highlights of the 2001 survey:

- Plan-wide member satisfaction with PCPs increased from 94% in 2000 to 95% in 2001.
- Member satisfaction for the following indicators also increased in 2001:
 - The ability to obtain a specialist referral.
 - The ability to contact the PCP after regular office hours and on weekends.
 - The friendliness and courtesy of the office staff.
 - The personal interest and attention shown by the PCP.
 - The explanation of the illness and treatment.
- The percentage of members surveyed who would recommend their PCP to a friend or relative was 93.1% in 2000 and 93.6% in 2002.

If you have any questions concerning the results of this survey, please contact your Network Coordinator.

Annual Keystone Health Plan East and Personal Choice® Primary Care Provider After-Hours Access Survey Results

On an annual basis, KHPE and Personal Choice® conduct telephone surveys of practitioners to assess compliance with after-hours accessibility. The objective of the after-hours survey was twofold:

- For PCPs and OB/GYNs using answering machines for after-hours coverage, the objective was to determine whether the messages supplied members with urgent care/emergency situation instructions.
- For those using answering services, the goals were to find out how physicians were notified by the answering service about urgent care/emergency situations and what kinds of instructions physicians left with their services.

Annual Keystone Health Plan East and Personal Choice® Primary Care Provider After-Hours Access Survey Results (continued)

Below are the 2001 results:

Characteristics of Answering Machines

	KHPE PCPs	Personal Choice Family Practitioners, General Practitioners, Pediatricians, and Internal Medicine	Personal Choice OB/GYNs
Percentage of answering machines that provided general instructions for urgent/emergent Care	88.7%	85.5%	82.9%

Characteristics of Answering Services

	KHPE PCPs	Personal Choice Family Practitioners, General Practitioners, Pediatricians, and Internal Medicine	Personal Choice OB/GYNs
Percentage of answering services that had a method of notifying the doctor about an urgent or emergent care situation	99.6%	99.4%	100.0%
Percentage of answering services that had special instructions for urgent/emergent care situations if the doctor cannot be reached	88.7%	90.1%	87.8%

Assessment of Continuity and Coordination of Care between Organizational Providers and PCPs

KHPE monitors the continuity and the coordination of care delivered to members to ensure that care is seamless, continuous, and appropriate. To this end, KHPE has created monitors such as medical record reviews and surveys to evaluate the continuity and coordination of care between PCPs and organizational providers.

As part of our ongoing efforts to improve the quality of care delivered to members, an on-site review of medical records was conducted among PCPs and four key organizational provider types:

- Hospitals.
- Home health agencies (HHAs).
- Skilled nursing facilities (SNFs).
- Ambulatory surgery units (ASUs).

Specific facilities were selected on the basis of volume. Members who had received services at these facilities during the study period were selected at random, and data were abstracted from medical records at both the PCP office and the facility to assess receipt and submission of appropriate information among PCPs, specialists, and organizational providers. Results of that study are as follows:

	Percentage of PCPs who received patient discharge information	Percentage of Continuity and Coordination of Care documentation in provider chart from PCP/specialist to Provider
Hospitals	81.4%	63.5%
Home Health Agencies	90.5%	100.0%
Skilled Nursing Facilities	64.3%	80.0%
Outpatient Surgery Centers	67.4%	86.7%

Assessment results revealed a reasonably high level of cross-communication between PCPs and organizational providers. KHPE encourages physicians responsible for dictating discharge summaries to include the member's PCP on the discharge summary distribution list. This will ensure that PCPs receive complete information regarding the member's hospitalization in cases in which the PCP is not the attending physician.