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This just in....



Revised guidelines for perinatal screening and prophylaxis of Group B Strep

The Centers for Disease Control and Prevention (CDC) has issued updated guidelines for screening and management of perinatal Group B Strep. These changes, published in the *Morbidity and Mortality Weekly Report*, can be found on the CDC website at www.cdc.gov/groupbstrep/guidelines/guidelines.html.



Updated payer ID grids now available

The professional and facility payer ID grids were recently updated with the following changes:

- New alpha prefixes were added for account-specific National BlueCard® PPO.
- New alpha prefixes were added for Independence Administrators.

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.

*Partners in Health Update*SM 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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For articles specific to your area of interest, look for the appropriate icon:

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

Request for medical records

Medical records may be required to finalize a review for several reasons including, but not limited to, a medical necessity review, pre-existing investigation, or cosmetic review.

When a written request is submitted, please be sure to attach the request letter to the medical records and submit records as instructed. Medical records that arrive attached to a request letter require less research and are rapidly forwarded to the appropriate team for review. We appreciate your cooperation in this matter.

REIMBURSEMENT

Reminder: 2011 performance incentive program revisions for PCPs

As previously communicated, changes were made to the Quality Incentive Payment System (QIPS) program for measurement year 2011 for participating primary care physicians (PCP) in Pennsylvania.

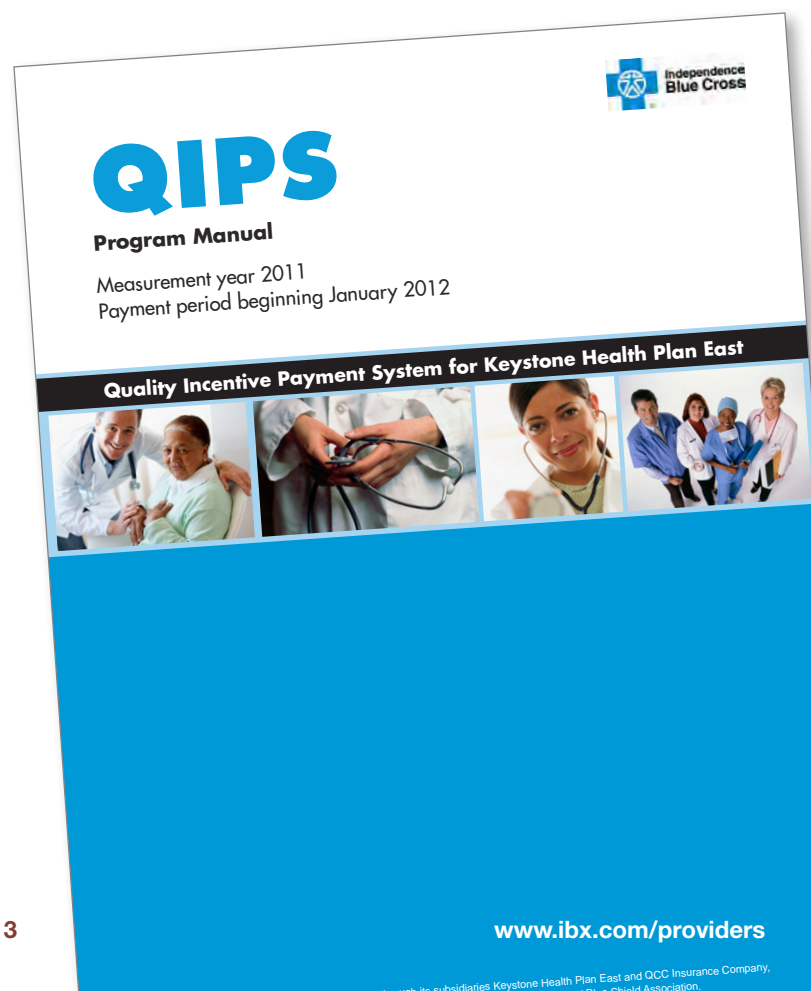
The QIPS Program Manual has been updated to reflect the following:

- **QPM feedback audit.** Provider office records may be audited based on feedback received from providers in response to the Quality Performance Measure (QPM) mailing sent in the first quarter following the end of the measurement period.
- **Medical cost exclusion.** Inpatient professional services were added to the list of exclusions.
- **Generic prescribing.** Changes were made to the generic prescribing measure.
- **Medical Cost Management guidelines for combining practices.** Guidelines were added for those providers requesting to combine their practice membership for purposes of meeting member thresholds as required by the Medical Cost Management Program.
- **Changes to practice composition.** Various scenarios are outlined and describe how each would affect the provider's QIPS status.

QIPS Program Manual

The *QIPS Program Manual – Measurement year 2011* is available on the NaviNet® web portal and provides additional information about these revisions. Order a printed copy of the QIPS Program Manual by submitting an online request at www.ibx.com/providersupplyline or by calling the Provider Supply Line at 1-800-858-4728.

For additional information regarding QIPS, please contact your Network Coordinator.



Surgery modifier usage

This is a reminder to providers about the appropriate use of assistant surgery and co-surgery modifiers.

Assistant surgery

Assistant surgery modifiers -80, -81, and -82 are used to denote surgical procedures that require both a primary and an assistant surgeon due to the complexity and/or time requirement of the surgery. An assistant surgeon is a surgeon who actively assists and supports a primary surgeon during a surgical procedure. Both primary and assistant surgeons should report the same procedure code.

Co-surgery

Co-surgery modifier -62 is used to denote when two surgeons act as primary surgeons during the same operative procedure or session for the same individual because of the complexity of the procedure and/or the patient's condition. The co-surgeons are typically of different specialties and perform consecutive or overlapping parts of the same procedure or simultaneous procedures during the same session with one of the following exceptions for co-surgeons of the same specialty:

- Each surgeon must perform a distinct part of the surgical procedure that requires the distinct skills of each surgeon.
- Each surgeon performs the same procedures simultaneously for different regions/organs (e.g., bilateral lung reduction, bilateral knee replacements). In such cases, the operative report must reflect the necessity of two primary surgeons with the same skills.

Each of the two surgeons should submit the same procedure code that represents the entire surgical procedure appended with modifier -62.

For more information about these surgery modifiers, please refer to their respective claim payment policies:

- Policy #00.10.18e: Modifiers for Assistant-at-Surgery Services: 80, 81, 82, and AS
- Policy #00.10.11f: Modifier 62: Two Surgeons

These claim payment policies are available at www.ibx.com/medpolicy. If you have any questions, contact your Network Coordinator.

Reporting services using modifier -50

Modifier -50 is used to denote bilateral procedures that can be performed on identical sites, aspects, or organs on both sides of the body during the same operative session or on the same day. This article is a reminder of the appropriate billing procedures for modifier -50. Examples are included on the following pages.

The Centers for Medicare & Medicaid Services (CMS) has defined codes that are subject to the bilateral payment rule (i.e., reimbursement at 150 percent of the fee schedule allowance), which accounts for multiple surgery adjustments when bilateral surgical procedures are performed. However, bilateral surgical procedures that are performed in conjunction with other surgical procedures may still be subject to multiple surgery reduction guidelines.

Certain other procedures are not subject to the 150 percent bilateral payment rule but may still be performed bilaterally. Payment for these procedures is based on 100 percent of the fee schedule allowance for each side,

as these are typically nonsurgical in nature and would therefore not be subject to multiple surgery adjustment when performed bilaterally.

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

Use of indicators

We apply the CMS Physician Fee Schedule Database bilateral indicators to services to determine reimbursement consideration. Services with the CMS Physician Fee Schedule Database bilateral indicators of 0 or 9 should not be reported with modifier -50, as this is

continued on next page

Reporting services using modifier -50 (continued)

inappropriate. When reported with modifier -50, services with an indicator of 0 or 9 will be denied as an invalid procedure code/modifier combination.

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

Services with the CMS Physician Fee Schedule Database bilateral indicators of 1 and 3 are appropriate to be reported with modifier -50. In addition, please note that modifier LT (left side) or RT (right side) is used to indicate on which side of the body a service or procedure is performed. They do not indicate a bilateral service and should not be used to report a service or procedure

performed bilaterally. If a provider bills incorrectly, overpayments may occur. Providers should be sure to bill correctly to avoid overpayments and subsequent retractions.

Since a code appended with modifier -50 describes a bilateral service, it is not appropriate to report the same code for the same date of service with modifiers -RT, -LT, or with no modifier. The same code for the same date of service with modifiers -RT, -LT, or with no modifier, will be denied, stating "Modifier 50 billing error. No payment made."

Below are examples demonstrating the correct and incorrect ways to report services with modifier -50 bilateral indicators of 1, 2, and 3. These examples are for informational purposes only.

Example 1

This is the **correct** way to bill a bilateral submucous resection. A bilateral submucous resection currently has a CMS bilateral indicator of 1.

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS
CPT/HCPCS	MODIFIER					
30140			50			1

These are **incorrect** ways to bill a bilateral submucous resection.

	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS
	CPT/HCPCS	MODIFIER					
Incorrect example 1	30140			50			2
Incorrect example 2	30140	RT	LT	50			1
Incorrect example 3	30140			50			1
	30140			LT			1
Incorrect example 4	30140			RT			1
	30140			LT			1
Incorrect example 5	30140						1
	30140			50			1

continued on next page

Reporting services using modifier -50 (continued)

Example 2

This is the **correct** way to bill a bilateral X-ray of the feet with two views. A bilateral X-ray of the feet with two views currently has a CMS bilateral indicator of 3.

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER			F. \$ CHARGES	G. DAYS OR UNITS
CPT/HCPCS	MODIFIER					
73620	50					1

These are **incorrect** ways to bill a radiological exam of the feet with two views.

	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER			F. \$ CHARGES	G. DAYS OR UNITS
	CPT/HCPCS	MODIFIER					
Incorrect example 1	73620			50			2
Incorrect example 2	73620	RT LT		50			1
Incorrect example 3	73620			50			1
	73620			LT			1
Incorrect example 4	73620			RT			1
	73620			LT			1
Incorrect example 5	73620						1
	73620			50			1

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Reporting services using modifier -50 (continued)

Example 3

This is the **correct** way to bill a bilateral ultrasound of the breast. A bilateral ultrasound of the breast currently has a CMS bilateral indicator of 2.

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS
CPT/HCPCS	MODIFIER					
76645						1

These are **incorrect** ways to bill a bilateral ultrasound of the breast.

	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS
	CPT/HCPCS	MODIFIER					
Incorrect example 1	76645				50		1
Incorrect example 2	76645		RT	LT			2
Incorrect example 3	76645			RT			1
	76645			LT			1

For more information about modifier -50, please refer to Claim Payment Policy #03.00.05g: Modifier 50: Bilateral Procedure, which is available at www.ibx.com/medpolicy by typing the policy name or number in the Search box. If you have any questions, contact your Network Coordinator.

HIPAA 5010 FAQ now available

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to adopt specific standards for electronic health care transactions (e.g., claims, eligibility inquiries, claims status requests, and responses). The current version is 4010A1, but federal regulation mandates that this version be replaced with the new 5010 version by January 1, 2012. Beginning January 1, 2012, providers and vendors must use the HIPAA 5010 electronic format to submit information to IBC and other payers. After January 1, 2012, version 4010A1 will no longer be accepted.

While the timeline to adopt the new version is distant, providers and billing vendors will need to make significant system changes to prepare for this mandatory conversion.

IBC has prepared a list of Frequently Asked Questions (FAQ) surrounding the conversion to 5010. Visit our website at www.ibx.com/icd10 to view the 5010 FAQ. IBC will continue to communicate to providers during the ongoing transition to 5010. Please continue to check *Partners in Health Update*, the NaviNet® web portal, and www.ibx.com/providers for information regarding the conversion to 5010.

Copayments relative to allowed amount for Managed Care products

When the copayment is greater than the allowable amount, only the allowable amount should be collected from the member. In the event that the copayment is collected and the practice subsequently determines that the allowed amount is less than the copayment, the difference between the allowable amount and the copayment for the service must be refunded to the member.

Please verify the member's specific benefits plan to determine all applicable copayments. If you have additional questions, please contact your Network Coordinator.

Clarification regarding the mental health and substance abuse benefits changes for Federal Employee Program

As communicated in the December edition of *Partners in Health Update*, effective January 1, 2011, changes will be made to the mental health and substance abuse benefits for the Federal Employee Program (FEP). However, the following clarification applies to the residential treatment centers information:

Residential Treatment Centers (RTCs) will no longer be treated as covered providers. Changes will be put in place to discontinue Preferred Mental Health/Substance Abuse benefits for *inpatient* facility claims submitted by RTCs unless they are provided *and approved* under the case management process. This applies to both the Standard and Basic Option for claims incurred on or after January 1, 2011, *with a type of bill equal to 086X* or have a revenue code equal to 1001 or 1002.

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



Policy notifications posted as of December 20, 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 December 20, 2010.

Policy effective date	Notification title	Notification issue date
January 1, 2011	08.00.66f Bevacizumab (Avastin [®])	September 30, 2010
January 1, 2011	08.00.26I Botulinum Toxin Agents	September 30, 2010
January 1, 2011	08.00.67e Cetuximab (Erbix [®])	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 (e.g., 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
January 1, 2011	00.10.39a Billing for Professional Office-Based Services Performed in an Outpatient Office-Based Setting Located within a Facility or on a Facility Campus	December 2, 2010
January 1, 2011	07.00.20d Routine Costs Associated with Qualifying Clinical Trials	December 2, 2010
January 7, 2011	05.00.24h Interstitial Continuous Glucose Monitoring Systems (CGMS)	December 8, 2010
January 11, 2011	11.14.06e Autologous Chondrocyte Implantation (ACI)/Carticel [®] and Other Cell-based Treatments of Focal Articular Cartilage Lesions	October 13, 2010

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Policy notifications posted as of December 20, 2010 (continued)

Policy effective date	Notification title	Notification issue date
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 15, 2011	07.02.07e Ambulatory, Real-Time Cardiac Surveillance System	December 15, 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
February 9, 2011	11.14.11d Arthroscopic Electrothermal Joint Repair	November 11, 2010
March 1, 2011	00.03.01h Podiatry Services Included in Capitation for Pennsylvania Based Health Maintenance Organization (HMO) or Health Maintenance Organization Point-of-Service (HMO-POS) Products	November 23, 2010

To view the policy notifications, go to www.ibx.com/medpolicy, select *Accept and Go to Medical Policy Online*, and then click on the *Policy Notifications* box. You can also view policy notifications using the NaviNet[®] web portal by selecting *Reference Materials and Reports* from the Plan Transactions menu and then *Medical Policy*. Once these policies are in effect, they will be available by using the Search box on the Medical Policy homepage. Be sure to check back often, as the site is updated frequently.

New guide available for submitting chemotherapy/infusion or home infusion authorizations



Beginning January 1, 2011, new Dosing and Frequency Requirements will be applied to the precertification process for eight drugs (please see the December edition of *Partners in Health Update* for more information about this change). Only new requests and extensions to existing authorizations for these drugs will be affected by these new requirements.

To help providers understand this change, a new guide – called *NaviNet[®] Chemotherapy/Infusion and Home Infusion Authorizations* – is available on the NaviNet[®] web portal in the Administrative Tools & Resources section. This guide includes sample screen shots of the NaviNet transactions and examples of the clinical question sets that will need to be completed when requesting these drugs for members.

The new clinical question sets are also available in the medical policy for each of the affected drugs. To view the clinical question sets in the medical policy, go to www.ibx.com/medpolicy, select *Accept and Go to Medical Policy Online*, and then type the drug name into the Search box. Select *Attachment B* in the Associated Attachments section of the medical policy.

Note: There are no clinical question sets available for onabotulinumtoxinA (Botox[®]).

Reminder: Choosing the most appropriate site of service

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: Referrals not needed for services provided through Direct Access OB/GYNSM

Direct Access OB/GYN allows HMO and POS members to receive certain services from any network obstetrical (OB) or gynecological (GYN) specialist or subspecialist without a referral for preventive care visits, routine OB/GYN care, or problem-related OB/GYN conditions.

Specialties and subspecialties not requiring referrals include, but are not limited to:

- OB
- GYN (including urogynecologist)
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist
- midwife

Services that do not require a referral from a primary care physician (PCP) or OB/GYN include, but are not limited to:

- all antenatal screening and testing
- fetal or maternal imaging
- hysterosalpingogram/sonohysterogram

You must continue to use the *OB/GYN Referral Request Form*, available on the NaviNet[®] web portal, for the following services:

- pelvic ultrasounds, abdominal X-rays, intravenous pyelograms, and DEXA scans (these tests should be performed at the member's capitated radiology site);
- initial consultations for HMO members for endocrinology, general surgery, genetics, gastrointestinal, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP referral).

Please remind your patients about referral requirements, and contact your Network Coordinator with any questions.



Capitation guidelines and the importance of specialty subcontractor arrangements

In order to obtain coverage under their health plan, HMO and POS members are required to receive the following specialty services from capitated providers:

- diagnostic radiology
- laboratory
- podiatry
- short-term rehabilitation (physical and occupational therapy)

If you are a provider who is contracted for specialty capitation for one of the above services, you are required to either provide that service or arrange for the service through a subcontractor arrangement. Therefore, it is important that you seek out an arrangement with a subcontractor and maintain that arrangement in order to serve your patients. If you do not already have subcontractors in place, please take steps to establish an arrangement.

Read more about capitation requirements by viewing the claim payment policies on capitation for each of the services listed above. To do so, go to www.ibx.com/medpolicy and type the name of the service in the Search box. For more information about subcontractor arrangements, please contact your Network Coordinator. If your IBC patients have questions about capitated services, please have them call Customer Service at 1-800-ASK-BLUE.



QIPS reminder for electronic connectivity requirements and transaction prerequisites

To participate in the Quality Incentive Payment System (QIPS) program, eligible Pennsylvania primary care physicians must be NaviNet-enabled at each practice site and utilize the NaviNet® web portal as the primary mechanism for claims status inquiries, adjustment requests, referrals, and initiation of applicable preauthorizations.

Practices must also register for electronic funds transfer (EFT) for non-capitated reimbursement and complete the following transactions electronically:

- member eligibility
- claims submissions
- encounters

The above prerequisites must be met to be eligible for QIPS payments beginning July 2011.

Please review the QIPS Program Manual, available on NaviNet, for additional information about these new requirements for measurement year 2010. Printed copies of the QIPS Program Manual can be ordered by submitting an online request at www.ibx.com/providersupplyline or by calling the Provider Supply Line at 1-800-858-4728.

For additional information regarding QIPS, please call your Network Coordinator.

Clarification: Medicare Advantage HMO and PPO benefits changes

Several changes to our Medicare Advantage HMO and PPO plans went into effect January 1, 2011, for individual/non-group members. 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.

Group members who have coverage through an employer group or union may or may not be impacted by similar changes. Therefore, some group members will continue to have no cost-share for Part B drugs, including chemotherapy, and dialysis benefits while others will have the same cost-share as individual/non-group members. Please be sure to verify member eligibility and benefits through the NaviNet[®] web portal for Medicare Advantage HMO and PPO members.

Keystone 65 HMO individual/non-group benefits changes

Benefit	Keystone 65 Advantage HMO		Keystone 65 Preferred HMO	
	2010	2011	2010	2011
Maximum out of pocket	N/A	\$6,700	N/A	\$6,700
Dialysis	Covered in full	\$25 copay per visit*	Covered in full	\$25 copay per visit*
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 SM Fitness Program	SilverSneakers Fitness Program	SilverSneakers Fitness Program

**In the unlikely event that a member receives dialysis in a primary care physician's office or specialist's office, the member should not be charged an additional office copay. Only the dialysis copay applies in this situation.*

Personal Choice 65SM PPO individual/non-group benefits changes

Benefit	In-network		Out-of-network	
	2010	2011	2010	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*	Covered same as in network	\$25 copay per visit*
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

**In the unlikely event that a member receives dialysis in a primary care physician's office or specialist's office, the member should not be charged an additional office copay. Only the dialysis copay applies in this situation.*

Clarification: Medicare Advantage HMO and PPO benefits changes (continued)

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

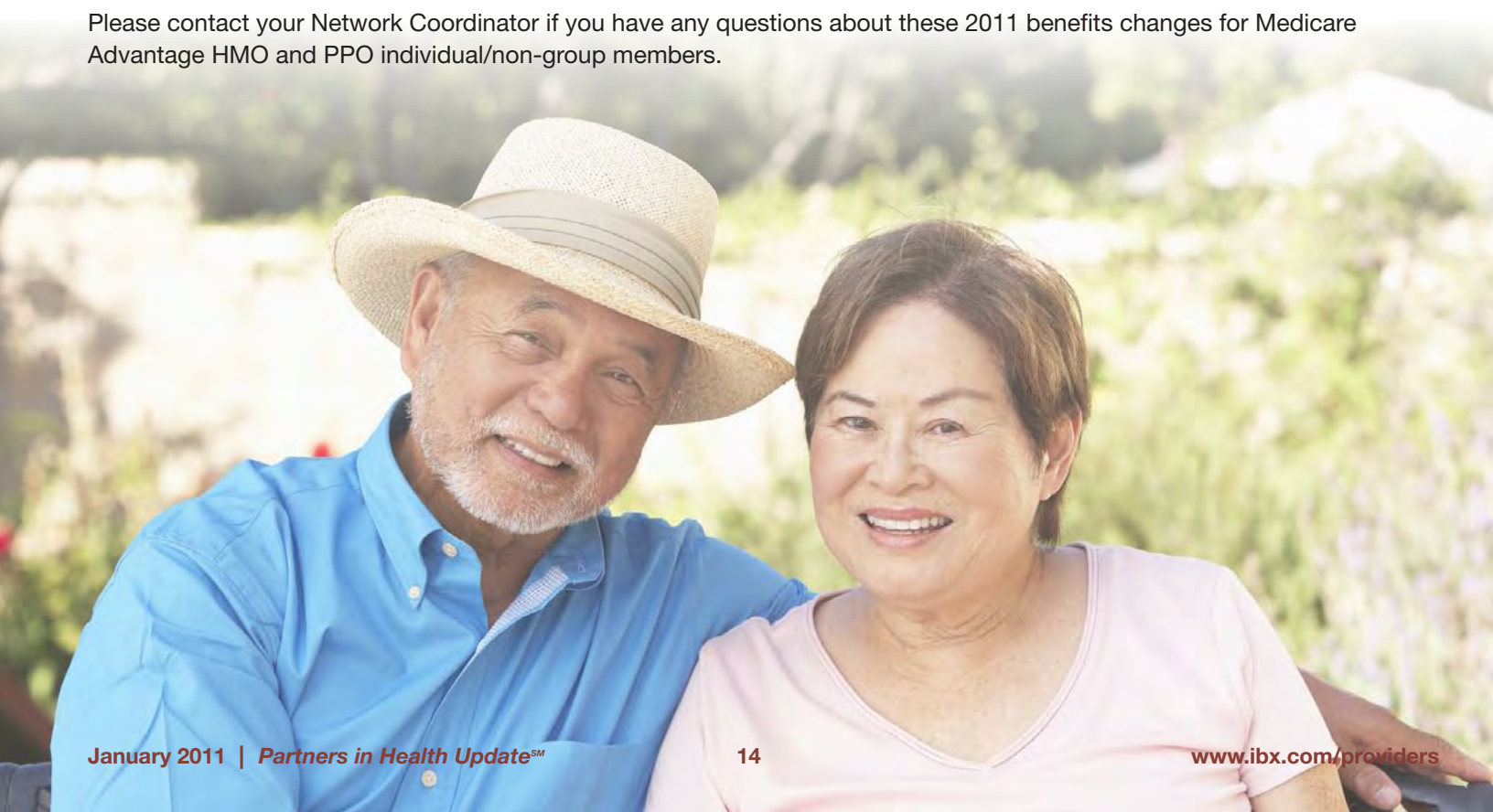
Our Keystone 65 Advantage HMO members now have the option to purchase the Keystone 65 Advantage HMO Choice Program, a Keystone 65 Advantage HMO plan that includes an optional supplemental benefits package for an additional \$10 a month. The optional supplemental benefits package will cover vision, dental, 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	
<ul style="list-style-type: none"> Exams and cleanings every six months 	<ul style="list-style-type: none"> \$15 copayment
Hearing services	
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> \$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	
<ul style="list-style-type: none"> Routine eye exams (not covered by Medicare), every two years Eyewear not covered by Medicare, every two years 	<ul style="list-style-type: none"> \$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 individual/non-group members.



Changes to the SMART[®] Registry from the ConnectionsSM Program

Since May 2004, the SMART[®] Registry has been mailed to our providers twice a year to provide information on doctors' Connections-eligible patients who have asthma, diabetes, heart failure, coronary heart disease (CHD), and chronic obstructive pulmonary disease (COPD). Along the way, changes have been made to improve the usability and security of the SMART Registry, as well as to provide additional levels of details, such as lab values and a record of when blood work was done.

In 2011, we are continuing to improve the SMART Registry by making two important changes:

- The SMART Registry will be sent on CD only once a year to all providers with eligible patients. The next SMART Registry release will be sent to provider offices in the third quarter of 2011. The Registry CDs will continue to be password-protected — password letters will be mailed to practices a few days before the SMART Registry is mailed. Practices may also look up their password on the NaviNet[®] web portal by selecting the *Reporting Material and Reports* option under the Plan Transactions menu.
- The reports will now be based on the Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures. Previously, the reports used internally developed quality indicators. By changing to HEDIS, Connections will adopt a larger, more universally accepted and benchmarked program for evaluating clinical quality.

New Member Campaign Reports menu

While we are switching to a once-a-year mailing, physicians can request monthly reports, called Member Campaign Reports, through the Provider Support Line. The Member Campaign Report is a tool physicians can use to identify patients included in the Connections Program's outreach campaigns. This monthly report includes the following information:

- patient's name
- date of birth
- chronic conditions
- effective care measures for each chronic condition
- most recent dates of service for tests or exams
- medication lists, fill dates, and persistence rates
- Connections Program outreach campaigns

The Member Campaign Report also allows you to sort and filter the report to find patients who may have a gap in care. For example, you can look for patients with diabetes who have not had their HbA1c or for those with an HbA1c value greater than seven.

If you would like to speak to a Connections Program Specialist (CPS) about the SMART Registry or to request a Member Campaign Report, please call the Provider Support Line at **1-866-866-4694**. A CPS can work with you and your clinical office staff to sort the reports to provide the most important information for you.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

ConnectionsSM 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)*
ConnectionsSM Health Management Programs	
Connections SM Health Management Program Provider Support Line	1-866-866-4694
Connections SM Complex Care Management Program	1-800-313-8628
Credentialing	215-988-6534
Credentialing Hotline	www.ibx.com/credentials
Credentialing Violation Hotline	215-988-1413
Customer Service/Provider Services	
<ul style="list-style-type: none">• Provider Automated System (eligibility/claims status/referrals)• Connections Health Management Programs• Precertification/maternity requests<ul style="list-style-type: none">– Imaging services (CT, MRI/MRA, PET, and nuclear cardiology)– Authorizations	1-800-ASK-BLUE
Provider Services user guide	www.ibx.com/providerautomatedsystem
Direct Ship Injectable Program (Medical Benefit)	www.ibx.com/directship
eBusiness Help Desk	215-241-2305
FutureScripts® (Pharmacy Benefits)	
Prescription drug authorization	1-888-678-7012
Toll-free fax	1-888-671-5285
Direct Ship Specialty Pharmacy Program	1-888-678-7012
Fax	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



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www.ibx.com/providercommunications