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*This just in....*



## Updated claims toolkit now available

The NPI toolkit has been revised and has a new name: *Claims submission toolkit for proper electronic and paper claims submissions.*

Use the claims submission toolkit as a reference guide to accurately submit electronic and paper claims. The toolkit provides tips for submitting your claims with information on the CMS-1500 form, key fields, loop and data elements, plus resources for finding additional information.

A sample CMS-1500 form is also included to make completion instructions easier to follow.

The revised toolkit is now available at [www.ibx.com/claims](http://www.ibx.com/claims).



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

- P** Professional
- F** Facility
- A** Ancillary



Keystone Health Plan East, Personal Choice®, Keystone 65, and Personal Choice 65<sup>SM</sup> have an accreditation status of *Excellent* from the National Committee for Quality Assurance (NCQA).

*Partners in Health Update<sup>SM</sup>* is a publication of Independence Blue Cross and its affiliates (IBC) created to provide valuable information to the IBC-participating provider community. This publication may include notice of changes or clarifications to administrative policies and procedures that are related to the covered services you provide in accordance with your participating professional provider, hospital, or ancillary provider/ancillary facility contract with IBC. This publication is the primary method for communicating such general changes. Suggestions are welcome.

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This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Program (HMO, PPO, Indemnity, etc.), and/or employer groups. Providers should call Provider Services for the member's applicable benefits information. Members should be instructed to call the Customer Service telephone number listed on their ID card.

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 are presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefits plans. Members should refer to their benefits contract for complete details of the terms, limitations, and exclusions of their coverage.

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FutureScripts® and FutureScripts® Secure are independent companies that provide pharmacy benefits management services.



## ClaimCheck® upgrade scheduled

In an effort to maintain an enhanced level of transparency, **effective December 18, 2009**, the ClaimCheck software will be upgraded from version 8.5.43.1 to version 8.5.44.

ClaimCheck is a comprehensive code-auditing tool that we use to evaluate the relationships between procedure codes submitted on the CMS-1500 form (paper or electronic formats). Claims are edited by ClaimCheck for correct coding rules and guidelines. Edits are sourced to various nationally accepted authorities, including the American Medical Association, CPT® (Current Procedural Terminology), the Centers for Medicare & Medicaid Services (CMS), and the coding and billing recommendations from national specialty societies.

Access to detailed disclosures of all ClaimCheck code edits is available through Clear Claim Connection™, which is accessible through the NaviNet® web portal 24 hours a day, 7 days a week.

This upgrade applies to all contracted providers who deliver professional services to members by way of a CMS-1500 form or equivalent electronic format. Upgrades to ClaimCheck are scheduled twice yearly, typically in the spring and fall. The release schedule for ClaimCheck upgrades is subject to modification for business reasons.

For more information about the ClaimCheck upgrade or how to access Clear Claim Connection, please contact your Network Coordinator.

## HMO/PPO Flex products require precertification for comprehensive outpatient pain management



**Effective January 1, 2010**, precertification will be required for comprehensive outpatient pain management for all HMO/PPO Flex products. The following list represents codes that will require precertification:

- 62280            ● 64470            ● 64476            ● 64483            ● 64622            ● 64627
- 62281            ● 64472            ● 64479            ● 64484            ● 64623            ● 64630
- 62282            ● 64475            ● 64480            ● 64510            ● 64626            ● 64640

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



## The IVR's name is changing to the Provider Automated System



In the coming weeks, we are changing the name of the Interactive Voice Response (IVR) system to the Provider Automated System to better reflect the services available. Through the Provider Automated System, you can still check member eligibility and claims status as well as submit referrals.

Please note this change when calling **1-800-ASK-BLUE**. Be sure to have your NPI or 10-digit legacy ID number and the last four digits of your tax ID number ready before calling the Provider Automated System.





## Reminder: New credentialing procedure effective January 1, 2010

**Effective January 1, 2010**, IBC will mandate the use of the Council for Affordable Quality Healthcare (CAQH) electronic credentialing application for new providers. The CAQH electronic credentialing application is free to providers and available on the CAQH website at <https://upd.caqh.org/oas>.

Providers interested in participating in our network should call the Network Credentialing Support Services Hotline at 215-241-4120. A credentialing packet that includes a

contract and a billing registration information form will then be sent to the provider. These forms must be signed and returned to IBC. It is the provider's responsibility to notify IBC upon completion of the CAQH form.

*Note:* The credentialing process will not continue unless all necessary documents are received.

For more information regarding our credentialing process, please contact Customer Service at 1-800-ASK-BLUE.



## Revenue codes that will require a HCPCS/CPT® code January 1, 2010

**Effective January 1, 2010**, certain revenue codes will require a HCPCS/CPT code. For a complete list of these revenue codes, please refer to Bulletin #14-09: Revenue codes that require a CPT/HCPCS code, which is on our website at [www.ibx.com/bulletins](http://www.ibx.com/bulletins). When billing one of the revenue codes listed in this bulletin, a corresponding HCPCS/CPT code must be reported on the claim line. Any claims using one of these revenue codes without a corresponding HCPCS/CPT code will be returned with the message: "HCPCS procedure code/CPT code required for revenue code is missing."

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

## PPO Program ID cards and claims submission



**Beginning January 1, 2010**, your office may see patients that have "PPO Program" on their ID cards rather than "Personal Choice®".

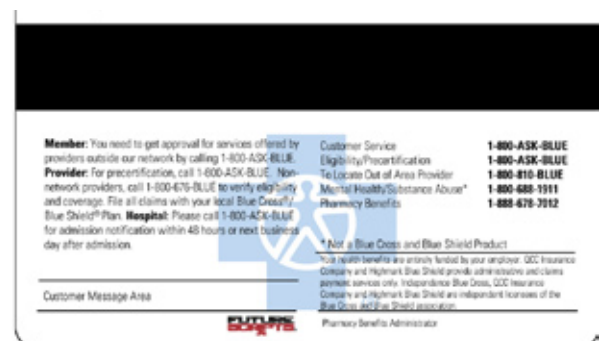
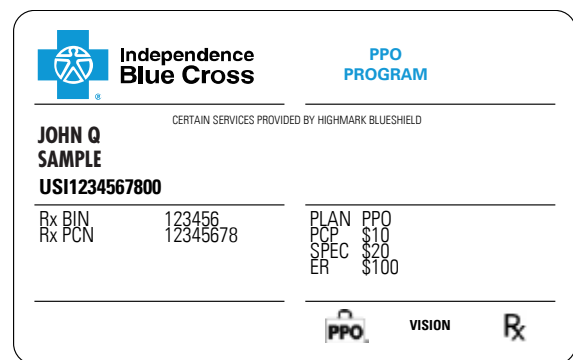
These ID cards are issued to members enrolled in Personal Choice through certain national/self-funded accounts.

Please refer to the sample ID card shown at the right.

Follow the current Personal Choice claims submission processes for PPO Program ID card Members.

You may check member eligibility and claims status through the NaviNet® web portal.

If you have any questions, please contact your Network Coordinator or call Customer Service at 1-800-ASK-BLUE.



## Billing requirements for administration of the H1N1 vaccine

In June 2009, the World Health Organization declared the novel H1N1 flu virus (swine flu) to be a worldwide pandemic. In response to this outbreak, several new monovalent flu vaccines have been developed and approved by the U.S. Food and Drug Administration (FDA). The FDA recommends that children (6 months to 9 years of age) should be administered two doses of the novel H1N1 monovalent flu vaccine with 21 – 28 days between the first and second dose. Adults and children 10 and older should be administered one dose of the novel H1N1 monovalent flu vaccine.

The novel H1N1 flu vaccine was made available to health care professionals at no cost starting in October 2009. The vaccine is available in a combination of settings, such as vaccination clinics organized by local health departments, health care provider offices, and other private settings (e.g., pharmacies, workplaces). Private providers wishing to administer the novel H1N1 flu vaccine may be able to enter into relationships with their public health departments to determine distribution options. However, because the Centers for Disease Control and Prevention has announced that the vaccine will be supplied at no cost, IBC will provide reimbursement only for the administration of the novel H1N1 flu vaccine, not for the vaccine itself.

### *Provider reimbursement*

The vaccine and the associated supplies are being provided by the federal government at no cost and will not be eligible for separate reimbursement.

Copayments should not be collected for the vaccine or administration. Additionally, an office visit evaluation and management (E&M) code should not be billed unless the individual is being treated for a separately identifiable medical problem or service. If an office visit E&M is being performed, applicable copayment requirements may apply.

Visit [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy) for more billing and policy information about the H1N1 virus and additional links to updated articles. Additional H1N1 information is also available at [www.ibx.com/H1N1](http://www.ibx.com/H1N1).



## Professional Injectable and Vaccine Fee Schedule updates effective January 1, 2010



**Effective January 1, 2010**, we will be implementing a quarterly update to our Injectable and Vaccine Fee Schedule.

These updates reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables. You will be able to

view these changes starting January 1, 2010, using the Fee Schedule Lookup Tool through the NaviNet® web portal.

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

## Reminder: Reporting services using modifier -50

As previously communicated in the September edition of *Partners in Health Update*, modifier -50 is used to denote bilateral procedures that can be performed on identical sites, aspects, or organs on both sides of the body during the same operative session or on the same day. The Centers for Medicare & Medicaid Services (CMS) has defined codes that are subject to the bilateral payment rule (i.e., reimbursement at 150% of the fee schedule allowance), which accounts for multiple surgery adjustments when bilateral surgical procedures are performed. However, bilateral surgical procedures that are performed in conjunction with other surgical procedures may still be subject to multiple surgery reduction guidelines.

Certain other nonsurgical procedures are not subject to the 150% bilateral payment rule but may still be performed bilaterally. Payment for these procedures is based on 100% of the fee schedule allowance for each side as these are typically nonsurgical in nature and would therefore not be subject to multiple surgery adjustment when performed bilaterally.

Reimbursement consideration for services reported with modifier -50 is contingent upon eligibility, benefits, exclusions, precertification/referral requirements, provider contracts, and applicable policies. Since a code appended with modifier -50 already describes a bilateral service, it is not appropriate to report multiple units in the *units* field on the claim. Claims reporting services with modifier -50 and more than one unit will be denied stating “Multiple units not appropriate with modifier -50.”

We apply the CMS Physician Fee Schedule Database bilateral indicators to services to determine reimbursement consideration. Services with the CMS

Physician Fee Schedule Database bilateral indicators of 0 or 9 should not be reported with modifier -50, as this is inappropriate. When reported with modifier -50, services with an indicator of 0 or 9 will be denied as an invalid procedure code/modifier combination.

Services with the CMS Physician Fee Schedule Database bilateral indicators of 2 should not be reported with modifier -50. These codes, by their terminology description, state that the procedure may be performed unilaterally or bilaterally. The bilateral payment allowance has been precalculated for the code. Services with the CMS Physician Fee Schedule Database bilateral indicators of 1 and 3 are appropriate to be reported with modifier -50.

In addition, please note modifier LT (left side) or RT (right side) is used to indicate on which side of the body a service or procedure is performed. They do not indicate a bilateral service and should not be used to report a service or procedure performed bilaterally.

If a provider bills incorrectly, overpayments may occur. Providers should bill correctly to avoid further overpayments and retractions.

Refer to the September edition of *Partners in Health Update* at [www.ibx.com/pihupdate](http://www.ibx.com/pihupdate) for examples demonstrating the correct and incorrect ways to report services with modifier -50 bilateral indicators.

For more information about modifier -50, please refer to our Claim Payment Policy #03.00.05f: Modifier 50 Bilateral Procedure, available on [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy). If you have any questions, contact your Network Coordinator.

## PROVIDER SATISFACTION SURVEY:

# Deadline Extended

## UNTIL DECEMBER 18

### TAKE OUR SURVEY!

All eligible participants will be entered into a drawing to receive one of 20 gift cards in the amount of \$100.

**GiftCARD**

The deadline for participating in our annual Provider Satisfaction Survey has been extended through Friday, December 18. Simply log on to the NaviNet web portal and click *Provider Satisfaction Survey* located at the bottom of the Plan Transactions menu.

The survey — available to office-based physicians, nurses, billing offices, office managers, and other office staff — is your opportunity to tell us about your experiences with us during the past year. Completion of the survey takes approximately 15 minutes.

*Note: We have contracted with Morpace Inc., an independent research firm, to help conduct our 2009 Provider Satisfaction Survey. Office-based physicians, nurses, billing offices, office managers, and other office staff who would like to participate, but do not have access to NaviNet, can request a paper copy by contacting Morpace at 1-866-786-0343.*

*Please review the [Provider Satisfaction Survey Terms and Conditions](#) for more information regarding the survey, including participation rules and confidentiality.*

Your response will help us evaluate our performance and improve the way we do business with you. We look forward to learning about your experiences with us and hope you will complete our survey.

If you have additional questions regarding the survey, please contact your Network Coordinator.

**NAVINET<sup>®</sup>**

## Change your practice information through the NaviNet web portal



As a reminder, you can submit edits and changes to your basic practice information through the *Provider Change Form* located on NaviNet Plan Central. This form, which is available to professional providers, allows you to quickly and easily submit changes to your practice information maintained by IBC.

Please note that the specific change requests available to you vary depending on your provider type as well as on the lines of business in which you participate.

To submit a change, click *Provider Change Form* from the Plan Transactions menu.

### **Primary care physicians (PCP) can:**

- change office hours, total hours, and phone or fax numbers;
- change selection of capitated providers (for HMO PCPs only);
- add newly credentialed providers or participating providers to participating group (applicable to group practices only);
- add hospital affiliation.

### **Specialists can:**

- change address, office hours, and phone or fax numbers;
- add newly credentialed providers or participating providers to participating group (applicable to group practices only);
- add hospital affiliation.

You should contact NaviNet Customer Care at [1-888-482-8057](tel:1-888-482-8057) for questions on any transaction through NaviNet.

*Note:* This is not applicable to Magellan Behavioral Health, Inc. contracted providers. Please contact Magellan at [1-800-688-1911](tel:1-800-688-1911) for further information.

*Magellan Behavioral Health, Inc. is an independent company contracted by IBC to manage and provide a provider network for behavioral health (mental health/substance abuse) benefits for the majority of benefits plans offered and administered by IBC.*

## New Clinical Alerts are now available

In April, IBC successfully launched Clinical Alerts — the latest in a series of new services that have expanded our prevention and wellness efforts for our members. To date, more than 12,000 of IBC's network physicians received approximately 350,000 Clinical Alerts, averaging more than 13,000 per week.

As a result of the success of Clinical Alerts, we are pleased to announce that we have recently added several new alerts that are now available to primary care physicians, OB/GYNs, endocrinologists, and cardiologists.\* These include:

- One bone mineral density test or drug to treat or prevent osteoporosis (for women over 67 years old or older who have suffered a fracture);
- HbA1C between 7-7.9%;
- HbA1C between 8-8.9%;
- HbA1C greater than 9.0%;
- LDL-C Cholesterol <100 mg/dL for patients with diabetic conditions;
- LDL Cholesterol <100 mg/dL for patients with cardiovascular conditions.

As a reminder, Clinical Alerts are notifications, based on administrative data, that an IBC member has not received a recommended service, medication, or lab value. These alerts are intended to be reviewed by providers in their offices when preparing for upcoming appointments and are intended to assist with identifying opportunities for improving clinical quality.

Clinical Alerts are accessible through the Member Eligibility and Benefits Inquiry screen on the NaviNet web portal.

Our Clinical Alerts Overview document, located in the Administrative Tools and Resources section of NaviNet Plan Central, provides you with all of the information you need to take advantage of this new tool.

*\*Clinical Alerts will be made available to additional specialties over time.*

## Electronic Funds Transfer feature available through the NaviNet web portal



NaviNet offers you the opportunity to receive payments electronically by registering an Electronic Funds Transfer (EFT) account. The EFT account will result in faster payments and reduced administration costs for your office.

Your NaviNet security officer sets the appropriate level of security in order to determine who has the ability to register, view, and update the provider's EFT account information. These settings are accessible through the *User Permissions Manager* button located under the Plan Transactions menu on NaviNet.

Once an account has been registered, payments to your office can begin in less than two weeks.

Detailed information and instructions on how to set up and administer an EFT account can be found through a new downloadable EFT guide available in the Administrative Tools and Resources section of NaviNet Plan Central.

You may also contact NaviNet Customer Care at [1-888-482-8057](tel:1-888-482-8057) for assistance.

*Note:* EFT is not available for capitated payment.



## Member benefits changes and clarifications

**Effective January 1, 2010**, the following member benefits changes and clarifications will be implemented for several programs in Pennsylvania:

**Durable medical equipment** (HMO, Flex HMO, POS, Flex POS, Direct POS, PPO, Flex PPO, HSA-qualified HDHP PPO, Flex HDHP PPO): Language is being clarified to define how durable medical equipment (DME) is repaired and replaced. In addition, the definition of non-reusable DME is being clarified to remove anti-embolism stockings. Anti-embolism stockings are a covered item when pre-authorized as medically necessary.

**PPO member appeals** (PPO, Flex PPO, HSA-qualified HDHP PPO, Flex HDHP PPO): Language is being revised to allow changes to the PPO member appeal process at any time. Information about this process is now available for members at [www.ibxpress.com](http://www.ibxpress.com).

**Precertification changes – medical injectables** (HMO, Flex HMO, POS, Flex POS, Direct POS, PPO, Flex PPO, HSA-qualified HDHP PPO, Flex HDHP PPO): The medical injectable/infusion precertification list is being revised to add the following drugs to the list: Ampligen<sup>®</sup>, Mozobil<sup>™</sup>, and Temodar<sup>®</sup>.

**Varicose vein treatment** (HMO, Flex HMO, POS, Flex POS, Direct POS, PPO, Flex PPO, HSA-qualified HDHP PPO, Flex HDHP PPO): Language is being clarified to state that all varicose vein procedures require precertification in all settings.

*Note: The Specialty Drugs Requiring Precertification document provides a complete list of infusion therapy and injectable drugs that require precertification and is included with this edition of Partners in Health Update and will also be available at [www.ibx.com/providers/preapproval](http://www.ibx.com/providers/preapproval).*

*Note: This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Plan (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified by calling Customer Service.*

## Reminder: Medicare Advantage plan offerings for 2010



We want to remind you of the changes we are making to our Medicare Advantage products effective January 1, 2010. Medicare beneficiaries will continue to receive a diverse array of products and services, and we are committed to working closely with the members and eligible beneficiaries to help them choose a plan that best suits their needs. However, as we have stated in previous editions of *Partners in Health Update*, unprecedented decreases in government reimbursement for Medicare Advantage products have led to our decision not to renew some products for 2010.

The following is a summary of our individual product offerings:\*

Products offered in 2010	Products not renewed in 2010
Keystone 65 Advantage HMO	Keystone 65 Complete
Keystone 65 Preferred HMO	Keystone 65 Value
Personal Choice 65 <sup>SM</sup> PPO – individual product in Bucks and Philadelphia counties only*	Personal Choice 65 <sup>SM</sup> PPO – individual product in Chester, Delaware, and Montgomery counties only*
Security 65 <sup>®</sup> (Medicare supplement)	Select Advantage
Select Option <sup>®</sup> PDP	

\*Group Medicare Advantage products are not affected by these changes. The group product will remain in place in all five counties. All members in the Personal Choice 65 PPO plan may continue to use any provider in the 5-county service area.

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

## Reimbursement information regarding Special Care<sup>SM</sup>

We inadvertently omitted the highlighted reimbursement information below regarding the Special Care product on page 2.1 of the *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers (Hospital Manual)*. This information was contained in the previous version of the *Hospital Manual* and will be added to the next update of the *Hospital Manual* in December.

Product	Alpha prefix
Traditional Blue Cross Hospitalization (Indemnity)	Any of the following prefixes: <ul style="list-style-type: none"> <li>• QCW</li> <li>• QCD</li> <li>• YXD</li> </ul>
Comprehensive Major Medical and CompSelect <sup>®</sup> products	QCT
Major Medical	Supplemental coverage to these prefixes: <ul style="list-style-type: none"> <li>• QCW</li> <li>• QCD</li> <li>• QCS</li> </ul>
Security 65 <sup>®</sup>	QCS or QCW
65 Special	QCW
Special Care <sup>SM*</sup>	QCP prefix and group number 90002 or 90020
Select Advantage	YXP

*\*Special Care is not affiliated with Special Care, Inc., a home health company. Special Care is a limited benefit plan available to individuals and families who are not eligible for Medical Assistance and who do not have access to group health insurance. Claims are reimbursed according to the Hospital's contracted PPO rates.*

## Policy notifications posted as of November 18, 2009

All policies are posted prior to their effective date. Below is a listing of the policy notifications that we have posted to our website as of November 18, 2009.

Policy effective date	Notification title	Notification issue date
December 1, 2009	<b>05.00.29d</b> Automatic External and Wearable Cardioverter Defibrillators	September 2, 2009
December 1, 2009	<b>05.00.58c</b> Home Oxygen Therapy	September 2, 2009
December 1, 2009	<b>11.14.20c</b> Metal-on-Metal Total Hip Resurfacing	September 2, 2009
December 7, 2009	<b>09.00.49</b> Proton Beam Radiation Therapy	November 6, 2009
December 11, 2009	<b>07.13.01e</b> Orthoptic/Pleoptic Training	November 11, 2009
December 30, 2009	<b>11.00.06c</b> Treatment of Obstructive Sleep Apnea (OSA) and Primary Snoring for Adults	October 1, 2009
January 1, 2010	<b>11.00.10f</b> Multiple Surgical Reduction Guidelines	October 2, 2009
January 1, 2010	<b>08.00.79</b> Plerixafor Injection (Mozobil™)	October 2, 2009
January 1, 2010	<b>08.00.80</b> Temozolomide (Temodar®) for Injection	October 2, 2009
January 1, 2010	<b>08.00.78</b> Self-Injectable Drugs	July 22, 2009
January 12, 2010	<b>11.16.01f</b> Septoplasty, Rhinoplasty, and Septorhinoplasty	October 14, 2009
January 26, 2010	<b>07.03.08c</b> Neuropsychological Evaluation/Testing	October 28, 2009
February 10, 2010	<b>05.00.60c</b> Pressure Reducing Support Surfaces	November 12, 2009

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

1. Visit [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).
2. Select *Accept and Go to Medical Policy Online*.
3. Select *Policy Notifications*.

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

## 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 clinical decision support criteria from InterQual<sup>®</sup>, a product of McKesson Corporation, an independent company. 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.

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

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](http://www.mckesson.com).

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 IBC medical director and denied if guidelines are not met. Observation services do not need preapproval but are subject to InterQual criteria for medical necessity, which requires that the treatment and/or procedures includes 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.



## Changes to self-injectable drug coverage effective January 1, 2010

We are changing the way we cover self-injectable drugs in an effort to provide our commercial HMO, POS, Direct POS, and PPO members access to self-injectable drugs in the right setting at the right time for a good value. These changes are part of our evolving approach to managing specialty pharmaceutical benefits.

### Changes for self-injectable drugs

**Effective January 1, 2010**, we will no longer provide benefits for most self-injectable drugs under our medical benefits program. However, HMO, POS, Direct POS, and PPO members who have IBC pharmacy coverage will continue to be covered for self-injectables under their pharmacy benefits. Members who have pharmacy coverage from another carrier should check their benefits to determine whether their prescription drug plan includes coverage for self-injectable drugs.

Please note that the *Specialty Drugs Requiring Precertification* document has been updated to reflect these upcoming changes and is included with this edition of *Partners in Health Update* for your reference. It will also be available on our website at [www.ibx.com/providers/preapproval](http://www.ibx.com/providers/preapproval).

### Self-injectable drugs through our pharmacy benefits program

The self-injectable drugs that are available under our pharmacy benefits program are those that patients typically administer themselves and do not require physician monitoring. A current list of drugs is maintained in our medical policy. Please note that effective January 1, 2010, self-injectable growth hormones will be added to the pharmacy benefits program and require prior authorization.

We will continue to cover the following types of injectables under our medical benefits program at the appropriate level of cost-sharing:

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

### Direct ship option available

We coordinate with our pharmacy benefits manager, FutureScripts, an independent company, to offer the FutureScripts® Direct Ship Specialty Pharmacy Program for members with IBC pharmacy coverage.\* You may use this program to order self-injectable drugs and have them shipped either directly to the member or to your office, and coverage for these self-injectable drugs is provided under the pharmacy benefit. You and your patients can benefit from key features of this program, including:

- free shipping;
- educational information and pharmacists available to answer questions about therapies and possible side effects;
- proactive refill service, providing your patient with a phone call the week before the prescribed refill date to schedule the next delivery.

To enroll a patient in the FutureScripts Direct Ship Specialty Pharmacy Program, call FutureScripts at 1-888-678-7012, option 3, or go to [www.futurescripts.com/priorauthorization](http://www.futurescripts.com/priorauthorization) and download the *Direct Ship Injectable Form*. FutureScripts will coordinate the shipment and delivery of the self-injectables.

If you have any questions about these changes, please call Customer Service at 1-800-ASK-BLUE. You can also refer to the notification for Policy #08.00.78: Self-Injectable Drugs on our website at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

\*Please note that the FutureScripts Direct Ship Specialty Pharmacy Program is available for members who have either medical or pharmacy coverage through IBC. However, as of January 1, 2010, self-injectables through the FutureScripts Direct Ship Specialty Pharmacy Program will **only** be available for members who have pharmacy coverage through IBC. Accessing the FutureScripts Direct Ship Specialty Pharmacy Program under the medical benefit after January 1, 2010, is only for non-self-injectable specialty drugs that are typically administered in a provider's office.

Note: Some members are not affected by the change of coverage of self-injectable drugs to the pharmacy benefit. In addition, some self-funded groups may be transitioning at a later date. This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Plan (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified by calling Customer Service.





## All members must obtain self-injectable Low Molecular Weight Heparin through pharmacy benefit

Currently, Medicare Advantage HMO and PPO members must obtain Low Molecular Weight Heparin (LMWH) through their Part D pharmacy benefit. **Effective January 1, 2010**, commercial managed care members must also obtain LMWH through their pharmacy benefit as this will be excluded under the medical benefit. Home-care visits may be arranged to assist patients with the drug

administration. To request authorization for home-care visits through IBC's Care Management and Coordination Department, call Customer Service at 1-800-ASK-BLUE or submit your request through the NaviNet® web portal.

If you have any questions, contact your Network Coordinator.

## Select Drug Program® Formulary changes



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 most recent changes are listed below.

### Generic additions

These generic drugs recently became available in the marketplace. When these generic drugs became available, we began covering them at the appropriate generic formulary level of cost-sharing:

Generic drug	Brand drug	Formulary chapter	Effective date
bencort lotion kit	Vanoxide®-HC	5. Skin Medications	September 2, 2009
brimonidine tartrate	Alphagan® P	12. Eye Medications	October 9, 2009
clindamycin-benzoyl peroxide gel	BenzaClin®	5. Skin Medications	August 31, 2009
clonidine patch	Catapres-TTS®	4. Heart, Blood Pressure, & Cholesterol	August 19, 2009
fenofibric acid	Fibricor™	4. Heart, Blood Pressure, & Cholesterol	September 26, 2009
lansoprazole 30 mg	Prevacid® 30 mg	8. Stomach, Ulcer, & Bowel Meds	November 12, 2009
levalbuterol inhalation solution	Xopenex® Inhalation Solution	13. Allergy, Cough & Cold, Lung Meds	September 1, 2009
nateglinide	Starlix®	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones	September 10, 2009
tacrolimus	Prograf®	2. Cancer & Organ Transplant Drugs	August 10, 2009
tri-lo-sprintec	Ortho Tri-Cyclen® Lo	11. Female, Hormone, Replacement, Birth Control	July 2, 2009

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## Select Drug Program® Formulary changes (continued)

### Brand additions

These brand drugs are covered at the appropriate brand formulary level of cost-sharing:

*Effective: October 1, 2009*

Brand drug	Formulary chapter
Advair® HFA	13. Allergy, Cough & Cold, Lung Meds
Symbicort®	13. Allergy, Cough & Cold, Lung Meds

### Brand deletions

These brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

*Effective: January 1, 2010*

Brand drug	Generic drug	Formulary chapter
Alphagan® P	brimonidine tartrate	12. Eye Medications
Prevacid®	lansoprazole	8. Stomach, Ulcer, & Bowel Meds
Prograf®	tacrolimus	2. Cancer & Organ Transplant Drugs
Starlix®	nateglinide	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones
Voltaren Ophthalmic®	diclofenac sodium	12. Eye Medications

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

Brand drug	Generic drug	Formulary therapeutic alternative
Noritate®	Not available	metronidazole

There is no generic equivalent available for the above brand drug; however, there is a formulary generic therapeutic alternative drug. This therapeutic alternative drug is available at the appropriate formulary level of cost-sharing.

## Prescription drug changes

For members enrolled in an IBC prescription drug program, there is a drug that will be excluded from coverage because it is available over the counter. Over-the-counter medications are standardly excluded from all IBC prescription drug programs. There will also 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 below.

### Over-the-counter exclusion

This brand drug is no longer covered under the prescription drug benefit because it is available over the counter:

*Effective: November 12, 2009*

Brand drug	Drug chapter
Prevacid® 24HR*	Stomach, Ulcer, & Bowel Medications

\*This drug is equivalent to Prevacid® 15 mg.

### Drugs requiring prior authorization

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

Brand drug	Generic drug	Drug category	Effective date
Edluar™	Not available	Pain, Nervous System, & Psych	July 2, 2009
Effient™	Not available	Heart, Blood Pressure, & Cholesterol	July 17, 2009
Nucynta™	Not available	Pain, Nervous System, & Psych	June 23, 2009
Onglyza™	Not available	Diabetes	August 3, 2009
Onsolis™	Not available	Pain, Nervous System, & Psych	October 5, 2009
Sabril®	Not available	Pain, Nervous System, & Psych	September 3, 2009
Saphris®	Not available	Pain, Nervous System, & Psych	September 2, 2009
Valturna®	Not available	Heart, Blood Pressure, & Cholesterol	September 26, 2009

Prior authorization will be required for the following drugs. Any prior authorization approval already received under IBC's medical program for one of these drugs will be transferred to IBC's prescription drug program:

*Effective: January 1, 2010*

Brand drug	Generic drug	Drug category
Genotropin®	Not available	Hormones
Humatrope®	Not available	Hormones
Norditropin®	Not available	Hormones
Nutropin®	Not available	Hormones
Nutropin AQ®	Not available	Hormones
Omnitrope®	Not available	Hormones
Saizen®	Not available	Hormones
Serostim®	Not available	Hormones
Tev-Tropin®	Not available	Hormones
Zorbtive®	Not available	Hormones

## New weight gain guidelines for pregnancy

It has been nearly two decades since guidelines for how much weight a woman should gain during pregnancy were issued by the Institute of Medicine (IOM). *The Committee to Reexamine IOM Pregnancy Weight Guidelines* has recently developed new guidelines based on several prepregnancy factors.

Weight gain during pregnancy depends on a number of factors including the patient's prepregnancy weight, eating habits, exercise frequency (before and during pregnancy), and the number of babies the patient is carrying. Below are the new weight gain guidelines that can be discussed with your patients. It is important that your patients understand the new weight gain guidelines.

### Weight gain during pregnancy

Gaining too much weight during pregnancy can lead to gestational diabetes, high blood pressure, and other complications. To improve maternal and child health outcomes, women not only should be within a normal body mass index (BMI) range when they conceive, but also should gain within the ranges recommended in the new guidelines. Meeting these challenges means that women will need preconception counseling, which may include plans for weight loss.

There are specific weight gain guidelines for those that are underweight, normal weight, overweight, and obese at the start of pregnancy. According to Armando Hernandez-Rey, M.D., a spokesman for the American College of Obstetricians and Gynecologists (ACOG), women of normal weight should gain between 25 to 35 pounds while pregnant. Those who are underweight should gain more. Those who are overweight or obese when they become pregnant should gain less.

According to *The Committee to Reexamine IOM Pregnancy Weight Guidelines*, teenagers who are pregnant should use the adult BMI categories to determine their weight gain range until more research is done to determine whether special categories are needed for them. Women who are pregnant with twins are given provisional guidelines. Those in the normal BMI category should aim to gain 37-54 pounds; overweight women, 31-50 pounds; and obese women, 25-42 pounds.

The chart below details the specific BMI categories and weight gain ranges.

### New weight gain recommendations for pregnant women

Prepregnancy BMI	BMI* (kg/m <sup>2</sup> ) (WHO)	Total weight gain range (lbs)	Rates of weight gain <sup>†</sup> 2nd and 3rd trimester (mean range in lbs/wk)
Underweight	<18.5	28-40	1 (1-1.3)
Normal weight	18.5-24.9	25-35	1 (0.8-1)
Overweight	25.0-29.9	15-25	0.6 (0.5-0.7)
Obese (includes all classes)	≥30.0	11-20	0.5 (0.4-0.6)

\*To calculate BMI, go to [www.nhlbisupport.com/bmi](http://www.nhlbisupport.com/bmi).

<sup>†</sup>Calculations assume a 0.5-2 kg (1.1-4.4 lbs) weight gain in the first trimester (based on Siega-Riz et al., 1994; Abrams et al., 1995; Carmichael et al., 1997).

## Discontinuation of the Connections<sup>SM</sup> AccordantCare<sup>TM</sup> program for Medicare Advantage members effective January 1, 2010

**Effective January 1, 2010**, the Connections AccordantCare Program offered by IBC will be discontinued for Keystone 65, Personal Choice 65<sup>SM</sup>, and Select Advantage members.

We will be working with our program vendor, Accordant Health Services, an independent company, to seamlessly transition Medicare Advantage members currently participating in the program to our existing case management program, when appropriate. Although we have decided to discontinue the program for the Medicare Advantage population, we feel that the program has *positively affected both providers and members*.

This voluntary program will provide your patients with access to a registered nurse who will work with them, via telephone, to support their individual health care needs. The primary objective of the nurse's role is to offer support through education, guidance, and assistance.

*Note:* This change is only for Medicare Advantage members in Keystone 65, Personal Choice 65, and Select Advantage plans who are currently enrolled in the Connections AccordantCare program.

Members enrolled in the Connections AccordantCare Program are those with any of the following complex, chronic conditions:

- seizure disorders
- rheumatoid arthritis

- Parkinson's disease
- Crohn's disease
- multiple sclerosis
- systemic lupus erythematosus (SLE)
- myasthenia gravis
- sickle cell disease
- chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- cystic fibrosis
- hemophilia
- scleroderma
- polymyositis
- dermatomyositis
- amyotrophic lateral sclerosis (ALS)
- Gaucher disease

If you feel that your Medicare Advantage patients could benefit from case management for any of the above chronic conditions, please call our Care Management and Coordination Department at **1-800-313-8628**.

Please call your Network Coordinator with any questions.

*Accordant Health Services is an independent company that administers certain disease management services for Independence Blue Cross members.*



### Connections<sup>SM</sup> Health Management Program: Supporting your patients, our members



Call the Provider Support Line at **1-866-866-4694** to refer a member for health coaching if the member has any of the following conditions:

- |  |                                |  |
|--|--------------------------------|--|
| ■ asthma                                       | ■ coronary heart disease (CHD) | ■ gastroesophageal reflux disease (GERD) |
| ■ diabetes                                     | ■ migraine                     | ■ medication persistence                 |
| ■ cardiometabolic risk                         | ■ heart failure                | ■ peptic ulcer disease (PUD)             |
| ■ chronic obstructive pulmonary disease (COPD) | ■ hypertension                 |  |

Health Coaches also provide decision support for numerous health-related issues, including chronic pain, weight loss surgery, depression, and breast or prostate cancer.

Connections Health Management Program information is available by visiting [www.ibx.com/providerconnections](http://www.ibx.com/providerconnections).

# IMPORTANT RESOURCES

<b>American Imaging Management (AIM)</b> Call for CT, MRI/MRA, PET, and nuclear cardiology	1-800-ASK-BLUE
<b>Care Management and Coordination</b> Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Healthy Lifestyles <sup>SM</sup> Keys to Wellness	215-567-3570 1-800-313-8628* <a href="http://www.ibx.com/providerkeystowellness">www.ibx.com/providerkeystowellness</a>
<b>Connections<sup>SM</sup> Health Management Program Provider Support Line</b>	1-866-866-4694
<b>Corporate and Financial Investigations Department</b> Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 <a href="http://www.ibx.com/antifraud">www.ibx.com/antifraud</a>
<b>Credentialing</b> Credentialing Hotline	215-988-6534 <a href="http://www.ibx.com/credentials">www.ibx.com/credentials</a>
Credentialing Violation Hotline	215-988-1413
<b>Customer Service</b> (policies/procedures/claims) HMO and PPO	1-800-ASK-BLUE
<b>eBusiness</b> Help Desk	215-241-2305
<b>FutureScripts®</b> Prescription drug authorization Toll-free fax	1-888-678-7012 1-888-671-5285
Direct Ship Specialty Pharmacy Program Fax	1-888-678-7012 215-761-9165
Blood Glucose Meter Hotline	1-888-678-7012
<b>FutureScripts® Secure</b> Medicare Part D	1-888-678-7015
Formulary updates	<a href="http://www.site65.com">www.site65.com</a>
<b>Health Resource Center</b> Healthy Lifestyles <sup>SM</sup>	1-800-ASK-BLUE
Precertification	1-800-ASK-BLUE
<b>Interactive Voice Response system</b> (changing to Provider Automated System)	1-800-ASK-BLUE
<b>NaviNet® Portal Registration</b>	<a href="http://www.ibx.com/navinet">www.ibx.com/navinet</a>
<b>Provider Medical Policy website</b>	<a href="http://www.ibx.com/medpolicy">www.ibx.com/medpolicy</a>
<b>Provider Pharmacy website</b>	<a href="http://www.ibx.com/rx">www.ibx.com/rx</a>
<b>Provider Supply Line</b>	1-800-858-4728

\* Outside 215 area code



Visit our website: [www.ibx.com/providercommunications](http://www.ibx.com/providercommunications)

# Specialty Drugs Requiring Precertification

All listed brand injectables and their generic equivalents require precertification.  
(This list is subject to change.)

## INFUSION THERAPY DRUGS AND MEDICAL INJECTABLE DRUGS

Precertification requirements apply only to members enrolled in all PPO, POS, DPOS, and HMO plans.

### INFUSION THERAPY DRUGS

Aldurazyme®	Eloxatin®
Ampligen® <sup>1</sup>	Erbitux®
Aredia®	Fabrazyme®
Avastin®	Herceptin®
(except for certain ophthalmological conditions)	IVIG
Boniva®	Myozyme®
Ceredase®	Orencia®
Cerezyme®	Remicade®
Elaprase®	rituximab
	Temodar® <sup>1</sup>
	Tysabri®

### MEDICAL INJECTABLE DRUGS

#### BOTULINUM TOXIN AGENTS

Botox®

#### HEMATOPOIETIC AGENTS<sup>1</sup>

Mozobil™<sup>1</sup>

#### HYALURONATE AGENTS

Euflexxa™	Supartz®
Hyalgan®	Synvisc®
Orthovisc®	Synvisc-One™

#### RESPIRATORY AGENTS

Synagis®

## BIOTECH/SPECIALTY INJECTABLE DRUGS

Precertification requirements apply to members enrolled in all Flex products including PPO, POS, DPOS, and HMO Flex Copay and Flex Deductible; Flex High Deductible PPO and HSA-Qualified High Deductible PPO health plans. All biotech speciality injectable drugs listed are subject to applicable cost-sharing.

### BOTULINUM TOXIN AGENTS

Botox®	Myobloc®
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### CENTRAL NERVOUS SYSTEM AGENTS

Vivitrol®

### ENDOCRINE/METABOLIC AGENTS

Eligard®	Thyrogen®
Faslodex®	Trelstar®
Sandostatin LAR®	Vantas®
Somatuline® Depot	Viadur®
Supprelin® LA	Zoladex®

### HEMATOPOIETIC AGENTS

Aranesp®	Neumega®
Epogen®	Neupogen®
Leukine®	Procrit®
Neulasta®	

### HEPATITIS/INTERFERON AGENTS

Alferon N®

### HYALURONATE AGENTS

Euflexxa™	Supartz®
Hyalgan®	Synvisc®
Orthovisc®	Synvisc-One™

### IMMUNOLOGICAL MODIFIERS

Amevive™

### INTRAOCULAR AGENTS

Lucentis®	Vitrasert®
Macugen®	

### RESPIRATORY AGENTS

Synagis®	Xolair®
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<sup>1</sup>Added to the specialty drug list effective 1/1/10.



We're here for you every step of the way. For more information visit [www.ibx.com](http://www.ibx.com)