



Independence
Blue Cross

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PARTNERS IN HEALTH UPDATE

August 2007

Working Together For Quality Health Care

Health Resource Center hours of operation change

On August 6, 2007, the Health Resource Center for Precertification will change its hours to correspond to the Provider Services' hours of operation.






Precertification Specialists will be available to take your call from 8 a.m. through 5 p.m., Monday through Friday. This change will allow us to better serve our provider population in a more effective manner during peak business hours.

For articles specific to your area of interest, look for the appropriate icon:



-  Professional
-  Facility
-  Ancillary

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10 digits. BIG IMPACT.

The Power of NPI



Share your NPI now to avoid potential regulatory penalties and impact to cash flow

Get It. Get it **NOW** from the National Plan and Provider Enumeration System (NPPES).

- Get your NPI(s): a unique 10-digit identification number. We recommend you enumerate with your current corporate ID configuration.
- Get it now. Do not wait.
- Get it faster on the Web at <https://nppes.cms.hhs.gov>.

Share It. Share it **NOW** with us, billing companies, and clearinghouses. Failure to share your NPI may result in regulatory penalties and may impact cash flow.

- Share your NPI with us before you file your next claim.
- Share it with your colleagues who rely on your NPI to submit their claims.
- Share it with your billing service, vendor, or clearinghouse.

Use It. Use it **NOW** to identify yourself.

- Use it now along with your 10-digit legacy provider identifiers on your electronic and paper claims (if you have reported your NPI(s) to IBC).
- Use it now to facilitate accurate and streamlined processing of claims.
- Use it to be HIPAA-compliant.

How to obtain an NPI

NPPES is currently accepting applications for NPIs. Providers who have not yet obtained an NPI may apply for it in one of the following ways:

Electronic

- ▶ Complete the Web-based application online at <https://nppes.cms.hhs.gov>. It takes approximately 20 minutes to complete and is the most time-efficient method of obtaining an NPI.

Paper

- ▶ Providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator. The form will be available only upon request through the NPI Enumerator. Providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of the following ways:

- ▶ **Phone:** 1-800-465-3203 or TTY/TDD 1-800-692-2326
- ▶ **Email:** customerservice@npienumerator.com
- ▶ **Mail:**
NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

Information about NPI is available at www.ibx.com/providers/npi

Failure to prepare could result in a disruption in cash flow.
Are you ready to use your NPI?

IBC NPI contingency plan



Background

In response to concerns over the health care industry's state of readiness for the May 23, 2007, National Provider Identifier (NPI) compliance date, the Centers for Medicare & Medicaid Services (CMS) announced that through May 23, 2008, they will not impose penalties on covered entities that deploy contingency plans to facilitate NPI compliance of their trading partners. CMS is encouraging health plans to assess the readiness of their provider communities and determine the need to implement contingency plans to maintain the processing of payments, while continuing to work toward compliance.

IBC has conducted sustained and targeted outreach to the provider community, requesting that all providers share their NPIs with us prior to the May 23, 2007, NPI compliance date. When providers share their NPIs with IBC, we are able to link the NPIs to existing data in our internal processing systems. We call this process "registering" NPIs with IBC. This is the only way to ensure that all existing provider data in the IBC claims (and other) systems are properly linked to newly assigned NPIs. To mitigate any potential impact in a provider's cash flow, we have requested that providers register their NPIs with us *prior to submitting an NPI claim*.

Because of providers responding favorably to IBC's requests, we have made demonstrable progress to date in receiving a significant percentage of provider NPIs. Despite this progress, less than 100 percent of our participating (and other) providers and trading partners have registered their NPIs with us. In order to allow additional time for providers to register their NPIs with us, IBC is deploying the contingency plan outlined below, which is in alignment with CMS' guidance.

IBC's contingency plan: Dual use

Currently, IBC has the ability to accept claims with an NPI as the primary identifier if the provider has registered their NPI with us.

However, providers must register their NPI with IBC prior to submitting NPI-only claims.* Beginning July 1, 2007, NPI-only claims will reject if the provider has not registered their NPI with us. To avoid any potential business disruption for those providers who have not registered their NPI with IBC, we have recommended a dual use strategy for claims submissions.

The dual use strategy allows providers to submit all electronic and paper claims with NPIs and 10-digit legacy provider identifiers (IBC-assigned IDs providers use to identify themselves as an IBC participating health care provider). We will continue this dual use strategy until further notice while continuing our provider outreach and testing efforts. If providers have registered their NPI with IBC or submitted an NPI with a CMS certification, they may continue to submit claims with their NPI and 10-digit legacy identifier, consistent with our dual use strategy, until further notice.

Our dual use strategy is intended to ensure that IBC is NPI compliant, but in a manner that maintains operations, recognizes providers' varying states of readiness, and avoids unnecessary disruption in their cash flow.

IBC will assess provider readiness and the continued necessity of its dual use strategy periodically. Once IBC determines that a sufficient percentage of providers have registered their NPIs with us and are submitting their NPIs on claims, we will end the contingency plan and begin rejecting claims without an NPI as the primary identifier. We will give 60 days prior notice to providers, their clearinghouses, and vendors before implementing this course of action. However, after May 23, 2008, only the NPI will be accepted on inbound or outbound transactions.

*IBC will receive contracted Behavioral Health Providers' NPI information directly from Magellan Behavioral Health, Inc. For further information, please contact Magellan National Provider Services Line at 1-800-788-4005 or go online to www.MagellanHealth.com.

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NATIONAL PROVIDER IDENTIFIER (NPI)

IBC NPI contingency plan (continued)

More information about IBC's NPI Dual Use Claims Submission, including electronic and paper claim submission instructions and relevant FAQs, is available at www.ibx.com/providers/npi.

Steps IBC has taken to assist providers with NPI compliance

IBC has assisted providers with their NPI compliance efforts by establishing a comprehensive targeted communication and outreach campaign to the provider network.

The outreach campaign focuses on the following goals:

- 100 percent receipt of NPIs from our participating providers
- Continued education of providers on NPI enumeration, registration, and compliance
- Increased provider readiness/compliance

To further assist providers with NPI-related questions, IBC has increased NPI awareness internally with employee training modules and various print and electronic communications.

Continued steps IBC will take to assist providers

IBC will continue to assist providers with their NPI compliance efforts by following an established plan, which includes:

- Continued targeted communications and provider outreach to increase NPI registration
- Continued internal awareness and education through employee training modules and instructor-led training sessions
- Ongoing monitoring and assessment of provider network readiness

For more information regarding NPI, including instructions for obtaining an NPI or registering NPIs with IBC, please visit www.ibx.com/providers/npi.

You can find detailed IBC NPI Dual Use Claims Submission instructions in the following locations:

- **837P and 837I Companion Guides.** The 837P Companion Guide and 837I Companion

Guide provide instructions for submitting dual use claims for electronic claims submissions. The companion guides are available online at www.ibx.com/providers/self_service_tools/edit/forms.html. These companion guides should be used as a supplement to the HIPAA guidelines for claim submission.

- **Revised CMS-1500 and New UB-04 Claim Forms and Instructions.** These reference tools were published as enclosures with the October 2006 and February 2007 editions of *Partners in Health Update*. They provide instructions for submitting dual use claims for paper submissions. These reference tools are also available at www.ibx.com/providers/npi/forms.html.

Questions regarding NPI dual use claims submission

Please contact your Network Coordinator with any questions regarding IBC NPI Dual Use Claims Submission.

If you have not yet obtained your NPI(s) and reported them to us, please refer to the How to Obtain an NPI sidebar, or visit www.ibx.com/providers/npi.

You may also visit the following websites for additional information:

IBC provider NPI website

www.ibx.com/providers/npi

Contains NPI background, FAQs, submission instructions, Web links, and other information.

CMS main NPI website

www.cms.hhs.gov/NationalProvIdentStand/

Contains NPI Final Rule, FAQs, fact sheets, tip sheets, NPI Viewlet, Medicare MedLearn articles, and enumeration statistics.

NPI Enumerator website

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

Main site to enter an NPI application.

WEDI NPI outreach initiative

www.wedi.org/npioi/index.shtml

NPI Resource Center with information resources, Industry readiness assessment survey, etc.

Settlement update: Provider claim payment appeal process



Beginning September 1, 2007, IBC will supplement our Provider Claim Inquiry process with a new two-level Claim Payment Appeal process for Professional Providers. This opportunity for additional claim payment review is available to PA and DE providers who agreed to the court-approved Class Action settlement in the consolidated cases of Gregg, et al. vs. Independence Blue Cross et al. Good vs. Independence Blue Cross, et al. and Pennsylvania Orthopaedic Society vs. Independence Blue Cross, et al. Providers who submit claims related to services provided to members enrolled in New Jersey will continue to use the appeal process mandated by New Jersey law.

Eligibility for this process is based on a member's plan as opposed to the location of the provider that rendered the service. For example, a provider who submits claims for services provided to members enrolled in Pennsylvania benefit plans will be eligible to pursue the provider claims payment appeals process described below. A member's plan information can be found on his or her ID card.

The new two-level Provider Claim Payment Appeal process applies to payment concerns related to general coding and claims processing issues for HMO, POS, and PPO claims. Some examples of appealable events include:

- **Coding** (example: The payment made on a particular claim is unexpected because of a difference in IBC's treatment of codes in the claim and the Provider's use of code.)
- **Claim payment policy** (example: IBC indicates additional substantiating documentation is required to support the claim. Provider believes required information is inconsistent with IBC stated claims handling policy and procedures, or is not relevant to claim.)
- **Claim adjudication** (example: Provider believes IBC has failed to adjudicate a claim or an uncontested portion of a claim in a manner consistent with law, and the terms of the provider's contract, if any.)

The claim must be for medically necessary covered services provided to eligible members.

The Provider Claim Payment Appeal process does not apply to:

- **Utilization management determination** (example: claims for services considered non-medically necessary, experimental/investigational, cosmetic, dental rather than medical)
- **Medical necessity determination**
- **Eligibility determination** (example: claims for services provided to a person who is not a member)
- **Audit and investigations performed by the Corporate and Financial Investigations department**
- **Fee schedule dispute**

Claim inquiry process

To facilitate claim payment review, we encourage providers to submit a claim inquiry by calling Provider Services at [215-567-3590](tel:215-567-3590) or submitting a Claim Inquiry Form to:

Physician Claim Inquiry
P.O. Box 7930
Philadelphia, PA 19101-7930

The time period for claim inquiries is subject to applicable law and the provider's contract.

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Settlement update: Provider claim payment appeal process (continued)

EFFECTIVE SEPTEMBER 1, 2007

First Level claim payment appeal

Providers who disagree with a claim payment decision may initiate a First Level Provider Claim Payment Appeal by submitting the claim form, supporting documentation, and alternative claim payment justification to:

First Level Provider Claim Payment Appeals
P.O. Box 42500
Philadelphia, PA 19101-2500

This process is applicable for claims with a date of service on or after August 1, 2006.

IBC will notify the provider within 30 days of receipt of the appeal if any additional documentation is required for resolution of the appeal. The appeal will be reviewed and a determination will be made within 30 days of receipt of all information necessary to process the appeal. The provider will be notified of the decision and a detailed explanation of what action was taken and the reason for the action will be provided.

Second Level provider claim payment appeal

If a provider disputes the First Level Provider Claim Payment Appeal determination, he or she may then submit a Second Level Provider Claim Payment Appeal by sending in a written request within 60 days of receipt of the decision of the First Level Provider Claim Payment Appeal. The request must include a copy of the written outcome received through the First Level Provider Claim Payment Appeal process, alternative claim payment justification, and any other supporting documentation the provider feels is necessary to support the appeal. This request and information should be sent to:

Second Level Provider Claim Payment Appeals
P.O. Box 42500
Philadelphia, PA 19101-2500

IBC will notify the provider within 30 days of receipt of the appeal if additional documentation is required for resolution of the appeal. The appeal will be reviewed by an internal Provider Appeals Review Board (PARB) consisting of three members: One medical director and two associates with no direct daily responsibility for claims issues. The decision of the Second Level Provider Claim Payment Appeal will be made within thirty (30) days of receipt of all information necessary to process the appeal. The decision will then be communicated to the provider and will include a detailed explanation of what action was taken and the reason for the action. The decision of the PARB will be the final decision of IBC. There will be no appeal from the decision of the PARB within IBC.

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 terms:

- Enhanced disclosure to Settlement Providers, including standard fee schedules, changes to schedules, and medical and payment policies that may affect payment/reimbursement of services which is available online via NaviNet[®], our secure provider portal.
- Enhanced 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).
- A two-level, formal claims appeal process for Settlement Providers will become effective September 1, 2007. This claims appeal process is applicable for claims with a date of service on or after August 1, 2006. Providers who submit claims related to services to members enrolled in New Jersey benefit plans will continue to use the appeal process mandated by New Jersey law.

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IBC expands contract with Genzyme Genetics



We are pleased to announce that we have expanded the services under our agreement with Genzyme Genetics to provide oncology testing services for our network providers. Genzyme Genetics continues to be an in-network provider for reproductive and prenatal testing.

When ordering laboratory services for our members, IBC network providers must refer members to an in-network laboratory provider in order for the

member to receive maximum benefits. By using in-network laboratory providers, we help ensure that members and physicians receive quality, cost-effective services.

For more information about Genzyme's oncology services, please contact Genzyme directly at [1-800-447-5816](tel:1-800-447-5816).

Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.

Addition of Litholink to laboratory provider network



We are pleased to inform you about a prevention service now available in network to members who suffer from kidney stones. This service is provided by Litholink Corporation, a laboratory and education service for people with kidney stones. By using appropriate urine testing and support services, Litholink works with doctors and their patients to greatly reduce the chance that kidney stones will occur again.

If patients have had kidney stones and are not currently engaged in some preventive measures, they may have a recurrence. The Litholink program is being offered to decrease the chance of this happening.

Using the Litholink program is simple:

- Members can get access to the program from their home.
- The program involves testing a urine sample to determine why a person has formed stones in the past.
- After testing, Litholink works with patients and their physicians to develop a plan to try to prevent future stones. The plan may involve diet changes, additional fluid intake or medication to prevent kidney stone recurrence.

If you wish to obtain more information, you may also call Litholink directly at [1-800-338-4333](tel:1-800-338-4333).

Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.

Laboratory services clarification



We would like to take this opportunity to reiterate our policy regarding lab services.

Please review the information on Laboratory Services in the Administrative Section of the November 2006 *Provider Manual*. In summary, the Laboratory Services PPO section of the *Provider Manual* states: (1) Covered Level I and Level II outpatient laboratory tests, as defined by the Pennsylvania Department of Health Bureau of Laboratories, may be performed in the physician's office; and (2) Level III outpatient laboratory tests must be referred to a contracted commercial laboratory or one of the network hospitals that is to perform outpatient laboratory services.

We also want to remind you that if you are a participating physician provider, you may only bill us for services that you or your staff performs. Participating physician provider offices are not permitted to submit claims for services that they have ordered, but not rendered (also known as "pass-through" billing). "Pass-through" billing of laboratory services performed by a contracted or noncontracted laboratory is not reimbursable under your professional provider agreement with IBC.

For a list of participating clinical laboratories in our network, please refer to the Administrative Section of the *Provider Manual*. Please call Provider Services or contact your Network Coordinator with any questions.

PRODUCTS

Coming soon: Medicare Private Fee-For-Service plan



We are pleased to announce that on January 1, 2008, QCC will launch a new Medicare Advantage Private Fee-For-Service plan. A Medicare Advantage Private Fee-For-Service plan is not an HMO or PPO plan and generally combines the benefits of Medicare Part A and Part B with additional services not covered by Medicare. Unlike our Medicare Advantage HMO and PPO benefit programs, the Medicare Advantage Private Fee-For-Service plan is a non-network, non-managed care product, and enrollees in this plan can

go to any Medicare participating doctor or hospital in the United States that accepts the Plan's Terms and Conditions and is willing to provide service to the enrollee. This new product will be offered in addition to our current Medicare Advantage HMO and PPO benefit programs. Check future editions of *Partners in Health Update* for additional information on this new Medicare Advantage Private Fee-For-Service plan.

Consultations and the requisite documentation



As a result of the widely variable usage trends found during routine audits performed on evaluation and management services by IBC's Professional Provider Audit area, we would like to remind providers of the distinction between consultations (CPT® codes 99241-99245), established office visits (CPT codes 99212-99215), and new patient visits (CPT codes 99201-99205).

Be advised that a referral does not constitute a consultation. According to the Current Procedural Terminology* (CPT) Guidelines Assistant, August 2001, "The terms *consultation* and *referral* may be mistakenly interchanged. However, the CPT book does not recognize these terms as synonymous."

The following information has been obtained from a Medicare article available on CMS's website:

"According to the American Medical Association's CPT guidelines, a consultation is defined as: 'a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for a consult may be by a physician or other appropriate source and documented in the patients' medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and

communicated by written report to the requesting physician or other appropriate source.'

CPT Guidelines describe the distinction between consultations, established office visits, and new patient visits as follows: 'If subsequent to the completion of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate Evaluation and Management service code for the site of service should be reported. In the hospital setting, the consulting physician should use the appropriate inpatient hospital consultation code for the initial encounter and then subsequent hospital care codes. In the office setting, the physician should use the appropriate office or other outpatient consultation codes and then the established patient office or other outpatient service codes.' If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or other appropriate source and documented in the medical record, the office consultation codes may be used again."

Please visit the following Medicare website for the article in its entirety and for clinical examples that meet the criteria for consultations: www.cms.hhs.gov/transmittals/downloads/R782CP.pdf.

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Statement of remittance: New enhancements



We will begin sending you a new, enhanced paper statement of remittance in the coming months. Developed with input from the provider community, the new statement of remittance will feature a variety of improvements and is consistent with our ongoing efforts to streamline our interaction with you. The enhancements include:

- adoption of a wider, easy-to-read "landscape" format
- addition of a new field showing interest at the claim level
- inclusion of contact phone numbers

- redefinition of the "Allowed Amount" column to contain the "Contract Amount"
- addition of remark codes after each claim (to make posting easier for billing offices)
- refinement of sorting and subtotaling for ease of posting
- summarization of inpatient facility claims when there is only one payment reimbursement (for ease of posting)
- suppression of lines (on adjustments when changes do not affect the payment)

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

Announcing IBC's new position on criteria for gradient compression stockings and antiembolism stockings



Effective September 1, 2007, for services provided on and after September 1, 2007, IBC coverage criteria for gradient compression stockings and antiembolism stockings will be revised as follows:

Gradient compression stockings

IBC member coverage

Gradient compression stockings, commonly referred to as Jobst® stockings, will be eligible for payment when prescribed by a physician for the treatment of conditions such as chronic venous insufficiency, lymphedema, and the prevention and treatment of venous stasis ulcers. Members will be eligible to receive up to 12 individual gradient compression stockings (or six pairs if the individual requires the stockings for both lower extremities) within a calendar year.

Medicare Advantage HMO/Medicare Advantage PPO member coverage

Coverage will only be provided when a below-the-knee gradient compression stocking with a pressure of 30-50 millimeters of mercury (mmHg) is prescribed and needed to secure a primary dressing over a debrided venous stasis ulcer. All other gradient compression stockings will not be eligible for payment for Medicare Advantage HMO/Medicare

Advantage PPO members as they are not covered by traditional Medicare.

Antiembolism stockings

IBC member coverage

Antiembolism stockings, commonly referred to as TED stockings or surgical stockings, will be eligible for payment. Members will be eligible to receive up to 12 individual antiembolism stockings (or six pairs if the individual requires to stockings for both lower extremities) within a calendar year.

Medicare Advantage HMO/Medicare Advantage PPO member coverage

Antiembolism stockings will not be eligible for payment for Medicare Advantage HMO/Medicare Advantage PPO members as these stockings are not covered by traditional Medicare.

Revisions to the policy are the result of research into benefit contracts and national standards regarding these items. For more information, please contact your Network Coordinator or visit www.ibx.com/medpolicy to view the policy in its entirety.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.

Simplifying provider bulletins on ibx.com



As part of our continuing process of streamlining our online communications, we will be revamping the Provider Bulletin Web pages on ibx.com in the upcoming weeks.

We will accomplish this by reducing the time necessary to navigate our site by eliminating unnecessary Web pages and by deleting redundant copies of our archived bulletins. This will reduce the time necessary to navigate our site and find the information that you need.

All facility and ancillary bulletins will be combined onto two easy-to-read pages, listed in simple, chronological tables dating back to 2000. You will be able to determine a bulletin's title, mail date, original

target audience, and memo number (if applicable) on all bulletin communications at a glance.

This means *less clicking* for you and your office staff.

You will be able to access the bulletins in the same area of www.ibx.com — just go to the “For Providers” section of our site, and choose “Communications.” All Provider Bulletins, as well as our archived editions of *Partners in Health Update*, *Coding Guidelines and Policy Update (CGPU)*, and *Clinical Update*, can be found at this page. Be sure to update your bookmarks once the change has taken place.

We will publish the new, updated links in the September edition of *Partners in Health Update*.

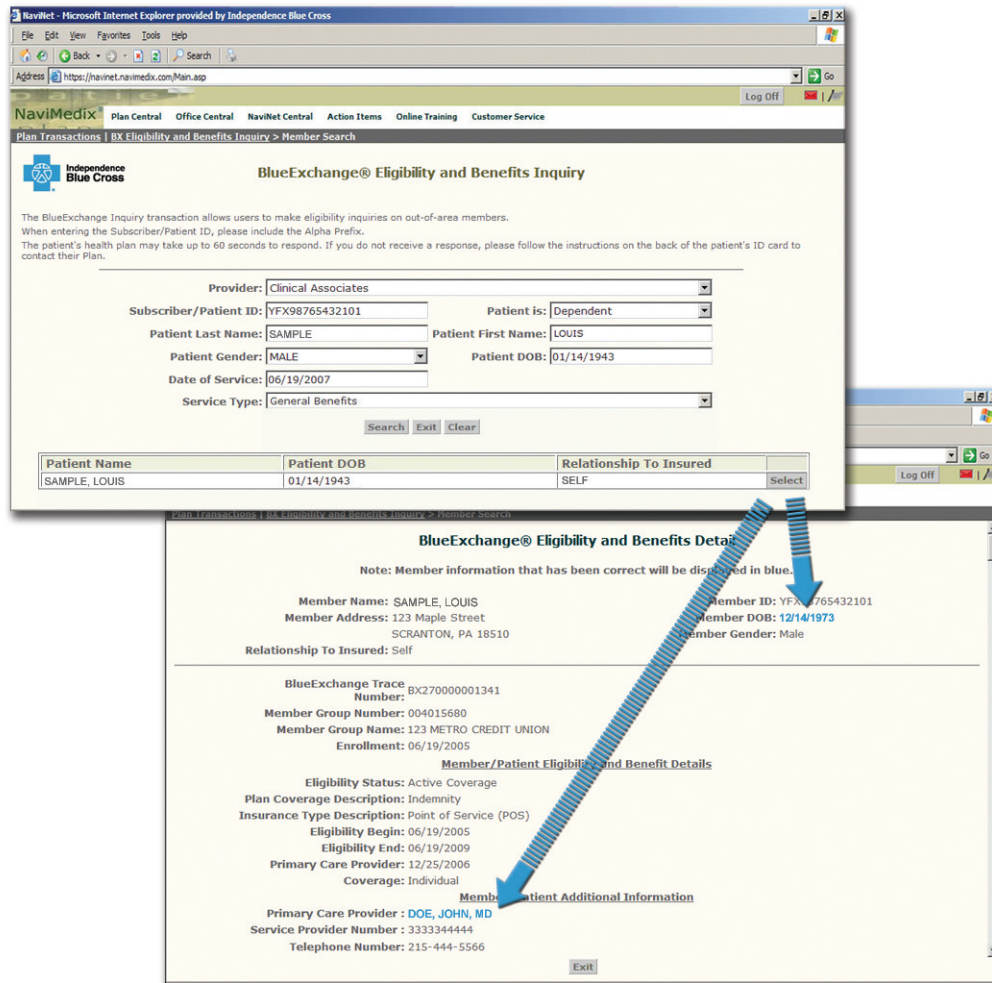
New enhancement to BlueExchange® Out-Of-Area transaction: Eligibility and benefits inquiry

The BlueExchange® out-of-area eligibility and benefits inquiry transaction has been enhanced to alert you of potential patient data discrepancies.

When searching for eligibility and benefit information for an out-of-area subscriber or dependent, you are required to select your provider ID and enter your patient's ID number, name, gender, and date of birth. If your patient's identifying data, as returned by the Home Plan, differs from what you submitted via NaviNet®, that information will appear in blue.

This enhancement provides you with an easy, at-a-glance method for identifying and eliminating data errors. The sample screen shot (shown below) illustrates this enhancement by indicating a change in the patient's primary care physician and a discrepancy with the patient's date of birth.

If you have any questions or if you need additional information, please refer to the User Guides (under the Customer Service drop-down menu), or contact NaviNet Customer Care at 1-888-482-8057.



New opportunities for change in quality and cost of care



Measuring quality and cost of care is a sensitive subject for physicians. We believe the more closely we work on this effort with our network physicians, the better the outcome. Throughout 2006, we hosted physician advisory group meetings to discuss a performance measurement program. We are continuing that effort in 2007.

Based on these meetings, we are developing a new tool to report on physician measures in quality and

cost of care. Beginning late in the third quarter of 2007, we plan to introduce this tool to select specialists where there are an adequate number of clinically relevant, statistically valid measures.

The goal of this program is to provide actionable information that will assist you in delivering timely and evidence-based care to your patients. As this program evolves, we anticipate introducing Pay for Performance incentives.

PREVENTIVE HEALTH

2007 Clinical Practice Guidelines: Now available



The 2007 Clinical Practice Guideline Grid, which includes all IBC *Clinical Practice Guidelines* are now available. The *Clinical Practice Guidelines* are a generally accepted minimum standard of care in the medical profession. Adherence to these guidelines may lead to improved patient outcomes. Individual clinical decisions should be tailored to specific patient medical and psychosocial needs. As national guideline recommendations evolve, please update your practice accordingly.

We update the guidelines annually based on changes made to nationally recognized sources. Changes are reviewed by internal and external consultants as appropriate, as well as by IBC quality committees, and are incorporated into the guidelines.

The guidelines are not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), or employer group. Individual member coverage will need to be verified with us. If you have any questions or concerns regarding member coverage, or if you would like more information on specific benefits coverage, please contact Provider Services.

You may access the *Clinical Practice Guidelines* on our website at www.ibx.com/providers, or you may call the Provider Supply Line at 1-800-858-4728 to obtain a printed copy of the guideline grid or of any of the individual guidelines.

Independence Blue Cross 2007 Clinical Practice Guidelines*			
Connections™ Programs* Clinical Practice Guidelines (CPG)			
Condition	Evidence	Reference	URL
Asthma	Guidelines for the Diagnosis and Management of Asthma—Expert Panel Report 4 (NAEPF)	NHL, NHLBI, NIH Publication No. 01-401 (1997)	http://www.ncbi.nlm.nih.gov/guidelines/asthma/asthgydfr.pdf
Asthma	Guidelines for the Diagnosis and Management of Asthma—Update on Selected Topics 2002 (NAEPF)	NAEPF, Federal Government Agency (U.S.), National Heart, Lung, and Blood Institute (U.S.), 1997 (2002), 78 pages, NIH Publication No. 02-5025 and No. 02-5024	Quick Reference: http://www.ncbi.nlm.nih.gov/guidelines/asthma/asthmaupdates.pdf Full update: http://www.ncbi.nlm.nih.gov/guidelines/asthma/asthastdfr.pdf
Asthma	Pediatric Asthma: Promoting Best Practices, Guide for Managing Asthma in Children	The American Academy of Allergy, Asthma, & Immunology, Inc. 1999-2004*	http://www.aaaaai.org/asthma/asthmaupdates/pediatricasthma/guidelines/asthastdfr.pdf
Chronic Heart Disease (CHD)	AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary Artery Disease: 2005 Update. Endorsed by the National Heart, Lung, and Blood Institute	Circulation 112(26):2371-2389	http://circ.ahajournals.org/cgi/rapidlink/112/26/2371
Chronic Heart Disease (CHD)	ACC/AHA 2002 Guidelines Update for the Management of Patients with Chronic Stable Angina	Circulation 107:149-158 (2002)	Summary article: http://circ.ahajournals.org/cgi/rapidlink/107/1/149.pdf Full text: http://www.aic.org/quicklookup.action?clinicalguidelines/asthastdfr_asthma_clean.pdf
Chronic Heart Disease (CHD)	Core Components of Cardiac Rehabilitation/Secondary Prevention Programs (AHA/ACC/AHA)	Circulation 102:1889-73 (2000)	http://circ.ahajournals.org/cgi/rapidlink/102/19/1889.pdf
Chronic Heart Disease (CHD)	Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women: 2007 Update	Circulation 115:1481-1501 (2007)	http://circ.ahajournals.org/cgi/rapidlink/115/14/1481.pdf
Chronic Heart Disease (CHD)	Antithrombotic Therapy for Coronary Artery Disease: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy	Chest 126:533-548 (2004)	http://www.chestjournal.org/cgi/rapidlink/126/4/533.pdf
Heart Failure (HF)	ACC/AHA Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult	Circulation 112:154-235 (2005)	http://circ.ahajournals.org/cgi/rapidlink/112/2/154.pdf
Heart Failure (HF)	HFSA 2005 Comprehensive Heart Failure Practice Guidelines	Heart Failure Society of America, Journal of Cardiac Failure 2006, 12(4):e1-52	http://www.hfsa.org/guidelines/heart_failure_guidelines.pdf
Chronic Obstructive Pulmonary Disease (COPD)	Global Strategy for Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease	2006 Global Initiative for Chronic Obstructive Lung Disease*	http://www.goldonline.org/Guidelines/asthastdfr_asthma_clean.pdf
Diabetes	Standards of Medical Care in Diabetes-2007	Diabetes Care American Diabetes Association 30 (Supplement 1):S4	Standards: http://www.diabetesstandards.org/rapidlink/30/suppl_1/S4

Supporting our members, your patients: ConnectionsSM Health Management Programs



Call the Provider Support Line at [1-866-866-4694](tel:1-866-866-4694) to refer a patient to the ConnectionsSM Health Management Program for Health Coaching. Health Coaches provide disease management for asthma, diabetes, COPD, CHF, and CAD, as well as decision support for numerous health care issues.

Call [1-866-398-8761](tel:1-866-398-8761) to refer patients with the following diseases to the ConnectionsSM AccordantCareTM Program:

- Seizure Disorders
- Rheumatoid Arthritis
- Multiple Sclerosis
- Crohn's Disease
- Parkinson's Disease

- Systemic Lupus Erythematosus (SLE)
- Myasthenia Gravis
- Sickle Cell Disease
- Cystic Fibrosis
- Hemophilia
- Scleroderma
- Polymyositis
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Amyotrophic Lateral Sclerosis (ALS)
- Dermatomyositis
- Gaucher Disease

Contact the ConnectionsSM Kidney Program at [1-866-303-4CKP \[4257\]](tel:1-866-303-4CKP) to refer a patient with end-stage renal disease on chronic outpatient dialysis.

REMINDER

New nutrition counseling benefit available to commercial HMO, POS, and PPO members



As announced in the June edition of *Partners in Health Update*, we have introduced a new nutrition counseling benefit for our members. **Effective July 1, 2007**, physicians and registered dietitians may provide up to six nutrition counseling visits per year to adults and children covered by commercial HMO, POS, and PPO plans. PCPs may bill for nutrition counseling visits above capitation.

The purpose of the six nutrition counseling visits is to support our members in establishing good eating habits that will contribute to a healthier lifestyle. We recognize the impact of a well-balanced diet on good health, and we are proud to offer the nutrition counseling visits as a core benefit to our already comprehensive benefits plans.

A nutrition counseling visit could include:

- an assessment of dietary habits
- the use of measurement tools, such as the Body Mass Index, to assess risk

- development of a strategy and goals to achieve the dietary change
- ongoing support to maintain dietary changes and reevaluate goals
- guidance toward an appropriate exercise program

Members pay nothing out of pocket when a participating physician or participating registered dietitian provides the nutrition counseling. No copayments will be due from HMO, POS, or PPO members receiving services from participating physicians or participating registered dietitians. Participating registered dietitians will be listed on NaviNet[®] and in our online directories. A referral is required for HMO members seeking services from a participating registered dietitian or a physician. PPO and POS members must satisfy any deductibles or coinsurance when utilizing out-of-network and self-referred benefits.

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REMINDER

New nutrition counseling benefit available to commercial HMO, POS, and PPO members *(continued)*

Billing

The following codes should be used when billing for nutrition counseling. (The specifics of the clinical scenario will dictate the appropriate code.

Documentation to support the use of the codes submitted should be made available to us upon request.)

Code	Narrative
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment, and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
S9449	Weight management classes, nonphysician provider, per session
S9452	Nutrition classes, nonphysician provider, per session
S9470	Nutritional counseling, dietitian visit

In addition to the nutrition counseling visit codes listed above, the following diagnosis codes should be used to report the Body Mass Index for adult members who are utilizing the nutrition counseling benefit. Based on official guidelines for coding and

reporting, these secondary codes should not be listed in the first position on a claim or reported as the principal diagnosis. Reporting these additional codes will help us determine member eligibility for additional interventions and/or outreach programs.

Diagnosis Code	Description
V85.0	Body Mass Index less than 19, adult
V85.1	Body Mass Index between 19-24, adult
V85.21	Body Mass Index 25.0-25.9, adult
V85.22	Body Mass Index 26.0-26.9, adult
V85.23	Body Mass Index 27.0-27.9, adult
V85.24	Body Mass Index 28.0-28.9, adult
V85.25	Body Mass Index 29.0-29.9, adult

New nutrition counseling benefit available to commercial HMO, POS, and PPO members *(continued)*

Diagnosis Code	Description
V85.30	Body Mass Index 30.0-30.9, adult
V85.31	Body Mass Index 31.0-31.9, adult
V85.32	Body Mass Index 32.0-32.9, adult
V85.33	Body Mass Index 33.0-33.9, adult
V85.34	Body Mass Index 34.0-34.9, adult
V85.35	Body Mass Index 35.0-35.9, adult
V85.36	Body Mass Index 36.0-36.9, adult
V85.37	Body Mass Index 37.0-37.9, adult
V85.38	Body Mass Index 38.0-38.9, adult
V85.39	Body Mass Index 39.0-39.9, adult
V85.4	Body Mass Index 40 and over, adult
V85.51	Body Mass Index, pediatric, less than 5th percentile for age
V85.52	Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age
V85.53	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age
V85.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age

Additional programs

Our long-standing commitment to helping our members exercise healthy eating habits goes beyond our new nutrition counseling benefit. Members can also take advantage of our Healthy LifestylesSM programs, which include reimbursements for fitness center fees and approved weight loss programs as well as discounts on vitamins and nutritional supplements. Our Healthy Lifestyles programs are designed to encourage healthy behavior. Members eligible for our ConnectionsSM programs who may be considering weight loss surgery can call the ConnectionsSM Health Management Program at **1-800-ASK-BLUE** to receive Health Coaching and a free Shared Decision-Making[®] video/DVD on bariatric surgery treatment options. If a member has a question regarding eligibility, he or she may call the Member Services number listed on his or her ID card.

We strive to help those at risk for obesity lead healthier lives and educate all members about how to maintain a healthy weight. For more information on the evaluation and treatment of overweight patients, please see our Clinical Practice Guidelines on obesity at www.ibx.com/providers/policies_guidelines/clinical_guidelines/index.html. PCPs are encouraged to talk to their patients about this benefit, refer them to a participating registered dietitian, or direct them to call Member Services or visit www.ibxpress.com.

If you have additional questions regarding the new nutrition counseling benefit, please contact Provider Services.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified through Provider Services.

Codes listed previously are subject to change due to quarterly and annual HCPCS/CPT and revenue code updates. The codes listed are current as of the date of this publication.



Partners in Health 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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This is not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, Indemnity, etc.), and/or employer groups. Providers should call Provider Services, listed at right, for the member's applicable benefit information. Members should be instructed to call the number on the back of their identification card.

Not all benefit plans use Magellan Behavioral Health, Inc. to administer behavioral health benefits. Please check the back of the member's ID card for the telephone number to contact for behavioral health services, if applicable.

The third-party websites 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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IMPORTANT RESOURCES

View our online provider directories at www.ibx.com

CARE MANAGEMENT AND COORDINATION 215-567-3570
Case Management 1-800-313-8628*

Baby BluePrints® 215-241-2198
1-800-598-BABY (2229)*

CONNECTIONSSM HEALTH MANAGEMENT PROGRAMS
ConnectionsSM Health Management Program Provider Support Line 1-866-866-4694

ConnectionsSM Kidney Program 1-866-303-4CKP (4257)

ConnectionsSM AccordantCareTM Program 1-866-398-8761

CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT 1-866-282-2707
Anti-Fraud and Corporate Compliance Hotline www.ibx.com/anti-fraud

CREDENTIALING VIOLATION HOTLINE 215-988-6534
www.ibx.com/credentials

eBUSINESS 215-241-2305
Help Desk

eBusiness Provider Hotline 215-640-7410

FutureScripts® 1-888-678-7012
Prescription Drug Authorization 1-888-671-5285
Toll Free Fax

Direct Ship Injectable 1-888-678-7012
Fax 215-761-9165

Blood Glucose Meter Hotline 1-888-494-8213 (option 2)

FutureScripts® Secure 1-888-678-7015
Medicare Part D

HEALTH RESOURCE CENTER 215-241-3367
Healthy LifestylesSM 1-800-275-2583*

Precertification 215-241-2100
1-800-227-3116*

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

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

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

PROVIDER PHARMACY WEB PAGE www.ibx.com/provider_rx

PROVIDER SERVICES (Policies/Procedures/Claims) 215-567-3590
HMO 1-800-227-3119*

PPO 215-567-3694
1-800-332-2566*

PROVIDER SUPPLY LINE 1-800-858-4728

* Outside 215 area code

Visit our website at www.ibx.com/providers/communications