



**Independence
Blue Cross**

www.ibx.com

November 2007



Provider Manual CD mailing soon

Be on the lookout for the CD version of the updated October 2007 *Provider Manual for Participating Professional Providers*. This manual includes valuable supplemental publications, tools, and resources to assist you in the daily administration of your practice.

If you need a print version, please call the Provider Supply Line to request a copy.

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.

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*)

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 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 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.

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



As you know, October was breast cancer awareness month. IBC recognizes the importance of breast cancer screening and will remove breast ultrasounds (CPT®* code 76645) from the Capitated Outpatient Radiology Program. **Effective December 1, 2007**, breast ultrasounds will no longer require a referral and may be performed by a participating radiology provider 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 NaviNet®'s online provider portal or by calling **1-800-227-3116**.

NaviNet is a registered trademark of NaviMedix®, Inc.

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 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 and 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.

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 plan. This new product will be offered in addition to our current Medicare Advantage HMO and PPO benefit programs.

To be eligible for this product, members must reside in the five-county service area, which includes Bucks, Delaware, Chester, Philadelphia, and Montgomery counties. However, members enrolled in this plan may obtain covered services from any Medicare-eligible provider in the United States who is state-licensed, has a Medicare billing number (or is eligible to obtain one), and is willing to provide services to the Private Fee-for-Service member under the terms and conditions of the plan.

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, 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.

For more information on this new product, please visit our website at www.ibx.com/providers or www.site65.com. 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.

Enhanced provider information and quality ratings available to members



Members now have access to a new and improved version of HealthGrades®' award-winning physician and hospital quality guides, which provide robust profiles on providers to help members make the best choices for themselves and family members. Members can view the online provider directory via our member portal, www.ibxpress.com, for expandable profiles, glossary terms, and an online consultant. HealthGrades is available to members only through our website, giving them additional tools for informed decision making.

Some of the new features include:

Physician quality information

- Personal facts: years in profession and care philosophy based on third party information or provided by physician
- Professional experience: selected state data from Procedure/Condition volumes reported on third party sites (e.g., CABG Volumes)
- Office information: location details, services on site, expanded payment details (e.g., payment expectancy and method accepted), and practice information

Hospital quality information

- New data elements: view overall hospital quality rating and HCAHPS survey results
- New functionality: includes overall quality search and user feedback survey

The **Physician Quality Guide™** provides members with the following provider information:

- board certification
- sanctions
- affiliated hospitals
- education and foreign languages spoken

The **Hospital Quality Guide™** allows members to:

- view an individual hospital;
- compare multiple hospitals based on overall quality rating, procedure/condition ratings, patient safety, safe practices, recognition, awards, and locations;
- verify one-, three-, and five-star ratings for more than 90 conditions and procedures.

HealthGrades, Inc., a leading health care ratings organization, provides ratings and profiles of hospitals, nursing homes, and physicians. Millions of consumers and many of the nation's largest employers, health plans, and hospitals rely on HealthGrades' independent ratings and decision-support resources to make health care decisions based on the quality of care. IBC makes this information available to members through an agreement with HealthGrades, Inc.

For more information about HealthGrades, please visit www.healthgrades.com.

Affirmative statement regarding physician incentives for utilization management decisions



It is our policy that all utilization review decisions are based on the appropriateness of health care services and supplies, in accordance with the benefits available under the member's coverage and our definition of medical necessity. Only physicians can make denials of coverage of health care services and supplies based on lack of medical necessity.

The nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services for us are not compensated or given incentives based on their

coverage review decisions. Medical directors and nurses are salaried employees, and contracted external physicians and other professional consultants are compensated on a per-case-reviewed basis, regardless of the coverage determination. We do not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage.

There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

Removal of Breast Implants Policy #11.08.14d



The medical policy on the Removal of Breast Implants #11.08.14c has been revised. **Effective for claims processed on or after December 1, 2007**, we are changing our coverage position on the removal of breast implants. The updated version of this policy now states:

- The removal of a ruptured saline-filled implant(s) originally placed for *reconstructive* treatment will be considered medically necessary.
- The removal of a ruptured saline-filled implant(s) originally placed for *cosmetic* purposes will be considered cosmetic and, therefore, a benefit contract exclusion. This indication is not considered a medical or surgical complication, but rather a poor cosmetic outcome from the cosmetic surgical procedure.
- Certain complications associated with saline-filled breast implant(s), such as extrusion, infection, siliconoma or granuloma, Baker Class IV contracture, interference with diagnosis of breast cancer, and surgical treatment for breast cancer are considered absolute medical indications for removal, whether the implant(s) were originally inserted for *cosmetic or reconstructive* purposes.

Previous versions of this policy stated that the removal of a documented implant rupture as a medically necessary indication.

- The removal of a silicone gel-filled implant(s) or saline-filled implant(s) placed for cosmetic purposes is a benefit contract exclusion for Baker Class III contracture (breast is firm, palpable, and the implant [or its distortion] is visible).

This indication is not considered a medical or surgical complication, but rather a poor cosmetic outcome from the cosmetic surgical procedure.

Previous versions of this policy stated that the removal of a breast implant with a Baker Class III contracture as a medically necessary indication.

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

Abdominoplasty and/or Panniculectomy Policy #11.08.06e



The medical policy on Abdominoplasty and/or Panniculectomy #11.08.06d has been revised.

Effective for claims processed on or after December 1, 2007, we are changing our coverage position on abdominoplasty. The updated version of this policy now states:

- Abdominoplasty performed to remove excess skin and fat and to tighten the fascia of the abdominal wall is considered a cosmetic service and, therefore, a benefit contract exclusion.

Previous versions of this policy stated under most circumstances abdominoplasty and/or panniculectomy are cosmetic services and benefit contract exclusions. However, the procedures are medically necessary in clinical situations when both of the following criteria are met:

- The panniculus hangs to or below the level of the pubis.
- The patient's medical record documents that the hanging panniculus causes skin irritation and/or infection that results in pain, ulceration, suprapubic intertrigo, monilial infestation,

and/or panniculitis that is chronic, persistent, and refractory to medical treatment for at least six months. Examples of agents that may be used for conservative treatment are: topically-applied skin barriers, supportive garments, and antifungal, antibacterial, and moisture-absorbing agents.

According to the American Society of Plastic Surgeons, abdominoplasty is typically performed for cosmetic purposes.

Current benefit contract language states that cosmetic services are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected.

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

Medicare Part D Formulary updates effective January 1, 2008



Generic additions

These generic drugs recently became available in the marketplace.
We will cover these drugs at the appropriate generic formulary copayment:

Effective January 1, 2008

Generic Drug	Brand Drug	Formulary Chapter
Amlodipine Besylate Tabs	Norvasc [®]	25. Cardiovascular Agents
Ammonium Lactate Lotion	Lac-Lotion [®] 12%	28. Dermatological Agents
Azithromycin (all dosage forms)	Zithromax [®]	3. Antibacterials
Bisoprolol Fumarate Tabs	Zebeta [®]	25. Cardiovascular Agents
Bupropion HCl SR Tabs	Wellbutrin SR [®]	6. Antidepressants
Cefepime	Maxipime [®]	3. Antibacterials
Cyclobenzaprine Tabs	Flexeril [®]	49. Skeletal Muscle Relaxants
Cyclosporine Soln	Sandimmune [®] Soln	41. Immunological Agents
Diltiazem HCl ER Caps	Cardizem [®] CD	25. Cardiovascular Agents
Estradiol Patch	Esclim [®]	26. Central Nervous Systems Agents
Estradiol Tabs	Gynodiol [®]	39. Hormonal agents, Suppressant (Sex Hormones/Modifiers)
Etidronate Tabs	Didronel [®]	43. Metabolic Bone Disease Agents
Fenofibrate Caps/Tabs	Lofibra [®]	25. Cardiovascular Agents
Finasteride Tabs	Proscar [®]	31. Genitourinary Agents
Flavoxate HCl Tabs	Urispas [®]	31. Genitourinary Agents
Fluconazole Tabs and Susp	Diflucan [®]	9. Antifungals
Gabapentin Caps	Neurontin [®]	4. Anticonvulsants
Glimepiride Tabs	Amaryl [®]	23. Blood Glucose Regulators
Leflunomide Tabs	Arava [®]	41. Immunological Agents
Loxapine Succinate Caps	Loxitane [®]	18. Antipsychotics
Meperidine Tabs	Demerol [®] Tabs	1. Analgesics
Methylphenidate HCl Tabs	Methylin Chew [®]	6. Antidepressants
Moexipril Tabs	Univasc [®]	25. Cardiovascular Agents
Nystatin Cream	Mycostatin [®]	9. Antifungals
Octreotide Acetate Inj	Sandostatin [®] Inj	38. Hormonal agents, Suppressant (Pituitary)
Oxycodone HCl Tabs	Roxicodone [®]	1. Analgesics
Oxycodone HCl ER Tabs	Oxycontin [®]	1. Analgesics
Oxycodone w/ Acetaminophen Tabs	Endocet [®]	1. Analgesics
Selenium Sulfate 2.5% Shampoo	Selsun [®] 2.5% Shampoo	9. Antifungals
Sulfacetamide Sodium Drops	Bleph [®] -10	45. Ophthalmic Agents

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Medicare Part D Formulary updates effective January 1, 2008 *(continued)*

Generic Drug	Brand Drug	Formulary Chapter
Sulfamethoxazole/ Trimethoprim DS Tabs	Septra® DS	3. Antibacterials
Tretinoin Gel 0.025%	Avita Gel® 0.025%	28. Dermatological Agents

Brand additions

These brand drugs will be covered at the appropriate brand preferred formulary copayment:

Effective January 1, 2008

Brand Drug	Formulary Chapter
Arixtra®	24. Blood Products/Modifiers/Volume Expanders
Dilantin® Infatabs	4. Anticonvulsants
Emtriva®	20. Antivirals
Fragmin®	24. Blood Products/Modifiers/Volume Expanders
Keppra® Tabs	4. Anticonvulsants
Lacrisert®	45. Ophthalmic Agents
Naftin® Gel	9. Antifungals
Niaspan®	25. Cardiovascular Agents
Nitro-Bid® 2% oint	25. Cardiovascular Agents
Precose®	23. Blood Glucose Regulators
Protopic®	28. Dermatological Agents
Zyprexa® Zydis	18. Antipsychotics

Brand deletions

These brand drugs will be covered at the appropriate non-preferred formulary copayment.

The generic drugs for all of these brand drugs are on our formulary, and available at the generic formulary copayment:

Effective January 1, 2008

Brand Drug	Generic Drug
Amaryl®	Glimepiride Tabs
Arava®	Leflunomide Tabs
Avita Gel® 0.025%	Tretinoin Gel 0.025%
Bleph®-10	Sulfacetamide Sodium Drops
Cardizem® CD	Diltiazem HCl ER Caps
Demerol® Tabs	Meperidine Tabs
Didronel®	Etidronate Tabs
Diflucan®	Fluconazole Tabs and Susp
Endocet®	Oxycodone w/Acetaminophen Tabs

Medicare Part D Formulary updates effective January 1, 2008 (continued)

Brand Drug	Generic Drug
Esclim [®]	Estradiol Patch
Flexeril [®]	Cyclobenzaprine Tabs
Gynodiol [®]	Estradiol Tabs
Lac-Lotion [®] 12%	Ammonium Lactate Lotion
Lofibra [®]	Fenofibrate Caps/Tabs
Loxitane [®]	Loxapine Succinate Caps
Maxipime [®]	Cefepime
Methylin Chew [®]	Methylphenidate HCl Tabs
Mycostatin [®]	Nystatin Cream
Neurontin [®]	Gabapentin Caps
Norvasc [®]	Amlodipine Besylate Tabs
Oxycontin [®]	Oxycodone HCl ER Tabs
Proscar [®]	Finasteride Tabs
Roxicodone [®]	Oxycodone HCl Tabs
Sandimmune [®] Soln	Cyclosporine Soln
Sandostatin [®] Inj	Octreotide Acetate Inj
Selsun [®] 2.5% Shampoo	Selenium Sulfate 2.5% Shampoo
Septra [®] DS	Sulfamethoxazole/Trimethoprim DS Tabs
Univasc [®]	Moexipril Tabs
Urispas [®]	Flavoxate HCl Tabs
Wellbutrin SR [®]	Bupropion Hcl SR Tabs
Zebeta [®]	Bisoprolol Fumarate Tabs
Zithromax [®]	Azithromycin all dosage forms

These brand drugs will be covered at the appropriate non-preferred copayment.
There is no generic equivalent available for these brand drugs:

Effective January 1, 2008

Brand Drug	Generic Drug
Advair [®] HFA	Not available
Avalide [®] 12.5/150mg	Not available
Creon [®]	Not available
Delestrogen [®]	Not available
E.E.S. [®] Granules	Not available
FazaClo [®]	Not available
Ketek [®]	Not available
Niacor [®]	Not available
Omacor [®]	Not available

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Medicare Part D Formulary updates effective January 1, 2008 *(continued)*

Brand Drug	Generic Drug
Ranexa®	Not available
Sandostatin Lar® Depot	Not available
Testim® Gel	Not available
Uniphyl®	Not available

Drug requiring prior authorization

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

Effective January 1, 2008

Brand Drug	Generic Drug
Xyzal®	Not available

Biotech/Specialty injectables update for Flex Series, Personal Choice® HSA-qualified High Deductible Health Plan (HDHP), and Individual HMO benefit programs



Effective January 1, 2008, three new drugs — Lucentis®, Macugen®, and Vitrasert® — will be added to the *Biotech/Specialty Injectables List* under Intra-Ocular Agents for all Flex Series (HMO, POS, Direct POS, and PPO), Personal Choice® HSA-qualified HDHP, and Individual HMO options. Iplex™ will be deleted from the *Biotech/Specialty Injectables List*. An updated *Biotech/Specialty Injectables List* is included with this issue.

Injectables listed on the *Injectables List* should be ordered through the Direct Ship Program administered by FutureScripts®.

For Flex Series, Personal Choice HSA-qualified HDHP, and Individual HMO members in Pennsylvania, *all listed brand injectables shown on the attached Biotech/Specialty Injectables List, and*

their generic equivalents, require preauthorization.

In addition, some injectables (e.g., Botox® and Amevive™) are subject to medical necessity review during preauthorization. Please refer to the list for all other injectables that require medical necessity review.

Standard office-based injectables *not* shown on the Biotech/Specialty Injectables List *should not* be ordered through the Direct Ship Program. You may continue to bill standard injections, such as antibiotics and steroids, through the member's medical plan (HMO, POS, PPO, or Direct POS).

If you have any questions concerning ordering injectables for members enrolled in these products, please call the Direct Ship Program administered by FutureScripts at [1-888-678-7012](tel:1-888-678-7012), [option 3](#).

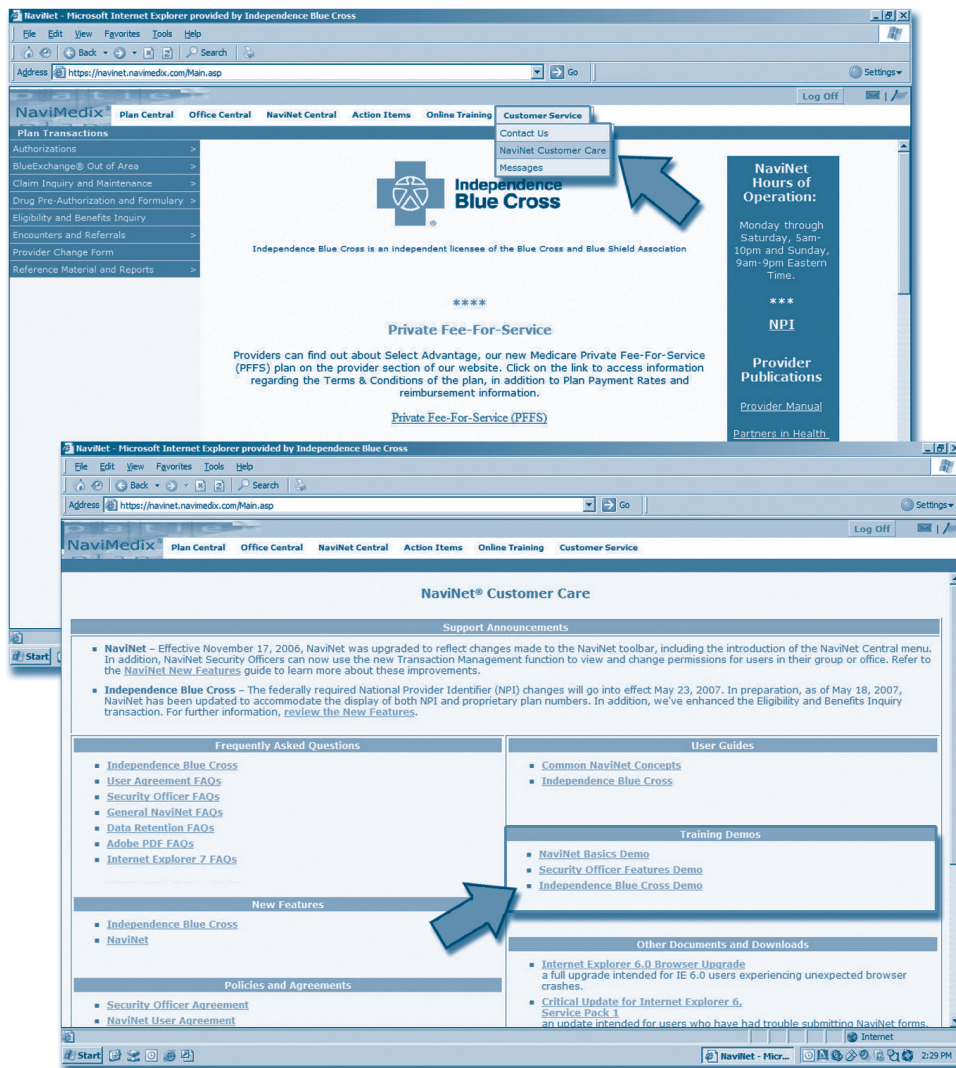
NaviNet® tutorials available



Would you or someone in your office benefit from additional training with NaviNet®? Self-guided tutorials are located within NaviNet Customer Care under the Customer Service menu. Users can view a variety of demos — NaviNet Basics, Security Officer Features, and IBC transactions.

The sample screen shots (shown below) illustrate how to view the tutorials. If you have any questions, or if you need additional information, please contact NaviNet Customer Care at 1-888-482-8057.

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Findings of the 2006 General Medical Record Review



Well-maintained medical records are critical to facilitating communication, continuity, coordination, and an effective plan of care. We, accordingly, have established standards to ensure that medical records are maintained in a manner that is current, detailed, and organized. A performance goal of 90 percent compliance with our medical record standards has been established. These standards are routinely distributed to primary care physicians (PCPs) via the *Provider Manual* or *Partners in Health Update*.

Compliance with the standards is assessed annually. We monitor the processes and procedures used by physician offices to facilitate delivery of continuous and coordinated medical care. This report presents the findings of our 2006 assessment.

Specific findings

The 2006 General Medical Record Review Study was based on an analysis of data abstracted from medical records and collected during office staff interviews. Findings were sorted into three categories:

1. General Medical Record Review. General medical record review indicator scores met the 90 percent performance goal with the exception of the following indicators:

- A separate problem list completed for each member (80.3 percent). Despite missing the 90 percent performance goal, a significant increase was noted when compared to 2005 (70.4 percent).
- A documented history of substance abuse for members 14 and older (73.8 percent).

- A separate immunization record for both children and adults is present in the chart (85.6 percent).

2. Clinical Appropriateness Review. Eight of the nine appropriateness review indicators were 100 percent compliant with the exception of evidence of discharge summaries for members discharged the previous year (72.3 percent).

3. Continuity of Care Review. Indicators revealed a compliance rate of 90 percent or higher in five of the nine indicators. The indicators that did not meet the established performance goal were:

- reminder system — database
- reminder system — manual
- reminder system — individual (reactive)
- reminder system — population-based.

Offices received credit for having any or all of these systems in place.

In the future

Opportunities to improve compliance remain in areas where indicators fell below the 90 percent compliance goal. We will continue to make tools available in order to promote continuity and coordination of care inclusive of medical record documentation tools, provider medical record standards, as well as the SMART[®] Registry for PCPs via the ConnectionsSM Health Management Program.

For a full listing of our standards for medical record documentation and record keeping, please refer to the Quality Management section of your *Provider Manual*.

Enhanced mechanisms for monitoring capitated programs



We are committed to working closely with our network of contracted providers to promote the delivery of quality, cost-effective care. To this end, we have expanded and enhanced our internal mechanisms for monitoring the capitated Physical Therapy, Radiology, Lab, and Podiatry programs that are an integral part of our HMO products.

If you provide any of these services to our HMO members, your office may be contacted in the

coming weeks and months regarding these capitated programs and their related IBC policies and procedures. We look forward to working with you and your staff to identify and address any issues related to our capitated programs, which are an important part of IBC's efforts to keep health care as affordable as possible.

Please contact your Network Coordinator with any questions.

PREVENTIVE HEALTH

No Pay Getaway member promotion*



To promote healthy lifestyle choices, we are pleased to announce our No Pay Getaway promotion. 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 in Philadelphia.

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

Please note: Your office may experience an increase in the number of flu shots requested this season due to this promotion.

**IBC members 18 and older are eligible to participate, except members with the Federal Employees Health Benefits Program and Medicare.*

New fitness program: SilverSneakers®



We are pleased to announce that **effective January 1, 2008**, IBC will introduce a new fitness program for our eligible Medicare Advantage members.* The SilverSneakers® Fitness Program is the nation's leading fitness program designed for Medicare members.

Members in our Medicare Advantage health plans will be offered a free membership in a health club participating in the SilverSneakers program

and access to fitness classes specially designed for Medicare members. This program will replace the current Healthy LifestylesSM fitness reimbursement program for Medicare members only.

We will provide you with additional information about SilverSneakers in the near future.

**Security 65® and 65 Special members are not eligible for SilverSneakers.*

Supporting our members, your patients: ConnectionsSM Health Management Programs



ConnectionsSM Health Management Program

To refer a patient for Health Coaching for the following chronic diseases or for general health support or to obtain additional information for your office, call the Connections Health Management Program Provider Support Line at [1-866-866-4694](tel:1-866-866-4694).

Diseases:

- Asthma
- Heart failure (HF)
- Coronary heart disease (CHD)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes

ConnectionsSM Kidney Program

To refer a patient or obtain additional information, call the Connections Kidney Program at [1-866-303-4CKP \(4257\)](tel:1-866-303-4CKP).

Disease:

- End-stage renal disease

ConnectionsSM AccordantCareTM Program

To refer a patient or obtain additional information concerning the following diseases, call the Connections AccordantCare Program at [1-866-398-8761](tel:1-866-398-8761).

Diseases:

- 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
- Dermatomyositis
- Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- Amyotrophic lateral sclerosis (ALS)
- Gaucher disease

Note: The Connections Health Management Programs are available to most members. Members should refer to their member materials for the terms, limitations, and exclusions of their health care coverage. They can also call Member Services at the telephone number listed on their ID card to check eligibility.

Anesthesia billing requirements



IBC plans to implement claim system enhancements, beginning November 9, 2007, that will improve accuracy and efficiency of anesthesia claims processing. Adhering to the following anesthesia billing requirements is necessary to facilitate correct billing and minimize the need for claim adjustments and resubmissions.

- Providers should not bill expected units. Actual anesthesia time should always be reported in minutes, except when reporting services that are reimbursed at a “flat rate.” Time in “total minutes” should be reported in block 24G of the CMS-1500 claim form.

- Providers billing for general anesthesia services must use a valid anesthesia CPT®* code. Do not bill using surgical CPT codes.

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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.

IBC transitioned to all-electronic referral submission (PCPs and specialists)



As previously communicated, effective April 1, 2007, IBC no longer accepts paper referrals. PCPs have been advised that they need to submit referrals through NaviNet® or through our Interactive Voice Response (IVR) system.

Before rendering services to our HMO members, it is important that specialists check NaviNet or the IVR to ensure that a referral was received for the member. This will help to ensure timely processing of specialists' claims and eliminate denials due to “no referral on file.”

Specialists should no longer accept paper referrals. A fax of an electronically submitted referral may be obtained by a specialist's office via our IVR.

If you have any questions or need additional information, please contact your Network Coordinator.

NaviNet is a registered trademark of NaviMedix®, Inc.



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.

CONTACT INFORMATION:

Rose Sutkowski
Managing Editor

Charleen Baselice
Production Coordinator

Provider Communications
Independence Blue Cross
1901 Market Street
35th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

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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 Member Services 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

eBusiness Provider Hotline 215-640-7410

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 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)

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**

Biotech/Specialty injectables information for Flex Series, Personal Choicefi HSA-qualified High Deductible Health Plan (HDHP), and Individual HMO benefit programs was published along with this edition of Partners in Health Update.

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

Biotech/Specialty injectables information for Flex Series, Personal Choice[®] HSA-qualified High Deductible Health Plan (HDHP), and Individual HMO benefit programs

For Flex Series, Personal Choice HSA-qualified HDHP, and Individual HMO members, *all listed brand injectables shown on the attached Biotech/Specialty Injectables List, and their generic equivalents, require preauthorization.* Additionally, certain Biotech/Specialty injectables require medical necessity review. Please refer to the *Biotech/Specialty Injectables List* to determine which injectables require medical necessity review.

Procedures for ordering and billing Biotech/Specialty injectables:

- *All injectables shown on the attached Biotech/Specialty Injectables List and their generic equivalents must be preauthorized* through the Direct Ship Program administered by FutureScripts[®]. Please complete the Direct Ship Injectable form, and fax it to [215-761-9165](tel:215-761-9165).
- The Direct Ship Program administered by FutureScripts will facilitate shipping of the Biotech/Specialty injectable to your office for administration or to the member's home for self-administration.
- Biotech/Specialty injectables provided in the physician's office from a physician's supply are subject to applicable member cost-sharing, as follows:
 - For Flex Series products (HMO, POS, Direct POS, PPO) and Individual HMO programs, a copayment applies as described in the member's benefits.
 - For Personal Choice HSA-qualified HDHP members, deductible and coinsurance apply as described in the member's benefits.

You must notify the Direct Ship Program administered by FutureScripts prior to the administration of any Biotech/Specialty injectable.

- For Flex Series and Individual HMO products, do not collect a copayment for Biotech/Specialty injectables ordered through the Direct Ship Injectable Unit. The injectable vendor will bill the member for his or her Biotech/Specialty injectable copay. The physician must collect the Biotech/Specialty applicable copayment when providing any of the Biotech/Specialty injectables from his or her own supply.
- Failure to preauthorize any of the Biotech/Specialty injectables on the attached list will result in a claim denial. *Claims denied for failure to preauthorize are not billable to the member.*

Standard office-based injectables *not* shown on the *Biotech/Specialty Injectables List* should *not* be ordered through the Direct Ship Program. You may continue to bill standard injections, such as antibiotics and steroids, through the patient's medical plan (HMO, POS, Direct POS, or PPO).

If you have any questions concerning ordering injectables for members enrolled in these products, please call the Direct Ship Program administered by FutureScripts at [1-888-678-7012](tel:1-888-678-7012), option 3.

Biotech/Specialty Injectables List (list subject to change)

Effective January 1, 2008

All listed brand injectables and their generic equivalents require preauthorization.

Injectable Product	Medical Necessity Review Required
ANTICOAGULANT/LOW MOLECULAR WEIGHT HEPARIN AGENTS	
Arixtra®	No
Fragmin®	No
Innohep®	No
Lovenox®	No
ANTIRETROVIRAL AGENTS	
Fuzeon®	No
BOTULINUM TOXIN AGENTS	
Botox®	Yes
Myobloc®	Yes
CENTRAL NERVOUS SYSTEM AGENTS	
Imitrex® Injection	No
Apokyn®	No
ENDOCRINE/METABOLIC AGENTS	
Eligard®	No
Faslodex®	No
Forteo™	Yes
Lupron®	No
Sandostatin®	No
Somavert®	No
Thyrogen®	No
Trelstar®	No
Vantas®	No
Viadur®	No
Zoladex®	No
GROWTH HORMONES and Related Agents	
Genotropin®	Yes
Humatrope®	Yes
Increlex™	Yes
Norditropin®	Yes
Nutropin®/Nutropin AQ®	Yes
Omnitrope™	Yes
Saizen®	Yes

Injectable Product	Medical Necessity Review Required
GROWTH HORMONES and Related Agents (cont.)	
Serostim®/Serostim LQ®	Yes
Tev-Tropin®	Yes
Zorbtive®	Yes
HEMATOPOIETIC AGENTS	
Aranesp®	No
Epogen®	No
Leukine®	No
Neulasta®	No
Neumega®	No
Neupogen®	No
Procrit®	No
HEPATITIS/INTERFERON AGENTS	
Actimmune®	No
Alferon N®	No
Infergen®	No
Intron-A®	No
Pegasys®	No
PEG-Intron®	No
Roferon-A®	No
HYALURONATE AGENTS	
Euflexxa™	Yes
Hyalgan®	Yes
Orthovisc®	Yes
Supartz®	Yes
Synvisc®	Yes
IMMUNOLOGICAL MODIFIERS	
Amevive®	Yes
Enbrel®	Yes
Humira®	Yes
Kineret®	Yes
Raptiva®	Yes

continued on page 4

Injectable Product	Medical Necessity Review Required
INTRA-OCULAR AGENTS	
Lucentis®*	No
Macugen®*	No
Vitrasert®*	No
MULTIPLE SCLEROSIS AGENTS/INTERFERON BETA AGENTS	
Avonex®	No
Betaseron®	No
Copaxone®	No
Rebif®	No
RESPIRATORY AGENTS	
Synagis®	Yes
Xolair®	Yes

* Added to the Biotech/Specialty Injectables List, effective January 1, 2008.