



U P D A T E

WORKING TOGETHER FOR QUALITY HEALTHCARE

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Change in National Account Processing Impacts Claims Submission for Three Employer Groups

The claims processing system formerly used by National Account customers New Jersey State Employees (member ID card alpha prefix: **NJP**), Pathmark Stores (member ID card alpha prefix: **NSP**), and Sylvan Learning Centers (member ID card alpha prefix: **SVP**) will be discontinued and no longer operational **effective December 31, 2004**.

Please submit all outstanding claims for New Jersey State Employees (NJP), Pathmark (NSP), and Sylvan (SVP) members with service dates on or before December 31, 2003 as soon as possible. This will help ensure all claims for these members are received and

adjudicated prior to December 31, 2004. Please also submit any processed/paid claims with the same service dates that need to be adjusted as well. We will work to adjust, process, and finalize these claims prior to December 31, 2004.

Please note: The claims processing system change for these National Account customers was implemented on January 1, 2004. The NJP, NSP, and SVP National Account alpha prefixes are still active and all claims with service dates of January 1, 2004 and after should continue to be submitted as usual. If you have any questions, please contact Provider Services.



Announcements

**ConnectionsSM Programs:
Introducing the ConnectionsSM Kidney Program**

Independence Blue Cross (IBC) is pleased to announce the launch of our ConnectionsSM Kidney Program, **effective June 1, 2004**. The Connections Kidney Program is a comprehensive disease management program to help you manage your IBC patients with end stage renal disease (ESRD). The goal is to work with you to improve the clinical outcomes of IBC members on chronic outpatient dialysis. Program resources include an

assigned Health Services Coordinator (HSC) to help coordinate care for your patients, as well as educational materials and round-the-clock HSC support for your patients. More information about this program will be provided in future *Partners in Health Update* articles and mailings to select network providers. **You may also contact the Connections Kidney Program at (866) 303-4CKP [4257].**

BlueCard[®] POS Provider Satisfaction Survey

To help determine whether the BlueCard[®] POS Program is meeting provider needs and expectations, IBC participates in an annual BlueCard POS Provider Satisfaction Survey. This year's survey is being administered from May through July. The Response Center, an independent research company, will conduct telephone interviews on behalf of IBC using a randomly selected sample of providers who have serviced BlueCard POS members within the past year.

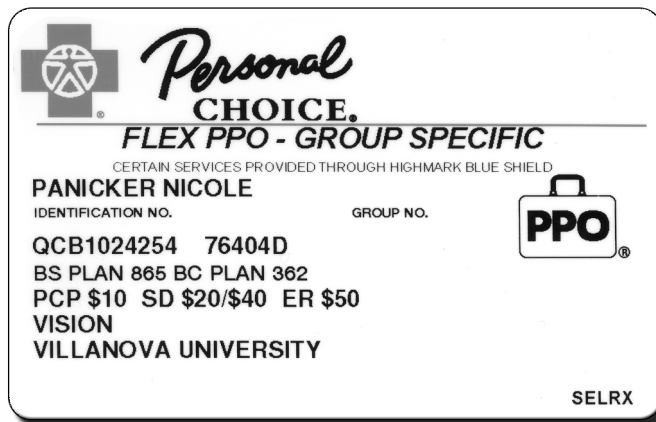
The Response Center will ask to speak with the billing department and/or the person who is most knowledgeable about filing Blue Cross[®] and Blue Shield[®] claims. *Please share this information with the appropriate staff in your office.* If you receive a call, we strongly encourage you to participate, as your feedback is important to us.

If you have questions about the BlueCard POS Program or suggestions for improvement, please contact your Network Coordinator.

New Villanova University Flex PPO Benefit Option

Effective June 1, 2004, employees of Villanova University will be enrolled in a customized Flex PPO benefit option. To help identify patients who are employees of Villanova University, the group name "Villanova University" has been placed on the ID card (see sample below). The PCP, Specialty/Diagnostic, and Emergency Room

copays are also displayed on the card. **However, please note that since these members have customized benefits, the members' specific coverage levels should be verified by either using NaviNetSM or by calling the phone number listed on the back of the member's identification card.**



Keystone 65 Basic Plan Offered to Dual Eligible Beneficiaries

We have improved and expanded our \$0 Premium Keystone 65 Basic Plan to include Bucks, Chester, Delaware, and Montgomery County dual eligible beneficiaries effective January 1, 2004. This plan has been available to Philadelphia County dual eligible beneficiaries since January 1, 2003. Keystone 65 has made a commitment to providing affordable, quality health care to dual eligible beneficiaries.

These enhanced benefits/services include important services that can improve care and outcomes:

- Transportation – Up to 12 round trips (door-to-door) to plan providers.
- Dental – Up to \$600 per year of comprehensive dental coverage.
- Podiatry Services – 4 routine visits per year at no cost to the member.
- Hearing Aids – \$1,500 reimbursement every three years.
- Eyewear – \$150 reimbursement every two years.

Dual eligible beneficiaries – low-income Medicare beneficiaries – are generally enrolled in one of the area Medicaid programs, such as Keystone Mercy Health Plan. Their primary insurance is original Medicare or a Medicare+Choice plan, such as

Keystone 65, and Medicaid is the secondary carrier. The benefit to members enrolling with Keystone 65 is better integration and coordination of health services and claims payment, reduced exposure to out-of-pocket expenses, and eligibility for value-added services that are provided by Keystone 65.

To help Medicaid-enrolled seniors in your practice receive the benefits of this new program, please tell them to call IBC Managed Care Programs at (888) 208-6076. A Keystone 65 representative will assist them in the enrollment process.

If you are in a primary care practice, the enrolled member will be added to your monthly capitation roster as a full Keystone 65 member. If the member is also enrolled in Keystone Mercy, **you will continue to receive that capitation as well.** As a result of the dual capitation, and in accordance with Section 4714 of the Balance Budget Act of 1997, the collection of the primary care office visit copay is prohibited.

Beginning in July 2004, Keystone representatives will be visiting selected network physicians to explain this new program and provide information. For additional information, or if you have questions about the program, call Provider Services at (215) 567-3590, or (800) 227-3119 outside the 215 area code.



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Introducing the New Pharmacy Benefit Manager and Medicare Drug Discount Card

IBC and its affiliates are pleased to announce AdvancePCS as our new Pharmacy Benefit Manager for all IBC members. To ensure a smooth transition for our members, we will implement the transition to AdvancePCS in two phases. Here is how this change will impact our members and your patients.

Changes for Medicare Members

- **Effective June 1, 2004**, Keystone 65, Personal Choice 65SM, and Security 65[®] Plan H drug programs will be transitioning to AdvancePCS. Please note that the move to AdvancePCS will not affect members' prescription drug coverage.
- In addition to this transition, IBC, in conjunction with AdvancePCS, will be offering the Medicare Drug Discount card to Keystone 65, Personal Choice 65, and Security 65 members **effective June 1, 2004**. This program offers Medicare members discounts on drugs at retail pharmacies and through mail order. In addition, Medicare members who meet certain limited income requirements may also be eligible for a \$600 credit per year towards the cost of prescription drugs. Keystone 65 and Personal Choice 65

members will be automatically enrolled in this program at no cost, unless they choose to opt-out. Security 65 members can call (866) 216-1687 to enroll in the program at a cost of \$19.95 per year.

Members impacted by these changes will receive new ID cards with the AdvancePCS logo and Medicare Drug Discount card information by June 1, 2004.

Changes for Commercial Members

- **Effective August 1, 2004**, the administration of prescription drug benefits for members enrolled in Keystone Health Plan East HMO, Keystone Point-of-Service, Personal Choice[®], Traditional Major Medical, and CompSelect[®] will be transitioning to AdvancePCS. Again, this move to AdvancePCS will not affect members' prescription drug coverage.

If you have any questions regarding our new Pharmacy Benefit Manager or the Medicare Drug Discount card program, 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, AND Providers who will successfully complete testing 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. We will no longer accept electronic transactions submitted in the National Standard Format (NSF) at that time. This deadline also applies to those providers and trading partners who will successfully complete testing by June 1, 2004.

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, begun testing for HIPAA-compliant electronic transaction formats, or completed testing by June 1, 2004:

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.**

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.

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.

For assistance with testing and conversion to the HIPAA-compliant claims transactions 837, please contact the NaviMedix®, Inc. HIPAA Conversion Team at (866) 877-6284 or the eBusiness Help Desk at (215) 241-2305 (select Option 1 for technical support). Please refer to our Web site at www.ibx.com/edi for additional details on our HIPAA Contingency Plan.



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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 recredentialed every two years) by IBC in order to see our HMO members, or any other IBC members on an in-network basis.

Credentialing Compliance Hotline and Web Page

Our corporate credentialing policy requires that our members receive in-network health care services only from fully credentialed, participating practitioners. As noted in your Professional Provider Agreement, *non-credentialed practitioners may not see our members on an in-network basis.* Therefore, we need your assistance in identifying credentialing noncompliance.

If you suspect any violations of our practitioner credentialing policies, please proceed with one of the following options:

- 1 Call the *confidential* Credentialing Corporate Compliance Hotline toll-free at (866) 282-2707.
- 2 Submit an online Credentialing Noncompliance Referral Form available at:
www.ibx.com/credentials.

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

We are introducing our new, 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 Health Plan East HMO or Point-of-Service members. The new form will provide more detailed diagnosis information (please refer to the ICD-9 Diagnosis Codes article published in the April 2004 *Partners in Health Update*) and house information in a more efficient and concise format.

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

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 will begin 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.

If you have any questions, please contact your Network Coordinator or Provider Services.

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.



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.

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.

“Do It All” with NaviNetSM: Reduce Time Spent on Administrative Tasks

Equipped with NaviNetSM, the HIPAA-compliant Web-based connectivity solution offered by NaviMedix[®], Inc., your office is able to connect with our back-end systems to streamline daily administrative tasks associated with your patients’ health care. With little effort, you can retrieve patients’ eligibility and benefit information – including their PCP and PCP-capitated site data – and even access claims status. As a result, administrative tasks can be handled more efficiently and will require less time, which may reduce your calls to the Plan. We encourage you to consider the advantages of NaviNetSM.

Other NaviNetSM features include, but are not limited to:

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



**NaviNetSM eBusiness Provider
Registration or
Questions** Inquiry Line
(215) 640-7410



Online Inquiry Form www.ibx.com/providers/navinet



**Technical Assistance
for Existing
NaviNetSM 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



U P D A T E

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

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 LifestylesSM

(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]*

CONNECTIONSSM 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

View our online provider directories at 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.

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 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.

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