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This just in....



Provider Services user guide now available

We have posted a guide to our website that contains step-by-step instructions on how to use all of the menu prompts available through Provider Services, including transactions in the Provider Automated System and authorization/precertification prompts. This instruction guide is available at www.ibx.com/providerautomatedsystem.

Partners in Health UpdateSM 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.

Contact Information:

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

John Shermer
Managing Editor

Charleen Baselice
Production Coordinator

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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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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.



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

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

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

Additional HMO/PPO Flex products requiring precertification for comprehensive outpatient pain management

In the December 2009 edition of *Partners in Health Update*, we communicated that **effective January 1, 2010**, precertification is required for comprehensive outpatient pain management for all HMO/PPO Flex products. As a result of the annual American Medical Association code update, the following codes will also require precertification effective January 1, 2010:

- 64490 ● 64493 ● 0213T ● 0216T
- 64491 ● 64494 ● 0214T ● 0217T
- 64492 ● 64495 ● 0215T ● 0218T

Additionally, **effective February 1, 2010**, the following two codes will require precertification:

- 62310 ● 62311

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

Changes to CMS compliance training for 2010



In accordance with a requirement from the Centers for Medicare & Medicaid Services (CMS), all network providers and their staff who treat our Medicare Advantage members must complete annual Medicare Advantage and Part D compliance training in an effort to combat fraud, waste, and abuse.

Completing the training requirement

To complete this required training, visit www.ibx.com/compliancetraining. There, you will find training materials that you can download and review. To confirm that you have completed the training, you will also need to provide your electronic signature using the Compliance Certification Form.

Please note that the Compliance Certification Form has been enhanced. To provide an electronic signature for completion of your 2010 CMS compliance training, follow these steps:

1. Click on the *Compliance Certification Form* link on www.ibx.com/compliancetraining.
2. Enter your corporate ID number or tax ID number, and click *Find*.
3. If the number of practices exceeds 25, you will have the option of narrowing your search by using your NPI. Please follow the prompts.

4. Choose whether you are attesting for all applicable practices under the corporate ID number or tax ID number you entered or if you'd like to select particular practices. Click *Continue*. (If you chose to attest for select practices, check off those for which you wish to attest. Then select *Continue*.)
5. Complete the required fields on the form and click *Submit*. Print and keep the confirmation screen for your records.

We recognize that other organizations may also require you to complete this annual training. If you complete the CMS compliance training for 2010 through another organization, we need your electronic signature for confirmation — go to www.ibx.com/compliancetraining and follow the steps previously listed to provide your signature.

If you do not have access to the Internet, call the Provider Supply Line at 1-800-858-4728 for a paper copy of the training materials and/or Compliance Certification Form. Please note that you will be responsible for mailing or faxing the form to us by December 31, 2010, in order to fulfill your training requirement.

If you have questions about this required training, please contact your Network Coordinator.

Call 1-800-ASK-BLUE: One number for all of your needs

P F A

Our toll-free number, **1-800-ASK-BLUE**, is a convenient way to access the following services:

- Provider Services
- Provider Automated System
- ConnectionsSM Health Management Programs
- Authorization/Precertification*

Please use **1-800-ASK-BLUE** for all of your needs. The former telephone numbers for the services listed above will eventually be disconnected.

*For behavioral health services, providers should still call the number listed on the back of the member's ID card under mental health/substance abuse.



BILLING

Revenue codes that require a HCPCS/CPT[®] code

F

Effective January 1, 2010, certain revenue codes require a HCPCS/CPT code. For a complete list of these revenue codes, please refer to Bulletin #14-09: Revenue codes that require a HCPCS/CPT code, which is available on our website at 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 a message that says, "HCPCS procedure code/CPT code required for revenue code is missing."

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

Billing for office-based services

P F

If an office-based service (e.g., an office visit or outpatient consultation) is performed by a professional provider in an office-based setting within a facility or on a facility campus, the facility is not eligible for reimbursement and should not bill for the service. Only the professional provider is eligible for reimbursement for the service provided to the member. The facility is not eligible to receive reimbursement for a room charge even though a professional provider office may be located within the facility.

If you have any questions about these billing practices, please call Customer Service at **1-800-ASK-BLUE**. You can also refer to the notification for Policy #00.10.39: Billing for Professional Office-Based Services Performed in an Outpatient Office-Based Setting Located within a Facility or on a Facility Campus, which will be available on our website at www.ibx.com/medpolicy.

Change in claims submission process for FEP members with Medicare/Medicaid and IBC coverage

Through the Medicare Crossover process, we now accept Federal Employee Program (FEP) facility claims electronically for members with Medicare/Medicaid and IBC coverage from Group Health Incorporated (GHI) and the Centers for Medicare & Medicaid Services (CMS). Previously, we accepted only Security 65® Supplemental claims through the Medicare Crossover process.

GHI and CMS process and adjudicate the primary benefit for FEP facility claims for members with FEP Medicare/Medicaid and IBC coverage and “cross over” these claims to us by an electronic file submission for secondary

processing and adjudication. We process and adjudicate the claims according to the IBC benefits plan (secondary coverage).

We implemented this change to improve the timeliness and accuracy of claims processing. Please do not send FEP Medicare/Medicaid secondary claims (IBC coverage) directly to us through paper or electronic submissions.

If you have any questions about this change, please contact your Network Coordinator.

Process for requesting claims adjustments and/or retractions

We would like to remind facility and ancillary providers that requests to retract a claim payment or to adjust a previously processed claim should be submitted through INFO.

In an effort to retract previously paid claims, some facility and ancillary providers have submitted new claims electronically with a “Frequency 8” value in the third position of the UB-04 claim form. While we recognize

that this is a valid HIPAA transaction, we ask that you submit all requests for claims adjustment and retraction through the established INFO process to assure accurate processing that is consistent with the terms of your provider contract.

If you have any questions about this process, please contact your Network Coordinator.

Updated UB-04 claim form and instructions available

The data field requirements on the UB-04 claim form, also known as the CMS-1450 form, have been revised for institutional providers.

The revised data field requirements and sample forms are available at www.ibx.com/claims.

Please use this updated information as a reference guide for accurately submitting electronic claims.

Field position UB-04	Description	Inpatient	Outpatient
7	Provider Name and Address	Required	Required
2a	Parent Control Number	Required	Required
2b	Medicare Request Number	Required	Required
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Coverd Period	Required	Required
7	Future Use	Required	Required
8a	Patient ID	Required	Required
8b	Patient Address	Required	Required
9	Patient Birthdate	Required	Required
10	Patient Sex	Required	Required, if applicable
11	Admission Date	Required	Required, if applicable
12	Admission Hour	Required	Required, if applicable
13	Admission Day	Required	Required, if applicable
14	Type of Admission/Visit	Required	Required
15	Discharge Date	Required	Required
16	Discharge Hour	Required	Required
17	Discharge Day	Required	Required
18-20	Procedure Code	Required, if applicable	Required, if applicable
21	Accident Status	Required	Required
22	Future Use	Required, if applicable	Required, if applicable
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable
35-36	Future Use	Required, if applicable	Required, if applicable
37	Responsible Party Name and Address	Required, if applicable	Required, if applicable
38-41	Revenue Code and Amount	Required	Required
42	Revenue Code	Required	Required
43	Revenue Code Description	Required, if applicable	Required, if applicable

Implementation of HIPAA 5010 standards

Beginning January 1, 2012, certain health care providers (as well as health plans and health care clearinghouses) will be required to adopt the new Health Insurance Portability and Accountability Act (HIPAA) 5010 standards in order to submit and receive select electronic transactions.

These transactions include claims (837P, 837I, 837D), remittances (835, online SORs), eligibility requests (270/271), claims status requests and responses (276/277), and others (such as the 278 and 834 transactions), and they affect *all physicians, providers, and suppliers who bill Medicare carriers, durable medical equipment (DME) providers that bill for services provided to Medicare beneficiaries, Medicare administrative contractors, and fiscal intermediaries.*

What your office can do

The adoption of HIPAA 5010 will require changes in the content of the data that you submit with your claims, as well as the data that is available to you in response to your electronic inquiries. These changes will require modifications to the software and systems that you use for billing IBC, Medicare, and other payers. It is extremely important that you are aware of these upcoming HIPAA changes.

In preparing for the implementation, **we encourage you to start a dialogue with the vendors and clearinghouses that support your business.** Specifically, you may want to ask about their plans for adopting these standards.

Why HIPAA 5010?

The current versions of the standards (the Accredited Standards Committee X12 Version 4010/4010A1 for health care transactions) do not fully support transactions submitted electronically. This is addressed with version 5010.

The new standards improve structural, front-matter, technical, and data content and expand the data that is collected and transmitted in typical transactions. Version 5010 also addresses new business needs by accommodating the use of the forthcoming ICD-10 code sets (which are not supported by Version 4010/4010A1). For example, the new claims transaction standards contain improvements for the reporting of clinical data, enabling the reporting of ICD-10 diagnosis and procedure codes.

While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Please be aware that we will reject claims submitted with ICD-10 codes *prior to* the ICD-10 compliance date.

Important dates

Effective January 1, 2012, you must submit your claims using the X12 Version 5010. However, there are two additional important deadlines to remember for specific levels of compliance:

- The Level 1 compliance deadline is December 31, 2010. This requires that payers (IBC) internally modify and test their systems and applications to ensure they meet the HIPAA 5010 standards.
- The Level 2 compliance deadline is December 31, 2011. This requires that providers, clearinghouses, and payers complete and test all HIPAA 5010 transactions and prepare to accept and transmit HIPAA 5010 transactions.

HIPAA standards, including the X12 Version 5010, are national and apply to your transactions with all payers, not just with IBC. The expectation is that the health care industry will be fully HIPAA 5010-compliant on January 1, 2012. Therefore, you must be prepared to implement these transactions with any payer with whom you do business. This means that IBC expects to receive HIPAA 5010-compliant transactions and will *transmit* HIPAA 5010 responses beginning January 1, 2012.

Please look for additional articles on HIPAA 5010 in upcoming editions of *Partners in Health Update*. If you have any questions about these changes, please contact your Network Coordinator.*

*Behavioral health providers contracted with Magellan Behavioral Health, Inc. should contact their Magellan Network Coordinator.

Policy notifications posted as of December 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 December 18, 2009.

Policy effective date	Notification title	Notification issue date
January 1, 2010	11.00.10f Multiple Surgical Reduction Guidelines	October 2, 2009
January 1, 2010	08.00.79 Plerixafor Injection (Mozobil™)	October 2, 2009
January 1, 2010	08.00.80 Temozolomide (Temodar®) for Injection	October 2, 2009
January 1, 2010	08.00.78 Self-Injectable Drugs	July 22, 2009
January 1, 2010	07.03.05h Adult Sleep Disorder Testing	November 23, 2009
January 6, 2010	05.00.24g Interstitial Continuous Glucose Monitoring Systems (CGMS)	December 6, 2009
January 8, 2010	05.00.05e Equipment, Supplies, and Pharmaceuticals for the Treatment of Diabetes	December 9, 2009
January 8, 2010	00.01.45 Intravenous (IV) Administration of Fluids as a Treatment of a Medical Condition or for the Preparation of Pharmaceuticals, Biologics, and other Substances	December 9, 2009
January 8, 2010	05.00.12c Manual Wheelchairs	December 9, 2009
January 8, 2010	05.00.30c Noninvasive Respiratory Assist Devices (RADs): Continuous Positive Airway Pressure (CPAP) Devices and Bi-Level Devices	December 9, 2009
January 8, 2010	08.00.65d Pamidronate Disodium (Aredia®) for Intravenous Infusion	December 9, 2009
January 12, 2010	11.16.01f Septoplasty, Rhinoplasty, and Septorhinoplasty	October 14, 2009
January 26, 2010	07.03.08c Neuropsychological Evaluation/Testing	October 28, 2009
February 10, 2010	05.00.60c Pressure Reducing Support Surfaces	November 12, 2009
February 23, 2010	06.03.044 Apheresis Therapy	November 25, 2009
February 23, 2010	11.05.02e Blepharoplasty with or without Repair of Blepharoptosis and/or Repair of Brow Ptosis	November 25, 2009
February 23, 2010	10.00.02 Day Rehabilitation	November 25, 2009
February 23, 2010	11.08.04e Selective Photothermolysis Using Pulsed-Dye Lasers (PDL)	November 25, 2009
March 9, 2010	05.00.54d Power Wheelchairs (PWCs), Power-Operated Vehicles (POVs), and Push-Rim Activated Power-Assist Devices	December 9, 2009

To access these notifications and then 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 *Policy Notifications*.

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



Guidelines for spinal surgical procedure requests

Effective February 1, 2010, we will review all requests for spinal surgical procedures according to InterQual® Care Planning Procedure guidelines. Requests for the following procedures will require submission of clinical justification prior to approval:

- discectomy, anterior cervical, +/- fusion
- discectomy, lumbar
- fusion, cervical spine
- fusion, lumbar spine
- fusion, thoracic spine
- hemilaminectomy, cervical, +/- discectomy/foraminotomy

- hemilaminectomy, lumbar, +/- discectomy/foraminotomy
- laminectomy, cervical, +/- discectomy/foraminotomy/fusion
- laminectomy, lumbar, +/- discectomy/foraminotomy/fusion

Information required to complete reviews will include diagnostic, clinical, historical, and radiologic findings. Specific InterQual guidelines will be provided upon request by calling Kimber Nettles in our Care Management and Coordination department at 215-241-3417.

Medicare Advantage HMO and PPO members must receive notice of noncovered/excluded services and member payment responsibility



As a reminder, we communicated in the January 2009 edition of *Partners in Health Update* that providers must furnish Keystone 65 HMO and Personal Choice 65SM PPO members with written notice that noncovered/excluded services are not covered and that the member will be responsible for payment before services are provided. Examples of noncovered/excluded services include, but are not limited to:

- comfort and convenience items (e.g., a totally electric hospital bed);
- equipment inappropriate for home use (e.g., a standing frame system);
- wheelchair van transportation and equipment that is not primarily medical in nature, such as some power wheelchair accessories (e.g., power seat elevation system, power standing feature, and remote operation);
- equipment with features of a medical nature that are not required by the individual's condition (e.g., a water-circulating cold pad with pump);
- cosmetic surgery, non-elastic binders, and gradient compression stockings (HCPCS codes A6530 and A6533-A6549).

This requirement for written notification of noncovered/excluded services and payment responsibility is contained in Section 2.10 of the *Professional Group Provider Agreement* (or 2.9 of the *Professional Provider Agreement*), which explains that in the event the Provider

provides Excluded services to the Beneficiary, the Provider must inform the Beneficiary in advance in writing: (i) of the service(s) to be provided; (ii) that Independence [Blue Cross] will not pay for or be financially liable for said services; and (iii) that the Member will be financially liable for such services.

If the provider does not give written notice of noncovered/excluded services to the member, then he or she is required to hold the member harmless.

For your convenience, the approved form of the Centers for Medicare & Medicaid Services, *Notice of Denial of Medical Coverage*, is included with this edition of *Partners in Health Update* and may be used when the member requests services that are not covered because they are not Medicare-covered benefits. This easy-to-use form requires the provider to list the item or service that is not covered and the reason for the noncoverage decision. Generally, the reason for noncoverage should be that Medicare does not cover the item or service. A copy of the form should be given to the member, and another copy should be made part of his or her medical record. The form also provides the member with appeal rights.

Please visit www.ibx.com/medpolicy for more information about noncovered services. You may also call Customer Service at 1-800-ASK-BLUE or contact your Network Coordinator.



New credentialing procedure*

As of January 1, 2010, IBC will require 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.

*CAQH is also available to Magellan Behavioral Health, Inc. providers but is not mandatory.

PRODUCTS



Reminder: Medicare Advantage HMO and PPO plan offerings for 2010

As we announced in 2009, IBC has made some changes to the Medicare Advantage HMO and PPO products it offers. These changes went into effect January 1, 2010, due to unprecedented decreases in government reimbursement for Medicare Advantage products.

Our individual Medicare Advantage products for 2010 include:

- Keystone 65 Advantage HMO
- Keystone 65 Preferred HMO

- Personal Choice 65SM PPO — individual product in Bucks and Philadelphia counties only*
- Security 65[®] (Medicare supplement)
- Select Option[®] PDP

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

*Group Medicare Advantage products are not impacted 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.

QUALITY MANAGEMENT



Making quality measure results available to members

Each year we mail quality and efficiency reports to professional providers in three specialty areas: cardiology, endocrinology, and obstetrics and gynecology. The quality measure results within each report are determined by using national standards that are endorsed or recommended by one or more of the following organizations:

- National Committee for Quality Assurance
- American Medical Association
- Ambulatory Care Quality Alliance
- National Quality Forum

The efficiency ratings in each report are derived from the Thomson Reuters Medical Episode Grouper[®].

As part of our transparency effort — to make more information available to our members — some or all of the quality measure results from the specialty reports may be made publicly available in the future. If we decide to move ahead with this transparency effort, the public information would be based initially on data from the 2010 calendar year. Please note that specialists who receive a report will have the opportunity to provide additional information about their 2010 quality measure results before they are made available to members.

We will provide additional details about this effort in future editions of *Partners in Health Update*.

Winter 2009 edition of *Inside IPP* now available

Inside IPP: An Inter-Plan Programs Publication is intended to increase provider awareness of and satisfaction with the BlueCard Program. The publication introduces new initiatives related to BlueCard processing and highlights plans for improvement.

The winter 2009 edition of *Inside IPP* is now available and features the following articles:

- *Precertification/preauthorization required for diagnostic imaging services*
- *Eligibility, benefits verification, and claims processing tips*
- *Blue Distinction® designation for delivering quality health care*
- *Factors determining pre-existing medical condition exclusions*
- *Requesting medical records provides resolution in BlueCard® claims issues*
- *Inter-Plan escalation process assists with timely and efficient resolution of BlueCard® claims*

Visit www.ibx.com/insideipp, where you can read the latest edition of *Inside IPP* as well as find a complete archive of past editions. Paper copies of *Inside IPP* are available through the Provider Supply Line upon request.



SMART® Registry release for January 2010

The next release of the SMART Registry will be mailed to our providers in January 2010. The SMART Registry provides information to doctors about their Connections-eligible patients who have any of the following chronic conditions: asthma, diabetes, heart failure, coronary heart disease, or chronic obstructive pulmonary disease.

As with the June 2009 release, SMART Registry CDs include a security measure to protect our member's health information. Practices with more than 11 Connections-eligible patients who have a chronic condition automatically receive the SMART Registry on CD. These CDs are password-protected; letters that provide the password will be mailed to practices approximately one week before the SMART Registry is mailed. Practices will also be able to look up their password on the NaviNet® web portal. To do so, select *Reference Material and Reports* from the Plan Transactions menu and then select *SMART Registry Password*.

If you have any questions about the SMART Registry CD or the encryption process, please contact a Provider Service Specialist (PSS) by calling the Connections Program Provider Support Line at 1-866-866-4694. A PSS can help you and your staff navigate the CD to locate the most important information.

You can also schedule an appointment for a PSS to meet with you and your staff to review the SMART Registry reports and to help with making referrals to the ConnectionsSM Health Management Program.

To speak with a PSS about the SMART Registry or any other aspect of the Connections Program, call the Provider Support Line.

ConnectionsSM Health Management Program: Supporting your patients, our members

P F A



Call the Provider Support Line at 1-866-866-4694 to refer a member to a Health Coach if the member has any of the following conditions:

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

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.

IMPORTANT RESOURCES

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* www.ibx.com/providerkeystowellness
ConnectionsSM Health Management Program – Provider Support Line	1-866-866-4694
Corporate and Financial Investigations Department Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/antifraud
Credentialing Credentialing Hotline	215-988-6534 www.ibx.com/credentials
Credentialing Violation Hotline	215-988-1413
Customer Service (policies/procedures/claims) HMO and PPO	1-800-ASK-BLUE
eBusiness Help Desk	215-241-2305
FutureScripts® 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
FutureScripts® Secure Medicare Part D Formulary updates	1-888-678-7015 www.site65.com
Health Resource Center Healthy Lifestyles SM Precertification	1-800-ASK-BLUE 1-800-ASK-BLUE
NaviNet® portal registration	www.ibx.com/navinet
Provider Automated System (formerly IVR system)	1-800-ASK-BLUE
Provider Medical Policy website	www.ibx.com/medpolicy
Provider Pharmacy website	www.ibx.com/rx
Provider Supply Line	1-800-858-4728

* Outside 215 area code



Visit our website: www.ibx.com/providercommunications

NOTICE OF DENIAL OF MEDICAL COVERAGE

Date:

Member ID Number:

Beneficiary's name:

We have denied coverage of the following medical services or items that you or your physician requested:

We denied this request because:

What If I Don't Agree With This Decision?

You have the right to appeal. To exercise it, file your appeal in writing within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Who May File An Appeal?

You or someone you name to act for you (your **representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others also already may be authorized under State law to act for you.

You can call us at: (____) _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TTY (____) _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

Form No. CMS-10003

Exp. Date 8/31/2010

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0829. The time required to complete this information collection is estimated to average 6.3 to 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can File

Standard (30 days)- You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Fast (72 hour review)- You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- **If any doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, **we will automatically give you a fast appeal.**
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within 30 days.

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call

your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How Do I File An Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to the address(es) below:

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax:

What Happens Next? If you appeal, we will review our decision. After we review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare Health Plan. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Contact Information:

If you need information or help, call **us** at:
Toll Free:
TTY:

Other Resources to Help You:

Medicare Rights Center:
Toll Free: 1-888-HMO-9050
Elder Care Locator
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048