



Health

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

**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**

* Outside 215 area code

*May 2002***Magellan Behavioral Health**

The mental health and substance abuse benefits available to most of our members are managed by Magellan Behavioral Health (Magellan)*. Magellan manages a full range of care, including mental health and substance abuse inpatient care, rehabilitation treatment, partial hospital programs, intensive outpatient programs, outpatient counseling, and other levels of care through a network of Magellan contracted behavioral health providers.

To access care, members may call the Magellan Member Services line at (800) 688-1911. PPO members may select any Magellan network mental health provider from the provider directory.

For HMO benefit programs, Magellan assigns each PCP a multidisciplinary mental health provider group for the PCP's HMO patients. HMO members may go directly to the Magellan contracted provider group that is assigned to their PCP and do not require a formal referral from their PCP. In the event that the PCP or member is unable to contact the assigned provider, he or she should contact Magellan directly at (800) 688-1911.

The mental health provider group is required to schedule appointments in accordance with the following time frames:

- Emergency appointments immediately.
- Urgent appointments within 48 hours (24 hours for Medicare members).
- Routine appointments within 10 business days.

A patient referred to Magellan will be evaluated for medical necessity and referred to the most appropriate level of care.

Where authorized by the member, a clinician from the mental health provider office will provide feedback to the member's PCP or treating physician regarding treatment recommendations following an evaluation. If PCPs have concerns about the patient evaluation or treatment recommendation, they may request a case discussion with a mental health clinician or the medical director at the mental health provider, subject to member authorization. If concerned with a patient's mental healthcare, PCPs or treating physicians are encouraged to contact Magellan directly at (800) 688-1911.

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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The third-party Web sites 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 benefit plans. Members should refer to their benefit contract for complete details of the terms, limitations, and exclusions of their coverage.

Magellan Behavioral Health (continued)

Magellan also offers informational brochures and clinical practice guidelines that can be easily accessed through their Web site at magellanprovider.com or by calling the Magellan PCP Information Line at (800) 281-3014, Monday through Friday, 9 A.M. through 5 P.M.

*Not all benefit plans use Magellan to administer mental health and substance abuse benefits. Please check the back of the member's ID card for specific benefit information.

Important Billing Information Regarding Identification of Performing Providers

As you have been previously notified, the performing provider of covered services must be identified on any CMS-1500 claims (formerly the HCFA 1500 claim form) submitted. This is now a required data element in conjunction with upcoming HIPAA compliance and other requirements. In order to allow providers an opportunity to update their systems, a six-month transition period has been established. **However, effective on 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 returned as a non-clean claim.**

The performing provider identification number should be reported in section 33 of the CMS-1500 claim form in the "PIN #" field. When submitting electronic claims the performing provider identification number should be entered in the rendering provider identification field. The applicable group number should continue to be reported in section 33 in the "Grp #" field and the tax identification number should continue to be reported in section 25 of the claim form.

Billing Reminder: Use Current HCPCS Codes

One of the simplest ways to facilitate appropriate payment when reporting HMO and PPO services is to use the most current HCFA Common Procedure Coding System (HCPCS) codes. Because our claims systems are updated each year using the most recent HCPCS updates, employing the most current HCPCS codes promotes speedy, efficient, and consistent claims processing. The most recent update was January 1, 2002.

Pennsylvania Blue Shield provides its participating physicians with an annual HCPCS update. You may also obtain information about current HCPCS codes at www.hcfa.gov/medicare/hcpcs.htm.

Billing Reminder: Use Current HCPCS Codes (continued)

The five-digit HCPCS codes are derived from the Current Procedure Terminology (CPT). The American Medical Association (AMA) copyrights the CPT. If your office needs more information about CPT coding than can be provided on the HCPCS Web site or provided by Pennsylvania Blue Shield, please contact the AMA at (800) 621-8335, Provider Services, or your Network Coordinator.

New HMO Rejected Claims Report Process

Effective April 11, 2002, the Paper Bill Return Form was replaced by the Rejected Claims Report as the tool Keystone Health Plan East uses to notify providers that claims they have submitted are incomplete.

Prior to April 11, 2002, claims missing critical front-end processing information such as member information, eligibility, procedure codes, revenue codes, etc. were returned to the billing provider accompanied by the Paper Bill Return Form.

Now these claims are being reviewed electronically by our Claims Inventory System (CIS) to verify that all required front-end processing information is included. When claims are found to be incomplete by the CIS, a Rejected Claims Report will be generated and forwarded to your office.

The Rejected Claims Report may be mailed to your office separately or mailed with your Statement of Remittance (SOR). Please take a moment to review the enclosed sample copy of this report provided for your convenience.

Please note that fully adjudicated claims will continue to be identified on the SOR.

Please call Provider Services with any questions regarding the new Rejected Claims Report.