Independence Blue Cross

www.ibx.com

Partners in Health UPDATE

March 2009

Working Together For Quality Health Care

Encourage members to receive colorectal cancer screenings

March is Colorectal Cancer Awareness Month, and we urge you to encourage your patients to be screened for colorectal cancer. Your personal recommendation has a tremendous influence on patients' decisions to seek recommended preventive health screenings.

Adherence to the colorectal cancer screening guidelines may lead to improved patient outcomes. To view our plan-adopted guidelines, go to *www.ibx.com/medpolicy* and select *Accept and Go to Medical Policy Online*. Individual clinical decisions should be tailored to specific patient medical and psychosocial needs. The information contained on this website is adapted from national sources and may evolve rapidly. As changes occur, please update your recommendations accordingly.

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 through Customer Service.

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

- Professional
- Facility
- Ancillary

INSIDE THIS ISSUE

Professional Injectable and Vaccine Fee Schedule updates effective April 1, 2009

Effective April 1, 2009, 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. The changes will be available April 1, 2009, on the *Fee Schedule Lookup Tool* through NaviNet®. If you have any questions about the updates, please contact your Network Coordinator.

Important information regarding hospice billing and services

Medicare Advantage HMO and PPO members may elect hospice care outside of their Medicare Advantage HMO and PPO plan under the same eligibility rules as beneficiaries in Original Medicare without disenrolling from their Medicare Advantage HMO or PPO plan. As members of an Independence Blue Cross Medicare Advantage HMO or PPO plan, they will continue to obtain non-Medicare benefits that their individual plan may offer, such as dental and vision.

Claims for services unrelated to the terminal condition

While Original Medicare covers and pays for hospice care for Medicare Advantage HMO and PPO members who have elected hospice, Original Medicare also pays for services unrelated to the terminal condition while the member has elected hospice.

The Medicare Advantage HMO and PPO plan is responsible for covering services unrelated to the terminal condition, but payment is made by Original Medicare. These claims should be submitted directly to the Medicare carrier. We will continue to process claims for non-Medicare benefits that may be offered by the individual plan.

Claims for services after member revokes hospice

Members may revoke hospice election at any time, although Original Medicare will continue to pay claims as if the member were an Original Medicare beneficiary until the first of the next month. Providers may submit claims to us for services provided thereafter.

Additional information can be found in the Medicare *Claims Processing Manual*, Chapter 11 – Processing Hospice Claims: *www.cms.hhs.gov/manuals/downloads/clm104c11.pdf.*

Reminder: billing for Part B vs. Part D home infusion drugs

As you may already know, the Centers for Medicare & Medicaid Services (CMS) mandates that certain drugs infused in the home be covered by the member's Part D pharmacy plan. Since CMS no longer allows us to pay for Part D services through a member's Part B medical plan, you must submit claims for Part D services to the member's Part D pharmacy plan.

When billing infusion drugs for our members, please keep in mind the following guidelines for whether it should be billed under Part B or Part D:

- Bill **Part B** if the drug is administered *with* an infusion pump or an implantable pump.
- Bill **Part D** if the drug is administered *without* an infusion pump (e.g., using an IV push).

We will be running periodic audits of claims submitted for Part B services. If any services are found to be billed incorrectly, we will retract these payments. After the claim has been denied, providers can reach out to members for payment on these services provided or submit a claim to the Part D carrier.

For more information, visit the CMS website at *www.cms.hhs.gov.* If you have any questions, please contact your Network Coordinator.

Diagnostic ultrasound reimbursement

Certain participating specialist types are eligible to provide specific diagnostic ultrasounds to HMO and PPO members. HMO members do not require a referral from their primary care physician for diagnostic ultrasound services provided by the OB/GYN specialists listed below. *Note:* Although these specialists are eligible to provide these services in some service areas, we have an arrangement in which Independence Blue Cross pays the hospital a global payment when the service is provided in the outpatient hospital. In these instances, the physician's statement of remittance will indicate that the physician must seek reimbursement from the hospital.

The eligible procedure code/diagnosis code combinations are as follows:

Reason for ultrasound	Specialists/Place of service	Procedure codes	Diagnosis codes
High-risk pregnancy	Perinatal, maternal fetal medicine (MFM)/office and hospital	76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 76819, 76820, 76821	V23.0-V23.9
Rule out ectopic pregnancy	OB/GYN, reproductive endocrinology and infertility (REI) specialist, and MFM/ office and hospital	76815, 76817, 76830, 76856, 76857	633.00-633.91, 761.0, 761.4, 635.70-635.92, V61.70
Rule out intrauterine pathology	OB/GYN and REI	76831, 58340	As appropriate
First-trimester screening	MFM	76801, 76802 When billed in conjunction with 76813 or 76814	V28.3
Fetal anomalies	MFM	76813, 76814, 76825, 76826, 76827, 76828	As appropriate
Infertility*	Reproductive endocrinologists/office	76830, 76857	256.1, 256.8, 256.9

**Covered benefits may vary by member's benefit plan.*

Outpatient hospital

Additionally, for HMO members, hospitals that are not the member's designated radiology site may perform and be reimbursed for the services listed below. If the hospital is the designated radiology site for the member, the covered services below are included in the capitation payment and no additional payment will be made.

Reason for ultrasound	Place of service	Procedure codes	Diagnosis codes
High-risk pregnancy	Outpatient hospital	76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 76819, 76820, 76821	V23.0-V23.9
Rule out ectopic pregnancy	Outpatient hospital	76815, 76817, 76830, 76856, 76857	633.00-633.91, 761.0, 761.4, 635.70-635.92, V61.70
First-trimester screening	Outpatient hospital	76801, 76802 When billed in conjunction with 76813 or 76814	V28.3

How to bill claims with multiple units

Our processing system contains certain procedure code edits used to appropriately adjudicate claims. One such edit is applied to the units of service at the procedure code level. Each procedure code is assigned a unit value, which represents the number of times a procedure may be performed at a single session or visit. A procedure or service may be provided with three possible unit values:

1. once per session or visit;
2. multiple times per session or visit; or
3. once in a lifetime.

The unit value is assigned based on an assessment of:

- the CPT® and HCPCS Level II code descriptions;
- whether it is clinically appropriate to perform or provide a service once per session or visit, multiple times per session or visit, or once per lifetime;
- limitations or requirements based on our publicly available policies.

If the procedure code description indicates that it is a single-unit service, it is not appropriate to bill more than one unit, and we will limit reimbursement to a single unit.

In a review of our claims data, we have identified instances where codes describing services that were eligible only for single units have been billed with multiple units. We would like to remind providers that, according to our policies, it is incorrect billing to submit claims for multiple units of procedure codes that are eligible only for single units. If, however, a procedure or service that is eligible only for a single unit is provided during a different session or visit on the same date of service, the second occurrence should be billed on a separate claim line with an appropriate modifier describing the circumstance.

Please refer to Claim Payment Policies *03.00.07g Modifier 51: Multiple Procedures* and *03.00.08c Modifier 59: Distinct Procedural Service* for more information on when to use these modifiers to describe these scenarios. These medical policies can be found on our website at *www.ibx.com/medpolicy.*

The Corporate and Financial Investigations Department regularly performs audits for correct billing, which includes the appropriate use of units.

Reminder: submit Coordination of Benefits information electronically

Providers and facilities can 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 a faster payment.

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

BILLING

Correction: laboratory services indicator

In the January 2009 edition of *Partners in Health Update,* we published an article encouraging professional providers to set up accounts with designated laboratory sites to accommodate testing needs, improve record-keeping, promote communication between the laboratory and the physician, and facilitate timely receipt of laboratory supplies.

We also listed participating contracted laboratories for outpatient services and their indicators. These laboratory indicators — located on the front of the member ID card, on NaviNet®, and/or the interactive voice response (IVR) system — *were listed incorrectly in the chart provided.*

Rather than the full name of the laboratory, the indicators are represented on the ID cards by a single letter as shown *in the chart below.*

The correct indicators are also available in the *Provider Manual for Participating Professional Providers* under Laboratory Services in the *Specialty Programs and Laboratory Services* section.

We apologize for any confusion this may have caused. If you have any questions, please contact your Network Coordinator.

Laboratory name	Laboratory Indicator	Phone Number
Abington Memorial Hospital Laboratory	A	215-481-2331
Health Network Laboratories	N	1-877-402-4221
Hospital of the University of Pennsylvania Laboratory*	H	1-800-789-7366
Laboratory Corporation of America	L	1-866-297-3210
Mercy Health Laboratory	M	610-237-4175
Quest Diagnostics, Inc.	Q	1-800-825-7320
SMA Medical Laboratories	F	215-322-6590
Thomas Jefferson University Laboratory*	T	215-955-6545

**Available to specific practices only*

NAVINET®

Clinical Alerts to be introduced on NaviNet

In the second quarter of 2009, we will be introducing Clinical Alerts, a new clinical practice tool designed to help physicians identify patient needs by providing member-specific information. This new tool will initially be available to primary care physicians (PCPs), OB/GYNs, endocrinologists, and cardiologists and will be expanded to include additional specialties over time.

What are Clinical Alerts?

Clinical Alerts are notifications, based on our medical, laboratory, and pharmacy data, that a member has not received a recommended service or medication. They 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.

Clinical Alerts will be available on NaviNet through the *Eligibility and Benefits Inquiry* Screen.

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

As a reminder, providers should contact NaviNet Customer Care at 1-888-482-8057 for assistance with any NaviNet transactions.

Medicare Advantage Private Fee-for-Service: provider qualifications and requirements

On January 1, 2008, we introduced Select Advantage, a Medicare Private Fee-for-Service (PFFS) plan. This Medicare Advantage PFFS plan is a non-network, 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.

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.

In order to be paid by Select Advantage for services provided to one of our members, you must:

- have a National Provider Identifier in order to submit electronic transactions to Select Advantage, in accordance with HIPAA requirements;
- submit paper claims to QCC Insurance Company at the following address:

  Select Advantage Claims
  P.O. Box 69350
  Harrisburg, PA 17110

- submit claims for routine eye exams and eyewear for Davis Vision® providers using the standard Davis Vision process. Claims for non-Davis Vision providers should be submitted on a CMS-approved claim form with CMS-approved CPT® and HCPCS codes to the following address:

  Davis Vision
  Vision Care Processing Unit
  P.O. Box 1525
  Latham, NY 12110

- furnish services to a Select Advantage member within the scope of your licensure or certification;
- provide only services that are covered by our plan and that are medically necessary by Medicare definitions;
- meet applicable Medicare certification requirements (if you are an institutional provider, such as a hospital or skilled nursing facility);
- have not opted out of participation in the Medicare program under §1802b of the Social Security Act, unless providing emergency or urgently needed services;
- not be on the U.S. Department of Health and Human Services Office of Inspector General's excluded and sanctioned provider lists;
- not be a federal health care provider, such as a Veterans' Administration provider, except when providing emergency care;
- comply with all applicable Medicare and other federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members;
- agree to cooperate with Select Advantage to resolve any member grievance involving the provider within the time frame required under federal law;
- provide applicable beneficiary appeals notices if you are a hospital, home health agency, or skilled nursing facility provider;
- not charge the member in excess of cost-sharing under any condition, including plan bankruptcy.

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

BLUECARD®

BlueCard Coordination of Benefits Questionnaire for out-of-area members

In January 2009, we updated the BlueCard Coordination of Benefits (COB) Questionnaire for out-of-area members and streamlined the submission process. Out-of-area members are HMO, Traditional Hospitalization, and PPO members of other Blue Cross® and Blue Shield® plans who travel or live in the Independence Blue Cross (IBC) five-county service area*. This BlueCard COB questionnaire should not be used for local IBC members or Federal Employees Program (FEP) members.

To avoid processing delays in claim payments, the provider or office staff *must* complete the first two fields on the questionnaire, which are the provider name and NPI. The provider or office staff should ask the out-of-area member to complete the remaining sections of the questionnaire before he or she leaves the office.

If the member chooses to complete the form outside of the office, he or she should be instructed to return the completed form to the provider's office. The provider or office staff should *immediately* forward the completed form to:

P.O. Box 69356
Harrisburg, PA 17106-9356

This mailing address is prominently printed on the front page of the questionnaire.

Providers should not delay submission of the BlueCard COB Questionnaire to coordinate with the claim submission. Claims should continue to be sent through your standard submission methods, which are separate from the submission of the BlueCard COB Questionnaire.

The BlueCard COB Questionnaire is available at *www.ibx.com/providers/blue_card/index.html* as well as the *Reference Material and Reports* section on NaviNet®.

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

Note: Do not use the P.O. Box/mailing address on the COB Questionnaire for any other correspondence. Only completed questionnaires for out-of-area members should be sent to this address.

**The five-county service area includes Philadelphia, Bucks, Montgomery, Chester, and Delaware counties.*

MEDICAL

Enhancements made to the provider interactive voice response system

On February 23, 2009, we implemented new enhancements to the provider interactive voice response (IVR) system. The new enhancements allow you to check the status of a previously submitted authorization, cancel an existing authorization, or submit a maternity delivery notification through our speech-enabled IVR system.* These services are directly accessible through Customer Service at 1-800-ASK-BLUE, prompt 2 for Provider Services.

Look for an instructional guide for these new enhancements, which will be posted to our website at *www.ibx.com/providers/ivr* and will be updated periodically as we make further changes in our phased approach towards an all-electronic format for authorization inquiry and authorization submission. We will announce all future enhancements in *Partners in Health Update* as they are implemented.

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

Policy notifications posted as of February 17, 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 February 17, 2009.

Policy effective date	Notification title	Notification issue date
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 6, 2009	07.03.13b Therapeutic Use of Transcranial Magnetic Stimulation	February 4, 2009
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
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:

Visit *www.ibx.com/medpolicy.*

1. Select *Accept and Go to Medical Policy Online*.
2. Select the *Commercial and Other Medicare Advantage policies* link.
3. Select *Policy Notifications* from the Medical Policy column on the left sidebar.

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

MEDICAL

CMS has changed its policy on stamped signatures

We would like to remind you that the Centers for Medicare & Medicaid Services (CMS) stopped accepting physician-stamped signatures on any medical records, including progress notes, orders, and treatment plans. Any documentation signed using a signature stamp is considered null and void. CMS only accepts written or electronic signatures or facsimiles of written or electronic signatures. This policy applies to all providers and suppliers.

As stated in the *MLN Matters* article[1] that announced the change, CMS's decision to no longer accept stamped signatures was in response to "problems of noncompliance with existing statutes, regulations, rules, and other systemic problems relating to standards of practice for a valid physician's signature on medical orders and related medical documents."

[1] *www.cms.hhs.gov/MLNMattersArticles/downloads/SE0829.pdf*

PHARMACY

Updating Safe Prescribing Procedures to include narcotics

While our existing pharmacy policies require a prior authorization and/or quantity limits for some narcotics, many narcotics do not have the necessary controls in place to prevent inappropriate use, abuse, or fraud. An ongoing review of narcotic utilization identified members who have filled multiple prescriptions for similar narcotics, have received excessive quantities per prescription, and have been prescribed narcotics to treat conditions not indicated by the label.

In order to address these issues, we have updated our Safe Prescribing Procedures to include guidelines for narcotics management. These updates will focus on the quality concerns associated with excessive or improper narcotics use, including an increased risk of dependence and the insufficient treatment of underlying conditions. We expect that these changes will significantly reduce medical costs associated with drug diversion (illegal trafficking of prescription drugs), overutilization, and off-label use, particularly for high-cost narcotics.

Changes to the narcotics prescribing procedures specifically focus on the following issues:

- **Expiration of Prior Authorizations.** We are implementing a time limit of 6 to 12 months on Prior Authorization approvals for narcotic drugs. Newly approved Prior Authorizations will include an expiration date at the time the approval is made. If you want your patient to continue the drug therapy after the expiration date, you will need to make a new request. Existing Prior Authorizations for narcotic drugs will expire on May 1, 2009.
- **New quantity limits.** We are adding quantity limits to certain narcotics. If you prescribe a prescription that exceeds the set quantity limit, your patient's pharmacist will fill the prescription only for the allowed supply. If you determine that your patient's therapy requires a larger dose of medication than the set quantity limit for that drug, you must request a Quantity Limit Exception.
- **Therapeutic drug class quantity limit.** We are applying a 30-day total quantity limit to each class of narcotic drugs. If you prescribe a patient more than one narcotic within the same class, or if the same drug is being taken in more than one strength, your patient may be receiving duplicate medications. Your patients will only be able to obtain a 30-day total supply of any combination of drugs in the same class each month. If you recommend drug therapy that exceeds the class quantity limits, you must submit a request for a Class Quantity Exception.
- **Expiration of Quantity Limit Exceptions.** If a Quantity Limit Exception is approved, it will be limited to 6 to 12 months. Newly approved Quantity Limit Exceptions will include an expiration date at the time the approval is made. If you want your patient to continue the drug therapy after the expiration date, you must make a new request.

Changes in narcotics prescribing for all commercial plans will go into effect May 1, 2009. This implementation will not include members of Independence Administrators. More information regarding these changes in narcotics management has been provided directly to affected providers and members.

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
acetazolamide ER	Diamox Sequels®	12. Eye Medications	December 12, 2008
calcitonin-salmon 200 units spray	Miacalcin®	10. Bones, Joints, & Muscles	December 12, 2008
didanosine 125mg DR	Videx® EC 125mg	1. Antibiotics & Other Drugs Used for Infection	November 26, 2008
dorzolamide HCL 2%	Trusopt®	12. Eye Medications	October 29, 2008
dorzolamide-timolol	Cosopt®	12. Eye Medications	October 29, 2008
levetiracetam	Keppra®	3. Pain, Nervous System, & Psych	November 7, 2008
stavudine	Zerit®	1. Antibiotics & Other Drugs Used for Infection	December 31, 2008
sumatriptan injection	Imitrex® Injection	3. Pain, Nervous System, & Psych	November 7, 2008
sumatriptan nasal spray	Imitrex® Nasal Spray	3. Pain, Nervous System, & Psych	December 19, 2008
sumatriptan tablets	Imitrex® Tablets	3. Pain, Nervous System, & Psych	November 26, 2008
tobramycin-dexamethasone	Tobradex®	12. Eye Medications	November 7, 2008

Brand Deletions

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

Brand Drug	Generic Drug	Formulary Chapter
Cosopt®	dorzolamide-timolol eye drops	12. Eye Medications
Diamox Sequels®	acetazolamide ER	12. Eye Medications
Imitrex® Injection	sumatriptan injection	3. Pain, Nervous System, & Psych
Imitrex® Nasal Spray	sumatriptan nasal spray	3. Pain, Nervous System, & Psych
Imitrex® Tablets	sumatriptan tablets	3. Pain, Nervous System, & Psych
Miacalcin®	calcitonin-salmon 200 units spray	10. Bones, Joints, & Muscles
Tobradex®	tobramycin-dexamethasone	12. Eye Medications
Trusopt®	dorzolamide HCL 2%	12. Eye Medications
Videx® EC 125mg	didanosine 125mg DR	1. Antibiotics & Other Drugs Used for Infection
Zerit®	stavudine	1. Antibiotics & Other Drugs Used for Infection

The generic drugs for the above brand drugs 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 and quantity limits. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. Quantity level limits are designed to allow a sufficient supply of medication based on FDA-approved maximum daily doses and length of therapy of a particular drug. These updates are reflected below.

Drugs Requiring Prior Authorization

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

Brand Drug	Generic Drug	Drug Category	Effective Date
PrandiMet™	not available	Diabetes	December 31, 2008
Trilipix™	not available	Cholesterol	January 2, 2009

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 April 1, 2009

Generic Drug	Brand Drug	Drug Category
Keppra XR™	not available	Pain & Nervous System
Requip® XL™	not available	Pain & Nervous System
Voltaren® Gel	not available	Pain & Nervous System

Drugs with Quantity Limits

Quantity limits will be added for the following narcotic drugs.

Effective May 1, 2009

Brand Drug	Generic Drug	Quantity Limit (per 30 days)
Darvocet-N®	propoxyphene/acetaminophen	180 tablets
Darvon®	propoxyphene 65mg	180 tablets
Darvon N® 100	not available	180 tablets
Demerol® Syrup	meperidine 50mg/5ml syrup	2000ml
Dilaudid® Liquid	hydromorphone 1mg/ml liquid	1500ml
ETH-Oxydose™, OxyFAST®, Roxicodone Intensol®	oxycodone 20mg/ml liquid	180ml
Fioricet® w/codeine	codeine/butalbital/acetaminophen/caffeine 30mg/50mg/325mg/40mg	180 capsules
Fiorinal®	butalbital/aspirin/caffeine 50mg/325mg/40mg	180 capsules
Fiorinal® w/codeine	codeine/butalbital/aspirin/caffeine 30mg/50mg/325mg/40mg	180 capsules
Hycet® Oral Solution	hydrocodone/acetaminophen oral solution 7.5mg/325mg/15ml	2700ml
Ibudone™, Vicoprofen®	hydrocodone/ibuprofen	150 tablets
Lortab® Elixir	hydrocodone/acetaminophen 7.5mg/500mg/15ml elixir	2700ml

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Prescription drug updates (continued)

Brand Drug	Generic Drug	Quantity Limit (per 30 days)
Lortab®, Norco®, Vicodin®	hydrocodone/acetaminophen (acetaminophen less than 750mg)	180 tablets
Maxidone®, Vicodin ES®	hydrocodone/acetaminophen 7.5mg/750mg and 10mg/750mg	150 tablets
MSIR® Oral Solution	morphine 10mg/5ml and 20mg/5ml oral solution	1000ml
Roxanol™ Oral Solution	morphine 20mg/1ml, 10mg/0.5ml, 5mg/0.25ml oral solution	180ml
Roxicet™ Oral Solution	not available	1000ml
Roxicodone® Oral Solution	oxycodone 5mg/5ml oral solution	2700ml
Tylenol® w/codeine	acetaminophen/codeine	180 tablets
Tylenol® with codeine elixir	acetaminophen/codeine elixir	2700ml
Zamicet™ Oral Solution	hydrocodone/acetaminophen 10mg/325mg/15ml oral solution	2700ml
not available	aspirin/codeine	180 tablets
not available	hydrocodone/acetaminophen 10mg/500mg/15ml oral solution	2700ml
not available	hydrocodone/acetaminophen 2.5mg/167mg/5ml oral solution	2700ml
not available	hydrocodone/acetaminophen 5mg/333mg/10ml oral solution	1800ml

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 HMO, POS, or PPO members have Independence Blue Cross pharmacy coverage, their self-injectable drugs will continue to be covered under their 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, prompt 2 for Provider Services.

Reminder: NDC code submission changes effective January 1, 2009

We want to remind you of some changes to the 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 and resubmission. Please note that this requirement applies to all claims received after January 1, 2009, and is not based on date of service.

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: Scheduled for future release in 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.

Disease management support through the Connections℠ Health Management Program

The Connections Health Management Program provides disease management and decision support to eligible Independence Blue Cross (IBC) members 24 hours a day, 7 days a week. Information and support are provided through online resources available at *www.ibxpress.com* and through Health Coaches, who are nurses, dietitians, and other health professionals.

The Connections Program is offered as a resource to help you and your patients to better manage conditions like asthma, coronary heart disease, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, migraines, hypertension, gastroesophageal reflux disease (GERD), and peptic ulcer disease (PUD). However, the program isn't just for those with a chronic condition. Any member in need of additional support or information on any health topic can benefit from the resources provided through the Connections Program. Members can speak to a Health Coach once or can arrange for regular follow-up calls.

To refer a patient for Health Coaching, complete the Connections Physician Referral Form and fax it to the Connections Health Management Program at 1-800-276-3075. The form is available at *www.ibx.com/providers/resources/connections.html* or by calling the Provider Support Line at 1-866-866-4694. You can also call the Provider Support Line to make a patient referral. Members can call 1-800-ASK-BLUE to speak with a Health Coach directly 24 hours a day, 7 days a week.

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

Note: Additional copies of the referral form or referral pads can be obtained by calling the Provider Support Line at 1-866-866-4694.

The Connections Health Management Program is available to most members. Members should call Customer Service at 1-800-ASK-BLUE, prompt 1, to find out if they are eligible.

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 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.

Connections℠ AccordantCare™ Program

Call the Connections AccordantCare Program at 1-866-398-8761 to refer a member 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 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 65℠ 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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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℠ 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 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℠	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*