



## U P D A T E

WORKING TOGETHER FOR QUALITY HEALTHCARE

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**Prior Authorization for Zavesca<sup>®</sup> (miglustat)**

Zavesca<sup>®</sup> (miglustat), approved in July 2003, is the first *oral* drug that has been approved by the U.S. Food & Drug Administration for adults for the treatment of mild to moderate type 1 Gaucher disease for whom traditional enzyme replacement therapy (Cerezyme<sup>®</sup> and Ceredase<sup>®</sup>) is not an option. Members who are prescribed Zavesca<sup>®</sup> (miglustat) will require prior

authorization from their physician. To obtain prior authorization, fax a prior authorization form to the Pharmacy Services Department at (888) 671-5285. Forms may be obtained at [www.ibx.com/providers](http://www.ibx.com/providers) or by calling (215) 241-9550, option 1; or (888) 671-5280, option 1, when calling outside of the 215 area code.



## Announcements

### Connections<sup>SM</sup> Programs: **New Connections<sup>SM</sup> Kidney Program Benefits ESRD Patients**

As a reminder, effective June 1, 2004, Independence Blue Cross (IBC) has contracted with RMS, a leading renal disease management provider, to launch the Connections<sup>SM</sup> Kidney Program.

The Connections<sup>SM</sup> Kidney Program provides additional resources to help manage your patients with end-stage renal disease (ESRD) to improve clinical outcomes of IBC members on chronic outpatient dialysis. Please note that this program does not change your relationship with IBC or with your patients. The program coordinates, assists, and supports the total care plan provided to your patients.

#### **The Connections<sup>SM</sup> Kidney Program Care Plan**

The Connections<sup>SM</sup> Kidney Program's emphasis on education and management of comorbid conditions focuses on the prevention of complications and hospitalizations. The care plan is created under the leadership of the patient's nephrologist and primary care provider (PCP), and

is implemented by a Health Service Coordinator (HSC), a registered nurse with at least three to five years' nephrology experience. The role of the HSC is to:

- Work with the renal care team to provide education to the patient and family members.
- Implement a care plan developed in conjunction with the nephrologist and PCP.
- Coordinate care for ESRD members, including comorbid conditions such as diabetes, cardiovascular disease, heart failure, and peripheral vascular disease.
- Report patient outcome data to the nephrologist, dialysis provider, PCP, and IBC.

We look forward to working with you in support of this program. If you have any questions, please call the Connections<sup>SM</sup> Kidney Program at (866) 303-4CKP [4257].

### **New Member ID Cards with AdvancePCS Logo**

As a reminder, AdvancePCS became our new Pharmacy Benefit Manager effective **June 1, 2004** for Keystone 65, Personal Choice 65<sup>SM</sup>, and Security 65<sup>®</sup> Plan H Medicare members and will be effective **August 1, 2004** for Keystone Health Plan East HMO, Keystone Point-of-Service, Personal Choice<sup>®</sup>, Traditional Major Medical, and CompSelect<sup>®</sup> members.

**Please note: This transition does not affect your practice or your prescription process.**

The move to AdvancePCS will **not** affect members' prescription drug coverage. If you have any questions regarding our new Pharmacy Benefit Manager, please contact Provider Services.

## Important HIPAA Transactions and Code Sets Contingency Plan Update

Please Share This Important Billing Information with Your Billing Vendor

### For providers who have successfully met HIPAA-compliant electronic transaction requirements by June 1, 2004:

Effective September 1, 2004, IBC will accept only HIPAA-compliant electronic transactions from those providers and trading partners that have successfully converted to HIPAA-compliant 837 Institutional and Professional claims transactions by June 1, 2004. We will no longer accept

electronic transactions submitted in the National Standard Format (NSF) at that time.

We thank you for your efforts in achieving HIPAA compliance. For questions or more information, please contact the eBusiness Help Desk at (215) 241-2305.

### For providers who have not yet converted or begun testing for HIPAA-compliant electronic transaction formats:

As previously announced in April 2004 *Partners in Health Update*, we have extended our contingency plans for achieving HIPAA Transactions and Code Sets compliance past our original extension date of February 29, 2004. **Providers who have not completed HIPAA testing and conversion should continue to work aggressively toward full compliance.**

As a general rule, trading partners who become HIPAA certified after June 1, 2004 will have 90 days from their certification date to begin sending only HIPAA compliant transactions. After the 90-day implementation period, any proprietary format received from a HIPAA-certified trading partner may be rejected.

The official deadline for compliance with HIPAA's electronic transaction requirement has not changed. It was October 16, 2003, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The deadline for our extended contingency plans will be announced as soon as possible, but providers should be advised that the extensions will not continue indefinitely and CMS may mandate compliance at any time.

For assistance with testing and conversion to the HIPAA-compliant claims transactions 837, please contact the NaviMedix<sup>®</sup>, Inc. HIPAA Conversion Team at (866) 877-6284 or the eBusiness Help Desk at (215) 241-2305. Please refer to our Web site at [www.ibx.com/edi](http://www.ibx.com/edi) for additional details on our HIPAA Contingency Plan.

## Reporting Guidelines for Stapled Rectal Mucosectomy

Stapled rectal mucosectomy does not have a specific code for reporting purposes. Therefore, the appropriate code to report this service is: **unlisted procedure, rectum**. Since this is an unlisted code, proper supporting documentation will need to be

provided. It is not appropriate to report the code for this service as: proctopexy for prolapse; perineal approach.

## Reduce Billing Issues when Requesting Laboratory Services

When requesting laboratory services, please include the most specific diagnosis code possible and fill out the lab requisition form completely with the member's billing information (including

the member's ID number, address, type of coverage, etc.). This helps ensure that the lab claim will process properly and reduces member billing issues.



## Avoid Claims Rejections: Include Performing Provider ID Number

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 box 33 of the CMS 1500 claim form in the "PIN #" field. **Note:** 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.

**Please Note:** 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.

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 transmission of electronic claims. **Note:** 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, when submitting electronic claims. Please consult the 837P HIPAA Transaction Companion Guide on our Web site at [www.ibx.com/edi](http://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 claims submissions, encounters, referrals, and related correspondence.** Enter your PPO provider ID number on all PPO claims and related correspondence.

### HIPAA COMPLIANCE

The updated EDI electronic claims instructions outlined above are compliant with HIPAA Transactions and Code Sets 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, **before** being able to test for conversion you must complete a new enrollment application at: [https://www.highmark.com/health/professionals/edi-services/edi\\_signup.html](https://www.highmark.com/health/professionals/edi-services/edi_signup.html).

## New Enhanced Remittance Reports for HMO/POS Claims

IBC has implemented enhanced Statement of Remittance, Accounts Receivable, and Interest Payment reports for HMO and POS claims. **You began receiving these enhanced reports in June 2004.** We have generated these new reports as part of our ongoing effort to improve reports

issued to providers and support HIPAA-compliant transactions. Please reference the May 2004 *Partners in Health Update* for details about the reports' new features and samples of the enhanced reports.

## 10-Digit HMO Provider ID Number 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 and POS claims submissions, encounters, referrals, and related correspondence. HMO and POS 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. This requirement applies to paper *and* electronic claims submissions.

**Please note the following:** The provider ID numbers that you currently use for Personal Choice® and BlueChoice® services are **not** affected and continue to be valid for Personal Choice and BlueChoice claims and related correspondence.

## Get Connected

### “Do It All” with NaviNet<sup>SM</sup>: New Enhancements

NaviNet<sup>SM</sup>, the HIPAA-compliant Web-based connectivity solution offered by NaviMedix®, Inc., has added significant feature enhancements designed to increase productivity and efficiency in your office.

#### New NaviNet<sup>SM</sup> Enhancements

After performing a “Patient Search” within the Referral Submission feature, you may now click “View” to verify the member’s Eligibility Details (which include PCP name, PCP effective date, and PCP-capitated site data) before proceeding to the Referral Request Form for completion. This enhancement reduces keystrokes and increases efficiency by eliminating your need to check Eligibility Details separately using the Eligibility and Benefits feature. You may also use the Referral Inquiry feature to retrieve *all* referrals (*paper and electronic*) issued to the Plan - not just those referrals issued via NaviNet<sup>SM</sup>.




With the NaviNet<sup>SM</sup> Drug Preauthorization feature, you may now streamline the preauthorization for the following medications:

Aciphex®, Amerge®, Amevive®, Axert®, Bextra®, Caverject®, Celebrex®, Cialis®, Edex™, Enbrel®, Forteo®, Frova®, Gleevec®, Humira™, Imitrex®, Kineret®, Levitra®, Maxalt®, Migranal®, Mobic®, Muse®, Prevacid®, Provigil®, Raptiva®, Singulair®, Stadol®, Thalomid®, Viagra®, Vioxx®, Xolair®, and Zomig®.

**Additional NaviNet<sup>SM</sup> features include, but are not limited to:**

Encounter Submission, Emergent Admission (ER) Notification, Preauthorization Submission, Authorization Status Inquiry, Claim Status Inquiry, and the Provider Change Form.

Equipped with NaviNet<sup>SM</sup>, your office can connect with our back-end systems to streamline many of the daily administrative tasks associated with your patients’ health care. We encourage you to consider the advantages of NaviNet<sup>SM</sup>.

	NaviNet <sup>SM</sup> eBusiness Provider Registration or Questions	NaviMedix®, Inc. (888) 482-8057 Inquiry Line (215) 640-7410
		Online Inquiry Form
	Technical Assistance for Existing NaviNet <sup>SM</sup> 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](http://www.ibx.com/providers)

### PROVIDER MEDICAL POLICY WEB PAGE

[www.ibx.com/medpolicy](http://www.ibx.com/medpolicy)

### PROVIDER ELECTRONIC DATA INTERCHANGE SERVICES WEB PAGE

[www.ibx.com/edi](http://www.ibx.com/edi)

### CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT Anti-Fraud and Corporate Compliance Hotline

(866) 282-2707

[www.ibx.com/anti-fraud](http://www.ibx.com/anti-fraud)

### CREDENTIALING COMPLIANCE HOTLINE

(866) 282-2707

[www.ibx.com/credentials](http://www.ibx.com/credentials)

### 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)

\* Outside 215 area code

### HEALTH RESOURCE CENTER

#### Healthy Lifestyles<sup>SM</sup>

(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<sup>®</sup>

(215) 241-2198

(800) 598-BABY [2229]\*

#### CONNECTIONS<sup>SM</sup> HEALTH MANAGEMENT PROGRAM PHYSICIAN HOTLINE and WEB PAGE

(866) 866-4694

[www.ibx.com/connections](http://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](http://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. 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 recertified 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](http://www.ibx.com).*

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.

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