Independence Blue Cross

Partners in Health UPDATE℠

Inside this edition

▶ Articles designated with an orange arrow include notice of changes or clarifications to administrative policies and procedures.

Addendum to the Annual Synagis® (palivizumab) distribution program

P F A

The addendum below is in reference to the Synagis® (palivizumab) distribution article that ran in both the September and October 2010 editions of *Partners in Health Update*.

Please note that the criteria for infants born with chronic lung disease of prematurity or congenital heart disease, as well as those infants born at less than 32 weeks gestation, has not changed and therefore was not published in the article. The article did, however, address the new criteria for infants born at 32 to 35 weeks gestation.

Enhancements to the NaviNet® web portal now available

P F A

On Monday, October 18, the following enhancements were added to NaviNet Plan Central:

- Additional information regarding preventive service copays (via the Eligibility Details screen under Eligibility and Benefits Inquiry)
- Information regarding Home plans' Medical Policy and precertification information (via the Medical Policy/PreCert Inquiry screen under BlueExchange® Out of Area)

Look for additional information on these enhancements in the December edition of *Partners in Health Update*.

Updated payer ID grids now available

P F

The professional and facility payer ID grids were recently updated to add a new alpha prefix for account-specific National BlueCard® PPO products.

Please be sure to use the most current version of the payer ID grids, which are available on our website at *www.ibx.com/edi*.

Keystone Health Plan East, Personal Choice®, Keystone 65 HMO, and Personal Choice 65℠ 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**

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

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PFA

Reminder: Timely submission of Medicare Advantage HMO and PPO members' medical records

As part of the federally mandated Medicare Advantage Appeals and Grievances process, IBC may be required to obtain a member's medical record in order to make a determination of coverage. Should we uphold our determination, we are required to forward the member's appeal file, which includes medical records, to an independent review entity (IRE). An IRE is contracted with the Centers for Medicare & Medicaid Services (CMS) to perform second-level independent reviews of Medicare Advantage HMO and PPO members' appeals. Medical records must be submitted to us in a timely manner. Receiving timely medical records enables us to submit them to an IRE and ensure compliance with mandated appeal deadlines.

CMS also requires that both IBC and an IRE make their determinations within 72 hours for an expedited appeal and within 30 calendar days for a standard appeal. If a member requests an expedited review, we will immediately send a request to the provider for medical records. We must receive the records within 24 hours for an expedited appeal and within ten calendar days for a standard appeal. If an appeal is sent to an IRE, the IRE may request additional records, which must be sent under the same time frames.

Upon our request, and in accordance with your Agreement, you must provide copies of a Medicare Advantage HMO or PPO member's medical records to us as requested.

Other reasons that we may require the timely submission of medical records include:

- facilitating the delivery of appropriate health care services to Medicare Advantage HMO and PPO members;
- assisting with utilization review decisions, including those related to disease management programs, quality management, grievances (as discussed above), claims adjudication, and other administrative programs;
- complying with applicable state and federal laws and accrediting body (e.g., National Committee for Quality Assurance) requirements;
- facilitating the sharing of such records among health care providers directly involved with the member's care.

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

PFA

Upcoming CFID provider audits

In addition to the Corporate and Financial Investigations Department's (CFID) role in combating fraudulent practices against IBC, CFID is also responsible for conducting audits of facility and professional providers, ancillary service providers, and pharmaceutical-related entities. By using sophisticated data-mining software tools, CFID analyzes claims and compares them to member enrollment data and overall provider information. Any trends, patterns, or aberrant billing practices are selected for an in-depth audit or investigation.

Upcoming audits to investigate trends in questionable billing

Based on recent trends that have been identified in the data, CFID would like to alert providers to some questionable billing practices that will be the focus of upcoming audits. *Note:* If you are selected for an audit, you will be notified by certified mail.

The CFID audit team, which consists of registered nurses, medical coders, and claims experts, will be conducting audits that focus on the areas listed below:

Facility provider audits

Never Events	high-cost drugs and implants	OB/GYN observation	blood transfusions	unbundling of low osmolar contrast agents
credit balance	pharmacy — injectable drugs, infusions, and radiopharmaceuticals	lithotripsy	urological lithotripsy	once-in-a-lifetime procedures
coordination of benefits	neonatal intensive care unit (NICU)	outpatient observation claims	capitation leakage	Medicare hospice
end-stage renal disease	diagnosis related groups	clinical trials	readmissions	cardiac ablation
investigational/ experimental procedures	stereotactic radiation	unidentified cash	IBC correct coding edits	one-day stay
outpatient services versus inpatient admission	double ER billing	preadmission testing	duplicate charges	gastrointestinal coding
not separately payable	outpatient OB/GYN	multiple endoscopies	split billing	cosmetic procedures
medical necessity and coding	neurostimulator implant	maternity ultrasound	medically unlikely edits	home health
echocardiography	cyberknife utilization	detained baby	outpatient fee schedule	critical care
cardiac monitoring	speech therapy	skilled nursing	drug wastage	self injectables
hospital charge audit	intensity modulated radiotherapy plan	level of care		

Professional provider audits

inpatient and outpatient E&M services	consultation codes	site of service	coding units — single or multiple
high-dollar medications	duplicate billing	anesthesia base codes	add-on codes
unbundling procedures	high utilization	appending modifiers	colonoscopy codes

Ancillary provider audits

high-dollar medications	durable medical equipment	medication compounding

Health care fraud is a violation of state and/or federal law. An easy-to-use process exists for reporting any suspected fraud, waste, or abuse. If you are suspicious of any health care-related activity, visit *www.ibx.com/antifraud* or call our toll-free Corporate Compliance and Fraud Hotline at 1-866-282-2707. These tips can lead to audits and/or fraud investigations that can result in monetary recoveries, all of which can help keep health care costs down.

Billing

P

Reminder: Revised capitation rates and $0 copayment for certain preventive services

IBC has changed primary care physician (PCP) capitation rates due to new cost-sharing rules mandated by the federal health care reform act known as the Patient Protection and Affordable Care Act of 2010 (Act). As required by the Act, as of October 1, 2010, there is no member cost-sharing (i.e., $0 copayment) for preventive services provided to members under certain health benefits plans. Please visit *www.ibx.com/medpolicy* or the NaviNet® web portal to view Medical Policy #00.06.02: Preventive Care Services, which includes the list of applicable preventive codes.

As it is expected to take several years for this change to be phased in across IBC health benefits plans based on the terms of the member's Benefits Program Agreement, it continues to be important that you always check NaviNet and ID cards for member benefits information.

The following changes are necessary as benefits modifications will be rolled out to existing employer groups upon their renewal:

- **Preventive care $0 copayment capitation rates.** Capitation rates have increased to account for this benefits change for members with a new $0 copayment benefits plan for preventive care services. This benefit and rate of capitation payment change went into effect October 1, 2010, for certain commercial HMO and POS benefits plans and will be effective January 1, 2011, for all Medicare Advantage HMO plans. The PCP capitation rates have been increased to account for the actuarial value of preventive care copayments currently collected under these benefits plans.
- **Other capitation rates.** For commercial and Medicare Advantage HMO members whose benefits for preventive services are not changing, the capitation rates currently in effect will continue to be paid.

To check a member's benefits on NaviNet, select *Member Eligibility and Benefits Inquiry* from the Plan Transactions menu. If you are not NaviNet-enabled, go to *www.navinet.net* and select *Sign up* from the top right. You can also register for NaviNet by calling the IBC eBusiness Provider Hotline at 215-640-7410.

Products

P F A

New maximum out-of-pocket limit for Medicare Advantage HMO and PPO members

Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) has mandated a maximum out-of-pocket (MOOP) limit for all Medicare enrollees. The MOOP will establish an annual limit on total enrollee cost-sharing liability (e.g., deductibles, copays, coinsurance) for Medicare Part A and B services. Its dollar amount will be established annually by CMS but will not change during the course of a calendar year.

The following MOOP amounts will apply for 2011:

- HMO members — $6,700;
- PPO members — $6,700 for in-network services, and $10,000 for in- and out-of-network services combined.

The following deductible, copay, and coinsurance amounts will be included in the MOOP:

- medical (Medicare Part A and B services);
- pharmacy (Medicare Part B drugs only; Part D drugs will continue to be part of the existing true out-of-pocket costs [TROOP] limit);
- mental health (Medicare Part A and B services).

Once Medicare Advantage HMO and PPO members reach their MOOP limit, they will have no liability for the remainder of the calendar year for Medicare Part A and B claims.

Use the NaviNet® web portal to check all Medicare Advantage HMO and PPO members' benefits as they relate to cost-sharing for every office visit or procedure.

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

PFA

Upcoming Medicare Advantage HMO and PPO benefits changes

Effective January 1, 2011, there will be several changes to our Medicare Advantage HMO and PPO plans. The tables below highlight some of these changes. Please note that this is a list of our significant benefits changes, not a comprehensive list of *all* benefits changes.

Keystone 65 HMO benefits changes

Benefit	Keystone 65 Advantage HMO		Keystone 65 Preferred HMO	
	Current	Changes for 2011	Current	Changes for 2011
Maximum out of pocket	N/A	$6,700	N/A	$6,700
Dialysis	Covered in full	$25 copay per visit *Note: If performed at the PCP's or specialist's office, only the dialysis copay should apply.*	Covered in full	$25 copay per visit *Note: If performed at the PCP's or specialist's office, only the dialysis copay should apply.*
Part B drugs, including chemotherapy	Covered in full	20% coinsurance	Covered in full	20% coinsurance
Therapeutic radiology (radiation therapy)	Covered in full	$25 copay	Covered in full	$25 copay
Chiropractic services	$45 copay	$15 copay	$35 copay	$15 copay
Fitness	SilverSneakers® Fitness Program	$150 reimbursement with Healthy Lifestyles℠ Fitness Program	SilverSneakers Fitness Program	SilverSneakers Fitness Program

Personal Choice 65℠ PPO benefits changes

Benefit	In-network		Out-of-network	
	Current	Changes for 2011	Current	Changes for 2011
Maximum out of pocket	N/A	$6,700	N/A	$10,000 in- and out-of-network combined
Dialysis	Covered in full	$25 copay per visit *Note: If performed at the PCP's or specialist's office, only the dialysis copay should apply.*	Covered same as in network	$25 copay per visit *Note: If performed at the PCP's or specialist's office, only the dialysis copay should apply.*
Part B drugs, including chemotherapy	Covered in full	20% coinsurance	Member responsible for 30% of charges after $500 deductible is met	Member responsible for 30% of charges after $500 deductible is met
Therapeutic radiology (radiation therapy)	Covered in full	$25 copay	Member responsible for 30% of charges after $500 deductible is met	Member responsible for 30% of charges after $500 deductible is met
Chiropractic services	$45 copay	$10 copay	Member responsible for 30% of charges after $500 deductible is met	Member responsible for 30% of charges after $500 deductible is met

SilverSneakers is a registered mark of Healthways, Inc., an independent company.

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Upcoming Medicare Advantage HMO and PPO benefits changes (continued)

New optional supplemental benefits package available to Keystone 65 Advantage HMO members

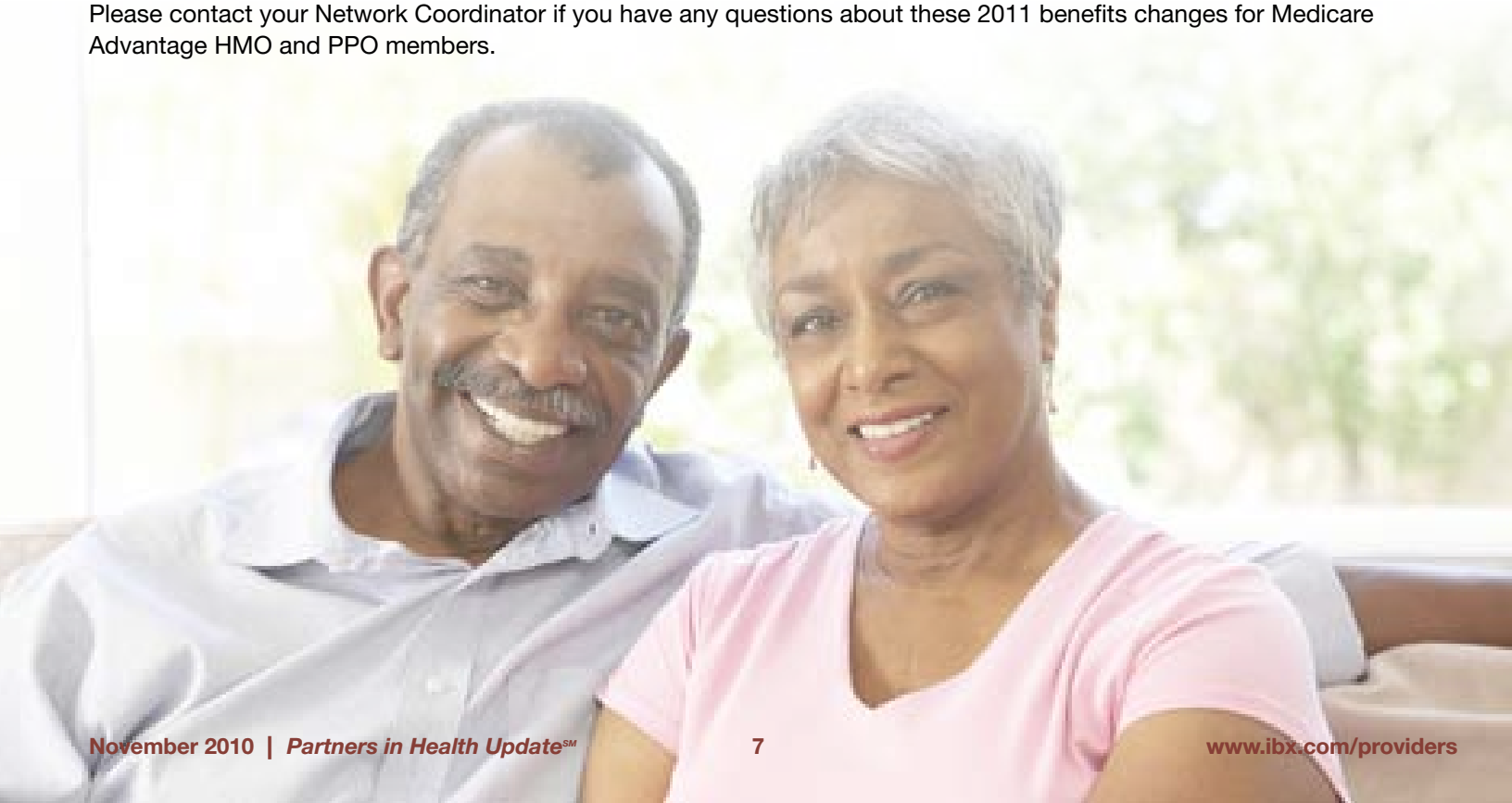
Our Keystone 65 Advantage HMO members will have the option to purchase the Keystone 65 Advantage HMO Choice Program, a Keystone 65 Advantage HMO plan that includes an optional supplemental benefits package for an additional $10 a month. The optional supplemental benefits package will cover vision, dental, and hearing, as these benefits are no longer included for Keystone 65 Advantage HMO members. See the table below for details about the supplemental benefits package.

Supplemental benefits package

Covered services	Member pays
Dental services — Preventive dental	
• Exams and cleanings every six months	• $15 copayment
Hearing services	
• Non-Medicare-covered routine hearing exams, including fitting and evaluation for two hearing aids, covered every three years • Medicare-covered hearing exams • Hearing aids, covered every three years	• $45 copay for non-Medicare-covered hearing exams and evaluation • $45 copay for Medicare-covered hearing exams • Up to $500 for two hearing aids
Vision care	
• Routine eye exams (not covered by Medicare), every two years • Eyewear not covered by Medicare, every two years	• $0 copay for routine eye exams, once every two years • $100 for eyewear

Note: Vision, dental, and hearing are still included in the benefits packages for Keystone 65 Preferred HMO and Personal Choice 65 PPO members.

Please contact your Network Coordinator if you have any questions about these 2011 benefits changes for Medicare Advantage HMO and PPO members.



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Member benefits changes and clarifications

Effective January 1, 2011, the following member benefits changes and clarifications will be implemented for several programs in Pennsylvania unless otherwise noted:

Type of service	Plans affected	Change/clarification
Precertification list updates	HMO, Flex HMO, POS, Flex POS, Keystone Choice, PPO, Flex PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO	A list of services that require precertification will no longer be included in the member handbooks. Members can access this information by logging on to *www.ibxpress.com* or by calling Customer Service.
BCBSA disclosure	HMO, Flex HMO, POS, Flex POS, Keystone Choice, PPO, Flex PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO, Comp Select (CMM), BC Hosp	Clarification language is being added regarding fees and compensation.
Bariatric surgery exclusion	HMO, Flex HMO, POS, Flex POS, Keystone Choice, PPO, Flex PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO	Language is being clarified to clearly communicate that when the benefit exists, only one type of bariatric surgical procedure is covered for a member. This refers to all types of bariatric surgery, not just the same procedure that was previously performed, even if the member regains weight. The existing exception to the exclusion would still apply and the company would continue to cover a second procedure if the first resulted in a surgical complication or surgical failure.
Diabetic insulin pumps	Flex HMO, Flex POS, PPO, Flex PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO	Language is being clarified in the medical forms to state that certain diabetic equipment and supplies are not available at a pharmacy.
ER follow-up care *Effective 1/1/2012*	POS self-referred only, Flex POS self-referred only	Language is being removed regarding the coverage of follow-up care in an emergency room or other outpatient emergency facility.
Health care reform *Effective 10/1/2010*	HMO, Flex HMO, POS, Flex POS, Keystone Choice, PPO, F PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO, Comp Select (CMM), BC Hosp, BC/BS Major Med	A letter amendment applicable to all products will contain 10/1/10 updates related to health care reform (effective on renewal date).
Outpatient detox (substance abuse) providers	HMO, Flex HMO, POS, Flex POS, Keystone Choice, PPO, Flex PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO	Benefit language for treatment for alcohol or drug abuse and dependency is being amended to include outpatient detoxification in an outpatient office setting by an appropriately licensed Behavioral Health/Substance Abuse Provider as a covered service.
Place of service exclusion	HMO, Flex HMO, POS, Flex POS, Keystone Choice, PPO, Flex PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO, Comp Select (CMM), BC Hosp, BC/BS Major Med	Exclusion language is being updated to include other places of service, such as camps and institutions.
Routine costs of clinical trials	HMO, Flex HMO, POS, Flex POS, Keystone Choice, PPO, Flex PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO	Language is being added to specify that we cover routine costs of phase I cancer clinical trials in the contracts, but we do not cover routine costs of non-cancer phase I clinical trials.
Specialty Rx definitions	HMO, Flex HMO, POS, Flex POS, Keystone Choice, PPO, Flex PPO, QCC HSA-qualified HDHP PPO, QCC Flex HDHP PPO	Definitions for "specialty drug" and "standard drug" are being revised. Language is also being revised for infusion therapy to address new distinction between specialty and standard drug.

If you have questions regarding these benefits changes and clarifications, please call Customer Service at 1-800-ASK-BLUE.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Plan (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified by calling Customer Service at 1-800-ASK-BLUE.

PFA

Reminder: Important information about the new Blue Cross® Blue Shield® Medicare Advantage PPO Network Sharing program

Effective for dates of service beginning January 1, 2011, IBC will be required by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield plans, to participate in the BCBSA national Medicare Advantage PPO Network Sharing program and accept Medicare Advantage PPO enrollees from other Blue Cross Blue Shield Plans who travel or reside in our 5-county Philadelphia service area as our local members. Similar to the current BlueCard® Program for commercial Blue Cross Blue Shield PPO Plans, this national BCBSA initiative enables enrollees in one Blue Cross Blue Shield Medicare Advantage Plan to obtain health care benefits and services from participating Blue Cross Blue Shield Plan providers while traveling or living in another Blue Cross Blue Shield Plan's service area.

How this affects participating providers

As a participating provider, you will be expected to provide services to these Blue Cross Blue Shield Medicare Advantage PPO plan enrollees who present to you for treatment as you would any other Blue Cross Blue Shield Medicare Advantage PPO member.

Facility providers

IBC will continue to process participating provider claims for covered facility services (e.g., hospitals, skilled nursing facilities, ambulatory surgery centers, renal dialysis) for these Blue Cross Blue Shield Medicare Advantage PPO enrollees. For admissions on or after January 1, 2011, you will be paid the contracted rates for covered services for these members. For more information on claims submission, please refer to the Facility Payer ID grid on our website at *www.ibx.com/edi*.

Professional and ancillary providers

For professional and ancillary providers who submit claims on the CMS-1500 claim form or through the 837P transaction, your contract will be amended to cover your provision of services to these Blue Cross Blue Shield Medicare Advantage PPO enrollees and claims for services rendered to them. You should continue to submit commercial BlueCard claims to Highmark Blue Shield, as this process will not change. IBC will process only Blue Cross Blue Shield Medicare Advantage PPO claims.

For Blue Cross Blue Shield Medicare Advantage PPO claims that span dates of service from 2010 into 2011, you will be required to split the claim for billing purposes. Claims with dates of service up to December 31, 2010, should continue to be submitted to Highmark Blue Shield. For information on where to submit claims for dates of service on or after January 1, 2011, please refer to the Professional Payer ID grid on our website at *www.ibx.com/edi*.

All providers

The ID cards for these Blue Cross Blue Shield Medicare Advantage PPO enrollees will contain "MA" in the suitcase logo. These enrollees have been instructed to provide their Blue Cross Blue Shield Medicare Advantage PPO ID card — not their standard Medicare ID card — when presenting to your office/facility for services.

The Centers for Medicare & Medicaid Services' (CMS) National Coverage Determinations (NCD) and the Local Coverage Determinations (LCD), as well as select IBC Reimbursement Policies, will be applied to claims for a Blue Cross Blue Shield Medicare Advantage PPO plan enrollee by IBC as a Host Plan. Home Plan medical policy may still be applied. For CMS-1500 or 837P claims received, the National Correct Coding Initiative edits of CMS will be applied during claims adjudication.

All claims for Blue Cross Blue Shield Medicare Advantage PPO enrollees submitted to IBC as the Host Plan, must be completed in accordance with Personal Choice 65℠ PPO guidelines.

Resources

Visit *www.ibx.com/medpolicy* for more detailed information regarding NCDs and LCDs or to view a list of the applicable IBC Reimbursement Policy documents. Be sure to visit the site often, as it is updated regularly.

If you have any questions about Blue Cross Blue Shield Medicare Advantage PPO, please contact your Network Coordinator.

Note: Behavioral health providers can expect to receive communications regarding this initiative directly from Magellan Behavioral Health, Inc., an independent company; however, all other aspects of this product apply.

PFA

Policy notifications posted as of October 28, 2010

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 October 28, 2010.

Policy effective date	Notification title		Notification issue date
November 10, 2010	**07.03.05j**	Sleep Disorder Testing	October 11, 2010
November 12, 2010	**08.00.72c**	Alglucosidase alfas, rhGAA (Myozyme®, Lumizyme®)	October 13, 2010
November 12, 2010	**00.10.38**	Billing Requirements for Multiple Births for Professional Providers	October 13, 2010
November 12, 2010	**06.02.06i**	Genetic Testing for Inherited Breast Cancer 1 (BRCA1) and Breast Cancer 2 (BRCA2) Mutations	October 13, 2010
November 12, 2010	**00.01.49**	Reporting Requirements for Drugs and Biologicals	October 13, 2010
December 15, 2010	**08.00.94**	Denosumab (Prolia™)	September 16, 2010
December 29, 2010	**08.00.82a**	Ustekinumab (Stelara™) for Subcutaneous Injection	September 29, 2010
January 1, 2011	**08.00.66f**	Bevacizumab (Avastin®)	September 30, 2010
January 1, 2011	**08.00.26l**	Botulinum Toxin Agents	September 30, 2010
January 1, 2011	**08.00.67e**	Cetuximab (Erbitux®)	September 30, 2010
January 1, 2011	**08.00.86**	Ecallantide (Kalbitor®)	September 30, 2010
January 1, 2011	**08.00.84**	Eculizumab (Soliris®)	September 30, 2010
January 1, 2011	**08.00.51c**	Enzyme Replacement for the Treatment of Gaucher's Disease (eg, Alglucerase [Ceredase®], Imiglucerase [Cerezyme®], Velaglucerase Alpha [VPRIV™])	September 30, 2010
January 1, 2011	**08.00.25f**	Epoprostenol (Flolan®) and Treprostinil (Remodulin®)	September 30, 2010
January 1, 2011	**08.00.13h**	Immune Globulin: Intravenous (IVIG), Subcutaneous (SCIG)	September 30, 2010
January 1, 2011	**08.00.76b**	Oxaliplatin (Eloxatin®)	September 30, 2010
January 1, 2011	**08.00.50h**	Rituximab (Rituxan®)	September 30, 2010
January 1, 2011	**08.00.85**	Tocilizumab (Actemra®)	September 30, 2010
January 1, 2011	**08.00.33h**	Trastuzumab (Herceptin®)	September 30, 2010
January 1, 2011	**08.00.91**	Alpha 1-Proteinase Inhibitor Therapy (e.g., Prolastin, Aralast, Aralast NP, Glassia, Zemaira)	October 1, 2010
January 1, 2011	**08.00.93**	C1 Esterase Inhibitors (Human): Cinryze® and Berinert®	October 1, 2010
January 1, 2011	**08.00.92**	Coagulation Factors for Hemophilia	October 1, 2010
January 1, 2011	**11.14.13e**	Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions	October 1, 2010
January 1, 2011	**08.00.34e**	Infliximab (Remicade®)	October 1, 2010
January 1, 2011	**08.00.88**	Ofatumumab (Arzerra™)	October 1, 2010
January 1, 2011	**08.00.95**	Sipuleucel-T (Provenge®)	October 1, 2010
January 1, 2011	**08.00.90**	Paclitaxel Protein-bound Particles for Injectable Suspension (Albumin-bound)/(Abraxane® for Injectable Suspension)	October 1, 2010
January 1, 2011	**08.00.87**	Pemetrexed (Alimta®)	October 1, 2010

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Policy notifications posted as of October 28, 2010 (continued)

Policy effective date	Notification title		Notification issue date
January 11, 2011	**11.14.06e**	Autologous Chondrocyte Implantation (ACI)/Carticel® and Other Cell-based Treatments of Focal Articular Cartilage Lesions	October 13, 2010
January 11, 2011	**08.00.68c**	Ibandronate Sodium (Boniva®) for Intravenous Injection	October 13, 2010
January 11, 2011	**11.14.12b**	Osteochondral Allograft Transplantation	October 13, 2010
January 11, 2011	**11.14.09d**	Osteochondral Autograft Transplantation (OAT) Procedure	October 13, 2010
January 11, 2011	**08.00.97**	Romidepsin (Istodax®)	October 13, 2010
January 12, 2011	**00.01.25j**	PPO Network Rules for Provision of Specialty Services for Durable Medical Equipment and Laboratory, Radiology, and Physical Medicine and Rehabilitative Services	October 14, 2010
January 25, 2011	**11.02.06f**	Catheter Ablation of Cardiac Arrhythmias	October 27, 2010
January 26, 2011	**07.03.07f**	Evaluation and Management of Autism Spectrum Disorders (ASD)	October 28, 2010

To view these notifications, as well as the policies in full, go to *www.ibx.com/medpolicy*, select *Accept and Go to Medical Policies*, and then select *Policy Notifications*. Be sure to check back often, as the site is updated frequently.

Changes for Independence Administrators pregnancy and delivery admission notifications

P F

Independence Administrators values the service and care that hospitals, physicians, and other health care professionals provide to our clients' plan members. Their online tools enhance convenience for health care professionals and help eliminate avoidable administrative costs. With iEXCHANGE® you can easily submit requests for precertification and prenotification of care online through a secure site at no cost. This online service is offered through AmeriHealth Administrators, an independent company that provides medical management services for Independence Administrators.

Effective January 1, 2011, all obstetrical provider offices and admitting facilities must use iEXCHANGE to submit notification of pregnancy (prenotification) and notification of admission for delivery for patients who carry an Independence Administrators ID card. Doing so will support more effective processing of prenotification and notification of maternity admission. Starting January 1, 2011, calls to the Patient Care Management (PCM) department to make these notifications will be referred to iEXCHANGE for submission.

iEXCHANGE will automatically authorize requests for admissions of up to two days for vaginal deliveries or four days for cesarean section deliveries. However, obstetrical offices must submit the notifications to ensure that patients receive the correct benefits from their health plan.

If a notification submitted through iEXCHANGE is pended (e.g., requests for inpatient days beyond the federal mandates for obstetrical admissions or requests for duplicative services), it may take up to one business day to be completed. If an authorization remains pended for more than one business day, please contact the PCM department at 1-888-234-2393.

You can also submit requests for services or admissions other than delivery through iEXCHANGE. For your convenience, iEXCHANGE is available seven days a week. (Maintenance takes place the third Sunday of every month.)

If you have not yet signed up for iEXCHANGE, register at *https://iexchange.medecision.com/IEApp/ProviderLogon.do*. For more information, visit *www.ibxtpa.com/providers* or call the iEXCHANGE help line at 1-888-444-4617.

Coverage for home blood pressure cuffs

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Please be aware that home blood pressure cuffs are covered for members for any of the following circumstances:

- end-stage renal disease in individuals who are receiving home dialysis;
- pregnancy-induced hypertension (gestational hypertension);
- hypertension complicated by pregnancy.

For members who do not meet the above criteria, home blood pressure cuffs are considered a benefits exclusion. For additional information on our policy, go to *www.ibx.com/medpolicy* and search for Claim Payment Policy #05.00.16c: Blood Pressure Devices for Home Use.

Our policy on concierge-style practices

P F

IBC will not contract with providers who provide personalized (i.e., concierge-style) health care services through a provider's own prepaid medical management plan. Charging a member for Covered Services beyond any applicable copayments or deductibles violates the terms of a provider's Professional Provider Agreement.

IBC strives to provide affordable access to health care coverage for all members. Therefore, we consider providers who offer personalized health care services through a prepaid medical management plan to be in violation of their network participation requirements and may be subject to termination. IBC may terminate contracts with participating providers who charge an access fee to our members for receipt of their services.

If you have concerns about this policy, please call your Network Coordinator.

Reminder: Choosing the most appropriate site of service

P F A

As a reminder, as part of our utilization review program, IBC evaluates the appropriateness of the setting (e.g., office, inpatient, outpatient) for Covered Services requested by a member's health care provider that may be provided in alternate settings or sites.

When a Covered Service can be administered in various settings, providers should request preapproval, as required by the applicable Benefits Program, to provide the Covered Services in the most appropriate and cost-effective setting for the member's current medical needs and condition, including any required monitoring. IBC's review for preapproval will be based on the clinical documentation from the requesting health care provider supporting the requested setting.

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

Reminder: Our policy on private duty nursing

P F A

As announced on our Medical Policy website, IBC has established a new policy on private duty nursing (PDN) that became effective October 15, 2010. Medical Policy #02.01.02: Private Duty Nursing sets forth the medical necessity requirements and explains what distinguishes PDN from a skilled nursing visit. PDN is considered medically necessary based on the medically appropriate criteria outlined in this policy.

PDN is defined as medically appropriate, complex skilled nursing care provided in the individual's private residence by a registered nurse or a licensed practical (vocational) nurse. The purpose of PDN is to provide continuous monitoring and observation of an individual who requires skilled nursing care on an hourly basis. In addition, PDN may assist in the transition of care from a more acute setting to the home and teaches competent caregivers the assumption of this care when the condition of the member is stabilized.

To read this policy in its entirety, visit *www.ibx.com/medpolicy* and enter the policy number in the search field.

Connections℠ AccordantCare™ Program transition to IBC care management department will be completed by December 31, 2010

Throughout 2010, we have been transitioning members who were previously enrolled in the Connections AccordantCare Program to our Connections Complex Care Management Program, which is an insourced care management program offered by IBC. The transition will be completed by the end of the year for all members.

This voluntary program provides your patients with access to an IBC registered nurse and social worker who work with our members to provide support and education and to coordinate necessary services and resources that are available under the member's health plan benefits.

Members eligible for the Connections Complex Care Management Program include those with any of the following complex, chronic conditions:

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

To refer a member with one of the above conditions to the Connections Complex Care Management Program, submit the physician referral form available at *www.ibx.com/providerconnections* or call 1-800-313-8628.

Please call your Network Coordinator with any questions.

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

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

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

Information about our Connections Health Management Programs is available at *www.ibx.com/providerconnections*.

Important Resources

Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/antifraud
Care Management and Coordination Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Connections℠ Health Management Programs Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ Complex Care Management Program	1-800-313-8628
Credentialing Credentialing Hotline	215-988-6534 www.ibx.com/credentials
Credentialing Violation Hotline	215-988-1413
Customer Service/Provider Services • Provider Automated System (eligibility/claims status/referrals) • Connections Health Management Programs • Precertification/maternity requests — Imaging services (CT, MRI/MRA, PET, and nuclear cardiology) — Authorizations	1-800-ASK-BLUE
Provider Services user guide	www.ibx.com/providerautomatedsystem
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
Pharmacy website (formulary updates, prior authorization)	www.ibx.com/rx
FutureScripts® Secure Medicare Part D	 1-888-678-7015
Formulary updates	www.ibxmedicare.com
Medical Policy website	www.ibx.com/medpolicy
NaviNet® portal registration	www.navinet.net
Provider Supply Line	1-800-858-4728 www.ibx.com/providersupplyline

* Outside 215 area code

Independence Blue Cross

Visit our website:
www.ibx.com/providercommunications