Independence Blue Cross

Partners in Health UPDATE℠

Long-term care billing and referral requirements
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Inside this edition

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

Reminder...

P F A

Sign up to receive IBC news and announcements via email

If you and your office staff would like to receive email providing you with the latest information of interest to participating IBC providers, including *Partners in Health Update* and breaking news alerts, simply complete the sign-up form located on our website.

Email sign-up: *www.ibx.com/providers/email*

All requests are processed within 48 hours. To prevent your firewall from marking our email messages as spam, please add IBC (*provider_communications@ibx.com*) to your email address book and provide your information services or information technology contacts with the domains and IP addresses listed on our website.

For professional providers only

Additionally, the IBC Network Medical Directors offer a physician-to-physician email platform, intended to provide direct and succinct messaging to assist physicians in providing quality care to our members. Email topics may include policy and billing changes, important upcoming mailings (e.g., QIPS), and more.

Participating professional providers are encouraged to join the Network Medical Directors Physician-to-Physician email list.

Physician-to-Physician email sign-up: *www.ibx.com/providers/physician_email*

We respect your privacy and will not make your email address available to third parties. For more information about our privacy policy, go to *www.ibx.com/privacy*.

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

Keystone Health Plan East has an accreditation status of *Commendable* from 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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Announcements

P F A

Blue plans and Lumeris complete acquisition of nation's largest real-time health care communication network

Three of the nation's leading Blue health plans, Highmark, Horizon Blue Cross Blue Shield of New Jersey (Horizon), and IBC, along with health IT provider Lumeris Corp., announced they have closed their transaction and finalized their arrangement to acquire NaviNet®. Terms of the acquisition were not disclosed.

"This new partnership is a great example of forward-thinking organizations working together to generate positive change, leverage the most modern technology, and activate the brightest minds in our industry," said Daniel J. Hilferty, president and CEO of IBC. "By acquiring NaviNet together, we are taking an important step toward transforming the delivery of health care in our country."

Through the new partnership, NaviNet will leverage its real-time communication network and Lumeris' accountable care delivery platform to drive the adoption of new accountable care models throughout the country. All over the nation, health plans, including Highmark, Horizon, and IBC, are developing new value-based payment models that reward physicians for highly coordinated, high-quality, more cost-effective care. The integration of NaviNet and Lumeris' capabilities will allow plans to develop next generation accountable care delivery systems to contain costs and improve quality, while continuing to handle administrative transactions easily and efficiently.

Provider access to the NaviNet web portal will remain unchanged, and the services, workflows, and transactions used to interact with health plans will be unaffected.

For more information, please read the IBC press release at *www.ibx.com/press_release/navinet*.

Administrative

A

Ambulance transport for Medicare Advantage HMO and PPO members receiving custodial and skilled nursing care

This is a reminder that Medicare pays for limited ambulance transport services for Medicare Advantage HMO and PPO members receiving custodial and skilled nursing care.

For members in custodial care

Ambulance transport services are *not* a covered benefit for Medicare Advantage HMO and PPO members in custodial care when they are being transported to a provider's office.

For members receiving skilled nursing care

If a Medicare Advantage HMO or PPO member who is receiving covered inpatient skilled nursing care is being transported to a provider's office, ambulance transport services are covered only if transportation in any other vehicle could endanger the member's health.

Please refer to Claim Payment Policy #12.04.02b: Nonemergency Ambulance Transport Services at *www.ibx.com/medpolicy* for further information on Medicare requirements for ambulance transport services.

Long-term care billing and referral requirements

P F A

This is a reminder of the billing guidelines and referral requirements for professional providers when rendering services to members in long-term care (LTC) facilities. Please review the information below and be sure to adhere to these requirements when providing such services.

Place-of-service codes

Primary care physicians (PCP) often visit their patients while they are in an LTC facility. On a professional claim, participating PCPs are required to use the most accurate place-of-service code to specify where a service is rendered. Therefore, it is important to distinguish between skilled nursing care visits and custodial care visits and use the appropriate place-of-service code on professional claims.

- **Skilled nursing care:** Place-of-service code = "31" Skilled nursing visits are intended for HMO, POS, and PPO members who need skilled or sub-acute care. Skilled nursing visits are subject to the precertification requirements and benefits limitations of the member's plan. Admissions to a skilled nursing facility (SNF) are arranged by care coordinators and must be preapproved through the precertification process. These admissions are reviewed weekly, or more often if applicable, to ensure the appropriate use of benefits and promote optimal benefits coverage. SNF reviews may be on-site or by telephone or fax, depending on the arrangement with the individual facility.
- **Custodial care:** Place-of-service code = "32" Many of the services provided by PCPs to members who have been admitted to an LTC facility are considered custodial care services. These services do not require precertification like skilled nursing care.

Referral requirements

We have established LTC panels for our PCPs who provide care in participating LTC facilities. PCPs with an LTC panel must issue referrals for any professional service or consultation that an LTC-panel member in long-term care receives, including:

- podiatry, physical therapy, and radiology services;
- consultation or follow-up with a specialist;
- ancillary services (note that LTC-panel members do not have capitation requirements for laboratory, physical therapy, radiology, or podiatry services).

PCPs should submit referrals for LTC-panel members in advance of the service being provided. Referrals can be submitted either by using the NaviNet® web portal or by calling the Provider Automated System at 1-800-ASK-BLUE, and they should be submitted in a timely manner to allow for appropriate claims processing. Claims will *not* be authorized for payment without a referral on file. In addition, consultants and ancillary providers are encouraged to provide the referral information with the claim to assist in processing.

Note: LTC-panel members do not need precertification for the services listed above. Precertification is required only for inpatient admissions for hospital care, skilled nursing care, short procedure unit cases, and outpatient ambulatory surgical center procedures. During an approved skilled nursing care admission, it is not necessary for the attending physician to issue a referral. However, all providers rendering care to the member should use the inpatient skilled nursing care authorization number on any claims during the dates of service within the skilled nursing inpatient stay.

Cost-sharing for preventive and nonpreventive services

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As previously communicated in *Partners in Health Update*, IBC announced there is no member cost-sharing ($0) for certain preventive services provided to certain members. These new cost-sharing rules are mandated by the Federal Health Care Reform act known as the Patient Protection and Affordable Care Act of 2010. The $0 copayment does *not* apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a copayment. However, if the member is experiencing a significant problem that requires a problem-focused service that cannot be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring adjustment of medications, and follow-up at a shorter interval than would be normally anticipated, it would allow for cost-sharing.

For questions regarding member benefits, log on to NaviNet and select *Eligibility and Benefits Inquiry* from the Plan Transactions menu. You can also use the Provider Automated System by calling 1-800-ASK-BLUE.

P F A

IBC follows CMS lead with second HIPAA 5010 90-day enforcement grace period

Consistent with the latest statement issued by the Centers for Medicare & Medicaid Services (CMS), IBC will observe a second 90-day grace period for enforcement of the new HIPAA 5010 transaction standards. This second grace period will expire on June 30, 2012.

The original rule from the U.S. Department of Health and Human Services (HHS) stipulated that any health care entity that submits electronic standard transactions must comply with HIPAA 5010 (errata version) by January 1, 2012. In late 2011, CMS issued a statement announcing a grace period of the enforcement of the new HIPAA 5010 transactions standards through March 30, 2012. CMS has issued a second statement extending the grace period to June 30, 2012.

IBC will comply with the HHS rule to move to 5010 standards. However, IBC will continue to accept and remit 4010A transactions through the recommended 90-day enforcement grace period, ending on June 30, 2012.

If you are not prepared to issue and accept HIPAA 5010-compliant transactions by June 30, 2012, you may be adversely affected by conversion activities initiated by IBC and/or your trading partner (clearinghouse/vendor). We encourage you to continue working with your trading partners to ensure your preparedness and to avoid any negative outcomes during this transition.

If you have any questions concerning your preparedness for the transition to 5010, please contact your trading partner (clearinghouse/vendor).

P F A

HIPAA 5010 troubleshooting information

As HIPAA 5010 claims submissions come in, IBC has been identifying the most common reasons for claims rejections. Please carefully review the examples below to avoid 5010 claims rejections.

Impacts 837P files only

When submitting Other Party Liability (OPL) claims, SBR09 not equal to “P”, the new 5010 AMT segment must be submitted when AMT01 = “EAF”.

Impacts both 837I and 837P files

- The description is required when submitting a non-specific procedure code. If this information is not present on the claim, the claim will fail compliance.

  -837I 2400.SV202-7

  -837P 2400.SV201-7

- REF segments are only allowed in the following loops when an NPI is submitted on the claim:

837P HIPAA 5010 Transaction	837I HIPAA 5010 Transaction
2010AA Billing Provider Name	2010BB Payer Name
2010BB Payer Name	2310A Attending Physician
2310A Referring Provider	2310B Operating Physician
2310B Rendering Provider	2310C Other Operating Physician
2310C Service Facility	
2420A Line Level Rendering Provider	

Note: If the subscriber is not the patient, please ensure that the patient’s ID is submitted in 2010BA.NM109.

HIPAA 5010 Companion Guides can be found on the IBC website at *www.ibx.com/edi*. If you have any questions concerning your HIPAA 5010-compliant transactions, please contact your trading partner (clearinghouse/vendor).

ICD-10 Spotlight:
Know the codes

ICD | 10
More codes • More detail • Improved accuracy℠

Each month, this section will feature an example of how ICD-9 codes will translate to ICD-10 codes. We will present coding examples from different specialties and popular disease categories to demonstrate the granularity that the new ICD-10 code set will provide.

CONDITIONS: CENTRAL CORNEAL ULCER AND MALIGNANT NEOPLASM OF LOWER-OUTER QUADRANT OF FEMALE BREAST

"Laterality" (side of the body affected) is a new coding convention added to relevant ICD-10 codes to increase specificity. Designated codes for conditions such as fractures, burns, ulcers, and certain neoplasms will require documentation of the side/region of the body where the condition occurs.

In ICD-10, laterality code descriptions include right, left, bilateral, or unspecified designations:

- Right side = character 1;
- Left side = character 2;
- Bilateral = character 3;
- Unspecified side/region = character 0 or 9 (depending on whether it is a 5th or 6th character).

The tables below compare the lack of specificity in ICD-9 to the greater level of specificity in ICD-10 when coding a corneal ulcer and female breast cancer.

Condition: Central Corneal Ulcer

ICD-9 coding table	ICD-10 coding table
• 370.03 Central corneal ulcer	• H16.011 Central corneal ulcer, right eye OR • H16.012 Central corneal ulcer, left eye OR • H16.013 Central corneal ulcer, bilateral OR • H16.019 Central corneal ulcer, unspecified

Condition: Malignant Neoplasm of Lower-Outer Quadrant of Female Breast

ICD-9 coding table	ICD-10 coding table
• 174.5 Malignant neoplasm of lower-outer quadrant of female breast	• C50.511 Malignant neoplasm of lower-outer quadrant of right female breast* AND/OR • C50.512 Malignant neoplasm of lower-outer quadrant of left female breast* OR • C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast

**If a bilateral code does not exist and the condition is bilateral, assign separate codes for both the left and right side.*

For additional information related to IBC's transition to ICD-10, please visit *www.ibx.com/icd10*.

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Coming soon: New tool for members to provide online reviews for their network physicians

To help members make informed decisions when seeking care, IBC will launch a new online capability that allows all commercial and Medicare Advantage HMO and PPO members, including those who carry an Independence Administrators ID card, to post reviews and ratings for IBC network physicians from whom they've received care. This initiative comes from the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield plans, and applies to all Blue plans nationally.

This new tool will be available to members through our secure consumer website, ibxpress.com, or through MyIBXTPA.com for Independence Administrators members.

Physicians will be able to view their reviews through the provider finder tool, which is available at ibx.com by selecting *Find a Provider.* Reviews will also be displayed nationally on the Blue National Doctor & Hospital Finder℠ at *www.bcbs.com*.

Members will be able to rate their network physicians in the following areas:

- **Experience:** Overall care provided by the physician.
- **Communication:** Willingness of physician to listen to their concerns.
- **Availability:** Ease and timeliness of obtaining an appointment.
- **Environment:** Friendliness of office staff.

Patient review is valuable

Not only is patient review a valuable tool that can provide you insight into your patients' experiences, but it can also attract new patients. While there are many factors to consider when patients choose a health care provider, online patient reviews are highly sought after pieces of information for consumers. And patient reviews are frequently positive – some providers have even used reviews as a means to promote their practice.

Once the tool is available, we encourage you to tell your patients so they can contribute to your reviews.

Moderation of reviews

It is important to note that a rigorous process will be in place to authenticate, verify, and moderate member reviews prior to them appearing on the provider finder tool, a process that will help ensure that only authenticated members who attest that they have seen the physician can contribute reviews. In addition, all reviews are checked for appropriateness of language and content.

Look for more information about this valuable new tool in future editions of *Partners in Health Update*.

Updated *Clinical Alerts Overview* is available

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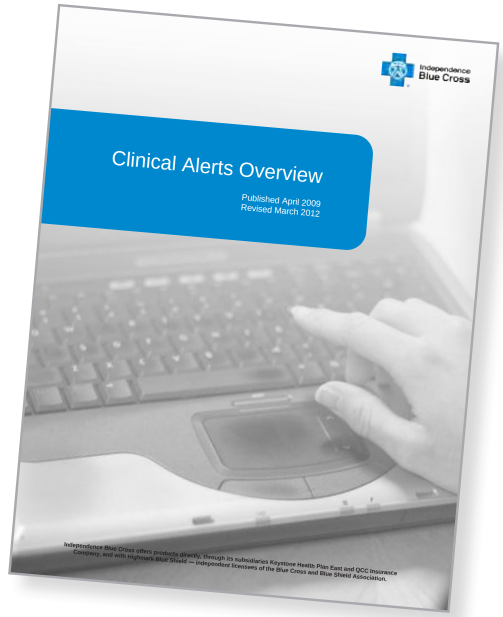
In 2009, Clinical Alerts were introduced as a tool to notify primary care physicians (PCP), OB/GYNs, cardiologists, and endocrinologists when their IBC patient has not received a recommended service or medication. These notifications are available on the NaviNet web portal through the Eligibility and Benefits Inquiry transaction.

Initially, 13 Clinical Alerts were introduced, including ones for missing mammograms and cholesterol screenings. Recently, the following new Clinical Alerts were added:

- bone mineral density test or drug to treat or prevent osteoporosis;
- HbA1c between 7% – 7.9% for patients with diabetes;
- HbA1c between 8% – 8.9% for patients with diabetes;
- HbA1c greater than 9.0% for patients with diabetes;
- cholesterol >=100 mg/dL for patients with diabetes;
- cholesterol >=100 mg/dL for patients with cardiovascular conditions.



The *Clinical Alerts Overview*, a user guide for how to access Clinical Alerts, has been updated to include these new alerts. The updated guide is available in the Administrative Tools & Resources section of IBC NaviNet Plan Central.

Note: PCPs are able to view all of a member's Clinical Alerts; however, specialists can view only those alerts pertaining to their specialty. Please refer to the *Clinical Alerts Overview* for a complete list of all alerts and the specialties they pertain to.

NaviNet enhancement features new urgent care copayment

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We have recently enhanced our Eligibility and Benefits Inquiry transaction on the NaviNet web portal to include copayment information for urgent care services.

To view the urgent care copayment for eligible members, select *Eligibility and Benefits Inquiry* from the Plan Transactions menu, enter the search criteria for the member, and hit *Select* next to the appropriate member. The urgent care copayment (if applicable) will be listed under *Copays*. The copayment, as well as any applicable coinsurance, will also appear on the *Additional Copays* screen. Please note that not all members are eligible for the urgent care benefit.

Only providers who are specifically credentialed and contracted with IBC as an urgent care provider can charge an urgent care copayment for urgent care services.

If you have questions related to the urgent care benefit, please contact Customer Service at 1-800-ASK-BLUE.

If you have any questions about viewing copayment information on NaviNet, please contact NaviNet Customer Service at 1-888-482-8057 or our eBusiness Provider Hotline at 215-640-7410.

P F

Use the Clinical Care Report to improve coordination of care

The Clinical Care Report was introduced in 2011 to promote better coordination of health care for our members and physicians. Unless a member has opted out, this tool is accessible through the NaviNet web portal and offers participating physicians a snapshot view of care that their patients have received based on IBC-paid medical and prescription drug claims.

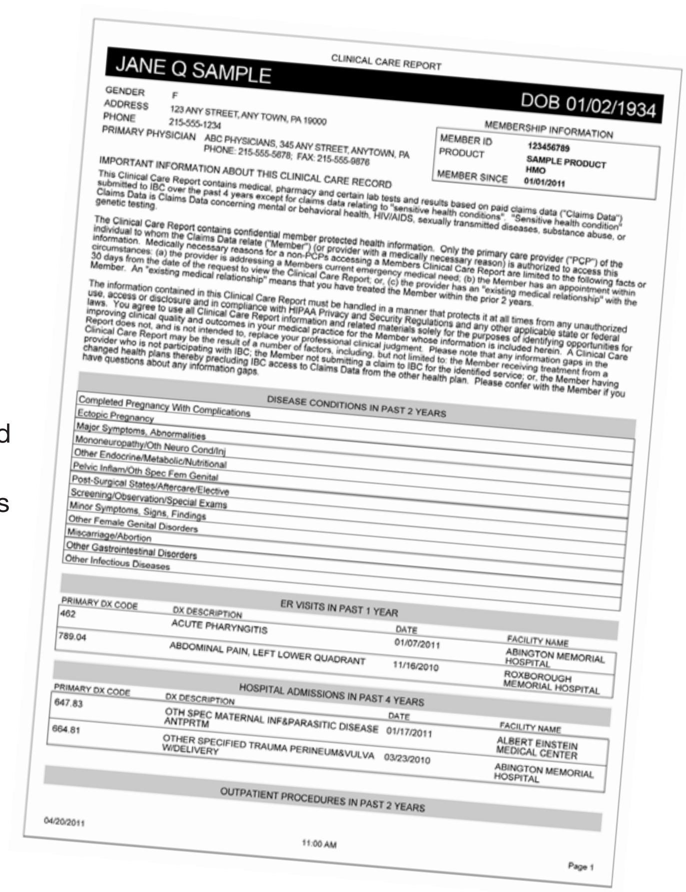
The Clinical Care Report is intended for viewing by the following participating health care providers:

- a member's personal or primary care physician;
- a new physician with whom a member has an upcoming scheduled appointment;
- a physician who is addressing a current emergency medical need.

Information available in the Clinical Care Report

The information populated in the Clinical Care Report is derived from member claims data and includes the following information:

- disease conditions reported in the past two years;
- visits to the emergency room in the past year;
- hospital admissions in the past four years;
- outpatient procedures in the past two years;
- specialists seen in the past two years;
- prescriptions filled in the past six months;
- alerts by condition (i.e., gaps in care), if any;
- lab tests with results (when available);
- diagnostic imaging in the past two years;
- immunizations in the past four years.



CLINICAL CARE REPORT

JANE Q SAMPLE

DOB 01/02/1934

GENDER F
ADDRESS 123 ANY STREET, ANY TOWN, PA 19000
PHONE 215-555-1234
PRIMARY PHYSICIAN ABC PHYSICIANS, 345 ANY STREET, ANYTOWN, PA
PHONE: 215-555-5678; FAX: 215-555-9876

MEMBERSHIP INFORMATION

MEMBER ID	123456789
PRODUCT	SAMPLE PRODUCT HMO
MEMBER SINCE	01/01/2011

IMPORTANT INFORMATION ABOUT THIS CLINICAL CARE RECORD

This Clinical Care Report contains medical, pharmacy and certain lab tests and results based on paid claims data ("Claims Data") submitted to IBC over the past 4 years except for claims data relating to "sensitive health conditions". "Sensitive health condition" Claims Data is Claims Data concerning mental or behavioral health, HIV/AIDS, sexually transmitted diseases, substance abuse, or genetic testing.

The Clinical Care Report contains confidential member protected health information. Only the primary care provider ("PCP") of the individual to whom the Claims Data relate ("Member") (or provider with a medically necessary reason) is authorized to access this information. Medically necessary reasons for a non-PCPs accessing a Members Clinical Care Report are limited to the following facts or circumstances: (a) the provider is addressing a Members current emergency medical need; (b) the Member has an appointment within 30 days from the date of the request to view the Clinical Care Report; or, (c) the provider has an "existing medical relationship" with the Member. An "existing medical relationship" means that you have treated the Member within the prior 2 years.

The information contained in this Clinical Care Report must be handled in a manner that protects it at all times from any unauthorized use, access or disclosure and in compliance with HIPAA Privacy and Security Regulations and any other applicable state or federal laws. You agree to use all Clinical Care Report information and related materials solely for the purposes of identifying opportunities for improving clinical quality and outcomes in your medical practice for the Member whose information is included herein. A Clinical Care Report does not, and is not intended to, replace your professional clinical judgment. Please note that any information gaps in the Clinical Care Report may be the result of a number of factors, including, but not limited to: the Member receiving treatment from a provider who is not participating with IBC; the Member not submitting a claim to IBC for the identified service; or, the Member having changed health plans thereby precluding IBC access to Claims Data from the other health plan. Please confer with the Member if you have questions about any information gaps.

DISEASE CONDITIONS IN PAST 2 YEARS
Completed Pregnancy With Complications
Ectopic Pregnancy
Major Symptoms, Abnormalities
Mononeuropathy/Oth Neuro Cond/Inj
Other Endocrine/Metabolic/Nutritional
Pelvic Inflam/Oth Spec Fem Genital
Post-Surgical States/Aftercare/Elective
Screening/Observation/Special Exams
Minor Symptoms, Signs, Findings
Other Female Genital Disorders
Miscarriage/Abortion
Other Gastrointestinal Disorders
Other Infectious Diseases

ER VISITS IN PAST 1 YEAR

PRIMARY DX CODE	DX DESCRIPTION	DATE	FACILITY NAME
462	ACUTE PHARYNGITIS	01/07/2011	ABINGTON MEMORIAL HOSPITAL
789.04	ABDOMINAL PAIN, LEFT LOWER QUADRANT	11/16/2010	ROXBOROUGH MEMORIAL HOSPITAL

HOSPITAL ADMISSIONS IN PAST 4 YEARS

PRIMARY DX CODE	DX DESCRIPTION	DATE	FACILITY NAME
647.83	OTH SPEC MATERNAL INF&PARASITIC DISEASE ANTPRTM	01/17/2011	ALBERT EINSTEIN MEDICAL CENTER
664.81	OTHER SPECIFIED TRAUMA PERINEUM&VULVA W/DELIVERY	03/23/2010	ABINGTON MEMORIAL HOSPITAL

OUTPATIENT PROCEDURES IN PAST 2 YEARS

04/20/2011

11:00 AM

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Note: The Clinical Care Report is not a complete medical record of all services, tests, or products that a member may have received. It does not include data for sensitive health conditions such as mental/behavioral health, substance abuse, HIV/AIDS, sexually transmitted diseases, genetic testing, or for services for which IBC did not pay a claim.

How to grant or remove access to the Clinical Care Report

Initially, only the designated Security Officer(s) in each provider office has access to the Clinical Care Report, and he or she can control user access through the User Management transaction on NaviNet.

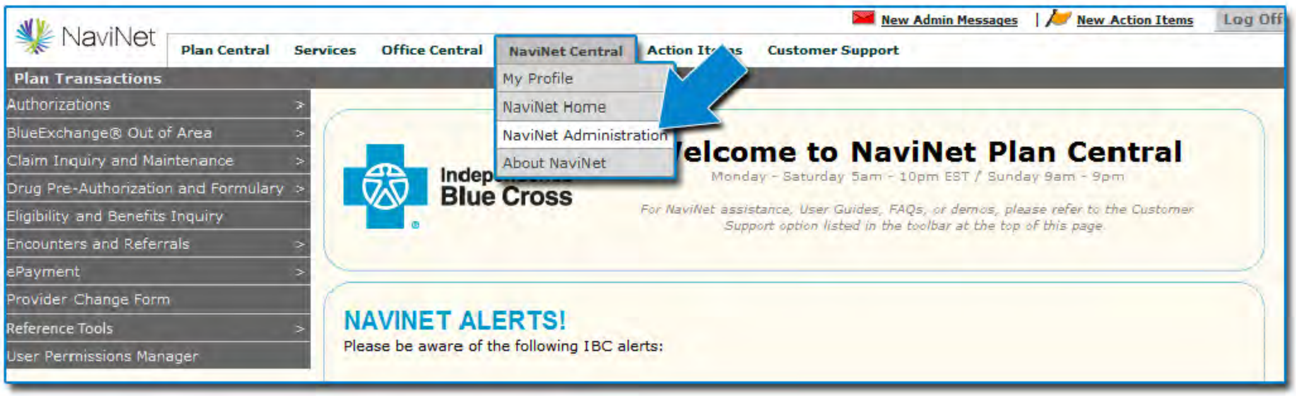
Therefore, in order for providers to access the Clinical Care Report, a designated Security Officer first must enable individual users or all users.

continued on the next page

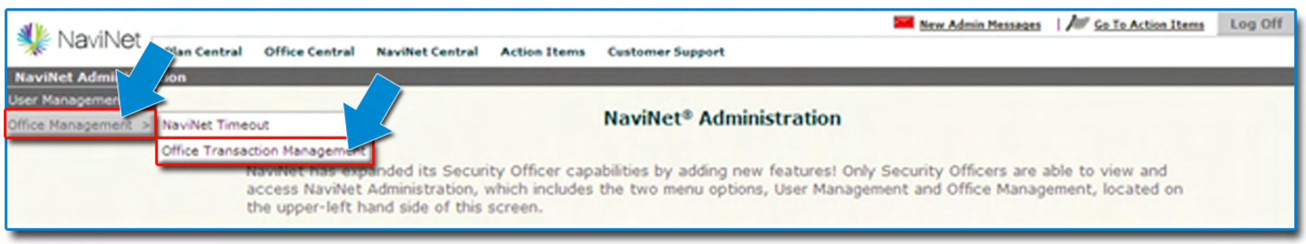
Use the Clinical Care Report to improve coordination of care (continued)

Granting access to all users within an office

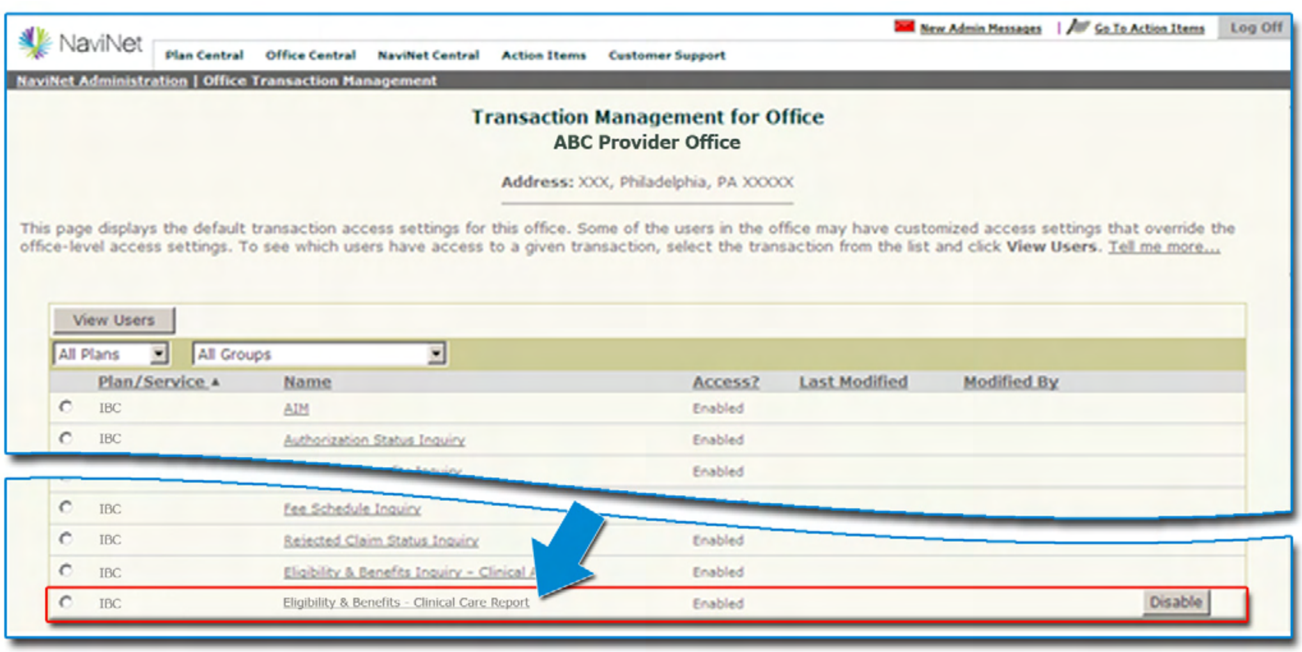
To update the settings to allow all users within an office access to the Clinical Care Report, the designated Security Officer must first select *NaviNet Administration* from the NaviNet Central menu.



Select *Office Management* from the drop-down menu on the left, and then select *Office Transaction Management*.



Scroll down the Transaction Management for Office screen until you find the transaction called *Eligibility & Benefits – Clinical Care Report* in the Name column. Click *Enable* to turn on access to all individuals in your office.



To turn off access for all users in your office, follow the same steps and click *Disable* instead.

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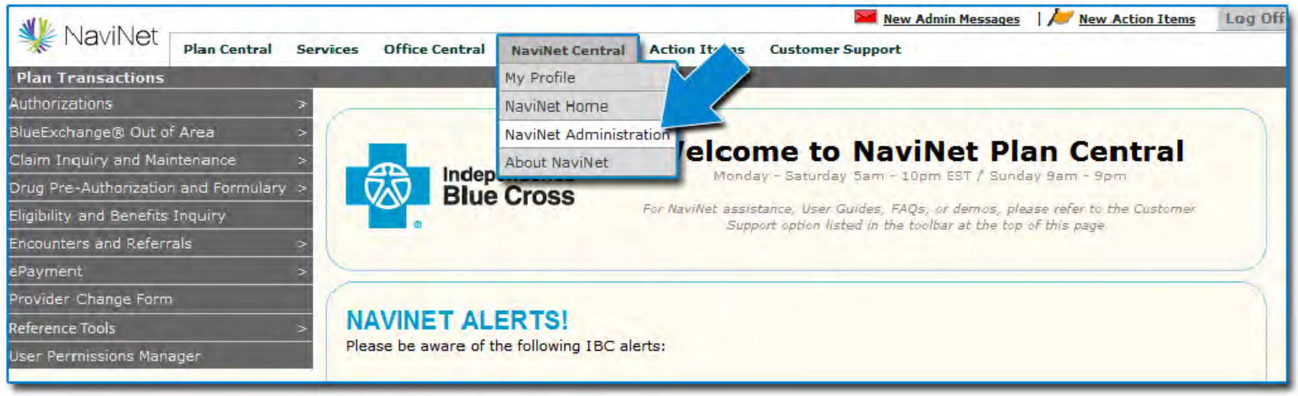
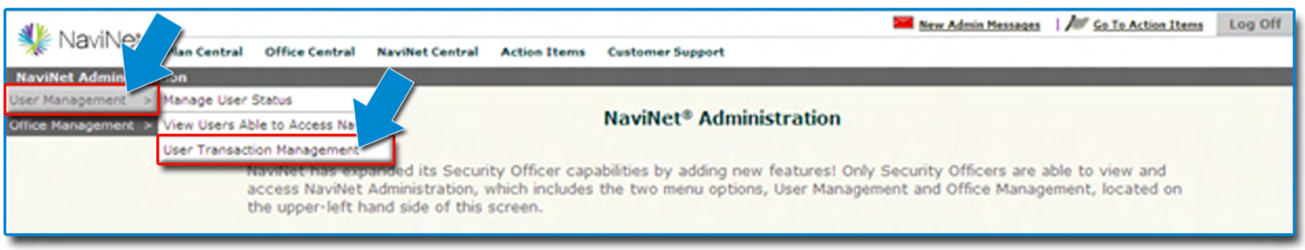
Use the Clinical Care Report to improve coordination of care (continued)

Granting access to only select individuals within an office

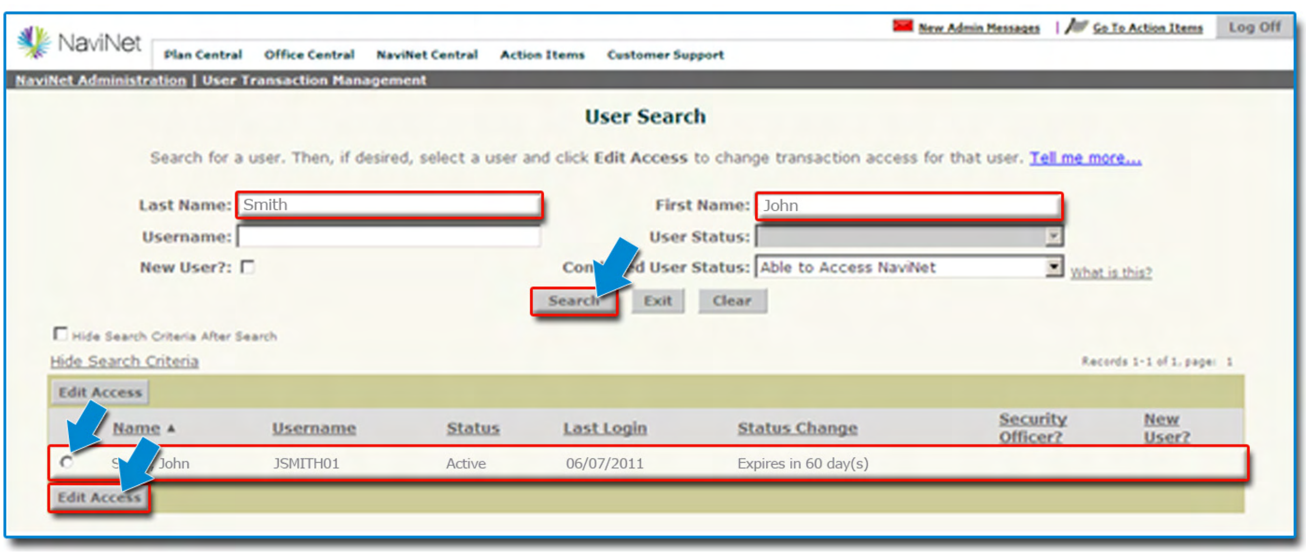
The designated Security Officer can also limit access to the Clinical Care Report to certain individuals within a provider office. To do so, first select *NaviNet Administration* from the NaviNet Central menu.



Select *User Management* from the drop-down menu on the left, and then select *User Transaction Management*.



The designated Security Officer must search for the appropriate user by entering a last and first name and then clicking *Search*. Select the appropriate user from the list that populates, and then select *Edit Access* to view the list of transactions.



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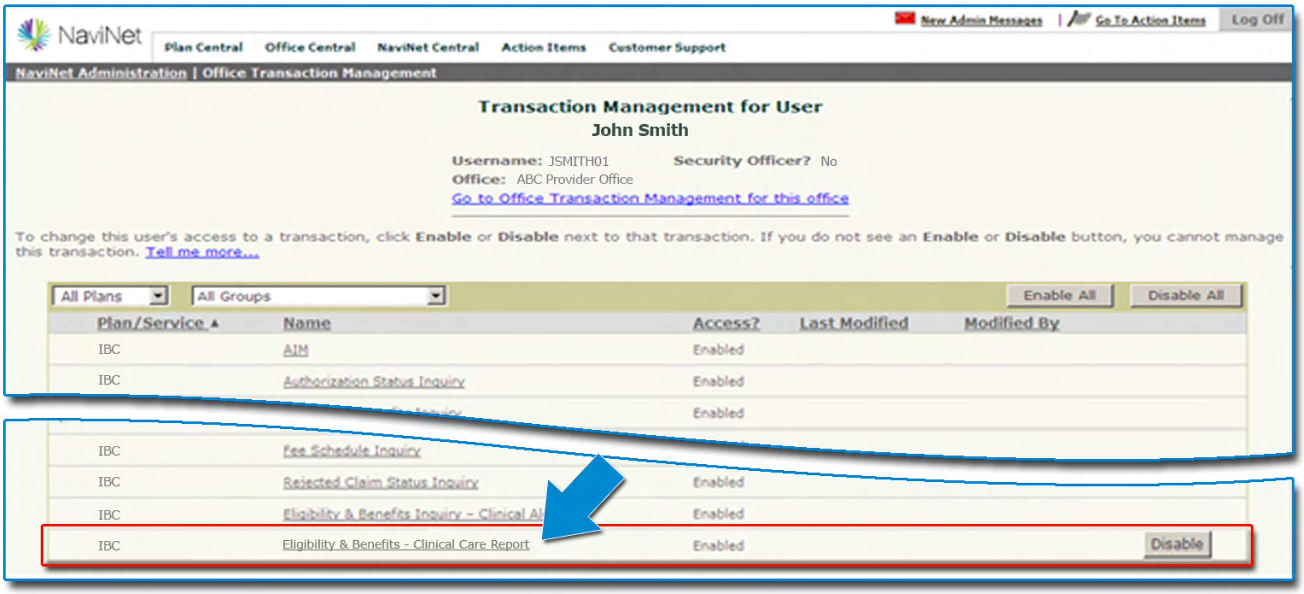
Use the Clinical Care Report to improve coordination of care (continued)

Scroll down the Transaction Management for User screen until you find the transaction called *Eligibility & Benefits – Clinical Care Report* in the Name column. Click *Enable* to turn on access to the individual.



To turn off access for certain individuals in your office, follow the same steps and click *Disable* instead.

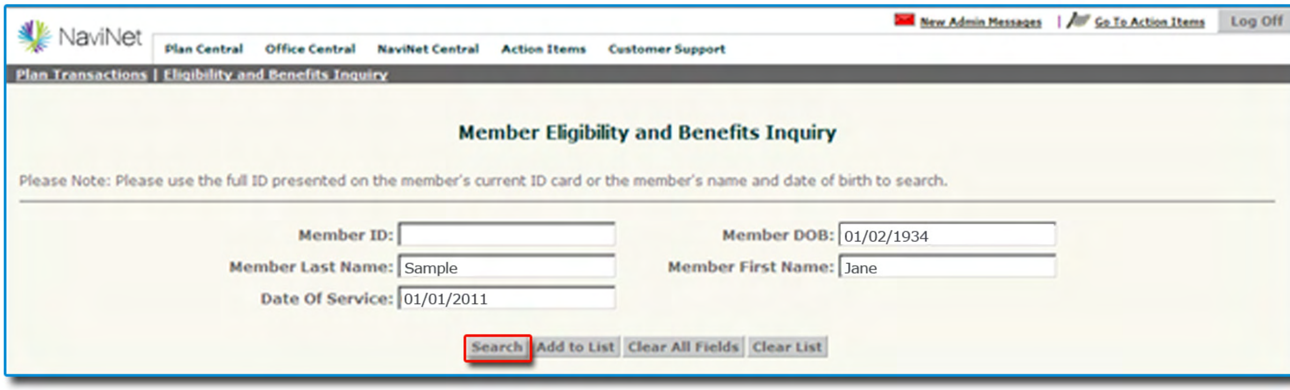
How enabled users can view a member's Clinical Care Report

Once enabled, physicians can view the Clinical Care Report by selecting the *Eligibility and Benefits Inquiry* option from the Plan Transactions menu.

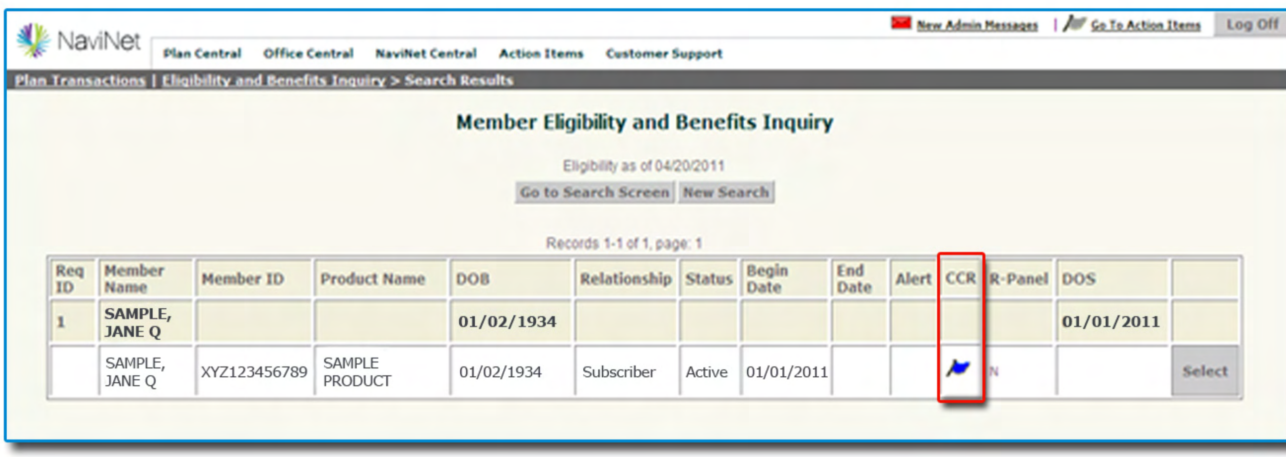
continued on the next page

Use the Clinical Care Report to improve coordination of care (continued)

To determine if a member has a Clinical Care Report, the user should enter the member's information (either the member ID number or last name, first name, and date of birth) and select the *Search* button.



If the member has not opted out of the tool, there will be a flag in the column labeled "CCR". The blue flag in that column indicates that the member's Clinical Care Report is available for you to view once you have agreed to abide by the terms and conditions. Click the blue flag to view the report.



We hope you'll find this tool valuable as you care for your patients, our members. If you have questions regarding this tool, please call the eBusiness Provider Hotline at 215-640-7410.

If you are not yet NaviNet-enabled at your office location, register by going to *www.navinet.net* and selecting *Sign up* from the top right.

PFA

Policy notifications posted as of March 26, 2012

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 March 26, 2012.

Policy effective date	Policy no.	Notification title	Notification issue date
March 20, 2012	11.08.03h	Lipectomy and Liposuction	December 21, 2011
March 21, 2012	10.01.01i	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Programs	January 18, 2012
March 30, 2012	07.00.14d	Cold Laser Therapy	February 29, 2012
March 30, 2012	07.03.05l	Sleep Disorder Testing	February 29, 2012
April 4, 2012	11.17.06h	Surgical and Minimally Invasive Treatments for Urinary Outlet Obstruction due to Benign Prostatic Hyperplasia (BPH)	January 5, 2012
April 4, 2012	10.06.01e	Speech Therapy	January 5, 2012
April 4, 2012	07.13.07e	Corneal Pachymetry Using Ultrasound	January 5, 2012
April 4, 2012	10.04.01j	Pulmonary Rehabilitation	January 5, 2012
April 4, 2012	11.08.12g	Surgery for Gynecomastia	January 5, 2012
April 4, 2012	05.00.09e	Bone Growth Stimulators	January 5, 2012
April 4, 2012	05.00.37d	Compression Garments	January 5, 2012
April 5, 2012	07.03.09h	Electromyography (EMG) Studies: Needle EMG, Surface EMG (SEMG)	January 6, 2012
April 5, 2012	07.03.18g	Nerve Conduction Studies (NCS) and Related Electrodiagnostic Studies	January 6, 2012
April 5, 2012	07.03.20	Surface Electromyelogram	March 6, 2012
June 1, 2012	09.00.46f	High-Technology Diagnostic Radiology Services	March 2, 2012

To view the policy notifications, go to *www.ibx.com/medpolicy*, select *Accept and Go to Medical Policy Online,* and click on the *Policy Notifications* box. You can also view policy notifications using the NaviNet® web portal by selecting *Reference Tools* from the Plan Transactions menu, 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.

Assessing the needs of high-risk Medicare Advantage HMO and PPO members

P F

We are pleased to announce two outreach initiatives in 2012 for our high-risk Medicare Advantage HMO and PPO members: one for members who are currently in a contracted facility that provides skilled or custodial care (SNF program), and another for select high-risk members who reside at home (In-Home program). Through MedAssurant, an independent company, local physicians, nurse practitioners, and physician assistants will conduct comprehensive health risk assessments for members either at the facility or in the member's home.

These programs provide face-to-face comprehensive medical assessments for high-risk Medicare Advantage HMO and PPO members with complex chronic conditions, at no cost to the member. These assessments will help support the care that primary care physicians (PCP) give to these Medicare Advantage HMO and PPO members and identify additional health risks and additional medical management opportunities.

As noted in communications to SNF and at-home members, a MedAssurant representative will contact applicable facilities and members to arrange these comprehensive health risk assessments and review charts as necessary with the members' consent. For the SNF program, facilities are responsible for providing inpatient medical records and assisting in contacting members' PCPs for information to complete the health risk assessments.

Once the comprehensive health risk assessment is completed, a letter will be sent to the Medicare Advantage HMO and PPO members' PCP or other designated provider informing them that an assessment was performed, along with the results. As part of the SNF program, a copy of the comprehensive health risk assessment shall be placed in the patient's medical records in the facility. PCPs should file the comprehensive health risk assessment in their patients' charts and review the results with them during their next visit.

Last year, the comprehensive health risk assessments were well-received by both patients and the provider community. This year we look forward to serving the selected high-risk members and the provider community.

Please call Customer Service at 1-800-ASK-BLUE if you would like more information about this initiative or if you have further questions.

Low-dose chest CT screening for individuals at high risk for lung cancer

P F A

As of March 23, 2012, IBC includes coverage of chest CT screening for our managed care members at high risk for lung cancer.

This decision was made based upon National Cancer Institute-sponsored research published by the National Lung Screening Trial Research Team, in addition to current clinical practice guideline recommendations. Results from the study illustrated a 20 percent reduction in overall lung cancer mortality among high-risk individuals who were randomized to the low-dose CT screening arm of the trial.

This benefit is available for members when all of the following are met:

- The patient has no signs or symptoms suggestive of underlying cancer.
- The patient is between 55 and 74 years of age.
- There is at least a 30 pack-year history of cigarette smoking (if former smoker, quit date is within the previous 15 years).

Providers are required to obtain precertification from AIM Specialty Health (AIM®), an independent company contracted with IBC to perform precertification for select diagnostic imaging services for our managed care members. Precertification can be requested through the AIM ***Provider****Portal*℠, which is available on the NaviNet® web portal by selecting *AIM* from the Authorizations option in the Plan Transactions menu, or at *www.aimspecialtyhealth.com/goweb*. If you do not have Internet access, you can also call 1-800-ASK-BLUE to request precertification.

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

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CMS patient safety measures and how you can help

The Centers for Medicare & Medicaid Services (CMS) uses performance and quality measures to help Medicare beneficiaries make informed decisions regarding medical and prescription drug programs. As part of this effort, CMS calculates and publicizes several patient safety measures, many of which are used to calculate ratings for health plans.

We are committed to working with our providers to improve outcomes on these patient safety measures. As a first step, we want to explain each measure as well as the role you can play to ensure that our Medicare Advantage HMO and PPO members are receiving care that is both safe and effective. The measures and their descriptions are listed below.

High-Risk Medication (HRM)

The HRM rate analyzes the percentage of Medicare Part D beneficiaries who are 65 and older and have filled prescriptions for medications with a high risk of serious side effects in the elderly. The list of medications that CMS defines as high-risk in the elderly was adapted from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and adapted and endorsed by the Pharmacy Quality Alliance (PQA). Go to *www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPatientSafetyMeasures_07.16.10.pdf* (see pages 3-4) for the complete list. Providers should avoid prescribing these medications, when possible, to patients who are 65 and older.

Diabetes Treatment (DT)

The DT rate analyzes the percentage of Medicare Part D beneficiaries who are 18 and older and have filled a prescription for both diabetes and hypertension but did *not* fill a prescription for an ACEI or ARB medication. Providers who have diabetic patients who also need hypertension medications are encouraged to prescribe an ACEI or ARB and educate their patients about the importance of taking an ACEI or ARB in conjunction with treatment for diabetes and hypertension. A list of the diabetes and hypertension medications included in this measure is available at *www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoPatientSafetyMeasures_07.16.10.pdf* (see pages 5-6).

Drug-Drug Interaction (DDI)

The DDI rate analyzes the percentage of Medicare Part D beneficiaries who have filled a prescription for a targeted medication during the measurement period and who also filled a prescription for a contraindicated medication, either at the same time or subsequent to the initial prescription. Providers can view the list of targeted and contraindicated medications at *www.cms.gov/PrescriptionDrugCovContra/Downloads/2010PtSafetyReportEnhan_memo_093010.pdf* (see page 8) and should avoid prescribing these medications together.

Diabetes Medication Dosage (DMD)

The DMD rate analyzes the percentage of Medicare Part D beneficiaries who filled a prescription at a dose that was higher than the daily recommended dose for biguanide, sulfonylurea, and thiazolidinedione therapeutic classes of oral hypoglycemic drugs. Providers can view the maximum recommended adult doses for these drugs at *www.cms.gov/PrescriptionDrugCovContra/Downloads/2010PtSafetyReportEnhan_memo_093010.pdf* (see pages 5-7) and are encouraged to prescribe them within the recommended dose range.

Part D Medication Adherence (ADH)

The ADH rates assess the extent to which Medicare Part D beneficiaries adhered to their prescribed medications in the following drug classes/therapeutic areas: antiretrovirals, cholesterol (statins), hypertension (ACEI or ARB), and oral diabetes medications. Providers are encouraged to educate their patients who have been prescribed these medications about the importance of taking and refilling their prescriptions.

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

Safe use of acetaminophen in infants and children

P

Since 2011, manufacturers of infant's and children's liquid acetaminophen products (e.g., Tylenol®) have changed the amount of acetaminophen to one standard amount to help eliminate dosage confusion among parents and guardians who administer these medications. Providers who see infants and children should make parents and guardians aware of this change to avoid an accidental overdose of acetaminophen.

More information is available at *www.fda.gov/Drugs/DrugSafety/ucm284756.htm*.

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Updated meningococcal vaccine/booster dose guidelines from the AAP

In December 2011, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the American Academy of Pediatrics (AAP) updated recommendations for the meningococcal vaccine and booster dose.[1]

Updated recommendations include vaccinating adolescents at 11 or 12 years with the quadrivalent meningococcal vaccine and administering a booster dose at age 16 with the objective of protecting adolescents and young adults between 16 and 21 years when meningococcal disease rates peak.

The article with the complete list of updated guidelines is published in the journal *Pediatrics*, available online at *http://pediatrics.aappublications.org/content/early/2011/11/22/peds.2011-2380.full.pdf+html*.

[1] *www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a4.htm?s_cid=mm6040a4_e%0d%0a*

Case management Help for your patients when they need it

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Sometimes members need extra support. Registered nurse case managers and social workers from IBC are available to provide telephone support and information to your patients who are experiencing complex health issues or are facing challenges in meeting health care goals. Consider making a referral to case management if any of your patients need help with the following:

- wound care
- cancer treatment education
- complications of pregnancy
- adherence to treatment plan
- community resource information
- coordination of home care services
- complex pediatric medical conditions
- socioeconomic support (medications)
- investigation of benefits for medical equipment
- chronic condition with multiple comorbid conditions

The case manager or social worker will work with your office to find out how best to support the member in following your treatment plan.

To refer a patient to case management, call 1-800-313-8628, or complete an online referral form at *www.ibx.com/case_mgmt_ref_form*.

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 Violation Hotline	215-988-1413 www.ibx.com/credentials
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 (275-2583)
Provider Services user guide	www.ibx.com/providerautomatedsystem
eBusiness Help Desk	215-241-2305
FutureScripts® (pharmacy benefits) Prescription drug prior authorization Fax	1-888-678-7012 1-888-671-5285
Direct Ship Specialty Pharmacy Program Fax	1-888-678-7012 1-888-671-5285
Mail order program toll-free fax	1-877-228-6162
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
Mail order program toll-free fax	1-877-344-1318
IBC Direct Ship Injectables Program (medical benefits)	www.ibx.com/directship
Medical Policy	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