



# UPDATE

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## ANNOUNCEMENTS

### Updated November 2005 Provider Manual

You may have recently received the updated November 2005 *Provider Manual*. The revised Independence Blue Cross (IBC) *Provider Manual* is organized as an easy-to-use reference tool for daily use in your practice. Our tabbed, color-coded, and indexed system is designed to provide easy access to the information you need most. The revised manual has separate sections for Administrative, Medical, Pharmacy, Preventive Health, and Quality Management information. This material reflects our monthly *Partners in Health Update* and website [www.ibx.com](http://www.ibx.com).

Ongoing updates to the IBC *Provider Manual* will reinforce the manual's purpose as a valuable reference tool that may save time and provide answers to commonly asked questions about our policies and procedures.

### CHANGES TO PQAS 2007:

### Measurement Year January Through December 2006

Several new Quality Performance Measures (QPMs) will be included in the January 2006 Practice Quality Assessment Score (PQAS) program for eligible Pennsylvania HMO practices. These QPMs (based on new Health Plan Employer Data and Information Set [HEDIS®]) measures will be part of the scoring for the 2006 assessment year and will be reflected in payments beginning **July 2007**. The following new measures will be reported in the July 2006 PQAS final report (measurement year 2005) **for informational purposes only** and will become part of the PQAS score for PQAS 2007, which are based on measurement year 2006:

#### Well-Child Visits in the First 15 Months of Life

- A child who turned 15 months of age during the measurement year (2005) and was identified as having 6 or more well-child visits on or between the ages of 0 to 15 months of age.
- Eligible patients: continuously enrolled members who turned 15 months of age in 2005.

#### Well-Child Visits in the Third to Sixth Years of Life

- A child who turned 3-6 years of age during the measurement year (2005) and was identified as having the following:
  - One well-child visit during the measurement year (2005).
  - Eligible patients: continuously enrolled members who turned 3-6 years of age in 2005.

#### Adolescent Well-Care Visits

- An adolescent who turned 12-21 years of age during the measurement year (2005) and was identified as having the following:
  - One adolescent well-care visit during the measurement year (2005).
  - Eligible patients: continuously enrolled members who turned 12-21 years of age in 2005.

Also new for PQAS 2007 (measurement year 2006) are Immunization Refusal Forms, such as those developed by the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) or the American Academy of Pediatrics. Immunization Refusal Forms will be accepted for members who have refused immunizations, for the date range indicated on the form. The submitted form must include the specific immunization(s) that is/are being refused, indicate that appropriate counseling was done by the provider, and must be dated and signed by the member or parent/guardian if the member is a minor. An entry in the clinical record that is without the accompanying approved form that indicates refusal, cannot serve as sufficient documentation.

Please contact your Network Coordinator with any questions.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.*



## Printable Temporary Member Identification Information is Available Effective December 17, 2005

Beginning December 17, 2005, IBC will provide member's with the ability to print temporary member insurance information through our online member portal, [www.ibxpress.com](http://www.ibxpress.com). Members must have active coverage with IBC.

Please accept this printed insurance information document as proof of coverage when members present them in your office. This document reflects all important member

information including member ID number, medical plan, primary care physician name, copay amounts, and prescription drug coverage, if applicable. The temporary ID card is valid for a maximum of 10 calendar days from the print date.

Please call Provider Services or your Network Coordinator with any questions.

## Removal of Referrals For Hemodialysis

IBC is pleased to announce the elimination of referrals for HMO/POS and Medicare Advantage members for hemodialysis visits for both facility claims and professional services received at participating hemodialysis centers. This will be effective for all treatments with a date of service beginning January 1, 2006. Claims from January 1, 2006

forward for professional and facility components from participating providers for hemodialysis, can be submitted to IBC for reimbursement without submitting a referral.

Please call Provider Services or your Network Coordinator with any questions.

## Clarification to Member Benefits

Effective January 1, 2006, the following benefit clarifications and enhancements will be implemented for the Keystone Health Plan East (KHPE) and IBC programs in Pennsylvania:

### Orthognathic Surgery (HMO, POS, PPO, and Flex HMO/PPO/POS/POS Direct):

- Coverage for medically necessary orthognathic surgery was added to standard and HMO and POS Flex benefits to align with the standard PPO and PPO Flex benefits.
- The distinction between oral surgery and dental services was defined.
- A definition of "sound natural teeth" was added.
- Dental exclusion language was clarified.
- Oral surgery benefits were clarified to define coverage for surgical procedures on the bones of the jaw for specific indications.
- Language was added to require precertification for coverage of accidental injury to sound natural teeth and orthognathic surgery.

### Guest Membership (HMO, POS, Flex

HMO/POS/POS Direct): Benefit language was added to clarify the situations in which the Guest Membership program is available.

### Cataract Glasses (HMO, POS, PPO, Flex

HMO/PPO/POS/POS Direct): Benefit language was added to clarify coverage for cataract glasses and other vision prosthetics.

### Conversion Coverage (HMO, POS, Flex

HMO/POS/POS Direct): Benefit language was added to clarify that the Member and eligible Dependents must reside in the 5-county service area in order to be eligible for Keystone conversion coverage.

### Rx Rebate Language (Rx Riders, Freestanding Riders,

Integrated Drug): A description of the prescription drug rebate program was added to both the Group Contracts and member booklets and handbooks.

*(continued on next page)*



## ANNOUNCEMENTS (continued)

### Clarification to Member Benefits (continued)

#### HMO Referrals (HMO, POS, Flex HMO/POS/POS Direct):

- Language was added to clarify that a provider can be an individual or a member of a group and that both written and electronic referrals are acceptable.
- Additionally, for inpatient hospital admissions and outpatient services, arrangements can be made by the PCP or Referred Specialist.
- During the 90-day referral period, the Referred Specialist may provide medically necessary follow-up care including inpatient and outpatient services.
- Certain services require preapproval. IBC/Keystone will not pay for services requiring preapproval without the necessary preapproval.
- Members under the age of 18 may go to any network podiatrist.
- Physical Therapy/Occupational Therapy is capitated for primary care physicians in the 5-county area.
- Laboratory services are capitated for all members.
- Radiology services are not capitated for members aged 0-4.

#### Utilization Management (UM) Language Disclosure (HMO, POS, PPO, Flex HMO/PPO/POS/POS Direct):

Disclosure of the UM process was expanded to reflect flexibility within the process.

#### Preventive Health (PPO, PPO Flex):

- Coverage was added to the Preventive Health Schedule for the Routine Fasting Blood Glucose Test, which is provided every 3 years beginning at the age of 45 for all adults.
- Routine Screening for Abdominal Aortic Aneurysm is a routine ultrasound provided once per lifetime for men 65-75 years of age who have ever smoked.

#### HMO Timely Filing (HMO, POS, Flex HMO/POS/POS Direct):

Information was added

regarding time limits for submission of claims by members. **HMO Exclusions Blood and Childbirth Deliveries (HMO, POS):** Exclusion language was removed for whole blood and blood plasma and for normal childbirth deliveries outside the service area within 30 days of the expected delivery date.

**Day Rehab (HMO, POS, PPO, Flex HMO/PPO/POS/POS Direct/CompSelect/MM/BC Hosp):** Language was added to clarify that the benefit for medical Day Rehabilitation is subject to 30 sessions maximum per calendar year and precertification/preauthorization is required.

**Dialysis (HMO, POS, and Flex HMO/POS):** The referral requirement for facility and professional services for dialysis was removed.

**Medicare Exclusions (HMO, POS, PPO, Flex HMO/PPO/POS/POS Direct/CompSelect/MM/BC Hosp):** Effective January 2007, for Covered Persons/Members who are eligible to enroll for Medicare benefits and for whom Medicare would be the primary payer, IBC/Keystone will pay for covered services only as the secondary payer even if the Covered Person/Member does not enroll for, pay applicable premiums for, maintain, claim or receive Medicare benefits.

Please note that this is only a brief summary of the benefit clarifications and enhancements. If you have any questions regarding these benefit clarifications or enhancements, please contact your Network Coordinator.



## ICD-9-CM Diagnosis Codes Change for Routine Gynecological Exams

**Effective January 1, 2006**, capitated PCPs billing for routine gynecological exams should report diagnosis code V72.31 with the applicable preventive evaluation and management Current Procedural Terminology (CPT)\* codes 99384-99387 and 99394-99397 or the Healthcare Common Procedure Coding System (HCPCS) codes S0610 and S0612 for reimbursement consideration.

Routine gynecological exams reported with ICD-9-CM code V72.32 for the CPT codes 99384-99387 and 99394-99397 are no longer eligible for additional payment outside the standard capitation amount. HCPCS codes S0610 and S0612 may still be reported with ICD-9-CM code V72.32 when appropriate.

For reference, the diagnosis code narratives are as follows:

- V72.31: Routine gynecological examination.
- V72.32: Encounter for Papanicolaou cervical smear to confirm findings of a recent normal smear following initial abnormal smear.

**Important reminder:** As previously communicated, **effective October 1, 2004**, we require all practitioners to report diagnosis codes to the highest degree of specificity, according to the ICD-9-CM Coding Manual.

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

*\* Current Procedural Terminology (CPT®) is a copyright of the American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the AMA.*

## NJ Plus, New Jersey State Health Benefits Program Point-of-Service (POS) Plan

NJ Plus, the New Jersey State Health Benefits Program Point-of-Service (POS) plan, is administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ). Currently, over 365,000 members nationwide are enrolled in NJ Plus, but members primarily reside in the tri-state area.

Historically, Horizon BCBSNJ has provided network access and administrative services for NJ Plus members in southeast Pennsylvania through the Blue Cross Blue Shield Association's (BCBSA) BlueCard® POS program. Recently, IBC elected to discontinue its participation in the BlueCard POS program based on a change in the rules by the BCBSA.

This change is **effective January 1, 2006** for NJ Plus members. If you are not contracted with Horizon BCBSNJ, then submit your claims to Highmark Blue Shield, the BlueCard Plan for professional services for most Pennsylvania providers. If you are not contracted with Highmark, but are contracted with Capital Blue Cross or BCBS of Delaware, then submit claims to those plans.



## ANNOUNCEMENTS (continued)

### Laboratory Services Reminder

**PPO:**

Routine laboratory services for PPO members must be sent to one of the in-network laboratories. For PPO members, *lab class code I and II* services may be performed in the physician's office, but *lab class code III* services must be sent to one of the participating laboratory providers.

**HMO/POS:**

All routine laboratory services for HMO/POS members must be directed to and processed by the PCP's designated laboratory site.

Please note that for PPO, HMO, and POS members, STAT lab services specifically listed on the STAT lab listing can be performed at one of the participating hospital facilities. Routine lab services and those not listed on the

approved STAT listing must be sent to the PCP's designated laboratory site. Please see your *Provider Manual* for a current STAT lab listing, which is located at the end of the Specialty Programs and Laboratory Services section.

If routine laboratory services are provided by a hospital, those services will not be reimbursed. Also, the member may be billed provided that they have been informed that routine lab services are not covered services and they agree, in writing, to be financially responsible.

We encourage you to set up accounts with the designated laboratory sites below to accommodate your testing needs, improve recordkeeping, and promote communication between the laboratory and the physician and to facilitate timely receipt of laboratory supplies. IBC contracts with the following laboratories for outpatient services:

Laboratory Name	Laboratory Indicator	Number
Abington Memorial Hospital Laboratory	A	(215) 481-2331
Health Network Laboratories	N	(877) 402-4221
Hospital of the University of PA Laboratory*	H	(800) 789-7366
Laboratory Corporation of America	L	(866) 297-3210
Mercy Health Laboratory	M	(610) 237-4175
Quest Diagnostics, Inc.	Q	(800) 825-7320
Thomas Jefferson University Laboratory*	T	(215) 955-6545

\* Available to specific practices only.

Specialized pathology testing for PPO, HMO, and POS members is offered by the designated laboratories as well as by the following specialized laboratory providers:

<b>Ameripath New York, Inc.</b> (Dermatopathology only)	(800) 553-6621
<b>Dianon</b> (Dermatopathology and certain other pathology tests)	(800) 328-2666
<b>Genzyme Genetics</b> (Reproductive/Genetic testing only)	(800) 848-4436
<b>Institute for Dermatopathology</b> (Dermatopathology only)	(610) 260-0555
<b>Penn Cutaneous Pathology</b> (Dermatopathology only)	(866) 337-6522

Laboratory indicators can be found on the member identification card next to the ID number, via NaviNet<sup>SM</sup>, or the IVR system.



## Clinical Criteria for Utilization Management Decisions

Clinical Decision Support Criteria is used to enhance Medical Necessity coverage decisions that are made by the Care Coordinators, who are Registered Nurses and Medical Directors.

Clinical Decision Support Criteria are an externally validated and computer-based system used to assist IBC in determining Medical Necessity. These evidence-based, Clinical Decision Support Criteria are nationally-recognized and validated. Using a model based on the evaluation of the intensity of service and severity of illness, this criteria assist the clinical staff in deciding upon the Medical Necessity and appropriateness of coverage, based on a member's specific clinical needs. Clinical Decision Support Criteria help promote consistency in the plan determinations for similar medical issues and requests and reduces practice variation among the clinical staff by minimizing subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including, but not limited to the following:

- Elective Surgeries: Appropriateness and setting for inpatient and outpatient procedures (e.g., hysterectomy and sinus surgery).
- Inpatient hospitalizations.
- Inpatient rehabilitation.
- Home Health.
- Durable Medical Equipment (DME).
- Skilled Nursing Facility.

Information about Clinical Decision Support Criteria regarding a specific case guideline may be obtained by calling (215) 241-3417 in Pennsylvania.

## Provider Supply Line: For Office Supplies and Resources

To replenish office supplies (e.g., referrals, forms, directories, and Clinical Practice Guidelines), please call the toll-free Provider Supply Line at (800) 858-4728 and have the following information ready so your order may be processed in an error-free, timely manner:

- Provider identification number.
- Office name.
- Office address.
- Office telephone number.

If any information is missing, your order may not be processed. If an order is submitted correctly, it may take 3-5 business days to receive your requested order. If you are unaware of your Provider Identification Number, contact Provider Services or your Network Coordinator.

**Please note:** Calls to the Provider Supply Line should be related to supply requests only. All other provider inquiries should be directed to Provider Services. Orders placed through Provider Services **will not** be accepted.

Please refer to the back page of this publication for phone number listings under the "Important Resources" heading.



## MEDICARE ANNOUNCEMENTS

# Changes In Drug Coverage with Medicare Part D Implementation

With the introduction of the Medicare Part D (Prescription Drug) benefit on **January 1, 2006**, there will be changes in the prescription drug coverage that includes certain infusion and injectable therapies for our Medicare Advantage members in Keystone 65 and Personal Choice 65<sup>SM</sup>. Please note these changes, listed below:

- Part D drug coverage will now include prescription drugs, biological products, insulin, medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze), vaccines, and smoking cessation agents.
- Part D excludes agents that are used for anorexia, weight loss/gain, fertility, and cosmetic/hair growth, and nonprescription drugs.
- Part D also excludes prescription cough and cold products, prescription vitamins and minerals (except prenatal and fluoride), barbiturates, benzodiazepines, blood glucose meters, test strips, and lancets. IBC has elected to cover these products for members who have selected a prescription drug plan under Medicare Advantage. Members will be charged a copay or coinsurance, but these payments will not be applied to their out-of-pocket expense.

For members who enroll in a Medicare drug program, the existing Medicare Drug formulary will be used. The copay structure for most members is as follows:

- All generic medications will be available at tier 1 (\$5 copay).
- All preferred, formulary brand medications will be available at tier 2 (\$20 copay).
- All non-preferred brand medications will be available at tier 3 (\$40 copay).

### New prior authorizations on the Part D benefit (specific to Medicare only):

- Lupron<sup>®</sup>, Zoladex<sup>®</sup>, and Trelstar<sup>®</sup>.
- Procrit<sup>®</sup>, Epogen<sup>®</sup>, and Aranesp<sup>®</sup>.
- Immunosuppressants: Cellcept<sup>®</sup>, Imuran<sup>®</sup>, Neoral<sup>®</sup>, Rapamune<sup>®</sup>, Prograf<sup>®</sup>, and Sandimmune<sup>®</sup>.
- Inhaled nebulized solutions: AccuNeb<sup>®</sup>, Albutero<sup>®</sup>, DuoNeb<sup>®</sup>, Pulmicort<sup>®</sup>, Ipratropium<sup>®</sup>, Xopenex<sup>®</sup>, Alupent<sup>®</sup>, Metaproterenol<sup>®</sup>, and TOBI<sup>®</sup>.

### New brand formulary additions (specific to Medicare only):

- Buproban<sup>®</sup>
- Imitrex Injection<sup>®</sup>
- Nicotrol<sup>®</sup>, Nicotrol NS<sup>®</sup>
- Nutropin<sup>®</sup>, Nutropin AQ<sup>®</sup>
- PhosLo<sup>®</sup>
- Peg-Intron<sup>®</sup>
- Procrit<sup>®</sup>
- Vaccines (except influenza, pneumococcal)
- Zyban<sup>®</sup>

### Changes in injectable coverage

Self-injectables are now covered under the Part D (drug) benefit. Members who may have received these medications with no copayment will now be responsible for the appropriate brand copayment if accessed through a member's Part D (drug) benefit. Examples include Avonex<sup>®</sup>, Betaseron<sup>®</sup>, Copaxone<sup>®</sup>, Rebif<sup>®</sup>, Procrit<sup>®</sup> and Peg-Intron<sup>®</sup>, Intron<sup>®</sup>, Roferon<sup>®</sup>, Rebetron<sup>®</sup>, Pegasys<sup>®</sup>, Roferon<sup>®</sup>-A, Lovenox<sup>®</sup>, Fragmin<sup>®</sup>, Arixtra<sup>®</sup>, Innohep<sup>®</sup>, Epogen<sup>®</sup>, Neupogen<sup>®</sup>, Aranesp<sup>®</sup>, Neulasta<sup>®</sup>, Leukine<sup>®</sup>, Xolair<sup>®</sup>, and Actimmune<sup>®</sup>.

### Please note the new quantity limits (specific to Medicare only):

Brand Name	Generic Name	Quantity Limit
Anzemet <sup>®</sup>	dolasetron	#6 units/prescription
Aranesp <sup>®</sup>	darbepoetin alfa	1 copay/7 days
Epogen <sup>®</sup>	epoetin alfa	1 copay/7 days
Kytril <sup>®</sup>	granisetron	#6 units/prescription
Neulasta <sup>®</sup>	pegfilgrastim	1 copay/7 days
Neumega <sup>®</sup>	oprelvekin	1 copay/7 days
Neupogen <sup>®</sup>	filgrastim	1 copay/7 days
Procrit <sup>®</sup>	epoetin alfa	1 copay/7 days
Zofran <sup>®</sup> , Zofran ODT <sup>®</sup>	ondansetron	#6 units/prescription



## Changes in Drug Coverage with Medicare Part D Implementation (continued)

Previously, some medications were available through the member's pharmacy benefit, but were covered under their medical benefit and carried no copayment. These medications will now be covered under the member's prescription benefit as required by the Centers for Medicare & Medicaid Services (CMS). Members will be responsible for the appropriate brand copayment. Examples of these drugs and drug classes include oral antineoplastics/chemotherapy drugs such as Tamoxifen<sup>®</sup>, diabetic supplies (needles, syringes, alcohol swabs, and gauze), anti-emetics/vertigo agents, hematinics, immunosuppressants, Enbrel<sup>®</sup>, Humira<sup>®</sup>, Kineret<sup>®</sup>, and Forteo<sup>®</sup>.

The following injectables, previously covered under the member's medical or pharmacy benefit, have now been defined as self-injectables under the Part D benefit only. Members will be responsible for the appropriate brand copayment. These injectables will **not** be available under the member's medical (Part B) benefit: Caverject<sup>®</sup>, Edex<sup>®</sup>, Muse<sup>®</sup> (alprostadil), Miacalcin<sup>®</sup>, Calcimar<sup>®</sup> (calcitonin), Enbrel<sup>®</sup> (etanercept), Humira<sup>®</sup>, Kineret<sup>®</sup>, Insulin<sup>®</sup>, Roferon<sup>®</sup>-A (interferon alfa 2a, recombinant), Inergen<sup>®</sup>, Intron-A<sup>®</sup>, Pegasys<sup>®</sup>, Peg-Intron<sup>®</sup>, Betaseron<sup>®</sup> (interferon beta 1b), Avonex<sup>®</sup>, Copaxone<sup>®</sup>, Rebif<sup>®</sup>, Actimmune<sup>®</sup> (interferon gamma 1b), Protropin<sup>®</sup>, Genotropin<sup>®</sup>, Humatrope<sup>®</sup>, Norditropin<sup>®</sup>, Nutropin<sup>®</sup>, Saizen<sup>®</sup>, Serostim<sup>®</sup> (somatrem, somatropin), Tev-Tropin<sup>®</sup>, Zorbtive<sup>®</sup>, Imitrex<sup>®</sup> (sumatriptan), Forteo<sup>®</sup> (teriparatide), Fuzeon<sup>®</sup>, Apokyn<sup>®</sup>, Byetta<sup>®</sup>, Symlin<sup>®</sup>, EpiPen<sup>®</sup>, Twinject<sup>®</sup>, and Raptiva<sup>®</sup>.

## Keystone 65 and Personal Choice 65<sup>SM</sup> Medicare Changes for 2006

Keystone 65 and Personal Choice 65<sup>SM</sup> members recently received a mailing that details their benefit changes for 2006. All changes begin **January 1, 2006** and will be in effect through December 31, 2006.

There are some important benefit changes to the 2006 Keystone 65 (Basic, Value, Standard, Generic, and Brand) and Personal Choice 65 (Value, Silver, and Gold) plans.

Starting **January 1, 2006**, the following changes will apply to Keystone 65 plans:

- **Keystone 65 Value**—This plan will expand to include Medicare Part D prescription drug coverage and includes a medical-only option and two prescription drug options.
- **Keystone 65 Standard**—This plan will expand to include Medicare Part D prescription drug coverage and includes a medical-only option and three prescription drug options.
- **Keystone 65 Basic**—Effective June 1, 2005, this became a Medicare Advantage Special Needs Plan known as Keystone 65 Complete. It is designed for Medicare Beneficiaries who are enrolled in a state Medical Assistance program (including Healthy Horizons). Keystone 65 Complete will include one Medicare Part D prescription drug option.
- **Keystone 65 Generic and Brand**—These plans will no longer be offered.

Starting **January 1, 2006**, the following changes will apply to Personal Choice 65 plans:

- **Personal Choice 65 Value**—This plan will expand to include Medicare Part D prescription drug coverage and includes a medical only option and two prescription drug options.
- **Personal Choice 65 Standard**—This is a new plan for 2006 with a medical-only option and three prescription drug options.
- **Personal Choice 65 Silver and Gold**—These plans will no longer be offered.

Group administrators may have elected changes in their members' coverage for 2006. Members will receive notification of any changes from their group administrator by **December 1, 2005**.

Please note that if employer group members have coverage through their former employer, Health and Welfare Fund, or association group, policy and procedures may differ. In some cases, benefits may also vary. Group members should consult their benefit administrator or Keystone 65 or Personal Choice 65 Member Services.

Please contact your Network Coordinator or Provider Services with any questions.



## CLASS ACTION SETTLEMENT UPDATE

### Clear Claim Connection™

#### IBC Implements Clear Claim Connection™ for Provider Class Action Settlement Providers on December 16, 2005

IBC is pleased to introduce McKesson's Clear Claim Connection™ to providers who agreed to the court-approved Class Action Settlement in the consolidated cases of Gregg, et al. v. Independence Blue Cross, et al., Good v. Independence Blue Cross, et al. and Pennsylvania Orthopaedic Society v. Independence Blue Cross, et al. Clear Claim Connection™ is a tool that explains how IBC applies procedure code combination logic; it is available via NaviNet<sup>SM</sup>, our online provider portal. Access to Clear Claim Connection™ is gained from Plan Central and is password protected (initial use only).

A letter detailing the necessary username and password to gain access to Clear Claim Connection™ and a Clear Claim Connection™ User's Guide is mailing in December 2005 to providers who accepted the settlement. The User's Guide will provide instruction and additional background information about the tool.

The web-based Clear Claim Connection™ is designed to offer information about how IBC evaluates certain procedure code combinations during professional claims processing. The information provided in Clear Claim Connection™ only speaks to the clinical relationship logic based within ClaimCheck®, as customized by IBC. Clear Claim Connection™ supplements the ClaimCheck® system:

- By decreasing time spent researching claims denials due to inappropriate procedure code combinations.
- By providing easy access to rationales for procedure codes that are clinically inappropriate to be submitted together.
- By assisting providers in reporting appropriate procedure code combinations.

Please call your Network Coordinator or Provider Services for more information.

### Settlement Claims Payment Policy and Processing Update

#### *Settlement-related claims processing changes*

To the extent a claim payment and/or processing policy was changed as part of the class action settlement, providers who opted-out are not entitled to these policy changes. **Any payments made pursuant to such policy changes to providers who opted out of the class action settlement are subject to retroactive adjustments.** The inclusion of a code/modifier in policy does not imply reimbursement. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, policy, and code relationship logic still apply.



## Announcements

### Modifier -51 Exempt

Recently, IBC revised the reimbursement methodologies regarding procedure codes that are exempt from being reported with Modifier -51 (multiple procedures).

Modifier -51 is used when multiple procedures other than evaluation and management (E&M) services are performed at the same session by the same provider. Surgical services reported with modifier -51 are subject to multiple surgical reduction guidelines.

As defined by the American Medical Association (AMA), Current Procedural Terminology (CPT)\*, modifier -51 exempt codes are procedure codes that are exempt or free from being reported with modifier -51 because reduction of the work values has already been accommodated and reflected in the reimbursement. Multiple surgery reduction logic is not applied to modifier -51 exempt procedure codes.

Modifier -51 Exempt codes:

- Should not be reported with modifier -51 and
- Should not have multiple surgery reduction logic applied when the modifier -51 exempt procedure codes are eligible and reported with other surgical services.

### Radiologic Guidance of a Procedure

IBC revised the reimbursement methodologies applied to claims processing of radiologic guidance and/or supervision and interpretation of a procedure.

Radiologic guidance and/or supervision and interpretation is performed by either the same professional provider who performs the surgical procedure or a different professional provider.

Radiologic guidance and/or supervision and interpretation of a procedure that is performed in conjunction with a covered procedure is eligible for separate reimbursement consideration by IBC.

When the same provider performs and reports both the radiologic **and** the diagnostic or therapeutic procedures, both procedures are eligible for reimbursement consideration to the provider. However, all of the following requirements must be met:

- Both the radiologic guidance and/or supervision and interpretation service **and** the procedure for which it is performed must be covered for the radiologic guidance and/or supervision and interpretation to be eligible for separate reimbursement consideration.
- Documentation in the medical record must reflect the radiologic guidance and/or supervision and interpretation procedure(s) performed by the physician. The medical record must be available to IBC upon request. Providers should not submit medical records to IBC unless otherwise requested.

This information supersedes the information in the policy addressing Interventional Radiology.



# CLASS ACTION SETTLEMENT UPDATE

## Announcements (continued)

### Surgical Team Modifier -66

Beginning in January 2006, IBC will enhance its processing system to apply the Centers for Medicare & Medicaid Services (CMS) payment methodology for Surgical Team modifier -66 as outlined in their Medicare Physician Fee Schedule Database found on the CMS website.\*\*

Surgical team modifier -66 is used to denote a procedure that requires a team of surgeons (more than two surgeons of different specialties) to perform various portions of a complicated surgical procedure. Each surgeon participating in the team surgery is a member of the surgical team. Participation in team surgery by a surgeon performing a surgical procedure is indicated by appending modifier -66 to the procedure code for that service.

Prior to adjudication, reimbursement consideration for services reported with modifier -66 will be reviewed for medical necessity and documentation completion. All team surgery claims require the submission of a completed surgical team documentation form. When the required documentation is unavailable or incomplete, claims will be denied. Please refer to the enclosed *Surgical Team Documentation* form.

The table below identifies and describes the processing outcome associated with each indicator. However, reimbursement is also contingent upon eligibility, benefits, exclusions, precertification/ referral requirements, provider contracts and applicable policies.

CMS utilizes a payment methodology for these types of services by applying team surgery payment indicators to procedure codes that, when submitted in combination with modifier -66, will allow or restrict payment consideration:

CMS Indicator & Description	Outcome for code/modifier -66 combination
(0) Team surgery payment is inappropriate.	Ineligible for team surgery reimbursement consideration.
(1) Team surgery payment is inappropriate unless supporting documentation establishes medical necessity.	Reimbursement consideration determined upon receipt and review of medical necessity and supporting documentation.
(2) Team surgery payment is appropriate.	Reimbursement consideration determined upon receipt and review of medical necessity and supporting documentation.
(9) Concept does not apply.	Invalid procedure/modifier code combination.

When determined as eligible by IBC for surgical team services, multiple surgical procedures reported by each surgeon are subject to multiple surgery reduction guidelines.

Medical records, operative reports, the surgical team documentation form and/or other supporting documentation should be submitted at the time of claim submission to the mailing address shown on the surgical team documentation form. The surgical team documentation form is enclosed with this mailing.

### Implementation Recap

To date, IBC has implemented several of the Settlement-related claims processing changes. These implementations include claims processing changes related to:

- Modifiers -25, -50, -51, -59, -RT, -LT
- Multiple Surgical Procedures
- Add-on codes
- Separate Procedures
- Modifier -51 Exempt
- Radiologic Guidance

For further detail on previously implemented Settlement related-changes, please refer to the April 2005 edition of *Transactions with IBC: Your Quick Reference to Billing, Referrals, and e-Connectivity* and to *Partners in Health* April and October *Update*. Please refer to future editions of *Update* for more information regarding implementation of pending claim processing changes.



# Settlement Recap

## Enhancements to Claim Payment Policy, Processing and Payment Disclosure, and an Appeals Process for Class Action Settlement Providers

The court-approved class action settlement between IBC and providers, who agreed to the terms of the class action settlement (“Settlement Providers”), includes the following enhancements:

- Improving disclosure to Settlement Providers, including standard fee schedules, changes to schedules, and medical and payment policies that may affect payment/reimbursement of services, which will be made available online via NaviNet<sup>SM</sup>, our secure provider portal.
- Changing claims processing for Settlement Providers on the following: selected modifiers (-25, -50, -51, -59, -62, -66, -80, -81, -82, -RT, -LT); multiple surgical procedures; radiological guidance during a procedure; and certain Current Procedural Terminology (CPT)\* code-level designations (Modifier -51 exempt, Separate Procedure, and Add-on codes).
- Introducing a two-level, formal claims appeal process for Settlement Providers.

Certain of these enhancements are currently available. Others will be announced as they become available.

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*\*\* The following is a link to the Medicare website: [www.cms.gov](http://www.cms.gov). These sites are maintained by organizations over which Independence Blue Cross exercises no control, and accordingly, Independence Blue Cross expressly disclaims any responsibility for the content, the accuracy of the information, and/or quality of the products or services provided by or advertised in these third-party sites. Certain services/treatments referred to in other sites may not be covered under specific benefit plans. Please refer to benefit contracts for complete details of the terms, limitations, and exclusions of coverage.*

## NAVINET<sup>SM</sup> ANNOUNCEMENTS

### New Features Available via the Navinet<sup>SM</sup> Provider Portal

IBC has made enhancements to NaviNet<sup>SM</sup> Plan Central—the HIPAA-compliant web-based provider portal offered by NaviMedix<sup>®</sup>, Inc.—that will streamline the e-billing claims payment and reconciliation processes and provide additional copayment information.

#### Effective December 9, 2005

IBC has made available additional copayment information, and providers will have the ability to view annual service and dollar accumulator information. This information will be accessible via the Eligibility Detail screen.

#### Effective January 1, 2006

Two new enhancements will be available: The Electronic Fund transfer (EFT) Online Statement of Remittance (SOR) and the Online SOR Inquiry.

NaviNet participating providers will have the ability to **register and maintain their EFT account** and begin to **receive claims payment electronically** from IBC. This information will be accessible via the ePayments screen. Completion of EFT SOR Online Registration will enable providers to **conduct Online SOR Inquiries**, which will allow providers to **view, sort, and filter their remittance data**. Appropriate levels of security can be set by the security officer to restrict the ability to register, view, and change the provider's EFT account information.

#### Information Access

Detailed information and instructions on how to use the new features can be found in the user guides on NaviNet<sup>SM</sup> Plan Central. The User guide can be accessed through NaviNet<sup>SM</sup> Plan Central by selecting **Customer Service, NaviMedix<sup>®</sup> Customer Care, and User Guide**. You may also contact NaviMedix<sup>®</sup> Customer Care at (888) 482-8057 for assistance.

## REMINDERS

# Medicare Tiered Hospital Networks Now Available for Members in Keystone 65 Value Plan and Personal Choice 65<sup>SM</sup> Value Plan

Effective January 1, 2006, IBC will, for the first time, offer a tiered hospital network benefit plan. The tiered hospital network will **only** be available for Keystone 65 and Personal Choice 65<sup>SM</sup> Value Plan members.

The Keystone 65 and Personal Choice 65<sup>SM</sup> Value Plans are changing the type of cost sharing for inpatient hospital services from coinsurance to copayment. This will provide members with a fixed out-of-pocket cost for these services.

There are two tiers of cost sharing, one for lower-cost (Tier I) hospitals, and another for higher-cost (Tier II) hospitals within the IBC hospital network. Keystone 65 and Personal Choice 65<sup>SM</sup> members will continue to have access to all hospitals in the IBC network.

Please note that if a member is referred, transferred, or admitted due to an emergency to a Tier II hospital, the member is responsible for the higher applicable copayment.

## Passive Enrollment of Dual Eligibles into Keystone 65 Complete

On January 1, 2006, full dual eligible Medicare beneficiaries—people eligible for both Medicare and Medicaid benefits—will begin receiving prescription drug benefits through the Medicare Part D program rather than Pennsylvania Medicaid. The Centers for Medicare & Medicaid Services (CMS) have authorized Keystone Health Plan East (KHPE) to passively enroll certain beneficiaries into its Special Needs Plan for dual eligibles. Through passive enrollment, beneficiaries are automatically enrolled in the plan. Dual eligibles currently enrolled with KHPE's affiliated plan, Keystone Mercy, will be passively enrolled into the Keystone 65 Medicare Advantage Special Needs Plan known as Keystone 65 Complete. These beneficiaries may "opt out" if they prefer by calling Member Services. Dual eligible members passively enrolled into Keystone 65 Complete will experience no interruptions to their prescription drug coverage during the transition to Medicare Part D.

Dual eligibles who have been passively enrolled into Keystone 65 Complete received letters in October welcoming them to the plan. The letter also explained their ability to "opt out" of Keystone 65 Complete.

If dual eligibles choose to "opt out" of Keystone 65 Complete, they have two options:

1. Return to Medicare fee-for-service and select a free-standing Prescription Drug Plan that offers Part D coverage only.
2. Select another Medicare Advantage plan in their area that includes Part D.

Keystone 65 Complete provides coverage for medical benefits that are the same as the Medicare fee-for-service benefit, as well as a number of additional benefits such as transportation services to network providers; hearing, dental, and vision benefits; disease management; and preventive health and wellness programs. These services can help members, especially those with complex medical needs, navigate more successfully through the health care system. Keystone 65 Complete also offers open access and referral-free behavioral health services. Additional mental health, alcohol, and chemical dependency support, and case management services will be offered.

In upcoming months, we will provide additional information regarding Keystone 65 Complete benefits, member identification cards, PCP selection, and billing. If you have any questions, please contact your Network Coordinator.





## BILLING REMINDERS

### Radiology Quality Initiative Grace Period Ended November 30, 2005

For services **scheduled on or after December 1, 2005**, Medical Necessity denials may be applied to CT or CTA Scans, MRIs, MRAs, and Nuclear Cardiology Services under the Radiology Quality Initiative (RQI).

**Effective December 1, 2005**, for Pennsylvania and Delaware managed care members, if you do not obtain prior approval for CT or CTA Scans, PET scans, MRIs, MRAs, or Nuclear Cardiology Services, your claim will be denied for lack of preauthorization. PET scans, Out-of-Network, Out-of-Capitation, and services that are experimental/investigational continue to require preauthorization.

As previously communicated, the RQI went into effect for services provided on or after October 10, 2005. The RQI is being administered through American Imaging

Management, Inc. (AIM). The outpatient diagnostic imaging services that require prior approval are PET Scans, CT or CTA Scans, MRIs, MRAs, or Nuclear Cardiology Services.

Medical Necessity denials for CT or CTA Scans, MRIs, MRAs, or Nuclear Cardiology Services for Medicare Advantage members will not be applied until January 1, 2006.

Questions about the RQI should be directed to AIM's Customer Service Department by calling the Health Resource Center at (800) 227-3116 and follow the prompts to AIM's RQI Department and then to Customer Service.

### Electronic Remittance Advices (835s) for Personal Choice® and Personal Choice 65<sup>SM</sup> Products to be Generated by IBC

As part of the IBC PPO conversion to the PowerMHS™ adjudication system, professional providers currently receiving electronic remittance advices (835s) for Personal Choice® and Personal Choice 65<sup>SM</sup> claims will begin receiving 835s generated by IBC. IBC will generate 835s for professional claims received on or after July 2, 2005 with dates of service of January 1, 2005 and later. IBC-generated 835s will contain combined payment information for your PPO and HMO claims.

Highmark Blue Shield will continue to generate 835s for all professional Personal Choice and Personal Choice 65 claims received prior to July 2, 2005. After the July 2, 2005 conversion, Highmark will continue to generate 835s for professional claims with dates of service prior to January 1, 2005.

Please be aware that during the claims processing run-out period after July 2, 2005, you may receive 835s for Personal Choice and Personal Choice 65 professional claims from both IBC and Highmark. There are also some differences in the content and enveloping information between the IBC- and Highmark-generated 835s. Please check with your vendor or clearinghouse to identify any changes necessary for this transition.

Please contact the eBusiness Help Desk at (215) 241-2305 or via e-mail at [claims.edi-admin@ibx.com](mailto:claims.edi-admin@ibx.com) with any questions or for more information.



# Claims Submission for Personal Choice® and Personal Choice 65<sup>SM</sup> Products Converted to PowerMHS™

In our ongoing effort to streamline administrative processes, Personal Choice® and Personal Choice 65<sup>SM</sup> products converted to our managed care information system, PowerMHS™, **effective July 2, 2005**. This enhancement included updated National Association of Insurance Commissioners (NAIC) codes for use, **effective July 2, 2005**. Additionally, you will receive enhanced reports including a consolidated Statement of Remittance for IBC product lines including Keystone Health Plan East (KHPE) HMO, KHPE Point-of-Service (POS), Personal Choice, and Personal Choice 65. We previously transitioned KHPE HMO and POS products to PowerMHS. We encourage you to prepare for this change as outlined below.

## Electronic Billers: NAIC Code Requirements

Effective for claims submitted on or after July 2, 2005, regardless of dates of service.

*Please share this information with your software and clearinghouse vendors to ensure there is no disruption in your claims payment.*

**Effective July 2, 2005**, the electronic submission of Personal Choice and Personal Choice 65 claims in HIPAA-compliant ANSI X12 837P format (version 4010A1) requires the **NAIC code of 54704 in ISA-08 in order to be routed correctly. Please use NAIC code 54704 in ISA-08 for Personal Choice and Personal Choice 65 effective July 2, 2005, regardless of dates of service.** This same code is presently used when electronically submitting KHPE HMO and POS. Continue to include the GS-03 NAIC code when submitting all claims to identify the line of business.

Questions regarding this electronic billing change should be directed to the eBusiness Help Desk at (215) 241-2305 (Monday through Friday; 8:30 a.m. to 4:30 p.m. EST) or via e-mail to [claims.edi-admin@ibx.com](mailto:claims.edi-admin@ibx.com).

## Paper Claims Submission

Paper claims for Personal Choice® and Personal Choice 65<sup>SM</sup> should continue to be submitted to:

Personal Choice Claims  
P.O. Box 890016  
Camp Hill, PA 17089-0016

To register to submit claims electronically, contact the eBusiness Provider Inquiry Line at (215) 640-7410 and leave a detailed message, or complete our Online Inquiry Form at [www.ibx.com/providers/navinet](http://www.ibx.com/providers/navinet). Thank you for your cooperation. If you have any questions regarding this new billing information, please contact your Network Coordinator.

### IMPORTANT BILLING REQUIREMENTS

**Please remember that group and performing PPO provider ID numbers are required.**

#### Solo Practitioners:

Providers must bill using either the individual provider's valid Highmark Blue Shield ID number or their 10-digit MHS Provider ID number for both the Performing Provider ID Number (PIN#) and Group Provider ID number (GRP#) in Field 33 for Personal Choice and Personal Choice 65 claims.

However, solo practitioners that bill with a Tax ID Number (TIN) should use the practice provider number associated with that TIN in Group Provider (GRP#) Field 33 for Personal Choice and Personal Choice 65 claims.

Note that you must make consistent use of either Highmark Blue Shield ID numbers or 10-digit MHS Provider ID numbers on a single claim.

#### Group Practices:

Practices must bill using the individual provider's valid Highmark Blue Shield ID number or their 10-digit MHS Provider ID number for the Performing Provider (PIN#), as well as the valid Highmark Blue Shield number or 10-digit MHS Provider ID number of the Group Provider (GRP#) in Field 33 for Personal Choice and Personal Choice 65 claims. Note that you must make consistent use of either Highmark Blue Shield ID numbers or 10-digit MHS Provider ID numbers on a single claim. In addition, in Field 31, the individual performing provider's name must appear.

The Highmark Blue Shield ID number is acceptable in any of the formats below:

- 123456
- 0123456
- 00123456
- 000123456

Highmark Blue Shield numbers with ten or more digits will be rejected. Any Highmark Blue Shield ID number billed with five or less digits will also be rejected.

NAIC Codes for Electronic Billers (ANSI X12 837P-4010A1)		
Product	ISA-08 NAIC Code	GS-03 NAIC Code
Personal Choice and Personal Choice 65	54704	54704
KHPE HMO / KHPE POS / Keystone 65		95056



## BILLING REMINDERS (continued)

# IBC Transitioned to All-Electronic Encounter and Referral Submission

As previously communicated, beginning August 1, 2005, IBC transitioned to an all-electronic format for referrals and encounters. Providers are required to submit referrals and encounters using NaviNet<sup>SM</sup> or via enhancements to our Interactive Voice Response (IVR) system. Encounters may also be submitted electronically via other vendors. (Please refer to the article titled *Providers Required to Use NaviNet<sup>SM</sup> or Telephonic Interactive Voice Response [IVR] System to Obtain Member Eligibility Information* on page 19).

Thank you for transitioning to electronic encounter and referral submissions. We recognize that occasional emergencies may require the use of paper referrals. However, as of **January 1, 2006**, paper referrals will no longer be available to providers located in Bucks, Chester, Delaware, Montgomery, and Philadelphia counties via the Provider Supply Line. In the event of an emergency, providers located in these five counties must contact their Network Coordinator to obtain paper referrals.

### Please also note the following important changes and the effective dates:

- **Effective May 1, 2005**, we can no longer accept only referral numbers in Field 19 of a CMS-1500 claim form to satisfy a member's referral requirement. In addition to the information in Field 19, a copy of the paper or electronic referral must be on file for the claim to process.
- **Effective August 1, 2005**, for all referral submissions, the 10-digit MHS Provider ID number of the referred-to provider is required.
- **Effective November 1, 2005**, new providers joining the network will no longer receive or have access to station plates. This change is in conjunction with the implementation of the electronic referral transition, which was effective August 1, 2005.

If you are not using NaviNet<sup>SM</sup> to submit electronic referrals today, we encourage you to discover the benefits that NaviNet<sup>SM</sup> has to offer and make the move toward a paperless office. For more information about NaviNet<sup>SM</sup>, contact the eBusiness Provider Inquiry Line at (215) 640-7410, or complete our Online Inquiry Form at: [www.ibx.com/providers/navinet](http://www.ibx.com/providers/navinet).

Note: Members may view and print referrals by logging on to our member portal, [www.ibxpress.com](http://www.ibxpress.com).

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

*Please note: This article does not apply to Behavioral Health services or providers.*

### QIPS<sup>®</sup> Modifications for PCPs

**Beginning August 1, 2005** (October 2005 incentive cycle), IBC modified the bimonthly Quality Incentive Payment System (QIPS<sup>®</sup>) payment to capitated PCPs for electronic connectivity and submissions as follows:

- **Referrals:** Capitated PCP offices submitting 80% of their referrals electronically will be eligible for the \$0.25 per member per month Connectivity Premium. The percentage calculation will be based on the previous two months' electronic referral submissions to the total number of referrals submitted (electronic and paper). PCP offices will continue to receive a \$0.50 payment for the submission of each electronic referral.
- **Encounters:** Capitated PCP offices will receive a \$1.00 payment for the submission of each electronic encounter. There will be no payment for the submission of paper encounters.
- **Electronic Transactions:** A \$0.50 premium per transaction\* will be paid to PCP offices for all electronically submitted:
  - Claims.
  - Referrals.
  - Drug preauthorizations.
  - Encounters.

As of August 1, 2005, submission of electronic encounters and referrals were tracked for the October 2005 QIPS<sup>®</sup> payment.

A revised QIPS<sup>®</sup> Manual was sent to your office as an enclosure with *Partners in Health July Update*.

\* Previously, only NaviNet<sup>SM</sup>-originated submissions were eligible for this payment.



## 13-Position Member Identification Number Update

As previously communicated, various states have enacted laws to limit the use of a member's Social Security Number (SSN) on ID cards and other materials. As a result of this legislative trend, and to better protect member identity and privacy, IBC has developed a non-SSN-based identifier to be used on external communications to members, including member identification cards.

In late summer, IBC began issuing ID cards featuring the new member identification number to members. The new member ID initiative is scheduled for completion in the fall of 2005. Please use the new member identification number when processing member information. However, you may continue to use the identification number on the member's

current ID card for those members who have not been issued new ID cards. The new member ID number consists of a three-position alpha prefix, an eight-position ID number, and a two-position suffix, which defines a member of the family unit. Traditional and CompSelect®/Comprehensive Major Medical (CMM) members will have a three-position alpha prefix and an eight-position ID number only.

Please note that the Group number will no longer appear on the ID card and is not required for submitting claims. Please call Provider Services or your Network Coordinator with questions.

## Alpha-Prefix Billing Requirement

To facilitate claims processing, please include the alpha-prefix along with the complete identification number as it appears on the member's ID card for all local and out-of-area claims. Previously, the alpha prefix was required only on out-of-area claims. For HMO and POS, please

note that the lab indicator (for example, "A," "H," "L," "M," "N," "T," or "Q") located on the front of HMO and POS ID cards **should not** be included in the member's ID number.

## Providers Required to Use Navinet<sup>SM</sup> or Telephonic Interactive Voice Response (IVR) System to Obtain Member Eligibility Information

**Effective August 1, 2005**, participating providers are required to use either Navinet<sup>SM</sup> or the telephonic Interactive Voice Response (IVR) system for all member eligibility inquiries.

Providers using Navinet<sup>SM</sup> have access to member eligibility information as well as many other resources, including encounter and referral submissions and referral and benefits inquiries. Navinet<sup>SM</sup> is only available to participating providers. To get started using Navinet<sup>SM</sup>, please contact the eBusiness Provider Inquiry Line at (215) 640-7410 or complete an Online Inquiry Form at: [www.ibx.com/providers/navinet](http://www.ibx.com/providers/navinet).

In addition, providers can use the IVR system, our voice-activated automated phone service, to retrieve member eligibility information for HMO and PPO members. The IVR system can be accessed 24-hours-a-day, 7-days-a-week at (866) 681-7370. Requested information can also be faxed to your office through the IVR system.

*Please note: This article does not apply to Behavioral Health services or providers.*

### Did you know?...

Claims status can be obtained via Navinet<sup>SM</sup> and the IVR system.



## FOR YOUR PATIENT'S HEALTH

### Supporting Our Members, Your Patients: Connections<sup>SM</sup> Health Management Programs

*Helping you and your patients manage five chronic conditions (Asthma, CAD, CHF, COPD, and Diabetes)*

#### CONTACT THE CONNECTIONS<sup>SM</sup> HEALTH MANAGEMENT PROGRAM PROVIDER SUPPORT LINE AT (866) 866-4694 TO:

- 1 Refer a member for Health Coaching.
- 2 Ask questions or provide feedback.
- 3 Request information regarding the SMART<sup>TM</sup> Registry.
- 4 Request Connections<sup>SM</sup> posters for your office, referral pads, or copies of the *Clinical Insights*.
- 5 Request individual patient information for the purposes of treatment or care coordination.

A Connections<sup>SM</sup> Provider Service Specialist will return your call within two business days.

*Promoting self-management and preventing disease complications for patients with complex chronic conditions*

#### CONTACT THE CONNECTIONS<sup>SM</sup> ACCORDANTCARE<sup>TM</sup> PROGRAM AT (866) 398-8761 TO:

- 1 Refer patients with the following complex chronic conditions for disease management support:

- Seizure Disorders
- Rheumatoid Arthritis
- Multiple Sclerosis
- Parkinson's Disease
- Systemic Lupus Erythematosus (SLE)
- Myasthenia Gravis
- Sickle Cell Disease
- Cystic Fibrosis
- Hemophilia
- Scleroderma
- Polymyositis
- Dermatomyositis
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Amyotrophic Lateral Sclerosis (ALS)
- Gaucher Disease

- 2 Ask questions or provide feedback.
- 3 Request an individual patient disease management plan for the purposes of care coordination for your patient.

*Providing resources for you and your patients with end-stage renal disease*

#### CONTACT THE CONNECTIONS<sup>SM</sup> KIDNEY PROGRAM AT (866) 303-4CKP [4257] TO:

- 1 Refer a member on chronic outpatient dialysis to a Health Service Coordinator.
- 2 Ask questions or provide feedback.
- 3 Request individual member information.

## Credentialing Compliance Hotline and Web Page

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

*except for urgent or emergent care.* 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](http://www.ibx.com/credentials).



## 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 PHARMACY WEBPAGE

[www.ibx.com/provider\\_rx](http://www.ibx.com/provider_rx)

### eBUSINESS HELP DESK

(215) 241-2305

### eBUSINESS PROVIDER INQUIRY LINE

(215) 640-7410

### 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)

### PROVIDER SUPPLY LINE

(800) 858-4728

\* 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

#### 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 PROGRAMS PROVIDER SUPPORT LINE

(866) 866-4694

### CONNECTIONS<sup>SM</sup> KIDNEY PROGRAM

(866) 303-4CKP [4257]

### CONNECTIONS<sup>SM</sup> ACCORDANTCARE<sup>™</sup> PROGRAM

(866) 398-8761

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 website at [www.ibx.com](http://www.ibx.com)

*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.

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.

Certain services/treatments referred to in other sites may not be covered by all benefit plans. Members should refer to their benefit description/contract material for complete details of the terms, limitations, and exclusions of their health care coverage. Benefits may be based on specific time frames. For coverage information and questions, members may contact Member Services at the phone number printed on their member ID card.

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

## Surgical Team Documentation Form

**Instructions:** Surgical Team (modifier -66) refers to surgeons with different skills, and different specialties, working together to carry out various portions of a complicated surgical procedure during the same operative session on the same date of service for the same member. The Company follows the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Database indicators for eligibility for team surgery. This form should be completed when requesting reimbursement for a team of surgeons. Each surgical team member should submit the same procedure code with modifier -66 indicating that a team of surgeons was required. Each surgical team member *must* provide their full name, provider and tax ID numbers, percentage of allowance, operative report, and signature. (Use an additional sheet if more than seven procedures were performed.)

Member Name	ID	Date of Service

Code for Team Surgery	Performing Surgeon Name/ Participating or Non-Participating ( <i>Please Print</i> )	Billed Amount (\$)
1		
2		
3		
4		
5		
6		
7		
<b>Total Billed Amount</b>		

Surgeon 1 ( <i>Please Print</i> )	Surgeon 2 ( <i>Please Print</i> )
Full Name:	Full Name:
Provider Number:	Provider Number:
Tax ID:	Tax ID:
% of Total Allowance for Surgeon 1:	% of Total Allowance for Surgeon 1:
Signature:	Signature:
Surgeon 3 ( <i>Please Print</i> )	Surgeon 4 ( <i>Please Print</i> )
Full Name:	Full Name:
Provider Number:	Provider Number:
Tax ID:	Tax ID:
% of Total Allowance for Surgeon 1:	% of Total Allowance for Surgeon 1:
Signature:	Signature:

*Total Percentage of Allowance for all surgeons cannot exceed 100%*

Return one completed form with all signatures and operative report attached from each surgeon to:  
 Claims Medical Review  
 1901 Market Street  
 Philadelphia, PA 19103  
 Attn: Lorraine O'Neal

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.

