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



This just in...



Updated payer ID grids now available

The professional and facility payer ID grids were recently updated to include new alpha prefixes for Independence Administrators and account-specific National BlueCard® PPO members.

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.

Reminder...



Get important information delivered through email

If you would like to receive email updates providing you with the latest information, including *Partners in Health Update* and news alerts, simply complete our email address submission form at www.ibx.com/providers/email.

Please allow up to two weeks for us to process your request. Remember to add IBC (provider_communications@ibx.com) to your email address book. 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.



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:

- Professional**
- Facility**
- 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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This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Program (HMO, PPO, Indemnity, etc.), and/or employer groups. Providers should call Provider Services for the member's applicable benefits information. Members should be instructed to call the Customer Service telephone number on their ID card.

The third-party websites mentioned in this publication are maintained by organizations over which IBC exercises no control, and accordingly, IBC disclaims any responsibility for the content, the accuracy of the information, and/or quality of products or services provided by or advertised in these third-party sites. URLs are presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefits plans. Members should refer to their benefits contract for complete details of the terms, limitations, and exclusions of their coverage.

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An affiliate of IBC holds a minority ownership interest in NaviNet, Inc., an independent company.

FutureScripts® and FutureScripts® Secure are independent companies that provide pharmacy benefits management services.

Reminder: Get involved this year and help us *stop* diabetes

We don't simply want to *fight* diabetes. We want to *stop* diabetes.

With more than 25.8 million people living with the disease and another 79 million at risk, your job as a health care professional grows more important every day. You play a significant role in the lives of your patients who have diabetes, and it's only natural that you might want to do more.

Get involved in this year's **Step Out®: Walk to Stop DiabetesSM**, the fourth annual family-friendly 5K fundraising walk of the American Diabetes Association (ADA). IBC is proud to once again be the presenting sponsor of the walk on Saturday, October 1, 2011. Participation shows your patients how much you care, promotes diabetes awareness and the benefits of living a healthy, active lifestyle, and helps provide needed funding for the ADA.

Walk with Your Doc

Walk with Your Doc is a program that encourages health care providers and their office staff to create a walking team for Step Out and to recruit their patients to join the team. Get started today — create a team by following these simple steps:

1. Go online to www.diabetes.org/stepoutphilly to register your team.
2. Name your team. The name should begin with "Walk with Your Doc" (e.g., *Walk with Your Doc – Diabetes and Endocrinology Associates*).
3. Once your team is registered, you can send emails to patients and staff or print registration forms to recruit them to your team. This is when the fund raising begins!

All funds raised through Step Out are used to support the ADA's ongoing research, education, and advocacy efforts. This includes the ADA's investment of \$300 million in diabetes research aimed at preventing and curing diabetes and helping people with diabetes live longer and healthier lives. In addition, the ADA offers education and other informative materials such as annual scientific sessions, medical care guidelines and recommendations, diabetes patient education program accreditation, and a Provider Recognition Program. Find out more at www.diabetes.org.

Not just for doctors

Walk with Your Doc isn't just for doctors. We want to encourage all concerned members of the health care community to form teams — nurses, physician assistants, diabetes educators, and support staff, too. Everyone should join in the fight to stop diabetes.

We'll see you there!

So gather up your colleagues, patients, family, and friends; grab your walking shoes; and head for the Philadelphia Museum of Art on October 1. By raising awareness of diabetes and helping to raise diabetes research funds, together we can strive towards eliminating diabetes. Don't forget to register at www.diabetes.org/stepout or by calling 1-888-DIABETES.

STEP | **WALK**
OUT | **TO STOP** DIABETESSM

American Diabetes Association.

PRESENTED BY



Changes to AIM request submission options

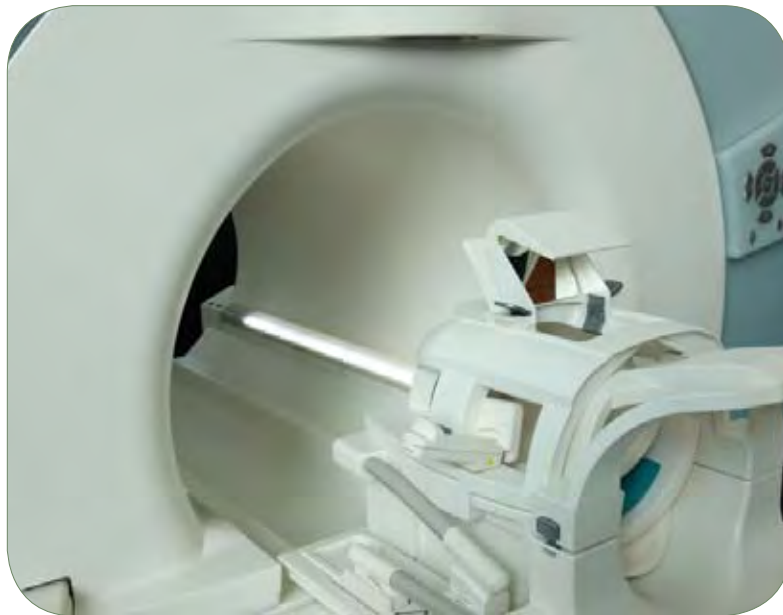
Beginning **October 1, 2011**, in order to expedite the processing of diagnostic imaging exam requests, American Imaging Management, Inc. (AIM), an independent company, will no longer support requests sent by fax. All diagnostic imaging requests submitted on or after October 1, 2011, should be submitted online through AIM's **ProviderPortalSM** or by telephone at 1-800-ASK-BLUE.

AIM's **ProviderPortal** is a Web-based application that is fully interactive and processes requests in real time.

Online order submission is available 24 hours a day, 7 days a week. Providers can visit www.americanimaging.net/goweb to register for AIM's **ProviderPortal**.

The fax option will continue to be available for physicians submitting additional clinical information for existing requests.

If you have any questions about the registration process, please contact AIM's Web Help Desk at 1-800-252-2021, prompt 3.

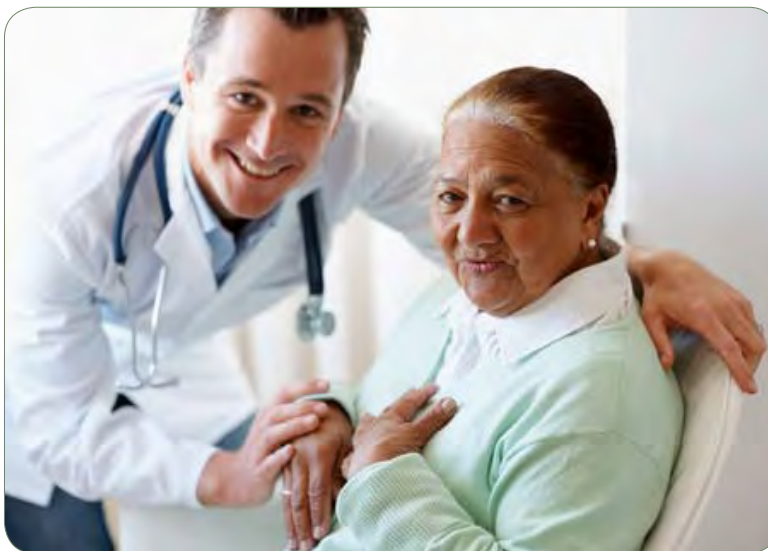


Cost-sharing for preventive and nonpreventive services



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 (i.e., nonpreventive) services. If a member is seen for both preventive and nonpreventive services during the same visit, cost-sharing may apply.

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



Reminder: Provider self-service requirements effective September 15, 2011

In our continuing efforts to provide the most current and reliable information to our network providers, **effective September 15, 2011**, we will enforce our policy that requires providers to use the NaviNet® web portal or the Provider Automated System when requesting member eligibility.

In addition, providers will be directed to use NaviNet or call the Provider Automated System when checking claims status information. The claim detail provided through either system includes specific information, such as:

- check date
- check number
- service codes
- paid amount
- member responsibility

To assist you in using these transactions in NaviNet, new user guides were recently posted in the *Administrative Tools & Resources* section of IBC Plan Central.

If your office location is not yet registered for NaviNet, please visit www.navinet.net and select *Sign up* from the top right. If your office is currently NaviNet-enabled but would like training on how to access member or claims information, please call the eBusiness Provider Hotline at 215-640-7410.

Providers without access to NaviNet must obtain eligibility and claims status information through the Provider Automated System by calling 1-800-ASK-BLUE and following the voice prompts.

BILLING

Professional Injectable and Vaccine Fee Schedule updates effective October 1, 2011

Effective October 1, 2011, we will implement a quarterly update to our Professional Injectable and Vaccine Fee Schedule for all Pennsylvania, New Jersey, and Delaware providers.

These updates reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables. You will be able to view these changes starting October 1, 2011, through NaviNet. To do so, select *Reference Material and Reports* from the Plan Transactions menu, and then select *Fee Schedule Inquiry*.

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

ICD-10

Now available: ICD-10 Frequently Asked Questions

A number of health care providers around the country are preparing for the transition to ICD-10, which mandates that:

- claims with a date of service on or after October 1, 2013, must be submitted with ICD-10-CM codes;
- all inpatient claims with discharge dates on or after October 1, 2013, must be submitted with ICD-10-PCS codes.

Claims that are submitted with noncompliant codes after this date will be rejected.

IBC has created a list of Frequently Asked Questions (FAQ) about the transition to ICD-10. Visit www.ibx.com/icd10 to access the FAQ as well as the latest information about ICD-10. IBC will continue to communicate to providers during the ongoing transition to ICD-10. Please continue to check *Partners in Health Update*, NaviNet, and www.ibx.com/icd10 for information regarding the conversion to ICD-10.

HIPAA 5010 go-live date change

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 4010A, 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 this date, version 4010A will no longer be valid.

There will be a transitional period of time when IBC will accept claims in both 4010A and 5010 formats. As stated in our HIPAA 5010 Frequently Asked Questions (FAQ) posted on www.ibx.com/hipaa5010, our initial target date for being dually compliant (accepting both 4010A and 5010 claims) was August 2011. However, due in part to 5010 Errata changes, the timelines for testing between IBC and its trading and provider partners have been

adversely impacted. To ensure a smooth transition, IBC will continue to focus on testing with providers and trading partners. As a result, we will *not* be accepting 5010 transactions in August as previously communicated.

As a reminder, HIPAA 5010 Transaction Companion Guides were recently posted on www.ibx.com/ediforms. Both 4010 and 5010 guides are available. We strongly encourage you to prepare for the implementation of the new 5010 standards by speaking to your trading partners to ensure they are compliant and ready to electronically submit standard transactions using version 5010 by January 1, 2012.

We will continue to communicate to providers as new information becomes available about HIPAA 5010. Please check *Partners in Health Update*, the NaviNet® web portal, and www.ibx.com/providers frequently for the latest information regarding our 5010 go-live date.

MEDICAL

New policy on inpatient hospital readmissions

IBC has established a new policy to address reimbursement for inpatient hospital readmissions to the same hospital, or a hospital within the same Health System, within three days of discharge from a previous inpatient hospital stay and for a condition directly related to the original inpatient hospital stay. **Effective September 1, 2011**, Claim Payment Policy #00.01.47: Inpatient Hospital Readmissions will be applied to all admissions that are paid on a per-case or per-admission basis.

To view this policy in its entirety, visit www.ibx.com/medpolicy and enter the policy number in the Search box.

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

Change in reimbursement for assistant-at-surgery services

Effective October 27, 2011, physicians and non-physician health care practitioners who provide assistant-at-surgery services will be reimbursed at 16 percent of the surgical allowance, replacing the current reimbursement amount of 20 percent of the surgical allowance.

This change will be reflected in Claim Payment Policy #00.10.18g: Modifiers for Assistant-at-Surgery Services: 80, 81, 82, and AS. The policy notification has been available for review by providers and their office staff since it was posted on our website on July 29, 2011. This version of the policy will become effective on October 27, 2011.

Policy notifications are available on our medical policy website at www.ibx.com/medpolicy. If you have any questions regarding this policy change, please contact your Network Coordinator.

Policy notifications posted as of August 19, 2011

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 August 19, 2011.

Policy effective date	Notification title	Notification issue date
August 19, 2011	08.00.92b Coagulation Factors for Hemophilia	July 20, 2011
August 19, 2011	07.00.03i Full-Body Monoplace or Multiplace Chamber Hyperbaric Oxygen Therapy	July 20, 2011
August 19, 2011	08.01.00 Hydroxyprogesterone Caproate Injection as a Technique to Reduce the Risk of Preterm Birth in High-Risk Pregnancies	July 20, 2011
August 19, 2011	11.15.23 Transforaminal Epidural Nerve Block Injections	July 20, 2011
August 22, 2011	11.06.09 Labiaplasty	July 22, 2011
August 24, 2011	09.00.36f First-Trimester Prenatal Screening for Fetal Aneuploidy	May 26, 2011
August 31, 2011	11.01.06 Bone-Anchored (Osseointegrated) Hearing Aids, Implantable Bone-Conduction Hearing Aids, and Semi-Implantable Hearing Aids	June 1, 2011
September 1, 2011	00.01.52 Always Bundled Procedure Codes	June 3, 2011
September 1, 2011	11.05.02f Blepharoplasty, Repair of Blepharoptosis, Repair of Brow Ptosis, and Canthoplasty/Canthopexy	June 3, 2011
September 1, 2011	10.02.02e Chiropractic Spinal and Extraplural Manipulation Therapy	June 1, 2011
September 1, 2011	00.01.47 Inpatient Hospital Readmission	August 2, 2011
September 1, 2011	10.03.01b Physical Medicine and Rehabilitation Services	June 1, 2011
September 1, 2011	11.08.13e Rhytidectomy and/or Cervicoplasty With or Without Liposuction and/or Platysmaplasty	August 1, 2011
September 1, 2011	11.02.01h Treatment of Varicose Veins of the Lower Extremities and Perforator Vein Incompetence	June 8, 2011
September 2, 2011	05.00.72 Upper-Limb Prostheses	August 3, 2011
September 14, 2011	07.10.04a Parenterally Administered Terbutaline Sulfate for the Prevention or Treatment of Pre-Term Labor	August 15, 2011
October 1, 2011	00.03.07 Laboratory Services for Members Enrolled in Health Maintenance Organization (HMO) or Health Maintenance Organization Point-of-Service (HMO-POS) Products	July 1, 2011
October 1, 2011	11.08.20h Wound Care: Bioengineered Skin Substitutes	July 1, 2011
October 4, 2011	08.00.44i Zoledronic Acid (Zometa®, Reclast®)	July 6, 2011
October 5, 2011	11.08.06f Abdominoplasty and/or Panniculectomy	July 7, 2011
October 27, 2011	00.10.18g Modifiers for Assistant-at-Surgery Services: 80, 81, 82, and AS	July 29, 2011
November 16, 2011	03.00.32 Modifier 52 Reduced Services	August 18, 2011

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 Materials and Reports* 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.



Reminder: Use updated precertification requirements lists

As previously communicated, important changes have been made to the list of services and drugs that require precertification for dates of service on or after September 1, 2011. It is very important that providers verify member-specific requirements using the NaviNet® web portal or by referring to the most current precertification requirements lists, which are available at www.ibx.com/providers/preapproval.

Failure to obtain precertification for any of the services or drugs that require it may result in a reduction in payment or nonpayment for the services not precertified. Please refer to the article in the June edition of *Partners in Health Update* for the complete list of changes to precertification requirements.

Note: These new precertification requirements apply to commercial members for dates of service on or after September 1, 2011; Medicare Advantage HMO and PPO members will transition for dates of service on or after January 1, 2012.

Transitioning select infusion therapy drugs from the outpatient setting to the office or home setting



We are advocating that members who receive infusion therapy drugs like alglucerase (Ceredase®), imiglucerase (Cerezyme®), velaglucerase alfa (VPRIV®), eculizumab (Soliris®), and intravenous immunoglobulin (IVIG) obtain these drugs in the setting that is most appropriate, based on factors such as, but not limited to:

- the setting that has been determined to be both cost-effective and safe for the member;
- the level of care required by the patient based on his or her medical history and current health status;
- recommendations from the drug manufacturer;
- current standards in medical practice.

Typically, only those patients who are starting a new treatment regimen for the drugs listed, or those who have a history of treatment-related adverse effects that require monitoring, require a higher level of care at an outpatient facility or hospital. Aside from these exceptions, most patients can safely receive these drugs in either a provider's office or in their home through a home infusion provider.

Administering drugs in the office or at home

The following options are available for administering these drugs in a provider's office or in the member's home:

- **Buy and bill.** Providers can buy the drug and bill the health plan for reimbursement once the drug has been given to the member.
- **Home infusion therapy.** Many patients prefer the

convenience of receiving these infusion therapy drugs in their home through an IBC-participating home infusion provider. Providers should discuss this option with their patients, when appropriate.

Requesting administration in an outpatient facility or hospital

Providers who request coverage for administration of these drugs in an outpatient facility or hospital may be asked during precertification to provide details about the patient's medical history to support the request. A team of IBC medical directors and nurses will review the submitted documentation and determine whether coverage in one of these settings is approved.

Impacts to coverage

IBC will continue to cover these infusion therapy drugs and all services associated with the administration of these drugs when both of the following requirements are met:

- The member meets the medical necessity criteria outlined in the applicable medical policy.
- The drug is given in the setting that has been determined by IBC as most appropriate for the member.

Please call Customer Service at 1-800-ASK-BLUE if you have any questions about setting options for these infusion therapy drugs. Customer Service can also assist you with home infusion options.

Select Drug Program® Formulary updates

The Select Drug Program Formulary is a list of medications approved by the U.S. Food and Drug Administration that were chosen for formulary coverage based on their medical effectiveness, safety, and value. The list changes periodically as the Pharmacy and Therapeutics Committee reviews the formulary to ensure its continued effectiveness. The most recent changes are listed below.

Generic additions

These generic drugs recently became available in the marketplace. When these generic drugs became available, we began covering them at the appropriate generic formulary level of cost-sharing:

Generic drug	Brand drug	Formulary chapter	Effective date
Amethia™	Seasonique®	11. Female, Hormone Replacement, Birth Control	August 1, 2011
budesonide	Entocort® EC	8. Stomach, Ulcer, & Bowel Meds	July 1, 2011
cyclobenzaprine	Amrix®	3. Pain, Nervous System, & Psych	May 20, 2011
doxycycline monohydrate	Adoxa®	1. Antibiotics & Other Drugs Used for Infection	June 3, 2011
epinastine HCl	Elestat®	12. Eye Medications	May 6, 2011
latanoprost	Xalatan®	12. Eye Medications	March 18, 2011
levofloxacin	Levaquin®	1. Antibiotics & Other Drugs Used for Infection	June 24, 2011
methylergonovine maleate	Methergine®	11. Female, Hormone Replacement, Birth Control	June 17, 2011
sumatriptan succinate	Alsuma™	3. Pain, Nervous System, & Psych	July 1, 2011
triamcinolone acetonide	Nasacort® AQ	13. Allergy, Cough & Cold, Lung Meds	June 17, 2011

Brand additions

These brand drugs were added to the formulary as of the dates indicated below and are covered at the appropriate brand formulary level of cost-sharing:

Brand drug	Formulary chapter	Effective date
Campral®	16. Diagnostic & Miscellaneous Agents	September 1, 2011
Edurant®	1. Antibiotics & Other Drugs Used for Infection	May 23, 2011
Viramune XR®	1. Antibiotics & Other Drugs Used for Infection	September 1, 2011

Brand deletions

These brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

Effective October 1, 2011.

Brand drug	Generic drug	Formulary chapter
Levaquin®	levofloxacin	1. Antibiotics & Other Drugs Used for Infection
Methergine®	methylergonovine maleate	11. Female, Hormone Replacement, Birth Control
Xalatan®	latanoprost	12. Eye Medications

The generic drugs for the above brand drugs are on our formulary and available at the generic formulary level of cost-sharing.

Prescription drug updates

For members enrolled in an IBC prescription drug program, prior authorization and quantity limit requirements will be applied to additional drugs. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. Quantity limits are designed to allow a sufficient supply of medication based upon the maximum daily dose and length of therapy approved by the U.S. Food and Drug Administration for a particular drug. The most recent updates are reflected below.

Drugs requiring prior authorization

The prior authorization requirement for the following non-formulary drugs was effective at the time the drugs became available in the marketplace:

Brand drug	Generic drug	Drug category	Effective date
Caprelsa®	Not available	Cancer & Organ Transplant Drugs	April 22, 2011
Zytiga™	Not available	Cancer & Organ Transplant Drugs	May 6, 2011

The following non-formulary drug will be added to the list of drugs requiring prior authorization for new prescriptions. Members taking this drug immediately prior to the effective date are not affected:

Effective October 1, 2011.

Brand drug	Generic drug	Drug category
Staxyn™	Not available	Urinary & Prostate Meds

The following non-formulary drugs will be added to the list of drugs requiring prior authorization for new prescriptions:

Effective October 1, 2011.

Brand drug	Generic drug	Drug category
Androderm®	Not available	Hormones
Axiron®	Not available	Hormones
Fortesta™	Not available	Hormones
Striant®	Not available	Hormones
Testim®	Not available	Hormones

For members currently taking the above drugs, the prior authorization requirement will not be effective until January 1, 2012.

Drugs with quantity limits

Quantity limits will be added for the following drug:

Effective October 1, 2011.

Brand drug	Generic drug	Quantity limit (per 30 days)
Staxyn™	Not available	8 tablets



Annual Synagis® (palivizumab) distribution program

We are pleased to announce the Synagis® (palivizumab) distribution program for the 2011-2012 respiratory syncytial virus (RSV) season, which is November through April in the United States. RSV is the most common cause of bronchiolitis and pneumonia among children younger than 1.

During the RSV season, we will approve the monthly administration of Synagis® (palivizumab) for at-risk children younger than 2. Synagis® (palivizumab) is a humanized monoclonal antibody that provides passive immunity against RSV. It is intended to decrease the morbidity and mortality associated with RSV lower respiratory tract disease in at-risk children. At-risk children include those with one of the following conditions or risk factors:

- chronic lung disease of prematurity (CLD, formerly called bronchopulmonary dysplasia);
- history of preterm birth (< 35 weeks 0 days gestation);
- congenital heart disease;
- severe neuromuscular disease;
- congenital abnormalities of the airway.

Recommendations for premature infants

Specific recommendations have been made to reduce the risk of RSV hospitalization for infants who are born at 32 through less than 35 weeks gestation (defined as 32 weeks 0 days through 34 weeks 6 days). Synagis® (palivizumab) prophylaxis should be limited to these infants who are at greatest risk of hospitalization due to RSV. This includes at-risk infants who are younger than 3 months and 0 days (less than 90 days) at the start of the RSV season, as well as those who are born during the RSV season and are likely to have an increased risk of exposure to RSV.

Epidemiologic data suggests that RSV infection is more likely to occur and lead to hospitalization for infants in this gestational age group when at least one of the following risk factors is present:

- The infant attends child care (defined as a home or facility where care is also provided for any number of infants or young toddlers in the same facility).
- The infant has a sibling younger than 5.

Prophylaxis may be considered for infants born at 32 to less than 35 weeks gestation whose chronological age is less than 3 months before the onset or during RSV season, and for whom at least one of the above factors is present.

Infants in this gestational age category should receive prophylaxis only until they reach 3 months of age. In addition, these infants should receive a maximum of three monthly doses; many will receive only one or two doses until they reach 3 months of age.

Once an infant has passed 3 months of age (older than 90 days), the risk of hospitalization attributable to RSV lower respiratory tract disease is reduced. Administration of Synagis® (palivizumab) is not recommended after 3 months of age. This criterion for premature infants is based on guidelines published in the 2009 American Academy of Pediatrics (AAP) *Red Book*®.



How to obtain Synagis® (palivizumab) for use in your office

Synagis® (palivizumab) is covered under the member's medical benefits. For the 2011-2012 RSV season, it is mandatory for all participating providers to obtain Synagis® (palivizumab) through ACRO Pharmaceutical Services, an independent company. IBC will coordinate with ACRO Pharmaceutical Services to facilitate delivery of Synagis® (palivizumab) to your office.

Note: MedImmune, LLC, the makers of Synagis® (palivizumab), has a voluntary program called RSV Connection™. However, IBC does not participate in this program. All requests for Synagis® (palivizumab) should be sent directly to ACRO Pharmaceutical Services.

continued on the next page

Annual Synagis® (palivizumab) distribution program (continued)

Guidelines for ordering Synagis® (palivizumab)

The following guidelines apply when ordering Synagis® (palivizumab):

- Synagis® (palivizumab) will generally be approved for office administration only, unless a patient is receiving home nursing services for a separate indication.
- The RSV Enrollment Form must include sufficient clinical information to meet our Synagis® (palivizumab) medical policy criteria, which is based on AAP recommendations.
- Tobacco smoke will not be accepted as an environmental pollutant. This guideline is based on the indication from the AAP Committee on Infectious Disease that, while at-risk infants should never be exposed to tobacco smoke, passive household exposure to tobacco smoke has not been associated with an increased risk of RSV hospitalization on a consistent basis.
- Fee-for-service providers will be reimbursed for the Evaluation & Management procedure codes that correspond to the patient's office visit. Since IBC pays ACRO Pharmaceutical Services directly, you neither pay for doses ordered through ACRO Pharmaceutical Services nor receive reimbursement for the actual pharmaceutical.

- Upon approval of your request, Synagis® (palivizumab) will be shipped to your office monthly during RSV season. Overnight shipping for the 2011-2012 RSV season begins on Wednesday, October 26, 2011, and ends on Thursday, March 29, 2012. Up to five doses (one shipment every 30 days) will be shipped per patient.

If you have questions about the Synagis® (palivizumab) distribution program, please contact Customer Service at **1-800-ASK-BLUE**.

Note: Synagis® (palivizumab) is not effective in the treatment of RSV disease, and it is not approved for this indication.

This is not a statement of benefits. Benefits may vary according to state requirements, product line (HMO, PPO, etc.), and/or employer groups. Member coverage can be verified through the NaviNet® web portal or by calling the Provider Automated System at 1-800-ASK-BLUE.

PRODUCTS



New options available for Blue Solutions® product portfolio

Beginning October 1, 2011, IBC will introduce three new prescription options designed to give members more affordable choices. Each option offers generic medications at a low \$10 copayment, with copayment amounts for brand-name medications varying from \$40 to \$75. Structuring plans with a low generic copayment encourages members to ask for and purchase generic medications instead of brand-name prescriptions.

In addition to these new prescription options, the Blue Solutions small group portfolio now includes new Personal Choice® deductible plans to meet the need for a modestly priced PPO option.

Please note that member ID cards will be reissued only if the member's medical plan changes.

For more information on these new options, please contact Customer Service at **1-800-ASK-BLUE**.

The Clinical Care Report is now available

The Clinical Care Report, unless a member chooses to opt out, can now be accessed through the NaviNet® web portal. The Clinical Care Report offers participating physicians a snapshot view of the care that their patients have received based on IBC-paid medical and prescription drug claims. It is intended for viewing by the following participating health care providers:

- a member’s personal or primary care physician;
- a physician who has treated a member in the past year;
- 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 our members’ Clinical Care Reports is derived from member claims data and includes:

- 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.

This 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, or sexually transmitted diseases; genetic testing; or 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 your provider office has access to the Clinical Care Report, and he or she can control user access through the User Management transaction on NaviNet. *Note:* In order for providers to access the Clinical Care Report, a designated Security Officer must enable individual or all users.

For detailed instructions on how the designated Security Officer(s) in each provider office can grant or remove individual or group access to the Clinical Care Report, please refer to the article in the July edition of *Partners in Health Update*.

CREDENTIALING

Reminder: New email address replaces the network credentialing support services hotline

As previously communicated, effective November 1, 2010, the Network Credentialing Support Services Hotline, 215-241-4120, previously designated for requesting your contract and billing registration forms, was replaced with an email address, Application_Requests@ibx.com. Please note that the hotline has been disconnected.

Providers interested in participating in our network are responsible for notifying IBC upon completion of their Council for Affordable Quality Healthcare (CAQH) credentialing form. Once the form is completed, providers should notify the Network Credentialing Support Services department using the email address indicated above. Please include the following information in your email:

- practitioner’s name
- practitioner’s specialty
- practitioner’s mailing address
- practitioner’s CAQH ID number
- practitioner’s office address
- contact person’s name, telephone number, and email address

If you have any questions regarding this process, please contact Customer Service at 1-800-ASK-BLUE.

Overview guides available for substance-use disorders, depression, and suicide

IBC and Magellan Behavioral Health, Inc. provide *Substance-Use Disorders Identification Overview* and *Depression/Suicide Overview* guides to all network providers. These guides are double-sided charts that include information on substance-use disorders and pharmacotherapy for substance-use disorders, depression treatment, and assessing and managing suicidal patients.

Each guide also provides resources that support clinical practices consistent with nationally recognized standards of care. We developed these guides in collaboration with Magellan Behavioral Health, Inc., and they are consistent with our clinical practice guidelines.

Download the guides from our website at www.ibx.com/providers/resources/worksheets or call the Provider Supply Line at 1-800-858-4728.

Magellan Behavioral Health, Inc. is an independent company contracted by IBC to manage and provide a provider network for behavioral health (mental health/substance abuse) benefits for the majority of benefits plans offered and administered by IBC.

This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Program (HMO, PPO, etc.), and/or employer groups. Providers should call Customer Service for the member's applicable benefits information. Members should be instructed to call the Customer Service telephone number listed on their ID card.

IBC launches new advanced illness support program for Medicare Advantage HMO and PPO members

As of August 1, 2011, IBC, in partnership with Vital Decisions, an independent company, began offering the *Living Well Program* to Medicare Advantage HMO and PPO members who have a serious illness and may need support in making end-of-life health care decisions. The program provides health care counseling and decision support services and is available at no cost to Medicare Advantage HMO and PPO members.

Vital Decisions' specially trained counselors work with Keystone 65 HMO and Personal Choice 65SM PPO members who are experiencing difficult health care situations. Members are identified through claims data and case manager or physician referrals.

Through a series of telephone conversations with the member and his or her family, the counselors help educate, discuss, and work through the important topics of advanced illness and life planning. The Vital Decisions counselor's role is to help individuals identify their quality-of-life preferences and to help them actively and effectively communicate their priorities to family and physicians. This service helps to ensure that more effective shared decision-making processes occur and helps to align decisions with the individual's priorities and goals.

The Vital Decisions counselors will at no time interfere with the physician-patient relationship, provide medical advice, or provide an opinion regarding the member's care plan. Vital Decisions believes that the counseling program enhances communication between the member and his or her physician and the overall patient-physician relationship.

Vital Decisions currently works with multiple national, regional, and local health plans across the country. Its *Living Well Program* has been recognized as a Best Practice in Consumer Protection and Empowerment by URAC.

To refer a patient to the *Living Well Program*, complete the online case management referral at www.ibx.com/case_mgmt_ref_form or contact IBC Case Management at 1-800-313-8628.

The ConnectionsSM Health Management Programs 2011 Annual Update is now available

Included with this edition of *Partners in Health Update* is the *ConnectionsSM Health Management Programs 2011 Annual Update (Annual Update)*. The *Annual Update* includes information on how you and your patients can benefit from the Connections Health Management Programs. It also provides information about new initiatives, outreaches, and tools to help you provide support to your patients, our members.

Health professionals from the Connections Programs work with members to encourage implementation of and adherence to your treatment plans. The programs also help your patients by offering disease management and decision support.

To learn more about the Connections Programs, visit www.ibx.com/providerconnections.



Case management

Help for your patients when they need it



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:

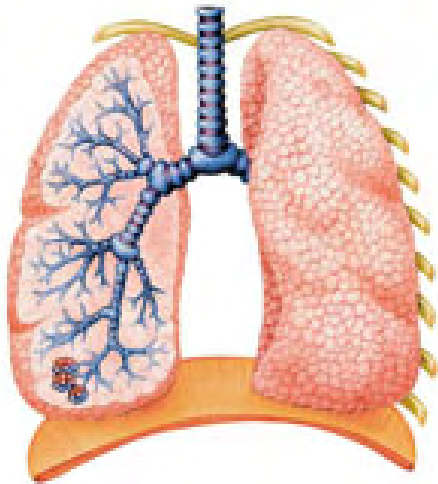
- ▶ wound care
- ▶ cancer treatment education
- ▶ complications of pregnancy
- ▶ adherence to treatment plan
- ▶ community resource information
- ▶ coordination of home care services
- ▶ complex pediatric medical conditions
- ▶ socioeconomic support (medications)
- ▶ investigation of benefits for medical 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. You can also complete an online referral form at www.ibx.com/case_mgmt_ref_form.

Using spirometry in COPD diagnosis

Chronic obstructive pulmonary disease (COPD) — an umbrella term for progressive respiratory conditions including emphysema and chronic bronchitis — is a rapidly escalating chronic health problem both in the United States and worldwide. An estimated 13 million Americans have been diagnosed with the disease and nearly twice that number show some degree of impaired lung function. The price tag for COPD is high — direct medical costs reached nearly \$30 billion in 2010.¹ The human toll is equally steep in terms of disability, poor quality of life, and premature death. Despite the magnitude of the problem, COPD is widely under-diagnosed and under-treated.²



Spirometry testing is a key tool for identifying COPD. This simple, noninvasive airflow measurement can be performed in a primary care physician's office by properly trained personnel.³ The test compares the volume of air a person can breathe out in one second (forced expiratory volume or FEV₁) to the maximum amount that can be expelled in a forced exhalation (forced vital capacity or FVC). A FEV₁/FVC ratio that is below 70 percent indicates impaired breathing function and the possibility of COPD. A key characteristic that differentiates COPD from other lung conditions (such as asthma) is that breathing does not improve with bronchodilation. After baseline testing, if the bronchodilator is administered and there is no difference between the two readings, the diagnosis of COPD is supported rather than asthma.²

Between 80 and 95 percent of deaths from COPD are related to cigarette smoking.¹ Other high-risk groups include those exposed to second-hand smoke and environmental or occupational pollutants and people with a family history of respiratory disease. Individuals fitting these criteria who exhibit symptoms of cough, sputum production, or dyspnea should be evaluated for COPD. The National Committee for Quality Assurance (NCQA) COPD Initiative recommends spirometry testing for:

- patients ages 40 or older who have newly diagnosed COPD;
- patients who have newly active disease (previously diagnosed COPD patients that have not seen a doctor about the disease or had spirometry testing within the two years prior to the current visit).

In both cases, the test should be performed within 180 days of the initial diagnosis or newly active disease.⁴

COPD is progressive and irreversible. Smoking cessation is the only intervention that has been proven to slow the decline in lung function. By identifying COPD at an early stage, primary care physicians are in a better position to help their patients make this lifestyle change before lung damage becomes severe. Treatment for most patients consists of a step-wise approach to managing symptoms with medications and oxygen therapy based on the stage of the disease.²

We can help

The ConnectionsSM Program offers your patients access to Health Coaches — health care professionals such as registered nurses and registered respiratory therapists — who can offer guidance and support to COPD patients. To learn more about the health coaching services available to your practice, call 1-866-866-4694. You can also refer your patients to a Health Coach by completing the fax referral form that is available online at www.ibx.com/providerconnections.

References:

¹American Lung Association. Chronic obstructive pulmonary disease: fact sheet. February 2011. www.lungusa.org/lung-disease/copd/resources/facts-figures/COPD-Fact-Sheet.html

²Global initiative for chronic obstructive lung disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. Updated 2010. www.goldcopd.org/guidelines-global-strategy-for-diagnosis-management.html

³American Thoracic Society. Standards for the diagnosis and management of patients with COPD. 2004. www.thoracic.org/clinical/copd-guidelines/resources/copddoc.pdf

⁴Health Dialog. COPD initiative: spirometry testing. 2010.

Serving up healthy eating and exercise habits



In recent months, the U.S. Department of Agriculture (USDA) replaced the familiar food pyramid model with a new model designed to promote better

food choices, just in time for “Fruits and Veggies — More Matters” Month. The month of September is dedicated to highlighting the benefits of eating colorful fruits and vegetables, and is a great time to encourage your Medicare Advantage HMO and PPO patients to focus on making healthy food choices. It’s also another good reason to help them commit to regular physical activity. According to Carol Johnston, Ph.D., R.D., director of the nutrition program at Arizona State University, “Good diet and exercise go hand in hand to help maintain optimal physical and mental functioning. They really cannot be separated.”

When it comes to the older adult population, proper nutrition is paramount. “Good nutrition is particularly important for the aging population for several reasons,” explains Johnston. “First, aging is often associated with greater chronic disease frequency, which can create a greater need for nutrients such as protein, vitamins, and minerals. Inflammation is a common consequence of obesity, heart disease, and diabetes — all conditions which are more common in aging populations.”

The need for proper nutrition in older adults doesn’t stop with chronic diseases. Johnston adds, “The ability to assimilate nutrients in foods declines with age, a reflection of an aging stomach and intestinal tract. That is why the recommended intake for some nutrients increases in the elderly [to compensate for poor absorption].” Add to the list the fact that many commonly used medications, such as antacids, can interfere with nutrient absorption and can adversely impact metabolic functions.

Encourage your patients to fill half their plate with more fruits and vegetables and share these helpful tips with them:

- Eat brightly colored fruits (reds, greens, purples) and vegetables daily. Avoid juice; eat the whole fruit instead.
- Choose high-fiber foods, particularly vegetables (e.g., leafy greens, broccoli, kale, cauliflower, brussels sprouts, and legumes).
- Eat lean sources of protein at each meal (e.g., egg substitutes, skim milk, low-fat yogurt, chicken, fish).
- Minimize grains (unless physically active every day) and choose mainly whole grains.

SilverSneakers® can help

It’s never too late to adopt healthy eating habits and, of course, the same goes for engaging in regular physical activity. Adopting an active lifestyle with the Healthways SilverSneakers® Fitness Program is a great way for Keystone 65 HMO Preferred and Personal Choice 65SM PPO members to get moving — all while having fun and making friends! Remind them to exercise regularly and to eat nutritious fruits and vegetables to maintain a healthy weight, reduce their risk of certain diseases, and get the vitamins and minerals they need to live an active and healthy lifestyle for years to come.

Note: SilverSneakers is offered to Keystone 65 Preferred HMO and Personal Choice 65 PPO members at no cost. To enroll in the program, members can simply bring their health plan ID card to any participating SilverSneakers location. For a complete list of locations, members can visit the SilverSneakers website at www.silversneakers.com or call 1-888-423-4632.

This is not a statement of benefits. Benefits may vary based on Federal requirements, Benefits Program (HMO, PPO, etc.), and/or employer groups. Providers should call Customer Service for the member’s applicable benefits information. Members should be instructed to call the Customer Service telephone number listed on their ID card.

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

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 Credentialing Violation Hotline	215-988-1413 www.ibx.com/credentials
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 (275-2583)
Provider Services user guide	www.ibx.com/providerautomatedsystem
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	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



Visit our website:
www.ibx.com/providercommunications



ConnectionsSM Health Management Programs
2011 Annual Update



**Independence
Blue Cross**

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

Annual Update summary

The 2011 Annual Update provides general information on the Connections Programs as well as information about new initiatives, outreach efforts, and tools to help you provide support to your patients, our members.

Connections is a comprehensive disease management and decision support program. The program strives to improve the quality of health care through more informed patient-physician communication. This is accomplished by providing individually tailored health coaching and support materials to patients and actionable clinical information to physicians.

There are two components to the Connections Programs. The Connections Health Management Program focuses on common, chronic diseases such as asthma, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), heart failure (HF), and diabetes. The program covers a variety of chronic conditions and offers disease management, decision support, and general health information. Providers with patients in the Connections Health Management Program also receive the SMART[®] Registry, an action-oriented clinical report that assists physicians in treating patients with specific health care gaps. The ConnectionsSM Complex Care Management Program supports members with one or more of 16 complex, chronic conditions such as seizure disorders, rheumatoid arthritis, and multiple sclerosis. Interventions include outreach telephone calls, interactive voice messaging, and/or mail campaigns.

ConnectionsSM Health Management Program

The Connections Health Management Program, offered in partnership with Health Dialog, an independent company, provides 24/7 disease management and decision support to eligible members through Health Coaches and online resources. For providers, it is a resource to help you manage your patients with asthma, CHD, COPD, HF, diabetes, migraine headache, hypertension, gastroesophageal reflux disease (GERD), peptic ulcer disease (PUD), cardiometabolic risk, poor medication persistence, chronic pain, and those at risk for falls.

The SMART[®] Registry

The SMART Registry tracks important evidence-based aspects of care for patients with one or more of the following conditions:

- asthma
- diabetes
- CHD
- HF
- COPD
- comorbid hypertension

In 2011, two important changes were made to the SMART Registry:

- The SMART Registry is now sent on CD once a year to all providers with eligible patients. This year, the Registry CDs were mailed to practices in early August.
- The reports included in the SMART Registry are now based on the Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures. Previously, the reports used internally developed quality indicators.

The most recent SMART Registry was sent to 2,762 participating primary care practices and provided information on 75,522 Independence Blue Cross (IBC) members. These reports offer practical, relevant information about your Connections-eligible patients in a convenient format to help you stay informed about your patients and monitor their care plans.

Please refer to your most recent SMART Registry to update the clinical care your patients have received and to refer those patients who may benefit from health coaching to the Connections Program.



Connections Program Specialists support provider offices

Connections Program Specialists (CPS) are local clinical professionals who provide support and offer information about the Connections Health Management Program. Your CPS can:

- help you understand the Connections Program and become an active participant;
- provide assistance and best practices for using the SMART Registry;
- provide you with clinical support tools to refer your patients to a Connections Health Coach.

Please call the Provider Support Line at [1-866-866-4694](tel:1-866-866-4694) for more information about how a CPS can help you or to schedule a visit from a CPS.

Tools and resources for providers who treat patients with chronic conditions

Multiple tools and resources are available to your office to help manage your patients with chronic conditions. Visit www.ibx.com/providerconnections to find tools such as the beta blocker and COPD brochure; action plans for HF, COPD, and diabetes; a patient medication tracker; a list of Shared Decision-Making[®] videos; and more. Additional quantities of print materials are available by contacting a CPS at [1-866-866-4694](tel:1-866-866-4694).

Provider satisfaction survey

The 2010 provider survey returned to the format of prior surveys and was mailed and available online to physicians. Approximately 5 percent of the physicians responded to the survey. The survey found that awareness of the program was high among respondents. Of those who responded:

- More than 64 percent of providers feel the information and health education materials their patients receive from Connections is useful.
- Fifty percent of providers feel that reports received about their patients, such as the SMART[®] Registry and monthly member report, are useful.
- More than 56 percent of providers think the program has a positive impact on their patients' health status.
- Fifty-six percent of respondents feel the program has a positive impact on adherence to treatment plans.
- More than 43 percent said the program improved communication with their patients.
- Forty-five percent found the support from the Connections staff to be helpful.
- Forty-six percent said the program provided a more positive image of the health plan.

Member satisfaction survey

Each year, we survey a sample of members to determine their levels of awareness, use, and satisfaction with the Connections Health Management Program. The survey is conducted by telephone by an outside company at the end of the year.

The 2010 survey sample population included members identified with and without one of the five managed common chronic conditions (asthma, CHD, HF, diabetes, and COPD), members who had telephone contact with a Health Coach, and members who had never spoken to a Health Coach. Of those who responded:

- Eighty-two percent indicated that their impression of IBC was positively affected because of the Connections Program.
- Ninety percent would recommend Connections to family and friends.
- Seventy-three percent indicated that it is important that IBC continue to offer the Connections Program.

The reasons that members most frequently cited for using Connections are:

- to obtain information about an illness or condition;
- to understand treatment options and choose among them;
- to help manage a chronic illness.

We encourage you to use the Connections Program to help you support your patients by calling [1-866-866-4694](tel:1-866-866-4694).

ConnectionsSM Complex Care Management Program

The Connections Complex Care Management Program supports eligible members with one or more of 16 complex, chronic conditions. Members in the program have access to an IBC care management nurse who can work with them by telephone to help them with their health care needs. The nurse's role is to offer support through education, guidance, and assistance in monitoring the member's health and to work with the physician to support the member's care plan.

Program conditions

The conditions covered by this program are:

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

If you think a patient with one of the complex, chronic conditions listed above could benefit from care management from a care management nurse, we encourage you to electronically complete the Case Management Physician Referral Form at www.ibx.com/case_mgmt_ref_form. You can also contact the Connections Complex Care Management Program by calling 1-800-313-8628 or 215-567-3570.

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

Shared Decision-Making[®] is a registered trademark of the Foundation for Informed Medical Decision Making. Used with permission.

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