



## Provider Administered Drug Program (PADP) Fast Tracker

Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and Health Options, Inc. contracted with ICORE Healthcare, LLC (ICORE) to assist in managing the new statewide Provider Administered Drug Program (PADP). The program is designed to maximize patient care in the most appropriate and affordable manner based on clinically accepted standards. Effective July 20, 2009, providers who have signed new BCBSF and Health Options agreements are subject to the PADP. Providers who are not yet under new agreements are encouraged to participate on a voluntary basis.

For newly contracted physicians who supply and bill, the PADP requires a pre-service review prior to the administration of certain specified drugs in the office, home, outpatient hospital, ambulatory surgical center, public health clinic and rural health clinic. These drugs are listed below:

- Aloxi
- Aranesp
- Avastin
- Epogen/Procrit
- Herceptin
- Neupogen
- Neulasta

Additions to this list will be made periodically in accordance with applicable provisions of your contract(s). Additionally, certain member benefit agreements may require prior authorization for certain drugs.

**Note:** The program is not applicable for drugs administered in an emergency room, observation unit or during an inpatient stay.

As with all utilization management programs, PADP will be utilized to determine if the proposed service meets the definition of medical necessity under the member's benefit plan. Details of this pre-service review process are listed below. Requirements for the pre-service review process are applicable to the following products:

- HMO (BlueCare, BlueMedicare HMO)
- PPO (BlueChoice, BlueMedicare PPO, BlueOptions, BlueSelect, GoBlue, Miami-Dade Blue)
- Traditional

The pre-service review process is unavailable for certain members including BlueCard, BlueMedicare Private Fee-for-Service, Medicare supplement, Federal Employee Program and State Employees' PPO Plan. It is also not available for members whose primary coverage is Medicare or the secondary insurance coverage is BCBSF. This information is set forth in the online *Manual for Physicians and Providers*, as specified in your contract.

### Procedures for Ordering Physicians

1. Prior to requesting a pre-service review verify member eligibility and benefits through the Availity<sup>®1</sup> Health Information Network at [www.availity.com](http://www.availity.com) or contact BCBSF at (800) 727-2227.
2. To expedite the process, have the following information ready:
  - Name and office phone number of the in-office physician
  - Member name and ID number
  - Requested medical pharmacy drug(s)
  - Anticipated start date of treatment (if known)
  - Patient weight and/or body surface area
  - Dosing information and frequency
  - Diagnosis
  - Past therapeutic failures (if applicable)

<sup>1</sup> Availity, LLC, is a multi-payer joint venture company. For more information or to register, visit Availity's website at [www.availity.com](http://www.availity.com).

3. If requested, be prepared to fax the following documents:

- Clinical notes
- Pathology reports
- Relevant lab test results

### **Ordering physicians who supply and bill the drug**

After following the above steps, contact ICORE by one of the following two methods:

- For future dates of service, please use the secure online website tool at [www.icorehealthcare.com](http://www.icorehealthcare.com) and click on the Physician tab, which is available 24 hours a day and 7 days a week.
- Toll-free call center at (800) 424-4947 (Monday – Friday, 8 a.m. to 6 p.m. Eastern Time)

### **Ordering physicians who participate in the Voluntary Stock Replacement Program with Caremark**

Contact Caremark at (866) 278-5108 or by fax at (800) 323-2445 within 30 days of the service date that the medication was administered in your office. Do not bill BCBSF for this service as Caremark will bill BCBSF directly.

## **ICORE Request Timeframes**

The provider must contact ICORE by accessing ICORE's website at [www.icorehealthcare.com](http://www.icorehealthcare.com) and click on the Physician tab or by calling the call center at (800) 424-4947. Urgent requests will be completed within 24 hours from receipt of the request. Non-urgent requests will be completed within five days from receipt of the request. In general, the request can be reviewed and pre-service review determined during the initial phone call if all of the necessary information needed to process the request is provided. The review and determination process can take longer if member or provider eligibility verification is required or if the request requires additional clinical review.

- For members who were already in care prior to July 20, 2009, providers were given 10 business days to obtain the first pre-service review with ICORE. During this timeframe, claims for dates of service between July 20, 2009, and July 31, 2009, will not be denied for lack of a pre-service review. However, claims for dates of service August 1, 2009, and after will be denied if the pre-service review process was not completed.
- For members who were not receiving treatment for one of the pre-service review drugs prior to July 20, 2009, a pre-service review must be completed prior to the initiation of treatment.

## **ICORE Access Information**

The physician administering a drug included in PADP is required to obtain pre-service review by accessing ICORE's website or by calling their call center.

- **Website Access**
  - Access ICORE's provider self-service at [www.icorehealthcare.com](http://www.icorehealthcare.com) and click on the physician tab.
  - If you need assistance with establishing a unique user name and password for your organization's administrator, please use the secure online website tool at [www.icorehealthcare.com](http://www.icorehealthcare.com) and click on Help.
  - Your administrator will then be able to set up a username for each individual user in your office.
  - If a prior authorization request is pended, you will receive a tracking number that you can use to check on the authorization status.
  - ICORE's website cannot be used for retrospective or expedited authorization requests. Those must be processed directly through ICORE's call center.
- **Telephone Access**
  - You may obtain prior authorization by calling (800) 424-4947.
  - ICORE can accept multiple requests during one phone call.

## Claim Submission Information

Submit claims for payment directly to BCBSF following the guidelines below.

- **Drug Units**
  - The drug units must always be included on the claim submission. The drug units should be based on the HCPCS code, not the National Drug Code (NDC), unless a specific J code is not assigned to the drug.
  - Unclassified drug codes (J3490, J3590, J9999, etc.) must always be billed with the drug name, NDC and NDC units. The NDC should be provided in field 24G on a CMS-1500 and in loop 2410 segment LIN on an electronic 837 Professional claim submission. If you have additional questions on how to bill NDCs for electronic claim submission, please contact your software management company or clearinghouse. Failure to provide this information may delay claim processing.
  
- **Diagnosis**
  - Include the primary diagnosis code on the claim, which is the reason for the drug use.
  - Claims submitted with only a V58.1 diagnosis code (Other and Unspecified After-Care Maintenance Chemotherapy) will require additional information prior to a coverage decision.
  
- **Modifiers**
  - If the remainder of a single use vial or other single use package must be discarded after administering a dose/quantity of the drug to a member, the claim should be submitted with two lines.
  - The portion of the drug that was administered should be submitted on one line and the JW modifier must be submitted on a separate claim line with the discarded amount.
  - The JW modifier should be used only on the claim line with the discarded amount.
  - Claims not submitted as noted, will be denied with directions for the provider to resubmit on two lines.

Claims should be submitted electronically through the Availity Health Information Network or a clearinghouse. Use of the appropriate National Provider Identifier (NPI) and BCBSF provider number are required. Medical policies used for pre- and post-service review that are related to the specified drugs are available on BCBSF's website, [www.bcbsfl.com](http://www.bcbsfl.com), by clicking on Physicians & Providers, Medical Information, then Medical Policies (Medical Coverage Guidelines).

If you have additional questions or need to verify your current contractual agreements require you to participate in the PADP, please contact the Network Management Service Unit at (800) 727-2227, say "More Choices," then "Network Management."

Fast Trackers are for general information only and are subject to the terms and conditions of any applicable agreement, policy or procedure. Fast Trackers may be altered or amended from time to time as necessary without any notice to you. If you are using a Fast Tracker, please check periodically to be sure you have the most recent version. If you have any questions or need more detailed information, please call us at (800) 727-2227.