



Independence
Blue Cross

www.ibx.com

PARTNERS IN HEALTH UPDATE

February 2009

Working Together For Quality Health Care



ICD-10 implementation timeline update

On January 16, 2009, the U.S. Department of Health and Human Services issued two final rules to move to the next generation of HIPAA electronic transaction standards (5010) and International Classification of Diseases (ICD-10). Both of these rules reflect the recommended implementation dates of January 1, 2012 for 5010; and October 1, 2013 for ICD-10.


Please visit our site www.ibx.com/providers/icd_10 frequently for updated information about ICD-10.

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

-  Professional
-  Facility
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ANNOUNCEMENT

Dear Valued Provider:

I am writing to let you know that on January 21, 2009, Independence Blue Cross (IBC) and Highmark announced that we have withdrawn our applications to the Pennsylvania Insurance Department to combine the two companies. We made this decision after it became clear to us that the Insurance Department would not approve it, despite the well-documented advantages of the consolidation.

I'd like to first assure you that we appreciate the valuable partnership we have with the many skilled health care professionals in our network. We will continue to look for ways to work together to benefit patients by improving access to quality, affordable health care coverage. As IBC moves ahead as an independent, financially stable company, we look forward to continuing to work with you to address the critical challenges facing all of us in health care today.

We believe that the proposed combination would have been of great benefit to all of those we serve and to our health care provider partners, and we are disappointed by this outcome. To explain why we felt compelled to make the decision to withdraw our applications from the Insurance Department, please read the joint press release available on our website www.ibx.com.

Going forward, Highmark and IBC will continue to work together under the Blue Cross and the Blue Shield banners, as we have for decades. We will also continue to look for opportunities to collaborate with other Blues, the Pennsylvania Insurance Department, the Governor, the General Assembly, and other key stakeholders in health care to achieve our mission: to improve access to affordable, quality health care and strengthen the wellbeing of the communities we serve.

In closing, I want to reiterate our commitment to you and our partnership in serving our members.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. Chaet', with a long, sweeping horizontal flourish extending to the right.

Douglas L. Chaet
Senior Vice President
Contracting and Provider Networks

Clinical Alerts coming soon to NaviNet



In the coming months, we will introduce Clinical Alerts, which is a clinical practice tool that will provide member-specific information to providers regarding their patients via the *Member Eligibility and Benefits Inquiry* screen on NaviNet. This new feature will initially be available to primary care physicians (PCPs), OB/GYNs, endocrinologists, and cardiologists and will be expanded to include additional specialties over time.

Clinical Alerts are notifications that a member has not received a recommended service or medication based on administrative data. The alerts are intended to assist with identifying opportunities for improving clinical quality and outcomes for our members. They do not — nor are they intended to — replace the provider’s professional, clinical judgment as the member’s treating physician.

When a Clinical Alert has been issued for a member, it will be clearly indicated by a flag in the alert column found on the *Eligibility and Benefits Inquiry* response screen shown below.

Req ID	Member Name	Member ID	Product Name	DOB	Relationship	Status	Begin Date	End Date	Alert	CR-Panel	DOS	
1	DOE, JANE	YXH101010101010	KHP East HMO	01/15/1948	Subscriber	Active	08/01/2001	08/01/2009		Y	05/27/2008	Select

Clinical Alert data contains confidential member protected health information; therefore, security officers are expected to manage access to the Clinical Alerts for all users through the *User and Office Transaction Manager* transaction. We require that security officers attest that they have received permission from the member to view the member’s clinical information *before* viewing the Clinical Alert.

A Clinical Alert is available for this member.

Patient Summary

Patient ID: 101010101010
 Patient Name: Jane Doe
 Patient DOB: 10/15/1956
 Patient Address: 10 Chestnut Street
 Philadelphia, PA 19103
 Patient's Product: KHP East HMO

This Clinical Alert contains confidential member protected health information. Only persons with a business need to know should view this information. The information should be handled in a manner so as to protect it at all times from unauthorized use or access.

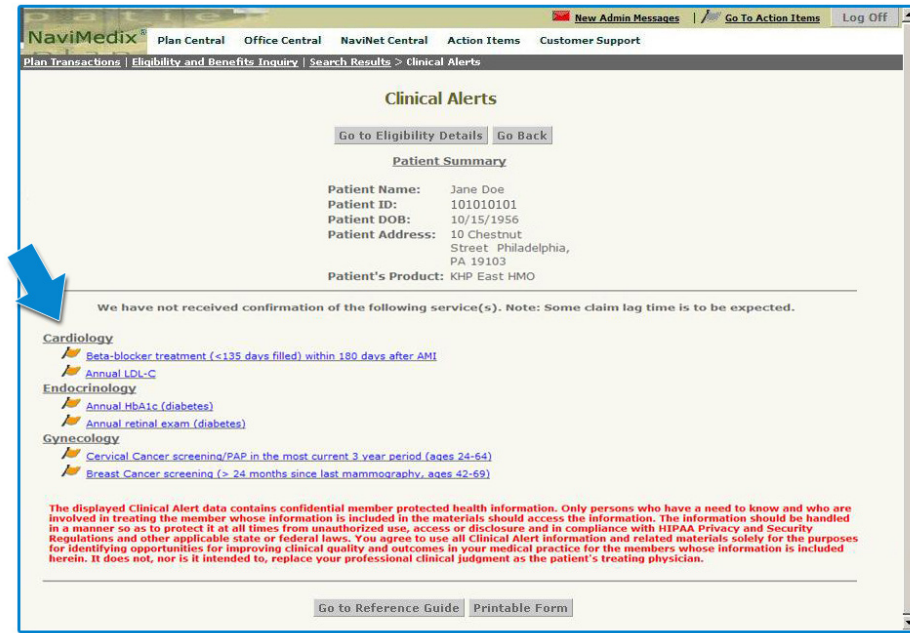
I confirm that I have received permission from this member to review all member protected health information.

continued on page 4

Clinical Alerts coming soon to NaviNet (continued)

Once an attestation has been completed and recorded, simply click on the flag to display the Clinical Alert. Below is an example of a screen demonstrating multiple Clinical Alerts targeted to both PCPs and multiple specialists. Click the alert to display additional information.

Note: PCPs will be able to view all of a member’s Clinical Alerts; however, specialists will be able to view only those alerts relating to their specialty.



Included below are examples of Clinical Alerts that may be displayed when there has been no confirmation that certain services or medications have been provided. *Note:* Some claim lag time should be expected.

Clinical Alerts

- annual LDL-C (cardiovascular condition)
- annual serum potassium for patients on ACE inhibitors or ARBs, digoxins, and/or diuretics
- annual blood urea nitrogen or serum creatinine for patients on ACE inhibitors or ARBs, digoxins, and/or diuretics
- annual serum concentration level for each anticonvulsant drug prescribed
- annual retinal exam (diabetes)
- annual LDL-C (diabetes)
- annual nephropathy testing which includes one of the following: microalbumin test or evidence of ACE/ARB prescription or nephrologist visit (diabetes)
- annual chlamydia screening (sexually active females between the ages of 16-25)
- beta-blocker treatment (at least 135 days filled within 180 days after AMI)
- annual HbA1c (diabetes)
- breast cancer screening/mammography in the most current 2 year period (ages 42-69)
- cervical cancer screening/PAP in the most current 3 year period (ages 24-64)
- colorectal cancer screening, either fecal occult blood test (FOBT, FOBI) annually or flexible sigmoidoscopy every 5 years or double contrast barium enema every 5 years or colonoscopy every 10 years (ages 51-75)

Additional information on Clinical Alerts will be made available in future editions of *Partners in Health Update*.

For assistance with any other transactions through NaviNet, providers should contact NaviNet Customer Care at 1-888-482-8057.

Medicare Advantage Private Fee-for-Service: when a provider is deemed to accept Select Advantage terms and conditions of payment



On January 1, 2008, we launched Select Advantage, a Medicare Advantage Private Fee-for-Service (PFFS) plan. This plan is a non-network and non-managed care product that does not include utilization management or require referrals. However, all services must meet Original Medicare guidelines for coverage and are subject to retrospective review audit.

Providers have the right to decide whether to treat Select Advantage PFFS members on a patient-by-patient and visit-by-visit basis. A decision to treat a specific member does not require the provider to treat other Select Advantage PFFS members.

A provider is considered by law to be *deemed* to have a contract with Select Advantage when all of the following criteria are met:

- The provider is aware, in advance of furnishing health care services, that the patient is a member of Select Advantage. All of our members receive a member ID card that includes the Select Advantage logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling Customer Service at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE), prompt 2 for Provider Services.
- The provider either has a copy of or has reasonable access to our terms and conditions of payment. The terms and conditions are available on our website at www.site65.com. The terms and conditions may also be obtained by calling Customer Service at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE), prompt 2 for Provider Services.
- The provider furnishes covered services to a Select Advantage member.

If all of these conditions are met, the provider is deemed to have agreed to Select Advantage terms and conditions of payment for that member at that visit. *Note:* Providers may decide whether or not to accept Select Advantage terms and conditions of payment each time they see a Select Advantage member. A decision to treat one plan member does not obligate you to treat other Select Advantage members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If a Select Advantage member shows an enrollment card identifying himself/herself as a member of Select Advantage and services are provided to that member, you will be considered a deemed provider. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services.

If you *do not* wish to accept Select Advantage terms and conditions of payment, then you should not furnish services to a Select Advantage member, except for emergency services. If you do provide non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Emergency services that are furnished will be treated as noncontracted services and will be paid at the amounts they would have been paid under Original Medicare.

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

Reminder: Keystone Direct Point-of-Service offers 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 is key to members receiving 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.

The Keystone 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

Retail health clinics offer convenient access to care



We recently introduced an entirely new health care provider option for our Personal Choice® members and for those enrolled in the National BlueCard® PPO plan. As of October 1, 2008, these members have been able to go to any one of the 19 MinuteClinic* retail health care centers in the Greater Philadelphia area and receive professional health services on a walk-in basis.

MinuteClinics are staffed by certified family nurse practitioners trained to diagnose, treat, and write prescriptions for (when clinically appropriate) common illnesses and medical conditions. Local supervising physicians are on call during clinic hours of operation to provide guidance and direction when necessary.

MinuteClinics — open seven days a week — are conveniently located in CVS pharmacy stores, office buildings, and shopping centers. Usual hours of operation are Monday through Friday, 8 a.m. to 8 p.m., and Saturday and Sunday, 10 a.m. to 4 p.m. No appointments are necessary.

You can view a list of MinuteClinic locations by selecting *Find Participating Doctors, Hospitals, and Ancillary Providers* from the “Find a Provider” page on www.ibx.com. Select the *Personal Choice PPO* option, click *Continue*, type “minute” into the *Hospital, Clinic, or Other Medical Facility* field, and then hit enter. The resulting list includes addresses and phone numbers.

Similarly, selecting *Retail Health Clinics* from the “Find a Provider” page on www.ibx.com will provide a quick list of MinuteClinic locations by City and County.

Note: This program does not apply to Keystone HMO or POS members because they have selected primary care practices to coordinate their care.

**MinuteClinic, L.L.C. is a Delaware corporation, accredited by The Joint Commission as a retail health provider licensed to operate retail-based health clinics.*

Policy notifications posted as of January 15, 2009



In order to better inform you, 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 posted to the site as of January 15, 2009.

Policy effective date	Notification title	Notification issue date
February 4, 2009	05.00.01d Pneumatic Compression Therapy Devices	January 5, 2009
February 6, 2009	05.00.39d Ankle-Foot/Knee-Ankle-Foot Orthoses	January 7, 2009
February 6, 2009	11.08.03f Lipectomy and/or Liposuction	January 7, 2009
February 6, 2009	06.02.18d Pharmacogenetics and Metabolite Monitoring Using Azathioprine (AZA)/ 6-Mercaptopurine (6-MP) Therapy	January 7, 2009
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
February 24, 2009	07.03.14d Intraoperative Neurophysiological Monitoring (INM)	November 26, 2008
February 25, 2009	11.14.23 Femoroacetabular Surgery	November 26, 2008
March 1, 2009	00.03.02f Diagnostic Radiology Services Included in Capitation	December 1, 2008
March 1, 2009	00.01.44 Never Events and Preventable Adverse Events	December 10, 2008
March 17, 2009	05.00.35a Foot Orthotics and Other Podiatric Appliances	November 12, 2008
March 17, 2009	05.00.59b Lower Limb Prosthesis	November 12, 2008
March 17, 2009	05.00.11b Therapeutic Shoes and Orthopedic Shoes	November 12, 2008
March 25, 2009	10.01.01f Cardiac Rehabilitation	December 23, 2008
March 25, 2009	05.00.54b Power Wheelchairs (PWCs), Power-Operated Vehicles (POVs), and Push-Rim Activated Power-Assist Devices	December 23, 2008
March 25, 2009	05.00.55c Wheelchair Cushions and Seating	December 23, 2008
March 25, 2009	05.00.67b Wheelchair Options and Accessories	December 23, 2008
April 7, 2009	08.00.62c Abatacept (Orencia®)	January 7, 2009
April 7, 2009	10.06.01c Outpatient Speech Therapy	January 7, 2009
April 7, 2009	11.15.09b Radiofrequency Lesioning of the Spinal Nerves for Chronic Pain	January 7, 2009
April 8, 2009	07.03.05g Adult Sleep Disorder Testing	January 8, 2009
April 8, 2009	09.00.04c Bone Mineral Density (BMD) Testing	January 7, 2009
April 8, 2009	07.03.21d Electromyography (EMG) (Needle and non-Needle) of the Anal or Urethral Sphincter	January 8, 2009
April 8, 2009	05.00.30b Noninvasive Respiratory Assist Devices (RADs): Continuous Positive Airway Pressure (CPAP) Devices and Bi-Level Devices	January 8, 2009

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.

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



In an effort to provide better 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 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 a good value.

Members received their first notification of these changes in January 2009 and may have questions for you. The following 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 should check their coverage to determine whether their prescription drug plan includes coverage for self-injectable drugs.

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 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 under the medical benefits program, such as self-injectable drugs that effectively counteract allergic reactions (e.g., EpiPen®).

If you have any questions about these impending changes, please call [1-800-ASK-BLUE](tel:1-800-ASK-BLUE), prompt 2 for Provider Services.

NDC code submission changes effective January 1, 2009



We want to remind you of some changes to National Drug Code (NDC) submission that went into effect January 1, 2009, as part of our overall approach to managing specialty pharmaceutical benefits.

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

For professional providers: Effective January 1, 2009, claims for all ***unlisted and non-specific*** drug codes (CPT® or HCPCS) require submission of an NDC in the correct format and location. 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. The complete list of unlisted and non-specific codes that require the submission of an NDC can be found in the January 2009 *Partners in Health Update*.

For home infusion providers: Effective January 1, 2009, ***all*** drug claims (not just the ***unlisted and non-specific*** CPT or HCPCS codes listed in the January 2009 *Partners in Health Update*) 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 of 2009, all claims for outpatient services containing the following pharmacy revenue codes ***and an unlisted and/or 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 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.

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.

ConnectionsSM Health Management Programs: supporting our members, your patients



CONNECTIONSSM HEALTH MANAGEMENT PROGRAM

Call the Provider Support Line at [1-866-866-4694](tel:1-866-866-4694) to refer a member for Health Coaching if the member has 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 also provide decision support for numerous health-related issues, such as breast and prostate cancer, weight loss surgery, back pain, and depression.

CONNECTIONSSM ACCORDANTCARETM PROGRAM

Call the Connections AccordantCare Program at [1-866-398-8761](tel:1-866-398-8761) to refer a member if the member has 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](tel:1-800-313-8628) to refer a member with end-stage renal disease on outpatient dialysis.

Connections Health Management Programs information, handouts, and brochures are available by visiting www.ibx.com/providers/resources/connections.html.



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

Partners in Health Update is a publication of the Provider Communications department for the exchange of information and ideas among the IBC provider community. Suggestions are welcome.

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

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

The third-party websites mentioned in this publication are maintained by organizations over which IBC exercises no control, and accordingly, IBC disclaims any responsibility for the content, the accuracy of the information, and/or quality of products or services provided by or advertised in these third-party sites. URLs presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefit plans. Members should refer to their benefit contract for complete details of the terms, limitations, and exclusions of their coverage.

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



IMPORTANT RESOURCES

View our online provider directories on www.ibx.com

American Imaging Management (AIM) Call for CT, MRI/MRA, PET, and Nuclear Cardiology	1-800-ASK-BLUE
CARE MANAGEMENT AND COORDINATION Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Healthy Lifestyles SM Keys to Wellness	215-567-3570 1-800-313-8628*
CONNECTIONSSM HEALTH MANAGEMENT PROGRAMS Connections SM Health Management Program Provider Support Line	1-866-866-4694
Connections SM AccordantCare TM Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/anti-fraud
CREDENTIALING Credentialing Hotline Credentialing Violation Hotline	www.ibx.com/credentials 215-988-6534 215-988-1413
CUSTOMER SERVICE (Policies/Procedures/Claims) HMO and PPO	1-800-ASK-BLUE, prompt 2 for Provider Services
eBUSINESS Help Desk	215-241-2305
FutureScripts® Prescription Drug Authorization Toll Free Fax	1-888-678-7012 1-888-671-5285
Direct Ship Injectable Fax	1-888-678-7012 215-761-9165
Blood Glucose Meter Hotline	1-888-678-7012
FutureScripts® Secure Medicare Part D Formulary updates	1-888-678-7015 www.site65.com
HEALTH RESOURCE CENTER Healthy Lifestyles SM	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

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