PARTNERS in Health

UPDATE

WORKING TOGETHER FOR QUALITY HEALTHCARE

April 2004 www.ibx.com

Independence Blue Cross

Chronic Condition Management Support with the SMART™ Registry

Beginning in spring 2004, primary care physician (PCP) offices will begin to receive the SMART™ Registry, a new practice support tool. The SMART Registry is a feature of our Connections℠ Health Management Program, which was launched in 2003 to help you and your patients manage chronic conditions. This tool tracks important evidence-based aspects of care for patients with one or more of the following chronic conditions: asthma, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes.

The SMART Registry helps you:

- Identify patients in your practice* with chronic diseases and comorbidities.
- Identify patients for whom there may be significant opportunities for clinical improvement.
- Identify practice-wide opportunities to enhance evidence-based practice and decrease inappropriate variation in effective care.
- Improve clinical quality and outcomes for your patients.

Using the SMART Registry, you can identify significant opportunities to improve the consistency and effectiveness of the care that you deliver, both for individual patients and for your practice care processes overall. Please look to our *Spring 2004 Partners in Health* newsletter for more detailed information on the SMART Registry.

If you have questions regarding the SMART Registry, or the Connections℠ Health Management Program in general, please contact a Connections℠ Provider Service Specialist through the Connections℠ Program Physician Hotline at (866) 866-4694. A Connections℠ Provider Service Specialist will return your call within two business days.

* The SMART Registry will include both HMO and PPO members. HMO members are assigned to the practice they have selected. PPO members are assigned using logic applied to PPO claims, which assigns a member to the PCP practice seen most often and/or most recently for primary care services.

INSIDE THIS ISSUE

Flexible Benefit Options for Delaware Now Available April 1, 2004

As previously announced, our Delaware affiliate is pleased to introduce new HMO, POS, and PPO flexible benefit options for group employers, **effective April 1, 2004.** These programs are designed to provide affordable health care coverage to our customers. These flexible benefit options feature consistency to members across product lines in copayments, benefit maximums, and precertification requirements. Delaware flexible benefit option members can be easily identified by the "FLEX" and state indicators on their ID cards. Contact Provider Services or your Network Coordinator with any questions about the new flexible benefit options.

Extension of HIPAA Transactions and Code Sets Contingency Plans

In recognition of the ongoing HIPAA compliance efforts of our providers, Independence Blue Cross (IBC) is extending its contingency plans for achieving HIPAA Transactions and Code Sets (TCS) compliance past our original extension date of February 29, 2004.

The official deadline for full compliance with HIPAA's electronic transaction requirements ***has not changed***. It remains October 16, 2003, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In fact, under traditional Medicare, the Centers for Medicare and Medicaid Services (CMS) has asked each Medicare intermediary to add two weeks to the payment cycle for any provider that has not yet converted to HIPAA-compliant transactions by July 1, 2004.

The end date of the IBC extended contingency plans will be announced as soon as possible, but providers should be advised that the final compliance date might follow very quickly after the announcement. Therefore, providers should continue to work aggressively toward full compliance. The end date will be determined based on guidance from the CMS, the Blue Cross Blue Shield Association (BCBSA), and other such sources.

Until a final deadline is established, IBC will continue to accept and process non-compliant electronic formats for providers and for their trading partners, but such extensions will not continue indefinitely and CMS may mandate compliance at any time.

Providers Who Have Not Yet Achieved Compliance

IBC strongly encourages providers to work with their software vendor, billing service, and clearinghouse to press forward with the steps necessary to achieve HIPAA TCS compliance as soon as possible. Please contact your vendor if it has not confirmed that your electronic claims are being sent in a HIPAA-compliant format.

Providers are especially urged not to drop their claim submissions to paper, since increased volumes of paper claims will create processing and payment backlogs. Besides the timeframe difficulties inherent in this manual process, providers are reminded that electronic submissions process faster than claims submitted on paper.

Resources Are Available

We continue to make information and testing resources available to providers who have not yet converted to HIPAA-compliant formats.

IBC Resources:

For the latest information on the contingency extension and IBC's transaction implementation guides, please visit our Electronic Data Interchange (EDI) services Web page at *www.ibx.com/edi*. This Web page will also have the most up-to-date listing of clearinghouses providers may use to submit their claims to IBC. Some of these clearinghouses include Web MD® Envoy, HDX®, Per-Se®, McKesson, and NaviMedix®.

Extension of HIPAA Transactions and Code Sets Contingency Plans (continued)

Free HIPAA-compliant claims submission software is available from NaviMedix® for all IBC lines of business:

NaviMedix® offers free claims submission software that can convert your non-HIPAA-compliant claims into HIPAA-compliant claims transactions at no cost to the provider for Keystone Health Plan East (KHPE) HMO lines of business. For information on this software, please call the eBusiness Provider Inquiry Line at (215) 640-7410 or complete the Online Inquiry Form at *www.ibx.com/providers/navinet*.

Important note for providers who submit electronic claims through Highmark®:

Please remember that Highmark® continues to offer free, secure Web-based HIPAA-compliant transaction testing. Providers must complete a new enrollment application before being able to test for conversion. To enroll, visit the Highmark® EDI Sign-Up Web page at *https://www.highmark.com/health/professionals/edi-services/edi_signup.html*. Once there, click on the link titled "EDI Transaction Application (Claims & Inquiry)."

After you submit your application, Highmark® will contact you with information on testing PPO claims. NaviMedix®, Inc. is supporting the HIPAA compliance testing of KHPE HMO claims. NaviMedix® will notify you to begin testing after they receive your application information from Highmark®.

In addition, you may contact the NaviMedix®, Inc. HIPAA Conversion Team at (866) 877-6284 for assistance with testing and converting to the HIPAA-compliant 837 claims transaction.

Select Drug Program® Formulary Status for Accutane® and Its Branded Generics

Accutane® (isotretinoin) is FDA-approved for the treatment of severe recalcitrant nodular acne that is unresponsive to conventional therapy. Currently, branded Accutane® is not included in the Select Drug Program Formulary; however, Claravis®, Sotret®, and Amnestine® – the three branded generics for Accutane® – have formulary status and are available at the generic copay.

Updated Imitrex® Quantity Limit

Imitrex® formulation of tablets has been changed by the manufacturer to a rapidly releasing tablet. Therefore, Imitrex® will now come in a new tri-fold card package to prevent the tablets from being separated and to ensure that they are not exposed to moisture. With the new packaging that combines all strengths and dosage forms of Imitrex®, the total amount a member can now receive has been increased to 1800 mg per 30 days from the previous 1200 mg per 30 days. Requested quantity level limits of Imitrex® exceeding 1800 mg total require prior authorization.

Remittance Reports to Be Revised for HMO Commercial and Medicare HMO Lines of Business

Effective in May 2004, the enhanced remittance reports, which include Statement of Remittance (SOR), Accounts Receivable (A/R), and Interest Payment reports, will be used for all of our HMO Commercial and Medicare HMO lines of business. In April 2003, providers were notified of the enhancements to our remittance reports, which initially only applied to self-referred HMO Point-of-Service (POS) claims.

Sample SOR, A/R, and Interest Payment reports will be included in a future *Partners in Health Update* mailing. Please alert your Business Office Management of the pending changes.

New HMO PCP Encounter/Referral Form: Features More Detailed Diagnosis Codes

This spring, we are introducing our redesigned HMO PCP Encounter/Referral Form to improve functionality by eliminating unnecessary fields and making it easier for your office to use when referring Keystone HMO or Point-of-Service members. The new form will provide more detailed diagnosis information (please refer to the ICD-9 Diagnosis article below) and house information in a more efficient and concise format.

The new HMO PCP Encounter/Referral Form will soon be available through the Provider Supply Line. Please note that encounters and referrals can be processed more quickly and efficiently by using NaviNet℠. To register for NaviNet℠, contact the eBusiness Provider Inquiry Unit at (215) 640-7410, or complete an Online Inquiry Form at *www.ibx.com/providers/navinet*.

Billing Tips

Important Claims Reminder:

Providers are Required to Report ICD-9 Diagnosis Codes to Highest Degree of Specificity

As previously communicated, **effective January 1, 2004,** IBC began requiring all practitioners to report diagnosis codes to the highest degree of specificity, according to the most current ICD-9-CM coding manual. This requirement reflects 1) the need for better diagnostic information for quality and medical management, 2) the decision to make our coding policy more consistent with that of Highmark Blue Shield and other major carriers, and the Centers for Medicare and Medicaid Services (CMS) ICD-9-CM coding guidelines, and 3) the decision by CMS to determine Medicare+Choice premiums based on the severity of illness of enrolled members.

The following are guidelines for diagnosis coding:

- Most ICD-9-CM codes require four or five digits. There are only about 100 valid three-digit codes.
- Most ICD-9-CM coding manuals include a color-coded system to designate diagnosis codes that require additional digits beyond the basic three digits. Please refer to your ICD-9-CM coding manual for specific instructions.
- Always include the fourth or fifth digit when indicated in the ICD-9-CM coding manual.

Exceptions: The following providers are not required to report ICD-9-CM diagnosis codes to the highest degree of specificity: home health agencies, independent laboratories, independent physiological laboratories, general dentists, orthodontists, endodontists, pedodontists, pharmacies, durable medical equipment suppliers, ambulance services, orthotic and prosthetic suppliers, and home infusion providers.

For examples of valid and invalid ICD-9-CM codes, please refer to the article published in the November 2003 *Partners in Health Update.*

If you have any questions about how to report diagnosis codes, please contact Provider Services.

Billing Reminders:
10-Digit HMO Provider ID Number and Performing Provider ID Number (PIN #) Required

PLEASE SHARE THIS IMPORTANT BILLING INFORMATION WITH YOUR BILLING VENDOR

As previously communicated, effective January 1, 2003, the **10-digit HMO provider ID number** is required on all HMO claims submissions, encounters, referrals, and related correspondence. HMO claims submitted without the 10-digit HMO provider ID number are being rejected as non-clean claims. Both your group provider ID number and the Performing Provider ID Number (PIN #) need to reflect the new 10-digit numbers.

The Performing Provider ID Number must be recorded on all claims. This is a **required** data element in conjunction with HIPAA compliance and other requirements. HMO, POS, and PPO claims submitted without the identification number of the physician or other professional provider performing the procedure or service are being rejected and returned as non-clean claims and must be resubmitted with the necessary information. The Performing Provider ID Number should be reported in section 33 of the CMS 1500 claim form in the "PIN #" field.

When submitting **HIPAA-compliant electronic claims** through Electronic Data Interchange (EDI) transmission, the Performing Provider ID Number should be entered in the rendering provider ID number field, located in the **REF02** data element, either in loop **2310B** (at the claim level) or loop **2420A** (at the line level). The referring physician's provider ID number should be reported in the **2310A** loop in the **REF02** data element. The applicable group provider ID number should be reported in the secondary billing provider segment, located in the **REF02** data element, in loop **2010AA**. For more information on EDI transmission of electronic claims, please consult the 837P HIPAA Transaction Companion Guide on our Web site at *www.ibx.com/edi*.

As always, the provider ID numbers entered on electronic and paper-based claims should directly reflect the member's benefit plan. **Please enter your 10-digit HMO provider ID number on all HMO and POS (referred and self-referred) claims submissions, encounters, referrals, and related correspondence.** Enter your PPO provider ID number on all PPO claims and related correspondence.

Please note the following:

- The requirements above apply to **paper *and* electronic claims submissions.**
- With the October 27, 2003 transition of POS self-referred claims processing to MHS, our managed care information system, you should enter your 10-digit HMO provider ID number on all POS claims (referred and self-referred).
- The updated EDI electronic claims instructions outlined above are compliant with HIPAA Transactions and Code Set rules, which require a transition from the National Standard Format (NSF) to the HIPAA 837P transaction when submitting electronic claims. The compliance deadline for HIPAA Transactions and Code Sets was October 16, 2003. For testing and conversion assistance to the HIPAA-compliant claims transaction (837), please contact the NaviMedix®, Inc. HIPAA Conversion Team at (866) 877-6284.

  Important note for providers who submit electronic claims through Highmark®: If you have not yet converted to the HIPAA-compliant 837 claims transaction, you must complete a new enrollment application at *https://www.highmark.com/health/professionals/edi-services/edi_signup.html* **before** being able to test for conversion.

10-Digit HMO Provider ID Number and Performing Provider ID Number (PIN #) Required (continued)

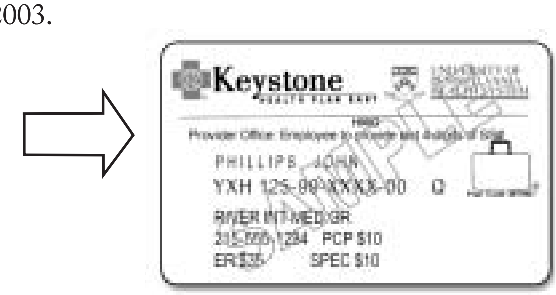
- The provider ID numbers that you currently use for Personal Choice® and BlueChoice® services are <u>not</u> affected and continue to be valid for Personal Choice and BlueChoice claims and related correspondence.
- Physical therapists and labs which have not been assigned a specific Performing Provider ID Number should submit their group provider ID number in both the "Grp #" and "PIN #" fields of box 33 on the CMS 1500 form. When submitting electronic claims, physical therapists and labs that have not been assigned a specific Performing Provider ID Number should report their group provider ID number in both the 2010AA loop ***and*** either the 2310B loop (at the claim level) or 2420A loop (at the line level) in the REF02 data element. **Claims submitted without information in both of these fields are now being rejected as non-clean claims and must be resubmitted with the necessary information.**

Important Reminder:
Hand Therapy Services Excluded from HMO Capitated Physical Therapy Program

As previously communicated, **effective October 1, 2003,** all hand therapy services are excluded from the HMO Capitated Physical Therapy Program. For dates of service October 1, 2003 and after, hand therapy services may be referred to any participating hand therapy provider.

Important Reminder:
University of Pennsylvania Keystone Health Plan East ID Card Change

In light of new privacy legislation, we have launched a major corporate project to analyze the impact of removing Social Security numbers from member materials, such as ID cards and certificates of coverage. As previously communicated, we have worked with the University of Pennsylvania to conceal the last four digits of the subscriber's Social Security number on their members' Keystone Health Plan East (KHPE) ID cards. Currently, this change only applies to the new University of Pennsylvania KHPE ID cards, which were issued in September 2003.



We have included an informational statement on the front of the ID card addressing the provider office, which states: "Employee to provide last 4 digits of SS#." **The provider-billing representative should ask the member for the last four digits of the employee's (subscriber) Social Security number and use the full 11-digit ID number when preparing laboratory referrals and presenting claims or inquiries to IBC.** Please note that the capitation roster will continue to display the full 11-digit ID number.

If you have any questions, please contact Provider Services.

"Do It All" with NaviNet℠: Including Enhancements to the Preauthorization Submission Feature

Streamline the daily administrative tasks associated with your patients' health care with NaviNet℠, the HIPAA-compliant Web-based connectivity solution offered by NaviMedix®, Inc. NaviNet℠ enables your office to connect with our back-end systems to reduce time and costs associated with health care administration.

NaviNet℠ features include, but are not limited to: Member Eligibility and Benefits Inquiry, Referral Submission, Referral Inquiry, Encounter Submission, Claims Status Inquiry, Drug Preauthorization Submission, Procedure and Diagnosis Code Inquiry*, Emergent Admission (ER) Notification, and the Provider Change Form.

Specialists, in particular, use the NaviNet℠ Preauthorization Submission feature to request preauthorization of procedures to be performed at an acute care facility or ambulatory surgical center. Recent enhancements to this feature enable specialists to preauthorize these procedures in an even more streamlined and efficient manner.

Regardless of the method used for preauthorization submission, primary care physicians (PCPs), the precertifying specialist, and the facility where the service is to take place may retrieve preauthorization records using the NaviNet℠ Authorization Status Inquiry feature. When applicable, the date of admission or service may be changed for approved authorizations in the Authorization Status Inquiry Transaction Detail screen.

This method of electronic submission reduces call volume and speeds the precertification process, contributing to improved provider satisfaction. We encourage you to consider the advantages of this comprehensive application.

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Improve Claims and Encounter Submission with NaviNet Claims℠

With NaviNet Claims℠, offered by NaviMedix®, Inc., network providers may submit HMO, PPO, and POS claims and encounters to IBC electronically, free of charge. In addition to converting all non-HIPAA-compliant claims to HIPAA-compliant versions, submission through NaviNet Claims℠ is simple and helps minimize claims rejections.

NaviNet Claims℠ can work with a provider's practice management system or can be supplied as desktop software for use with a PC and a modem or Internet access. Editing features allow for fast and simple correction of errors before claims are submitted, resulting in reduced claim rejections and administrative concerns. Reporting features enable claims to be tracked from the moment of submission through receipt by the health plan.

NaviNet℠ registration or questions:

eBusiness Provider Inquiry Line: (215) 640-7410

Or complete our Online Inquiry Form at *www.ibx.com/providers/navinet*

Technical Assistance for existing NaviNet℠ users:

NaviMedix®, Inc.: (888) 482-8057
8:00 A.M. to 8:00 P.M., EST, Monday through Friday, and 8:00 A.M. to 3:00 P.M., EST, Saturday

Investors in NaviMedix®, Inc. include an affiliate of IBC, which has a minority ownership interest in NaviMedix®, Inc.

IMPORTANT RESOURCES

PROVIDER INFORMATION and TOOLS WEB PAGE
www.ibx.com/providers

PROVIDER CLINICAL PRACTICE GUIDELINES WEB PAGE
www.ibx.com/guidelines

PROVIDER MEDICAL POLICY WEB PAGE
www.ibx.com/medpolicy

PROVIDER ELECTRONIC DATA INTERCHANGE SERVICES WEB PAGE
www.ibx.com/edi

CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT
Anti-Fraud and Corporate Compliance Hotline
(866) 282-2707
www.ibx.com/anti-fraud

CREDENTIALING COMPLIANCE HOTLINE
(866) 282-2707
www.ibx.com/credentials

* Outside 215 area code

PROVIDER SERVICES
Policies/Procedures/Claims

HMO
(215) 567-3590
(800) 227-3119*

PPO
(215) 567-3694
(800) 332-2566*

PHARMACY SERVICES

Prescription Drug Authorization
(888) 671-5280

Toll-Free Fax
(888) 671-5285

Direct Ship Injectable
(267) 402-1711
(888) 671-5280

Fax
(215) 761-9165

Blood Glucose Meter Hotline
(888) 494-8213 (option 2)

HEALTH RESOURCE CENTER

Healthy Lifestyles℠
(215) 241-3367
(800) 275-2583*

Precertification
(215) 241-2100
(800) 227-3116*

CARE MANAGEMENT AND COORDINATION (formerly Patient Care Management)

Case Management
(215) 567-3570
(800) 313-8628*

Baby BluePrints®
(215) 241-2198
(800) 598-BABY [2229]*

CONNECTIONS℠ HEALTH MANAGEMENT PROGRAM PHYSICIAN HOTLINE and WEB PAGE
(866) 866-4694
www.ibx.com/connections

PROVIDER SUPPLY LINE
(800) 858-4728

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 are welcome.

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Visit our Web site at *www.ibx.com*

Policy

Provider Rosters and Practice Attestation

As part of our continuing effort to update and maintain accurate provider files, and to monitor that only credentialed practitioners provide in-network services to our members, your office will receive a Provider Roster and Attestation packet annually. Both the Provider Roster and the Attestation need to be completed and returned to us, even if there are no changes. This packet, which is being sent in stages throughout the year, includes HMO and PPO Provider Rosters, which list the individual participating practitioners at your office location.

Please complete, sign, and return the Provider Roster Response form included in the packet to ensure our practice and practitioner records are accurate and up-to-date. The packet also includes a Practice Attestation, **which must be signed and returned by the designated physician or representative authorized to sign on behalf of the practice.** The attestation, which will be required annually, confirms that only credentialed participating practitioners at your office location will see our members for in-network services.

If you have any questions, please contact the Provider Roster Hotline at (267) 402-1588. Please note, a provider, including any part-time or locum tenens providers, must be fully credentialed (and recredentialed every two years) by IBC in order to see our HMO members, or any other IBC members on an in-network basis.

View our online provider directories at www.ibx.com.

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