Independence Blue Cross

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PARTNERS IN HEALTH UPDATE

December 2008

Working Together For Quality Health Care

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NATIONAL PROVIDER IDENTIFIER (NPI)

Claims submitted without a valid, registered NPI will reject

NPIs must be registered with IBC

As previously communicated, claims submitted to us without a registered NPI began rejecting as of May 23, 2008, per the Centers for Medicare & Medicaid Services mandate. NPIs can be registered online by submitting an NPI provider registration web form at *www.ibx.com/providers/npi/provider_registration.html.*

Claims submitted with invalid NPIs will reject

Each claim must pass an NPI check-digit validation to ensure that it has a valid NPI. To date, some claims are still not passing this check-digit validation. The most common reasons why claims are not passing the NPI check-digit validation are:

- The wrong provider identifier is entered in an NPI field.
- The NPI is entered incorrectly.
- The number entered is not a valid NPI.

Processing of claims

For purposes of processing a claim in accordance with the reimbursement terms of your provider contract, you may continue to provide your 10-digit legacy number in addition to your valid, registered NPI. The sole purpose for providing the 10-digit legacy number is to facilitate accurate claims payment — not to identify the claim for acceptance into our system. Only a valid NPI will be accepted by us as the primary identifier on the claim.

If you need more information about NPI claims submission, please refer to our *National Provider Identifier (NPI) Toolkit: Tips for Proper Electronic and Paper Claims Submission,* located at *www.ibx.com/pdfs/providers/npi/toolkit.pdf.*

Learn more about NPIs. Our previous communications, FAQs, and additional resources, are available at *www.ibx.com/providers/npi.*

Please note: We will receive contracted behavioral health providers' NPI information directly from Magellan Behavioral Health, Inc., an independent company. For more information, please contact Magellan National Provider Services Center at 1-800-788-4005, or visit Magellan at www.magellanhealth.com.

BILLING

Present on admission indicator billing requirements

Starting January 1, 2009, we will implement present on admission (POA) indicator billing requirements for acute-care hospitals. All hospitals are required to follow instructions from the Centers for Medicare & Medicaid Services regarding identification of the POA for all diagnosis codes for inpatient claims submitted on the UB-04 and ASC X12N 837 Institutional (837I) forms.

Additionally, we require providers submitting paper claims who are exempt from POA reporting, to report indicator "1" in the eighth digit of the UB-04 form locator 67. These POA requirements apply to all IBC claims submissions, independent of products. Claims submitted on or after January 1, 2009, without valid POA indicators will be rejected. This information has been provided to participating hospitals through bulletin #11-08.

If you have any questions about this bulletin, please contact your Network Coordinator. To download a copy of detailed instructions regarding the POA indicator billing requirements, please visit *www.ibx.com/providers/communications/bulletins/facility* and refer to bulletin #11-08.

Medicare Advantage Private Fee-for-Service: balance billing

On January 1, 2008, we launched Select Advantage, a new Medicare Advantage Private Fee-for-Service (PFFS) plan. This Medicare Advantage PFFS plan is a nonnetwork, nonmanaged 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.

Deemed providers may collect only applicable copayment and coinsurance amounts from Select Advantage PFFS members and may otherwise not charge or bill the members. Balance billing is prohibited by deemed providers who provide services to Select Advantage members.

Deemed providers have agreed that in no event, including but not limited to nonpayment by Select Advantage PFFS plan, insolvency of Select Advantage PFFS plan, or breach of these terms and conditions, shall a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an enrollee or persons (other than Select Advantage PFFS plans) acting on behalf of the enrollee for services provided pursuant to these terms and conditions. This provision does not prohibit deemed providers from collecting charges for noncovered services or cost-sharing amounts in accordance with the Medicare Fee Schedule.

If a provider mistakenly collects more from a member than the designated copayment or coinsurance, he or she must:

- return to the member the total reimbursement amount less member cost-sharing;
- collect the total reimbursement amount less member cost-sharing from Select Advantage.

For additional information, please visit our website at *www.ibx.com/providers/pffs.* Also, be sure to check future editions of *Partners in Health Update* for additional information about this Medicare Advantage PFFS plan.

Select Advantage 2009 terms and conditions now available

The Select Advantage terms and conditions for deemed providers have changed for 2009. The updated terms and conditions can be viewed online at *www.ibx.com/pdfs/providers/pffs/pffs_terms_conditions.pdf.*

Submit Coordination of Benefits information electronically

Providers and facilities may submit Coordination of Benefits (COB) information electronically for professional/facility services using the applicable 837P or 837I format. For instructions on how to bill electronically, please visit *www.ibx.com/providers/claims_and_billing/edi/forms.html.*

Submitting COB information electronically eliminates the need for paper claims submission. Claims submitted electronically are processed faster and have a significantly higher "first-pass" adjudication rate, which translates to faster payment.

For questions concerning electronic billing, please call the eBusiness Help Desk at 215-241-2305 or your Network Coordinator.

PRODUCTS

Keystone Direct Point-of-Service: offering members more direct access to participating providers

The Keystone Direct Point-of-Service (POS) benefits plan allows members to see most providers directly, *without a referral*. However, Direct POS requires primary care physician (PCP) referrals for routine radiology (except mammograms), physical/occupational therapy, spinal manipulations, and podiatry services. Obtaining a referral for these services ensures that the member receives the highest level of benefits. For laboratory services, members must obtain a laboratory requisition form from their PCP or specialist. For all other services, members may visit any Keystone Health Plan East network provider directly, *without a referral.* Utilizing providers who participate in the Keystone network ensures that members will receive the highest level of benefits and the lowest out-of-pocket costs.

Keystone's capitated program remains in effect for Direct POS. Similar to our Keystone HMO and POS benefits, PCPs must refer Direct POS members to capitated providers for capitated services (i.e., routine radiology, physical/occupational therapy, laboratory, and podiatry) for members to receive the highest level of benefits.

Please note that mammography services are not capitated. Direct POS members may go anywhere in network for mammography under their benefits.

How the plan works:

- A Direct POS member selects a participating PCP from the Keystone Health Plan East network.
- No referrals are required for members to see participating specialists.
- Referrals are required for routine radiology (except mammograms), podiatry, spinal manipulation, and physical/occupational therapy services.
- A requisition form is required for laboratory services.
- The member is responsible for applicable cost-sharing.
- The member does not need to file claim forms when services are provided by participating specialists.

Note: For services requiring precertification through AIM (CT/CT scans, MRI/MRA, nuclear cardiology services, and PET scans), a separate PCP referral is not required. Additionally, referrals are never required for mammography.

MEDICAL

Reminder: members may receive OB/GYN services without a referral

HMO/POS members receive direct access to any network obstetrical/gynecological (OB/GYN) specialist or subspecialist without a referral. Regardless of where the services are performed, no referrals are needed for preventive care visits, routine OB/GYN care, or problem-related OB/GYN conditions.

Specialties and subspecialties not requiring referrals include, but are not limited to, the following:

- OB
- GYN (including urogynecologist)
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist
- midwife

Services no longer requiring referrals from primary care physicians (PCP) or OB/GYNs include, but are not limited to, the following:

- all antenatal screening and testing;
- fetal or maternal imaging;
- hysterosalpingogram/sonohysterogram.

You must continue to use the OB/GYN Referral Request Form for the following services:

- pelvic ultrasounds, abdominal X-rays, intravenous pyelograms (IVPs), and DEXA scans (these tests must be performed at the member's capitated radiology site);
- initial consultations for HMO members for endocrinology, general surgery, genetics, GI, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP referral).

Please remind your patients about the change in referral requirements, and contact your Network Coordinator with any questions.

Independence Blue Cross to publish position on Never Events and Preventable Adverse Events

Independence Blue Cross (IBC) will publish a new claims payment policy on Never Events and Preventable Adverse Events. Under this policy, the company will not provide coverage for Never Events or the incremental costs associated with Preventable Adverse Events.

What are Never Events and Preventable Adverse Events?

Never Events are defined as:

- a surgical procedure performed in a facility on the wrong body part/wrong site;
- a surgical procedure performed in a facility on the wrong patient; or
- a wrong surgical procedure performed in a facility on a patient.

Never Events should never occur in a quality facility under any circumstances.

Preventable Adverse Events are defined as those facility-based events that:

- are preventable through the use of evidence-based guidelines and or criteria;
- are within the control of the facility or the providers practicing in the facility;
- are the result of a mistake made in the facility;
- result in serious or significant harm; and
- should be clearly and precisely defined in advance as risks.

Examples of Preventable Adverse Events are:

1. Foreign object (such as a sponge or needle) inadvertently left in patients after surgery
2. Air embolism
3. Transfusion with the wrong type of blood
4. Severe pressure ulcers
5. Certain falls and trauma that occur in the facility
6. Catheter-associated urinary tract infection (UTI)
7. Vascular catheter-associated infection
8. Manifestations of poor control of blood sugar levels
9. Surgical site infection following coronary artery bypass graft (CABG) (e.g., sternal wound infection)
10. Surgical site infection following certain orthopedic procedures
11. Surgical site infection following bariatric surgery for obesity
12. Deep vein thrombosis (a blood clot in a major vein) and pulmonary embolism (blockage in the lungs) following certain orthopedic procedures (e.g., knee and hip replacements).

IBC agrees that neither a health plan nor its members should be held financially responsible for the cost of any services related to Never Events or any incremental costs related to Preventable Adverse Events.

The full policy will be available on *www.ibx.com/medpolicy* on January 1, 2009. Please note that the full policy shall control to the extent there are any inconsistencies between this article and the full policy.

If you have questions, please contact your Network Coordinator.

Clinical criteria used for utilization management determinations

Clinical decision support criteria are used to enhance medical necessity coverage decisions that are made by registered nurse care coordinators and by medical directors.

Clinical decision support criteria are obtained through an externally validated and computer-based system and used to assist us 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.

We use InterQual®, a product of McKesson Corporation, an independent company, as our clinical decision support criteria. InterQual updates its criteria annually. To ensure that the criteria developed are in accordance with community standards, the guidelines are reviewed by the Clinical Quality Committee, whose membership is comprised of participating providers.

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

At a minimum, we review the clinical criteria annually. In addition, updates are made and released as they become available.

InterQual 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
- long-term, acute-care facility
- observation

In addition, we apply InterQual acute-care guidelines for all emergency admissions. Admissions that do not meet acute intensity of services and severity of illness are reviewed by an Independence Blue Cross medical director and denied if guidelines are not met. Hospitals may bill for observation level of care if acute level of care is not approved. Observation services do not require preapproval but are subject to InterQual criteria for medical necessity, which includes that the treatment and/or procedures require at least six hours of observation.

Information about clinical decision support criteria regarding a specific case guideline may be obtained by calling 215-241-3417.

ClaimCheck® offers automatic claim evaluation

As of December 22, 2008, ClaimCheck will be upgraded from Version 8.5.41.1 to Version 8.5.42. ClaimCheck is a comprehensive code-auditing tool that we use to evaluate the relationships between procedure codes submitted on the paper or electronic format of a CMS-1500 claim form. Claims are edited by the ClaimCheck software for correct coding rules and guidelines. Edits are sourced to various nationally accepted authorities, including the American Medical Association, Current Procedural Terminology (CPT®), the Centers for Medicare & Medicaid Services, as well as coding and billing recommendations from national specialty societies.

Easy access to a detailed disclosure of all ClaimCheck code edits is provided through Clear Claim Connection™, which is available 24 hours a day, 7 days a week, through the NaviNet® provider portal.

In an effort to maintain an enhanced level of transparency, we are issuing this ClaimCheck notification to inform you about the upgrade to the most up-to-date version of the ClaimCheck software. This is applicable to all contracted providers who deliver professional services to our members by way of a CMS-1500 or equivalent electronic format. Upgrades to ClaimCheck are scheduled twice a year, typically in the spring and fall. This release schedule for ClaimCheck upgrades is subject to modification for business reasons.

For more information on this ClaimCheck upgrade or how to get Clear Claim Connection, please contact your Network Coordinator.

Policy notifications posted as of November 12, 2008

In order to better inform providers, we have developed a *Policy Notifications* web page where our policies are posted prior to their effective date. Below is a listing of the policy notifications we have posted to the site as of November 12, 2008:

Policy effective date	Notification title	Notification issue date
December 1, 2008	**11.02.12b** Percutaneous Extracranial and Intracranial Cerebrovascular Artery Angioplasty and Stenting	October 29, 2008
December 16, 2008	**01.00.02b** Anesthesia Services for a Cancelled or Discontinued Procedure	September 17, 2008
December 16, 2008	**06.02.24d** Preimplantation Genetic Diagnosis (PGD) Testing	September 17, 2008
December 30, 2008	**07.13.01d** Orthoptic/Pleoptic Training	October 1, 2008
December 30, 2008	**11.15.17b** Paravertebral Facet Joint Nerve Block	October 1, 2008
January 1, 2009	**08.00.26h** Botulinum Toxin Type A and Type B	October 1, 2008
January 1, 2009	**04.00.05b** Extraction of Bony Impacted Teeth and Exposure of Impacted Teeth	October 1, 2008
January 1, 2009	**08.00.76** Oxaliplatin (Eloxatin®)	October 1, 2008
January 13, 2009	**05.00.25e** Cranial Remolding Orthoses (Helmets)	October 15, 2008
January 13, 2009	**05.00.21c** Durable Medical Equipment (DME)	October 15, 2008
January 27, 2009	**11.08.08d** Chemical Peels	October 29, 2008
January 27, 2009	**11.08.29c** Procedures for the Treatment of Acne	October 29, 2008
January 27, 2009	**11.08.25a** Scar Revision	October 29, 2008
January 27, 2009	**11.08.04d** Selective Photothermolysis Using Pulsed-Dye Lasers (PDL)	October 29, 2008
January 27, 2009	**11.08.20c** Wound Care: Bioengineered Skin Substitutes	October 29, 2008
February 10, 2009	**11.03.11e** Procedures for the Treatment of Gastroesophageal Reflux Disease (GERD)	November 12, 2008
February 11, 2009	**07.02.05e** External Counterpulsation (ECP)	November 12, 2008
March 17, 2009	**05.00.35a** Foot Orthotics and Other Podiatric Appliances	November 12, 2008
March 17, 2009	**05.00.59b** Lower Limb Prostheses	November 12, 2008
March 17, 2009	**05.00.11b** Therapeutic Shoes and Orthopedic Shoes	November 12, 2008

To access these notifications and view the policies in their entirety, follow these instructions:

1. Visit *www.ibx.com/medpolicy.*
2. Select *Accept and Go to Medical Policy Online*.
3. Select the *Commercial and Other Medicare Advantage policies* link.
4. Select *Policy Notifications* from the Medical Policy column on the left sidebar.

Be sure to check back often as the site is updated frequently.

Stay tuned — transition to all-electronic authorization inquiry and submission continues

New enhancements to the provider interactive voice response (IVR) system will launch soon. These enhancements will provide you with the ability to submit electronic authorization or precertification requests for outpatient and office medical and/or surgical procedures.* This service will be directly accessible through Customer Service at 1-800-ASK-BLUE, prompt 2, for Provider Services.

The updated system will be available soon as part of our phased approach toward an all-electronic format for authorization inquiry and authorization submission. When making an authorization or precertification request with the updated system, the following information is *required*:

- your provider ID number;
- the last four digits of your tax ID *or* your national provider identification (NPI) number;
- member's ID number;
- member's name and date of birth;
- date of service;
- setting, procedure code;
- diagnosis code;
- the name, address, and telephone number of both the servicing provider/facility and the requesting provider.

A tutorial for using the new IVR system will be included in a future edition of *Partners in Health Update*.

**For behavioral health services, providers should still call the number on the member's ID card under Mental Health/Substance Abuse.*

Benefits clarification language

Effective January 1, 2009 (unless otherwise noted), the following member benefit clarifications will be implemented for several programs in Pennsylvania:

1. **Preventive care update** (PPO, Flex [PPO], Personal Choice® HSA-qualified High Deductible Health Plans [HDHPs]): Language regarding the preventive care schedule is being enhanced to correspond to national wellness guidelines for the following services:
   - pediatric preventive schedule – two additional evaluations/visits have been added within 3 – 5 days of birth and at 30 months of age;
   - adult preventive schedule – three additional evaluations/visits have been added to allow for one examination every two years between the ages of 22 and 39;
   - adult preventive schedule – three additional complete blood count tests have been added to allow for one test every two years between the ages of 22 and 39.
2. **Preventive care update** (Self-Referred POS and Flex [Self-Referred POS]): Language regarding preventive care is being clarified to correspond to national wellness guidelines.
3. **Inpatient copay waiver** (HMO, POS, Flex [HMO/POS]): Information is being added to clarify inpatient copayment waiver language.
4. **Precertification changes — medical infusion drugs** (HMO, POS, PPO, Flex [HMO/POS/PPO], Personal Choice HSA-qualified HDHPs): **Effective July 1, 2009,** the following changes will be made to the precertification list for medical infusions:
   - Additions:
     - rituximab — infusion (medical)
     - Eloxatin® — infusion (medical)
   - Deletions:
     - Respigam®
     - Genasense®
5. **Precertification changes — medical injectable drugs** (HMO, POS, PPO): **Effective July 1, 2009,** the following medical injectable drugs will be added to the precertification list:
   - Botox®
   - Synagis®
   - Hyaluronan agents:
     - Synvisc®
     - Hyalgan®
     - Supartz®
     - Orthovisc®
     - Euflexxa™

Coverage of long-term invasive continuous glucose monitoring systems

Effective for dates of service on or after October 2, 2008, long-term continuous glucose monitor systems will be covered and considered eligible for reimbursement when an individual meets the medical necessity criteria outlined in medical policy 05.00.24e, Invasive Continuous Glucose Monitoring Systems (CGMS).

Long-term invasive CGMS

Use of a long-term invasive CGMS to measure interstitial glucose levels via a subcutaneously implanted sensor is considered medically necessary and, therefore, covered when an individual demonstrates one of the following criteria:

- The individual is a pregnant female with type I diabetes.
- The individual has type I diabetes and documentation of **all** of the following:
  - The CGMS is prescribed by an endocrinologist.
  - The individual is on an intensive insulin regimen, requiring two or more insulin injections per day, or utilizes an insulin pump.
  - The individual has a documented history of severe ketosis or hypoglycemic episodes without experiencing warning and recognition of symptoms (hypoglycemic unawareness).
  - The individual has demonstrated mastery of the fundamentals of diabetes self-management, which includes:
    - Routine, regular testing of blood glucose levels at least three times a day
    - Maintaining accurate records of blood glucose testing
  - The individual has received education and training from an accredited health care professional to master the CGMS, including all of the following:
    - Basic care of the device (e.g., insertion, calibration, expectations)
    - Use of real-time CGMS application in diabetic care
    - Alarm use and problem solving

All other uses for long-term invasive CGMSs are considered experimental/investigational and, therefore, not covered because their safety and/or efficacy cannot be established by review of the available published literature.

The following codes and limitations are in place for long-term CGMS:

- A9276: **Sensor:** One unit = 1-day supply, up to ten per month.
- A9277: **Transmitter:** One per continuous twelve-month period.
- A9278: **Monitor:** A one-time purchase, according to the product life expectancy.

The CGMS monitor requires precertification; the sensor and transmitter do not require precertification.

About CGMS

Long-term invasive CGMS devices are considered an adjunct to traditional blood glucose monitoring. These devices allow individuals with diabetes to track glucose levels and detect episodes of high and low blood sugar in real time on an ongoing basis. Current research trials and professional literature suggest the use of long-term CGMS devices to improve glycemic control for individuals with type I diabetes who are insulin-dependent and have a documented history of severe ketosis or hypoglycemic unawareness.

For additional information, refer to the full policy, which is available at *www.ibx.com/medpolicy,* or contact your Network Coordinator.

MEDICAL

Changes to precertification requirements for outpatient mental health

Beginning January 1, 2009, we are eliminating the requirement for providers to obtain prior and continuing authorizations for routine and medication management outpatient mental health services under most Independence Blue Cross (IBC) benefits plans.

Magellan Behavioral Health, Inc., an independent company, will be communicating this change to its mental health providers. Claims for mental health outpatient services with dates of service prior to January 1, 2009, will be subject to the current precertification requirements.

In addition, precertification requirements that are currently in place will continue to be required for substance and alcohol abuse services as well as mental health inpatient services, partial hospitalization programs, and intensive outpatient programs.

IBC and Magellan Behavioral Health, Inc. understand professional providers' concerns regarding perceived barriers related to authorization requirements for outpatient mental health services, and we are moving forward to address them.

CREDENTIALING

Reassessment for ancillary providers

As a reminder, all participating durable medical equipment (DME), home infusion, and hospice providers are required to be accredited by an Independence Blue Cross-recognized accrediting body, as described below. In 2009, we will be conducting a reassessment of our network providers to ensure compliance with this requirement. Should you have any questions concerning this information, please contact Theresa Sawyer, contract data coordinator, at 215-241-3846.

Provider type	Recognized accrediting organizations
DME providers	Any approved accrediting organization "deemed" by CMS for DME providers including but not limited to: ▪ Accreditation Commission for Health Care ▪ Community Health Accreditation Program ▪ The Exemplary Provider Accreditation Program (a.k.a. The Compliance Team) ▪ Joint Commission
DME – providers for orthotics and prosthetics only	▪ American Board for Certification in Orthotics and Prosthetics ▪ The Board of Orthotist/Prosthetist Certification ▪ The Exemplary Provider Accreditation Program (a.k.a. The Compliance Team)
Home infusion providers	▪ Accreditation Commission for Health Care ▪ Community Health Accreditation Program ▪ Joint Commission
Hospice providers	▪ Accreditation Commission for Health Care ▪ Community Health Accreditation Program ▪ Joint Commission

Reminder: albuterol inhalers with CFC propellants will no longer be available as of January 1, 2009

Albuterol inhalers containing chlorofluorocarbons (CFCs) will not be available in the United States after December 31, 2008. Albuterol inhalers containing hydrofluoroalkanes (HFAs) will replace albuterol CFC inhalers.[1]

The reason for this national transition to HFA-propelled albuterol inhalers is due to the harmful effects of CFCs on the ozone layer. The United States has agreed to phase out production and eventually eliminate ozone-depleting substances (ODS), including CFCs,[2] as part of an international environmental treaty called The Montreal Protocol on Substances that Deplete the Ozone Layer.

In May 2008, the FDA advised health care professionals to begin moving patients to the use of HFA-propelled inhalers. The manufacturers of HFA inhalers have increased production to ensure that there is an adequate supply of the three approved HFA-propelled albuterol inhalers: ProAir® HFA Inhalation Aerosol, Proventil® HFA Inhalation Aerosol, and Ventolin® HFA Inhalation Aerosol.[2]

Note: Proventil® HFA Inhalation Aerosol and Ventolin® HFA Inhalation Aerosol are currently listed on the Select Drug Program® formulary. ProAir® HFA Inhalation Aerosol is being added as a brand addition effective January 1, 2009.

[1] *Transition from CFC Propelled Albuterol Inhalers to HFA Propelled Albuterol Inhalers Questions and Answers. U.S. Department of Health and Human Services. U.S. Food and Drug Administration. May 30, 2008. Available at: www.fda.gov/cder/mdi/albuterol_faq_eng_low.pdf. Viewed August 14, 2008.*

[2] *U.S. Food and Drug Administration. Public Health Advisory National Transition from Chlorofluorocarbon (CFC) Propelled Albuterol Inhalers to Hydrofluoroalkane (HFA) Propelled Albuterol Inhalers. May 30, 2008. Available at: www.fda.gov/cder/drug/advisory/albuterol_cfc.htm. Viewed August 14, 2008.*

Rx for Better Health ends December 31, 2008

Rx for Better Health, our member incentive that waived copays on 75 generic drugs, is concluding December 31, 2008. Beginning January 1, 2009, members will pay their plan's lowest copay for generic drugs.

The program was designed to ease members' access to generic drugs for common chronic conditions, and to encourage their adherence to prescribed therapies. Studies show that consistent management of chronic conditions improves health, prevents unnecessary trips to the emergency room, and reduces the risk of serious complications.

Thank you for talking to our members about using generic drugs. We understand that you know best how to care for your patients, and we encourage you to continue prescribing generic equivalents and therapeutic alternatives, where appropriate. By doing so, you are helping to reduce patients' out-of-pocket costs.

If you have any questions about the conclusion of the *Rx for Better Health* program, please call 1-800-ASK-BLUE, prompt 2, for Provider Services, or ask your Network Coordinator.

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

The following generic drugs recently became available in the marketplace. When these generic drugs became available, we began covering them at the appropriate generic formulary cost-sharing.

Generic drug	Brand drug	Formulary chapter	Effective date
benzoyl peroxide gel	Brevoxyl® Gel	5. Skin Medications	August 29, 2008
calcium acetate	Phoslo®	16. Diagnostics & Misc Agents	October 17, 2008
carbidopa-levodopa ODT	Parcopa®	3. Pain, Nervous System, & Psych	September 19, 2008
divalproex sodium	Depakote®	3. Pain, Nervous System, & Psych	July 30, 2008
eplerenone	Inspra®	4. Heart, Blood Pressure, & Cholesterol	August 8, 2008
galantamine	Razadyne®	3. Pain, Nervous System, & Psych	August 29, 2008
galantamine ER	Razadyne® ER	3. Pain, Nervous System, & Psych	October 17, 2008
lamotrigine	LAMICTAL®	3. Pain, Nervous System, & Psych	July 25, 2008
Multigen/Multigen Plus	Chromagen®/ Chromagen® Forte	15. Vitamins & Electrolytes	July 18, 2008
nisoldipine	Sular®	4. Heart, Blood Pressure, & Cholesterol	August 1, 2008
omeprazole 40mg	Prilosec® 40mg	8. Stomach, Ulcer, & Bowel Meds	July 29, 2008
potassium chloride ext-release caps 8 mEq	Micro-K® 8 Extencaps®	15. Vitamins & Electrolytes	August 22, 2008

Brand addition

This brand drug will be covered at the appropriate brand formulary cost-sharing.

Effective January 1, 2009

Brand drug	Generic drug	Formulary chapter
ProAir® HFA	Not available	13. Allergy, Cough & Cold, Lung Meds

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 cost-sharing.

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Select Drug Program® formulary updates (continued)

Brand deletions

These brand drugs will be covered at the appropriate non-formulary cost-sharing:
Effective January 1, 2009

Brand drug	Generic drug	Formulary chapter
Depakote®	divalproex sodium	3. Pain, Nervous System, & Psych
Inderal® LA	propranolol	4. Heart, Blood Pressure, & Cholesterol
LAMICTAL®	lamotrigine	3. Pain, Nervous System, & Psych
Micro-K® 8 Extencaps®	potassium chloride ext-release caps 8 mEq	15. Vitamins & Electrolytes
Phoslo®	calcium acetate	16. Diagnostics & Misc Agents
Prilosec® 40mg	omeprazole 40mg	8. Stomach, Ulcer, & Bowel Meds
Sular®	nisoldipine	4. Heart, Blood Pressure, & Cholesterol

The generic drugs for the brand drugs listed above are on our formulary and available at the generic formulary cost-sharing.

Prescription drug updates

For members enrolled in an Independence Blue Cross prescription drug program, there will be additional drugs requiring prior authorization. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. These updates are reflected below.

Drugs requiring prior authorization

The prior authorization requirement for the following non-formulary drugs was effective at the time the drug became available in the marketplace.

Brand drug	Generic drug	Drug category	Effective date
Alvesco®	Not available	Ear, Nose, Throat	August 29, 2008
Hycamtin® capsules	Not available	Cancer	September 19, 2008

The following non-formulary drugs will be added to the list of drugs requiring prior authorization for new prescriptions. Members taking these drugs immediately prior to the effective date are not affected.
Effective January 1, 2009

Brand drug	Generic drug	Drug category
Actiq®	fentanyl citrate lozenges	Pain, Nervous System, & Psych
Flector® Patch	Not available	Pain, Nervous System, & Psych
Treximet™	Not available	Pain, Nervous System, & Psych

PHARMACY

Medicare formulary updates

We are always exploring new opportunities for improving safety and quality in prescription drug use. Aligning our efforts with the Centers for Medicare & Medicaid Services (CMS) under Medicare Part D, we would like to notify you of the following formulary policy update:

- We can expand coverage by lowering copayments or coinsurance, lowering tiers, or deleting utilization management at any time during the year.
- We can change its therapeutic categories and classes only at the beginning of each plan year, except to account for new therapeutic uses and newly approved drugs.
- After March 1 of a new year, we may make maintenance changes to its formulary (e.g., replacing brand-name drugs with generic drugs or making modifications based on new safety/effectiveness information).
  - Those cases must be approved by CMS, and we are required to notify CMS, State Pharmaceutical Assistance Programs, prescribers, network pharmacies, pharmacists, and "affected enrollees" 60 days before the effect of the change. We may make these changes only if enrollees currently taking the affected drug are exempt from the change for the remainder of the plan year.
- We are not required to receive CMS approval or provide 60 days notice when the U.S. Food and Drug Administration or a product manufacturer withdraws the drug from the market.

For more information about our Medicare Part D formulary changes and updates, visit *www.site65.com/drug_formulary/formulary/all_plans.html.*

SPECIALTY PHARMACY

Important changes about self-injectable drug coverage coming January 1, 2010

In an effort to provide greater access to self-injectable drugs with greater value for our commercial HMO, POS, and PPO members, we are changing the way we cover self-injectable drugs, effective January 1, 2010. These changes, in tandem with a series of billing code changes described in this *Specialty Pharmacy* section, are part of our evolving overall approach to managing specialty pharmaceutical benefits. We will be communicating a series of changes over the next two years, all aimed at ensuring that members are getting the right drug in the right setting at the right time for the best value.

Members will be notified of the change to self-injectable drug coverage beginning in January 2009 and may have questions for you. Below is a brief description of the scheduled changes to help you answer questions that your patients may have.

Starting on January 1, 2010, we will no longer provide benefits for most self-injectable drugs under our medical benefits program. However, if an HMO, POS, or PPO member has Independence Blue Cross pharmacy coverage, his or her self-injectable drugs will continue to be covered under his or her pharmacy benefits in 2010. If members have prescription coverage from another carrier, they may want to verify whether their plan includes coverage for self-injectables.

The self-injectable drugs that will no longer be covered under medical benefits programs are those that patients typically administer themselves and do not require physician monitoring.

We *will* continue to cover those self-injectables under the medical benefits program at the appropriate cost-sharing levels that:

- cannot be administered without medical supervision;
- are mandated by law to be covered (e.g., insulin);
- are required for emergency treatment, such as self-injectable drugs that effectively counteract allergic reactions under the medical benefits program (e.g., EpiPen®).

If you have any questions about these impending changes, please call 1-800-ASK-BLUE, prompt 2, for Provider Services.

Valid NDC required on claims submitted for drugs (e.g., J codes and other drug codes)

As part of our overall approach to managing specialty pharmaceutical benefits, we will be communicating to you over the next two years about some changes that will help ensure members are getting the right drug in the right setting at the right time for the best value. We want to share with you some changes to the National Drug Code (NDC) submission.

Please be advised that a new edit is now in place to validate the NDC on any paper or electronic claims submitted with an ***unlisted and non-specific*** drug code. By requesting this detailed drug billing information we can provide greater transparency for our members and providers. Please review the billing requirements below for your applicable provider type. Certain claims for unlisted and non-specific drug codes that are not accompanied by an NDC in the correct format and location as described below will not be processed and will be returned to you for correction prior to processing.

For professional providers: Effective January 1, 2009, claims for all ***unlisted and non-specific drug codes*** (CPT® or HCPCS) will require submission of an NDC in the correct format and location as described below. If the NDC is not submitted in the correct format or is missing, the claim will not be processed and will be returned to you for correction prior to processing. The complete list of unlisted and non-specific codes that require the submission of an NDC is below.

For home infusion providers: Effective January 1, 2009, ***all*** drug claims (not just the ***unlisted and non-specific*** CPT or HCPCS codes in the table below) will require the submission of an accompanying 11-digit NDC. This includes claims for Hemophilia Factor products that are currently submitted with specific J codes.

For institutional providers: Tentatively scheduled for mid first quarter, 2009, all claims for outpatient services containing the following pharmacy revenue codes, ***and an unlisted and non-specific*** (CPT or HCPCS) code will require a valid NDC when submitted: 250-259, 262, 263, 331, 332, 335, 343, 344, and 631-637.

NDC billing information

Please submit the NDC number using the 5-4-2 format when billing with hyphens (e.g., 12345-1234-12). NDC numbers without hyphens (e.g., 12345678911) will also be accepted. Please *do not* include spaces, decimals, or other characters in the 11-digit string or the claim will be returned for correction prior to processing.

Unlisted codes that will require submission of an NDC*

Code	Description
90399	Unlisted immune globulin
90749	Unlisted vaccine/toxoid
A4641	Radiopharmaceutical, diagnostic, not otherwise classified
A9150	Nonprescription drug
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified
A9579	Injection, gadolinium based magnetic resonance contrast agent, not otherwise specified, per ml
A9698	Nonradioactive contrast imaging material, not otherwise classified, per study
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
A9700	Supply of injectable contrast material for use in echocardiography, per study
C2698	Brachytherapy source, stranded, not otherwise specified, per source
C2699	Brachytherapy source, nonstranded, not otherwise specified, per source
C9399	Unclassified drugs or biologicals
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
J3490	Unclassified drugs

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Valid NDC required on claims submitted for drugs (continued)

Code	Description
J3530	Nasal vaccine inhalation
J3535	Drug administered through a metered dose inhaler
J3590	Unclassified biologics
J7199	Hemophilia clotting factor, not otherwise classified
J7599	Immunosuppressive drug, NOC
J7699	NOC drugs, inhalation solution administered through DME
J7799	NOC drugs, other than inhalation drugs, administered through DME
J8498	Antiemetic drug, rectal/suppository, not otherwise specified
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8597	Antiemetic drug, oral, not otherwise specified
J8999	Prescription drug, oral, nonchemotherapeutic, NOS
J9999	NOC, antineoplastic drug
Q3001	Radioelements for brachytherapy, any type, each
Q4082	Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP)
Q4096	Injection, von Willebrand factor complex human, ristocetin cofactor (not otherwise specified), per I.U. VWF:RCO
S5000	Prescription drug, generic
S5001	Prescription drug, brand name

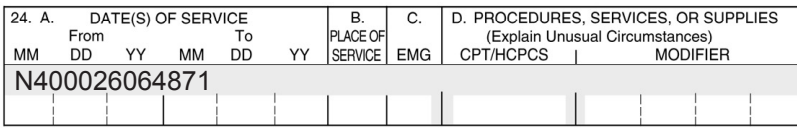
**These codes are subject to change pending routine updates.*

Listing of these codes on the table does not imply that a separate payment will be made for the code but that all current and future coding edits apply, and that these codes should only be reported when there is not a more specific code.

Please submit an NDC in the following fields:

- **Electronic professional claims:** 837P Loop 2410/Data Element LIN02 = N4 qualifier and Data Element LIN03 = NDC
  - Example: LIN**N4*00093723106~
- **Paper professional claims:** field 24A in the shaded area above the date of service.

  Report the N4 qualifier in the first two positions left-justified followed by the 11-digit NDC with no spaces in between.
  - Example:



- **Electronic institutional claims:** 837I Loop 2410/Data Element LIN02 = N4 qualifier and Data Element LIN03 = NDC
  - Example: LIN**N4*00093723106~
- **Paper institutional claims:** box 43 (revenue code description)

  Report the N4 qualifier in the first two positions left-justified followed by the 11-digit NDC with no spaces in between.
  - Example: N400093723106

For information on claims submission resolution, please view the *Claims Preprocessing Edits Claims Resolution Document* at: *www.ibx.com/providers/self_service_tools/edi/forms.html.*

If you have questions, please contact your Network Coordinator.

Enhancements made to the Connections℠ Program

The Connections℠ Health Management Program is designed to identify members who would benefit from targeted outreach. The type and frequency of this outreach is determined by the member's overall health and his or her specific needs. In the four years since we introduced the program, we have outreached to 96 percent of our high-risk members with chronic conditions and realized an average 4 percent reduction in medical cost trends for these chronic members for each year of the program.

We are pleased to announce that due to the success of the Connections Health Management Program and our ongoing commitment to the health of our members, we have added four new conditions to the program. Our member outreach has also been enhanced through the use of multicultural materials.

More conditions

Hypertension, peptic ulcer disease (PUD), gastroesophageal reflux disease (GERD), and migraines have been added to the list of conditions managed by the Connections Program. Members with these conditions can call a Health Coach, 24 hours a day, 7 days a week, to receive support in managing their condition and to discuss prevention and treatment options. In addition, members may also receive calls from a Health Coach and informational mailings from the program.

More culturally specific

The Connections Program also added cultural sensitivity to member materials, including welcome mailings, gap mailings, and preference-sensitive mailings. The campaign uses data analysis at a "zip code plus four" level to redesign welcome materials that appeal to different cultures through pictures, language (English or Spanish), and family composition.

These welcome materials will continue to introduce new members identified with a chronic condition to Connections and to the benefits of a Health Coach. The letters to members with chronic conditions allow up to three conditions to be mentioned and can include any of the following:

- asthma
- chronic obstructive pulmonary disease
- chronic pain
- coronary heart disease
- depression
- diabetes
- GERD
- heart failure
- hypertension
- migraine
- PUD

For more Connections Program information, as well as a variety of resources and tools for doctors and their eligible Independence Blue Cross members, visit *www.ibx.com/providers/resources/connections.html.* This website has recently been updated with new printable handouts on asthma, diabetes, Health Coaching, heart failure, and more.

Colorectal cancer screenings coverage enhanced

The Commonwealth of Pennsylvania recently passed a law requiring health insurers to cover colorectal cancer screenings for commercial members in groups with 51 or more employees, effective September 1, 2008. The new law reinforced policies already in place for all of Independence Blue Cross's (IBC) managed care products, including Personal Choice® and Keystone Health Plan East HMO/POS. For plans not already in compliance, the mandate requires the following coverage:

- **For all symptomatic (diagnostic) members:** Coverage includes a colonoscopy, sigmoidoscopy, or any combination of colorectal cancer screening tests at a frequency determined by a treating physician.
- **For all nonsymptomatic (routine) members, age 50 or older:** Coverage includes, but is not limited to: an annual fecal occult blood test; a sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five years; and a colonoscopy at least once every ten years.
- **For all nonsymptomatic (routine) high-risk members, younger than 50:** Coverage includes a colonoscopy or any combination of colorectal cancer screening tests.

To comply with this new law, group coverage will be enhanced for commercial members in groups with 51 or more employees currently enrolled in a Blue Cross® Hospitalization, Blue Shield® Medical/Surgical, Major Medical, or Comprehensive Major Medical group product. Those plans already included diagnostic services, but will now also include the aforementioned routine services. Member benefits will need to be verified to determine coverage.

For those plans not yet in compliance, we will be offering the coverage retroactive to September 1, 2008.

If you have any questions about this coverage, please call 1-800-ASK-BLUE, prompt 2, for Provider Services, or check with your Network Coordinator.

Connections℠ Health Management Programs: supporting our members, your patients

Connections℠ Health Management Program

Call the Provider Support Line at 1-866-866-4694 to refer a patient for Health Coaching with any of the following conditions:

- asthma
- diabetes
- chronic obstructive pulmonary disease (COPD)
- coronary heart disease (CHD)
- migraine
- heart failure
- hypertension
- gastroesophageal reflux disease (GERD)
- peptic ulcer disease (PUD)

Health Coaches provide disease management and decision support for numerous health-related issues.

Connections℠ AccordantCare™ Program

Call the Connections AccordantCare Program at 1-866-398-8761 to refer a patient with any of the following 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

Call our Care Management and Coordination department at 1-800-313-8628 to refer a patient with end-stage renal disease on outpatient dialysis.

Visit our enhanced provider website at *www.ibx.com/providers/resources/connections.html.* This information is also available through NaviNet®.

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:

Leni Tanenbaum
Managing Editor

Charleen Baselice
Production Coordinator

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

IMPORTANT RESOURCES

View our online provider directories on www.ibx.com

CARE MANAGEMENT AND COORDINATION	215-567-3570
Case Management	1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Healthy Lifestyles℠ Keys to Wellness	215-567-3570 1-800-313-8628*
CONNECTIONS℠ HEALTH MANAGEMENT PROGRAMS	
Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ AccordantCare™ Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT	1-866-282-2707
Anti-Fraud and Corporate Compliance Hotline	www.ibx.com/anti-fraud
CREDENTIALING	www.ibx.com/credentials
Credentialing Hotline	215-988-6534
Credentialing Violation Hotline	215-988-1413
CUSTOMER SERVICE (Policies/Procedures/Claims)	1-800-ASK-BLUE, prompt 2 for
HMO and PPO	Provider Services
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	1-888-678-7012
FutureScripts® Secure	
Medicare Part D	1-888-678-7015
Formulary updates	www.site65.com
HEALTH RESOURCE CENTER	215-241-3367
Healthy Lifestyles℠	1-800-ASK-BLUE*
Precertification	1-800-ASK-BLUE
NAVINET® PORTAL REGISTRATION	www.ibx.com/providers/navinet/index.html
PROVIDER MEDICAL POLICY WEB PAGE	www.ibx.com/medpolicy
PROVIDER PHARMACY WEB PAGE	www.ibx.com/provider_rx
PROVIDER SUPPLY LINE	1-800-858-4728

* Outside 215 area code

Independence Blue Cross

Visit our website: *www.ibx.com/providers/communications*