



Independence
Blue Cross

www.ibx.com

December 2007



Provider Manual CD

All participating professional providers should have recently received the CD version of the updated October 2007 *Provider Manual for Participating Professional Providers*. This CD includes valuable supplemental publications, tools, and resources to assist providers in the daily administration of their practice.

If your office did not receive a copy, please contact the Provider Supply Line to request the CD or the paper edition.

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

- Professional
- Facility
- Ancillary

PARTNERS IN HEALTH UPDATE

Working Together For Quality Health Care

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NATIONAL PROVIDER IDENTIFIER (NPI)

Register your NPI online with provider registration web form



Providers may now register their NPIs with IBC online by submitting an NPI provider registration web form.

Please visit www.ibx.com/providers/npi/provider_registration.html to register your NPI information with us.

NPIs must be registered with IBC



NPI-only claims will reject if NPI is not registered with IBC

As previously stated in our NPI Contingency Plan, NPI-only claims will reject if providers have not registered their NPIs with us. IBC has the ability to accept claims with an NPI as the primary identifier if providers have registered their NPI with us. Providers must register their NPI with IBC prior to submitting NPI-only claims.*

Registering your NPI(s) with IBC

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.

Registering your NPI with IBC is easy. Once you have obtained your NPIs, please submit them to us by completing and returning your custom IBC NPI Submission Form (included in our mailings to participating provider offices). You may also register your NPI information with us through a provider registration web form. Please visit www.ibx.com/providers/npi/provider_registration.html. Contact your Network Coordinator with questions regarding your custom IBC NPI Submission Form or the new provider registration web form.

NPIs will be required for new practitioners who request participation with IBC. The NPI, if not already registered, will also be requested as part of the recredentialing process.

IBC’s contingency plan: Dual use

The dual use strategy allows providers to submit all electronic and paper claims with NPIs *and* 10-digit legacy provider identifiers (IBC-assigned

How to obtain an NPI

National Plan and Provider Enumeration System (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

NPIs must be registered with IBC (*continued*)

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 the Centers for Medicare & Medicaid Services (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 providers' cash flow.

IBC will periodically assess provider readiness and the continued necessity of its dual use strategy. 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' notice to providers, their clearinghouses, and vendors before implementing this change. However, after May 23, 2008, the NPI must be present on all inbound and outbound transactions.

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

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

NPI Web resources

IBC provider NPI website

www.ibx.com/providers/npi

Contains NPI background, FAQs, registration forms, 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.

BILLING

New additions to Medicare crossover

The Blue Cross and Blue Shield Association has mandated changes that will improve our current Medicare crossover process beginning January 1, 2008.

Currently, providers submit Medicare-paid claims electronically through the intermediary, Group Health Incorporated (GHI). However, adjustment requests and 100 percent Medicare denied claims

(where there is additional beneficiary liability) are currently submitted to IBC via paper.

Effective January 2008, providers should submit the Medicare crossover adjustment requests and the 100 percent Medicare-denied claims (where there is additional beneficiary liability) electronically through GHI.



Use red CMS-1500 form for claims that are paper-billed



Please remember to use the standard *red* CMS-1500 form for claims that are paper-billed. This form is required because we currently utilize optical character recognition technology in processing paper-billed claims. You may experience processing delays and billing inaccuracies by not utilizing the *red* CMS-1500 form.

The following instructions explain how to facilitate automated processing:

- Please type clearly in the specified areas only. Change ribbons often or use a laser printer. Do not use red ink.
- Do not use bold, italic, or other non-standard fonts.

- Make sure the claim forms are complete and accurate. Extraneous writing on the form such as “This is a second submission” will cause delays.
- Do not use carbon copy forms because of the red transformation in the carbon.
- Non-standard forms, such as black-and-white, dot-matrix, handwritten, or laser-printed forms will cause processing delays.

Please contact your Network Coordinator with any questions.

Clarification on the BlueCard® Program for members who travel or live outside of the service area



BlueCard® is a national program through the Blue Cross and Blue Shield Association (BCBSA) that enables HMO and PPO members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan’s service area. The program links participating health care providers with the various Blue Cross and Blue Shield plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

Recently, the BCBSA clarified its payment, medical, and benefits policies regarding the BlueCard program. The goal of these policy clarifications is to improve your satisfaction with the program and help you provide quality health care services to Blue Plan members.

An attachment about BlueCard for facility and ancillary providers is included in this issue of *Update* to provide you with important information that will help you with:

- identifying members
- verifying eligibility
- obtaining precertifications/preauthorizations
- filing facility BlueCard claims (including ancillary claims)

If you have additional questions about the BlueCard program, please contact your Network Coordinator.

Additional resources:

- For inquiries on the status of HMO Facility BlueCard Claims, call IBC at [1-800-227-3119](tel:1-800-227-3119). For PPO Facility BlueCard Claims, call IBC at [1-800-443-1776](tel:1-800-443-1776).
- For questions about a member’s BlueCard eligibility, call the BlueCard eligibility line at [1-800-676-BLUE \(2583\)](tel:1-800-676-BLUE).

Claims preprocessor enhancements for paper claims



On December 20, 2006, IBC streamlined the pre-adjudication editing process for electronic professional claims. This process involved consolidating error codes, error descriptions, and instructions to resolve rejected claims onto one system for electronic claims only. **Effective December 14, 2007**, paper professional claims will now be streamlined and processed in the same manner as electronic claims.

The *Claims Preprocessing Edits Claims Resolution Document* included with the July 2007 *Partners in Health Update* has been revised to include information on paper professional claims. This worksheet will help you determine why a claim was rejected, provide a basis for resubmitting a clean claim, and provide guidance on rectifying current billing submission errors we have encountered.

To view or print a copy of this revised worksheet, please visit www.ibx.com/providers/self_service_tools/ediforms.html.

When referring to the worksheet, please keep in mind the following:

Column A: contains current error rejections

Column B: contains the Claims Preprocessing System (CPPS) error code and the general description of why the claim was rejected for both paper and electronic claim submissions

Column C: contains the error description reported on the Unsolicited 277 (U277) in data element STC12 for electronic claim and the rejected claim report for paper claim submissions

Column D: contains U277 HIPAA Status and HIPAA Category codes for electronic claim submissions only

Column E: contains the claim resolution instructions for 837P Loop/Data elements for electronic claim submissions only

Column F: contains the claim resolution instructions for CMS-1500 fields for paper claim submissions only

Column G: contains the claim resolution instructions for error resolutions for both paper and electronic claim submissions

Please note:

- Providers should continue to submit claims according to our guidelines.
- Provider claims will continue to be validated against the existing business rules.

Electronic Claim Submitters

If you submit claims electronically, you will continue to receive the U277 for notification of both rejected and accepted claims. The error description on the U277 will aid you in correcting and resending files to ensure an expedited remittance. In the worksheet, please pay special attention to columns A, B, C, D, E, and G, which refer to electronic submissions.

Paper Claim Submitters

If you submit paper claims, you will continue to receive the rejected claim report. If you are using a clearinghouse and are not receiving these reports, please contact your vendor to arrange to receive these reports. In the worksheet, please pay special attention to columns A, B, C, F and G, which refer to paper submissions.

New payment rationale for Medicare-eligible commercial members without Medicare Part B



IBC will soon coordinate benefits for commercial members who are Medicare eligible, have not enrolled in Medicare Part B, and for whom Medicare would be the primary payer.

If a member is eligible to enroll in Medicare Part B and has not done so, IBC will pay as the secondary payer for services covered under an IBC commercial group benefit program (e.g., Personal Choice®, Keystone Health Plan East), even if the member does not enroll for, pay applicable premiums for, maintain, claim, or receive Medicare Part B benefits. This change affects any member who is Medicare-eligible and for whom Medicare would be the primary payer.

It is important that you routinely ask your Medicare-eligible members to show their Medicare identification cards. If you have identified a member who is eligible to enroll in Medicare Part B, but has not done so, you may collect the amount under “Member Responsibility” on the SOR, which includes any cost-sharing (copayment, coinsurance, deductible) plus the amount Medicare would have paid as the primary payer.

Please contact Provider Services with any questions.

Facility Provider Audit's role in the claims reconciliation process



The Facility Provider Audit Team and the Revenue Cycle Management Team at the hospital share a common goal: claim payment accuracy. The major components of revenue cycle management in a health care system include:

- pre-claims submission activities
- claims processing activities
- accounts receivable
- claims reconciliation
- collection

The Corporate and Financial Investigations Department (CFID) of IBC, which includes the Facility Provider Audit Team, is a resource for hospitals during the claims reconciliation process.

The Facility Provider Audit Team consists of registered nurses, medical coders, and claims experts who conduct both routine and specialized audits of hospital claims to identify incorrect payment. Some examples are Credit Balance Audits (both onsite at the facility and offsite), DRG Validation, Fee Schedule Review, and Cosmetic Review. The Facility Provider Audit Team possesses clinical knowledge and claims processing expertise complemented by

experience with hospital-based Patient Accounting Systems, Chargemasters, Statement of Remittances, Coordination of Benefits, and Provider Contracts.

Facility Provider Audit values its relationships with providers and consistently delivers quality audits that use both a quantitative and qualitative approach to the identification and resolution of the issues that face health care today. As you complete your claim reconciliation process, remember that the Facility Provider Audit Team is accessible for on-site Credit Balance Audits and claims processing issues should the patient accounting department require assistance.

As always, CFID encourages members and providers to report suspected health care fraud. All reports are confidential and you are not required to provide your name, address, or other identifying information. The confidential anti-fraud and corporate compliance toll-free hotline can be reached at [1-866-282-2707](tel:1-866-282-2707).

NaviNet® referral and authorization submission



When initiating a referral or authorization request through NaviNet, be sure to verify that you are selecting the appropriate member prior to your submission. When searching for a member from the *Patient Search* screen to submit a referral or an authorization, enter the individual's entire identification number (including the alpha prefix

and numeric suffix), *or* the individual's last name, first name, and date of birth (in mm/dd/yyyy format). Select the *View* button to validate the individual's address.

NaviNet is a registered trademark of NaviMedix, Inc.

The top screenshot shows the NaviNet main menu with 'Referral Submission' selected. The bottom screenshot shows the 'Patient Search' form with the following data:

Please Note: Please use the full ID presented on the member's current ID card or the member's name and date of birth to search.

Member ID: Member DOB:
 Member Last Name: Member First Name:
 Referral Date:

Please verify that you have selected the correct patient by selecting 'View' and confirming name, address, and date of birth.

| Member Name | Member ID | Product Name | DOB | Relationship | Status | Begin Date | End Date | View | Select |
|-------------|---------------|---------------------------|------------|--------------|--------|------------|----------|------|--------|
| DOE, JOHN | ABC956887778 | KEYSTONE HEALTH PLAN EAST | 11/22/1945 | SUBSCRIBER | Active | 03/01/1994 | | View | Select |
| DOE, JOHN | ABC334442291 | PERSONAL CHOICE | 08/16/1970 | SUBSCRIBER | Active | 08/01/2008 | | View | Select |
| DOE, JOHN | ABC9888887776 | PERSONAL CHOICE | 05/04/2000 | SUBSCRIBER | Active | 11/01/2008 | | View | Select |
| DOE, JOHN | ABC112222294 | KEYSTONE HEALTH PLAN EAST | 02/27/1982 | SUBSCRIBER | Active | 08/01/1996 | | View | Select |

IBC introduces new Personal Choice® Flex High Deductible Health Plan (HDHP) flexibility for large group customers



We are pleased to announce new high deductible health plan (HDHP) options and enhancements to existing HSA-qualified HDHPs for large group customers (100+ employees), available **January 1, 2008**. The new plans provide a single high deductible platform for large group customers to custom design a plan that meets their goals. The same benefit structure, precertification list, and exclusions will be used for all HDHPs.

New Plans: Flex High Deductible Health Plans (Flex HDHPs)

Flex HDHPs are not HSA Qualified. Instead, they can be offered with a Health Reimbursement Account (HRA) or Flexible Spending Account (FSA), or can be offered as a stand-alone medical plan. Flex HDHPs will include the Flex *Precertification, Exclusions, and Biotech/Specialty Injectable Lists*. These plans do not have to be offered with an integrated drug plan. Instead, they may be offered with a freestanding or PPO Rider program.

Enhancements to existing HSA-qualified HDHPs

If an employer chooses to offer a Health Savings Account (HSA), it must offer a HSA-qualified HDHP. Our existing portfolio of HDHPs has been enhanced to give large group employers additional flexibility in creating an HSA-qualified HDHP. As a reminder, HSA-qualified HDHPs also include the *Flex Precertification, Exclusion, and Biotech/Specialty Injectable Lists*.

A note to physicians regarding billing

The member's actual financial responsibility may not be available at the time of service. Therefore, claims (other than the copayments associated with preventive office visits and routine gynecological exams) should be submitted for adjudication by IBC before the member is billed, to ensure that members are billed correctly.

For more information or for questions about HDHPs, contact your Network Coordinator.

More news about Medicare Private Fee-for-Service



On **January 1, 2008**, we will launch Select Advantage, a new Medicare Advantage Private Fee-for-Service (PFFS) plan. This new product will be offered in addition to our current Medicare Advantage HMO and PPO benefit programs. The Medicare Advantage PFFS plan is a non-network, non-managed care product that does not include utilization management or require referrals. However, all services must meet Original Medicare guidelines for coverage and are subject to retrospective review audit.

A PFFS plan generally combines the benefits of Medicare Part A and Part B with additional services not covered by Medicare. Members can go to any Medicare participating doctor or hospital in the United States that accepts the Plan's Terms & Conditions and is willing to provide service to the member.

Members covered under this product are eligible for the ConnectionsSM Health Management Program. Connections offers information and support to members living with common chronic conditions such as heart disease and respiratory disorders; as well as decision support around significant medical decisions such as joint pain and men's and women's health issues. Members can be referred via the Provider Support Line at **1-866-866-4694**.

For your convenience, now available on our websites are the Plan's Terms & Conditions, Reimbursement Grid, and Payment Methodology information. For this and more information on Select Advantage, please visit our website at www.ibx.com/providers. Also, be sure to check future editions of *Partners in Health Update* for additional information on this new Medicare Advantage Private Fee-for-Service plan.

INDEPENDENCE ADMINISTRATORS

Update: Submitting claims to Independence Administrators



Independence Administrators has expanded its capabilities to receive electronic claims by adding payer IDs.

Submit claims — For your patients who carry an Independence Administrators ID card, please send their claims directly to Independence Administrators.

- For 837I and 837P electronic claims transmissions:
 - for ISA-08, use payer ID number **54704**
 - for GS-03, use payer ID number **TA720 or 54763**

This information applies to claims you submit through NaviMedix[®]. If you use a different clearinghouse or vendor, please check with them to confirm how to submit your claims.

- For paper claims submission, send claims to:
 - Independence Administrators
 - P.O. Box 1010
 - Horsham, PA 19044

Get answers — You can view eligibility status and claims information on NaviNet[®] for Independence Administrators.

Please share this information with the parties who perform billing services for your office.

If you have any questions about how to handle claims for your patients who present Independence Administrators ID cards, please contact our Customer Service team at the number on your patient's ID card.

NaviNet is a registered trademark of NaviMedix, Inc.

Direct Access OB/GYNSM expanded



Effective January 1, 2008, female HMO/POS members will have direct access to any network obstetrical/gynecological sub-specialist as well as obstetrical/gynecological specialists without a referral. This is true whether the visit is for preventive care, routine obstetrical/gynecological care, or problem-related obstetrical/gynecological conditions.

Specialties and sub-specialties include, but are not limited to, the following:

- OB
- GYN
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist

Please advise your patients about this expanded benefit.

Clinical decision support criteria assists with medical necessity determinations



Clinical decision support criteria are used to enhance medical necessity coverage decisions that are made by the Registered Nurse Care Coordinators and by 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 evaluating intensity of service and severity of illness, these criteria assist our clinical staff in evaluating the medical necessity and appropriateness of coverage based on a member's specific clinical needs. Clinical decision support criteria help promote consistency in our plan determinations for similar medical issues and requests, and reduce practice variation among our clinical staff to minimize subjective decision-making.

IBC utilizes InterQual[®] for our clinical decision support criteria. InterQual updates its criteria on an annual basis. To assure that the criteria developed are in accordance with community standards, the guidelines are reviewed by the Clinical Quality Management Committee, whose membership is comprised of participating providers.

At a minimum, IBC reviews the clinical guidelines annually. In addition, updates are made and released as they become available.

Participating providers may give input on the clinical criteria, which will be forwarded to McKesson. The participating provider may also contact McKesson through its website www.mckesson.com.

IBC also utilizes Solucient, LLC criteria for length-of-stay determinations. Visit www.solucient.com for more information on its role in providing value-added health care information.

Clinical decision support criteria may be applied for covered services including, but not limited to, the following:

- some elective surgeries and/or settings for inpatient and outpatient procedures (e.g., hysterectomy and sinus surgery)
- inpatient hospitalizations
- inpatient rehabilitation
- skilled nursing facility

Information about clinical decision support criteria regarding a specific case guideline may be obtained by calling [215-241-3417](tel:215-241-3417).

30-day advance policy change notifications available online



To better communicate policy changes to providers, advance notification articles regarding changes to medical policies will now be published on www.ibx.com/medpolicy. Beginning December 1, 2007, these notification articles will be available at least 30 days in advance of the proposed changes.

Please follow these instructions to read about the notifications:

1. Visit www.ibx.com/medpolicy.
2. Select *Policies & Guidelines*.
3. Select *Medical Policy*.

4. Review the Medical Policy Terms and Conditions.
5. Select *Accept and Go to Medical Policy Online*.
6. Select *News and Announcements* from the Medical Policy column on the left side.

You can also view the *Recently Released Policies*, another new enhancement available on the *News and Announcements* page. The *Recently Released Policies* section details all policies published by month and updated in real time.

In vivo allergy testing policy 07.00.05c



For claims processed on or after January 1, 2008, IBC is changing its medical policy for in vivo allergy testing.

Based on a recent review of available literature, the current yearly limit of 80 tests for in vivo testing for percutaneous and intracutaneous tests will change to 70 tests per year for percutaneous testing (CPT[®]* code 95004) and 40 tests per year for intracutaneous testing (CPT codes 95024 and 95028). Under the new policy, serial endpoint titration (SET) testing will now be subject to a cumulative limit of 80 tests per year (CPT codes 95010, 95015, and 95027).

For more information about in vivo allergy testing, please contact your Network Coordinator or visit www.ibx.com/medpolicy to view the medical policy in its entirety.

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Percutaneous discectomy policy change 11.15.15b



For claims processed on or after January 1, 2008, IBC is changing its medical policy for Percutaneous Discectomy to Experimental/Investigational.

A recent review of available literature, both peer-reviewed and clinical, shows that there are very few randomized, controlled trials evaluating the efficacy of percutaneous discectomy compared to current standard, surgical, and nonsurgical approaches.

Based on this review, there is no support for the use of this service in the lumbar, thoracic, and cervical areas of the spine.

For more information, please contact your Network Coordinator or visit www.ibx.com/medpolicy to view the medical policy in its entirety.

Select Drug Program[®] formulary updates



The Select Drug Program[®] formulary is a list of FDA-approved medications that were chosen for their medical effectiveness, safety, and value. The list changes periodically as the FutureScripts[®] Pharmacy and Therapeutics Committee reviews the formulary to ensure its continued effectiveness. The following are the most recent changes:

Generic additions

These generic drugs recently became available in the marketplace. When these generic drugs became available, we began covering them at the appropriate generic formulary copayment:

| Generic Drug | Brand Drug | Formulary Chapter | Effective Date |
|-------------------------------|-------------------------|---|--------------------|
| carvedilol | Coreg [®] | 4. Heart, Blood Pressure, & Cholesterol | September 5, 2007 |
| ciclopirox solution | Penlac [®] | 5. Skin Medications | September 18, 2007 |
| famciclovir | Famvir [®] | 1. Antibiotics & Other Drugs Used For Infection | September 5, 2007 |
| flunisolide | Nasarel [®] | 6. Ear, Nose, Throat Medications | August 9, 2007 |
| nadolol-bendroflumethiazide | Corzide [®] | 4. Heart, Blood Pressure, & Cholesterol | August 23, 2007 |
| verapamil extended-release PM | Verelan [®] PM | 4. Heart, Blood Pressure, & Cholesterol | August 9, 2007 |

Brand addition

This brand drug is covered at the appropriate brand formulary copayment:

Effective September 4, 2007

| Brand Drug | Formulary Chapter |
|------------------------|---|
| Selzentry [™] | 1. Antibiotics & Other Drugs Used For Infection |

Once a brand drug becomes available in the marketplace, and is approved by the FutureScripts Pharmacy and Therapeutics Committee as a formulary drug, it will be added to the formulary and will be available at the brand formulary copayment.

Brand deletion

This brand drug will be covered at the appropriate non-formulary copayment:

Effective January 1, 2008

| Brand Drug | Generic Drug | Formulary Chapter |
|--------------------|--------------|---|
| Coreg [®] | carvedilol | 4. Heart, Blood Pressure, & Cholesterol |

The generic drug for the above brand drug is on our formulary and available at the generic formulary copayment.

Prescription drug updates



For members enrolled in an IBC prescription drug program, the drugs listed below now require prior authorization. Prior authorization ensures that the drugs are being used appropriately and guards against drug overuse. The updates are below.

Drugs requiring prior authorization

The prior authorization requirements for the following non-formulary drug was effective at the time the drug became available in the marketplace:

Effective September 1, 2007

| Brand Drug | Generic Drug | Drug Category |
|------------|---------------|------------------------|
| Xyzal® | Not available | Allergy, Cough, & Cold |

The following non-formulary drug will be added to the list of drugs requiring prior authorization for new prescriptions. Members taking this drug immediately prior to the effective date are not affected.

Effective January 1, 2008

| Brand Drug | Generic Drug | Drug Category |
|------------|---------------|------------------|
| Taclonex® | Not available | Skin Medications |

2008 Medicare Part D vaccine administration changes



Effective January 1, 2008, CMS requires that Medicare members' vaccine administration be covered under their Medicare Part D benefit. As you know, CMS has considered the vaccines part of the Part D pharmacy benefit since January 2006.

As of January 1, 2008, Part D members will have four options for receiving a vaccination. The table below shows the available options, and how you may collect payment from the member.

| Member receives vaccine from: | Vaccine administered by: | Member payment: |
|----------------------------------|--------------------------|--|
| Pharmacy | Pharmacy | Member pays his or her pharmacy copayment/coinsurance to the pharmacy |
| Physician's office | Physician | Providers may request the standard fee for the vaccine and its administration upfront. |
| Pharmacy | Physician | Providers may request the standard fee for the administration upfront. |
| Direct Ship Injectables Program* | Physician | Providers may request the standard fee for the administration upfront. |

**Direct Ship is covered under the member's pharmacy benefit. Please refer to the October 2007 edition of Partners in Health for instructions on ordering vaccines through the Direct Ship Injectables Program.*

It is important that you routinely ask your Medicare-eligible members to show their Medicare identification cards. This will ensure appropriate collection of member responsibility.

When you are collecting payment directly from the member for either vaccine or administration, please be sure to provide the member with a receipt. The members will then submit the receipt along with a Direct Member Reimbursement form to the Part D carrier for reimbursement consideration and to assure all out-of-pocket expenses are accurately accumulated toward his/her pharmacy benefit. Members can request this form by contacting Member Services.

Note: These new procedures do not apply to flu, pneumonia, or hepatitis B vaccines.

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

180-day appeal filing limit for adverse benefit determination for commercial members



IBC maintains a formal appeal process for its commercial members. A provider authorized to act on behalf of a member may appeal decisions related to either medical necessity/appropriateness or non-medical necessity denials. In most cases, the member's written consent is required for a provider to act as the member's authorized representative.

Commercial member appeals filed by providers must be filed within 180 days of receipt of a decision from IBC stating an adverse benefit determination. IBC will not accept provider-on-behalf-of-member appeal requests that are submitted after the member appeal filing deadline.

Please contact Provider Services with any questions about the appeal process.

PREVENTIVE HEALTH

SMART[®] Registry release with clinical initiative on asthma for January 2008



The next release of the SMART[®] Registry will be mailed to IBC providers in early January 2008. This biannual report provides information that assists doctors in providing integrated care to patients with one or more of five chronic conditions: asthma, diabetes, chronic obstructive pulmonary disease, coronary heart disease, and heart failure. The member level report is designed to give providers actionable clinical information at the point of care. In addition to the standard Registry reports, each Registry also emphasizes a particular care gap.

The January 2008 release will launch a new targeted clinical initiative on asthma. The featured article provides information on the change from chlorofluorocarbon propellant metered-dose inhalers to the more environmentally friendly hydrofluoroalkane propellant inhalers.

Provider Service Specialists (PSSs) may meet with doctors and other clinical office staff to review the SMART Registry reports and to help with making referrals to the ConnectionsSM Health Management Program. PSSs may provide new asthma education tools, including an asthma symptom response plan, information about inhaled steroid medications, and a brochure on asthma and controller medications. Doctors may request reports filtered for other conditions, such as heart failure, or request a CD version of the SMART Registry, so that they can sort the reports themselves.

To speak with a PSS about the SMART Registry or any other aspect of the Connections Program, call the Provider Support Line at [1-866-866-4694](tel:1-866-866-4694).

REMINDERS

IBC will soon reject paper claims submitted on forms CMS-1500 (12/90) and UB-92



Effective December 17, 2007, IBC will no longer accept paper claims submitted on forms CMS-1500 (12/90) and UB-92. All paper claims received on or after December 17, 2007, must be submitted on

revised forms CMS-1500 (08/05) and UB-04. Paper claims submitted on forms CMS-1500 (12/90) and UB-92 will reject as of December 17, 2007.

No Pay Getaway member promotion ends December 31, 2007*



There's still time to participate in our No Pay Getaway promotion, designed to promote healthy lifestyle choices. Members can enter to win exciting prizes for getting a flu shot, signing up for an approved weight-loss program, or joining an approved smoking cessation program before December 31, 2007. By taking one of these healthy steps, members are eligible to win a tropical No Pay Getaway in Hawaii for themselves and a guest. Hundreds of other prizes are also available, including three No Pay Getaway weekends and tickets to many Philadelphia events and venues.

To learn more about our Healthy LifestylesSM Programs and to register for the No Pay Getaway promotion, please visit www.ibx.com.

**IBC members 18 and older are eligible to participate, except Federal Employees Benefit Health Plan members, Medicare members, employees of Independence Blue Cross (and its affiliated companies) and their immediate family members (spouse, parent, child, sibling, and their respective spouses, regardless of where they reside) and those living in the same household of each such employee, whether or not related, are not eligible to enter or win a prize.*

Note: IBC members are encouraged to participate in a health program or get a flu shot; however, participation is not required to enter the promotion.

Update to the Capitated Radiology Program: Breast ultrasounds and coronary CTA services



In recognition of the importance of breast cancer screening, IBC has removed the referral requirements from breast ultrasounds (*CPT*^{®*} code 76645). Additionally, effective **December 1, 2007**, breast ultrasounds will be removed from the Capitated Outpatient Radiology Program which will allow members to receive these services by a participating radiologist or outpatient department of a hospital.

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Note: These changes apply to members who have a Pennsylvania primary care physician only.

Affected providers received a Provider Bulletin dated October 1, 2007 announcing a change in the requirements.

Effective November 1, 2007, Coronary CTA services (*CPT* codes 0144T through 0149T and 0151T) will be excluded from the Capitated Radiology Program. These services must be performed by a participating radiology provider or at the outpatient department of a participating hospital and will continue to require preauthorization. The preauthorization must be obtained from American Imaging Management (AIM) through the NaviNet[®] provider portal or by calling **1-800-227-3116**.

NaviNet is a registered trademark of NaviMedix, Inc.

Provider Supply Line: For office supplies and resources



To replenish office supplies such as a *Provider Manual*, directories, and *Clinical Practice Guidelines*, please call the toll-free Provider Supply Line at **1-800-858-4728**.

Please have the following information ready so that 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. A properly submitted order may take three to five business days to arrive at your office. If you are unsure of your provider identification number, contact Provider Services or your Network Coordinator.

Please note: Calls to the Provider Supply Line should be for supply requests only. All other provider inquiries should be directed to Provider Services.



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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Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield—independent licensees of the Blue Cross and Blue Shield Association.

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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 Customer Service telephone number listed on their ID 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

Case Management 215-567-3570
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

Anti-Fraud and Corporate Compliance Hotline 1-866-282-2707
www.ibx.com/anti-fraud

CREDENTIALING VIOLATION HOTLINE

215-988-6534
www.ibx.com/credentials

eBUSINESS

Help Desk 215-241-2305

FutureScripts®

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

Direct Ship Injectable 1-888-678-7012

Fax 215-761-9165

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

FutureScripts® Secure

Medicare Part D 1-888-678-7015

HEALTH RESOURCE CENTER

Healthy LifestylesSM 215-241-3367
1-800-275-2583*

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

PROVIDER MEDICAL POLICY WEB PAGE

www.ibx.com/medpolicy

PROVIDER NETWORK eSERVICES

NaviNet® Portal Registration www.ibx.com/providers
EDI Claim Registration 215-640-7410

PROVIDER PHARMACY WEB PAGE

www.ibx.com/provider_rx

PROVIDER SERVICES (Policies/Procedures/Claims)

HMO 215-567-3590
1-800-227-3119*

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

PROVIDER SUPPLY LINE

1-800-858-4728

* Outside 215 area code



**Independence
Blue Cross**

The BlueCard[®] /Out-of-Area Program (Facility claims only)
was published along with this edition of *Partners in Health Update*.

The file has been added to this PDF for your convenience.

The BlueCard® /Out-of-Area Program (Facility claims only)

As a participating Facility or Facility ancillary provider for Independence Blue Cross (IBC), you may render services to HMO and PPO patients who are members of other Blue Cross® and Blue Shield® plans who travel or live in the IBC five-county service area.

Please refer to this enclosure when providing services to out-of-area members. We have compiled the following information to assist you in providing services to these members. Topics include:

- identifying members
- verifying eligibility
- obtaining precertifications/preauthorizations
- filing BlueCard facility claims

IBC continues to experience growth in out-of-area membership because of its partnership with you. We are committed to meeting your needs and expectations and ensuring that members receive the appropriate care through the program.

Please note: This information is specific to the handling and processing of BlueCard facility claims only.

What is BlueCard®?

BlueCard is a national program through the Blue Cross and Blue Shield Association (BCBSA) that enables HMO and PPO members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan's service area. The program links participating health care providers with the various Blue Cross and Blue Shield plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

Accounts excluded from the BlueCard Program

These claims are excluded from the BlueCard Program:

- stand-alone dental
- prescription drugs
- the Federal Employee Program (FEP)

How the BlueCard Program works

Identifying members in the United States

Member ID cards

When members of other Blue Plans arrive at your office, be sure to ask them for their current Blue Plan ID card.

The main identifier for out-of-area members is the alpha prefix. The ID cards may also include:

- a logo with the letters “PPO” in a suitcase, for eligible PPO members;
- a logo with a blank suitcase.



Important facts concerning member ID cards:

- The three-character alpha prefix at the beginning of the member's ID number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a member's membership and coverage.
- A correct member ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 3 and 14 numbers/letters following the alpha prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.

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.

- Members who are part of the FEP will have the letter “R” in front of their member ID number instead of an alpha prefix. These members are excluded from the BlueCard® program.

Examples of ID numbers:

ABC1234567
 {
 Alpha
 prefix

ABC1234H567
 {
 Alpha
 prefix

ABC12345678901234
 {
 Alpha
 prefix

Please note the following:

- Ask the member for the most current ID card each time services are rendered. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient’s file.
- Make copies of the front and the back of the member’s ID card and pass this key information on to your billing staff.
- Member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers. Please remove spaces if the suffix is separated from the ID by a space on the ID card.
- To ensure accurate claims processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing.

Identifying international members

Occasionally, you may see identification cards from foreign Blue Plan members. These ID cards will also contain three-character alpha prefixes. Please treat these members just as you would domestic Blue Plan members.

Note: The Canadian Association of Blue Cross Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the U.S.

Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard program. Please follow the instructions on the ID cards for servicing their members. The Blue Cross Plans in Canada are the following:

- Alberta Blue Cross
- Manitoba Blue Cross
- Atlantic Blue Cross Care
- Quebec Blue Cross
- Saskatchewan Blue Cross
- Pacific Blue Cross

Verifying eligibility

To verify eligibility and coverage information for members from other Blue Plans, please do one of the following:

- Submit a HIPAA 270 transaction (eligibility request) electronically to IBC. *You can receive real-time responses to your eligibility requests for out-of-area members Monday through Saturday, from 7 a.m. until 1 a.m. the next morning EST.*
- Log onto IBC’s BlueExchange® via NaviNet®.
 - Go to the BlueExchange out-of-area *Eligibility and Benefits* link and enter all required fields for the search. *You can receive real-time responses to your BlueExchange eligibility requests for out-of-area members Monday through Saturday, from 5 a.m. to 10 p.m. EST, and Sunday, from 9 a.m. to 9 p.m. EST.*
 - If you require assistance with IBC’s BlueExchange, please refer to the User Guides on the NaviNet Customer Care web page for more information.
- Call BlueCard eligibility at **1-800-676-BLUE (2583)**.
 - English and Spanish speaking phone operators are available to assist you.
 - Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than IBC. You may be transferred to a voice response system linked to customer enrollment and benefits.
 - The BlueCard eligibility line is for eligibility, benefits, and precertification/referral authorization inquiries only.

Obtaining precertifications/ preauthorizations

You should remind patients that when they are out-of-area, they are responsible for obtaining precertification/preauthorization for their services from their Home Blue Plan.

You may also contact the out-of-area member's plan on the member's behalf. You can do so by:

- calling BlueCard® eligibility at **1-800-676-BLUE (2583)** and ask to be transferred to the utilization review area.
- submitting a HIPAA 278 transaction (referral/ authorization request) electronically to IBC.
- logging onto NaviNet® and going to the BlueExchange® *Out-of-Area Referral/Authorization Submission* link (HIPAA 278 transaction). If you require assistance with IBC's BlueExchange, please refer to the User Guides on the NaviNet Customer Care web page for more information.

Filing BlueCard Facility claims

When you provide services to an out-of area Blue Plan member (non-IBC member), the claim is considered a Facility BlueCard claim. Facility BlueCard claims for out-of-area members *must* be submitted to IBC. IBC is the BlueCard processor for Facility services and will be your point of contact for claims-related questions.

To send claims electronically to IBC, use the 837i HIPAA transaction. The list of available ISA and GS codes to use can be found at www.ibx.com/pdfs/providers/self_service_tools/edi/inbound_env_ibx.pdf.

To send paper claims to IBC, please submit them to:
Independence Blue Cross
1901 Market Street
Front End Operations, 1500 SG
Philadelphia, PA 19103

Claims process flow

Below is an example of how Facility BlueCard claims for out-of-area members flow through the BlueCard program for processing:

1. A member of another Blue Plan receives services from a participating facility in IBC's five-county service area.

2. The facility submits the claim to IBC (the local Blue Plan)
3. IBC recognizes the BlueCard member and transmits the claim to the member's Home Blue Plan.
4. The member's Home Blue Plan adjudicates the claim according to the member's benefit plan.
5. The member's Home Blue Plan issues an Explanation of Benefits to the member.
6. The member's Home Blue Plan transmits the claim processing results to IBC.
7. IBC issues a Statement of Remittance and payment to the participating facility provider.

The following suggestions may improve your claims experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically by calling **1-800-676-BLUE (2583)** or by logging onto IBC's BlueExchange via NaviNet and selecting *Eligibility and Benefits*. Be sure to provide the member's alpha prefix.
- Verify the member's cost-sharing amount. Any applicable copayment can be collected from the member at the time of service.
- Indicate on the claim any payment you collected from the member. For details on how to do this, please consult the Companion Guide.
- Submit all Facility BlueCard claims for out-of-area members to IBC. Be sure to include the member's complete identification number when you submit the claim.
- Do not send duplicate claims. Sending another claim or having your billing agency resubmit claims automatically actually slows down the claims payment process and creates confusion for the member.
- If out-of-area members contact you, advise them to contact their Home Blue Plan and refer them to their ID card for a customer service number.

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The member's Home Blue Plan should not contact you directly regarding claims issues, but if the member's Home Blue Plan contacts you, refer them to IBC.

Claim status inquiries

IBC is your single point of contact for all BlueCard® Facility claim inquiries.

Claim status inquiries can be done by:

- **Phone.** For HMO facility claims, call IBC at [1-800-227-3119](tel:1-800-227-3119). For PPO facility claims, call IBC at [1-800-443-1776](tel:1-800-443-1776). Hours of operation are from 8 a.m. to 5 p.m., Monday through Friday.
- **Electronically.** Send a HIPAA transaction 276 claim status inquiry transaction to IBC, or log on to IBC's NaviNet® and submit a HIPAA 276.

Remember: These filing instructions are specific and applicable to BlueCard Host claims. Please refer to Provider Bulletins and *Partners in Health Update* via www.ibx.com/providers for information and filing instructions for submitting IBC member claims.