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Partners in Health UPDATE

November 2008

Working Together For Quality Health Care

Submit Coordination of Benefits information electronically

Providers may submit Coordination of Benefits (COB) information electronically for professional services using the 837P format. For instructions on how to bill electronically, please visit *www.ibx.com/providers/claims_and_billing/edi/forms.html.*

Submitting COB information electronically eliminates the need for paper claims submission. Claims submitted electronically are processed faster and have a significantly higher "first-pass" adjudication rate. This means faster payment to you.

For questions concerning electronic billing, please call the eBusiness Help Desk at 215-241-2305 or your Network Coordinator.

For articles specific to your area of interest, look for the appropriate icon:
- Professional
- Facility
- Ancillary

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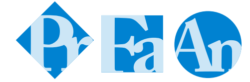
NATIONAL PROVIDER IDENTIFIER (NPI)

Claims submitted without a valid, registered NPI will reject



NPIs must be registered with IBC

As mentioned in previous publications, claims submitted to Independence Blue Cross (IBC) without a registered NPI have been rejecting since May 23, 2008, per the Centers for Medicare & Medicaid Services mandate. NPIs may be registered online by submitting an NPI provider registration web form at *www.ibx.com/providers/npi/provider_registration.html.*

Claims submitted with invalid NPIs will reject

Each claim must pass an NPI check-digit validation to ensure that it has a valid NPI. To date, many claims are not passing this check-digit validation. The most common reasons why claims are not passing the NPI check-digit validation are:

- The wrong provider identifier is entered in an NPI field.
- The NPI is entered incorrectly.
- The number entered is not a valid NPI.

Processing of claims

For purposes of processing a claim in accordance with the reimbursement terms of your IBC provider contract, you may continue to provide your 10-digit legacy number in addition to your valid, registered NPI. The sole purpose for providing the 10-digit legacy number is to facilitate accurate claims payment — not to identify the claim for acceptance into our system. Only a valid NPI will be accepted by IBC as the primary identifier on the claim.

If you need more information about NPI claims submission, please refer to our *National Provider Identifier (NPI) Toolkit: Tips for Proper Electronic and Paper Claims Submission*. The document can be found at *www.ibx.com/pdfs/providers/npi/toolkit.pdf.*

Learn more about NPIs. Our previous communications, FAQs, and additional resources are available at *www.ibx.com/providers/npi.*

Please note: IBC will receive contracted behavioral health providers' NPI information directly from Magellan Behavioral Health, Inc., an independent company. For more information, please contact Magellan National Provider Services Center at 1-800-788-4005, or visit Magellan at www.magellanhealth.com.

BILLING

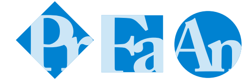
Redesigned HIPAA 835 available in December

To help streamline reporting claims payments, a newly designed HIPAA 835 will be sent electronically to providers and facilities and/or their clearinghouses beginning in December 2008.

The new format features a more streamlined and user-friendly design. This new design includes summaries of inpatient facility claims (when there is only one payment reimbursement) for ease of posting suppressed lines on adjustments.

The new look is based on feedback and collaboration with a group of facility and professional providers. The project is part of the 835 redesign initiative to streamline reporting claims payments.

Valid NDC required on claims submitted for drugs (e.g., J codes and other drug codes)



Please be advised that a new edit to validate the National Drug Code (NDC) submitted on paper and electronic claims is forthcoming for claims submitted with an unlisted and non-specific drug code. Please review the billing requirements below for your applicable provider type. Certain claims for unlisted and non-specific drug codes that are not accompanied by an NDC in the correct format and location will not be processed and will be returned to you for correction prior to processing.

For professional providers: Effective January 1, 2009, claims for all ***unlisted and non-specific*** drug codes (CPT® or HCPCS) will require submission of an NDC in the correct format and location as described on page 4. If the NDC is not submitted in the correct format or is missing, the claim will not be processed and will be returned to you for correction prior to processing. The complete list of unlisted and non-specific codes that require the submission of an NDC is below.

For home infusion providers: Effective January 1, 2009, ***all*** drug claims (not just the ***unlisted and non-specific*** CPT or HCPCS codes in the table below) will require the submission of an accompanying 11-digit NDC. This includes claims for Hemophilia Factor products that are currently submitted with specific J codes.

For institutional providers: Effective February 1, 2009, all claims for outpatient services containing the following pharmacy revenue codes and an ***unlisted and non-specific*** (CPT or HCPCS) code will require a valid NDC when submitted: 250-259, 262, 263, 331, 332, 335, 343, 344, and 631-637.

NDC billing information

Please submit the NDC number using the 5-4-2 format when billing with hyphens (e.g., 12345-1234-12). NDC numbers without hyphens (e.g., 12345678911) will also be accepted. Please *do not* include spaces, decimals, or other characters in the 11-digit string or the claim will be returned for correction prior to processing.

CPT® (Current Procedural Terminology) is a copyright of the American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a registered trademark of the AMA.

Unlisted codes that will require submission of an NDC*

Code	Description
90399	Unlisted immune globulin
90749	Unlisted vaccine/toxoid
A4641	Radiopharmaceutical, diagnostic, not otherwise classified
A9150	Nonprescription drug
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified
A9579	Injection, gadolinium based magnetic resonance contrast agent, not otherwise specified, per ml
A9698	Nonradioactive contrast imaging material, not otherwise classified, per study
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
A9700	Supply of injectable contrast material for use in echocardiography, per study
C2698	Brachytherapy source, stranded, not otherwise specified, per source
C2699	Brachytherapy source, nonstranded, not otherwise specified, per source
C9399	Unclassified drugs or biologicals
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
J3490	Unclassified drugs
J3530	Nasal vaccine inhalation
J3535	Drug administered through a metered dose inhaler
J3590	Unclassified biologics
J7199	Hemophilia clotting factor, not otherwise classified
J7599	Immunosuppressive drug, NOC

continued on page 4

Valid NDC required on claims submitted for drugs (continued)

J7699	NOC drugs, inhalation solution administered through DME
J7799	NOC drugs, other than inhalation drugs, administered through DME
J8498	Antiemetic drug, rectal/suppository, not otherwise specified
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8597	Antiemetic drug, oral, not otherwise specified
J8999	Prescription drug, oral, nonchemotherapeutic, NOS
J9999	NOC, antineoplastic drug
Q3001	Radioelements for brachytherapy, any type, each
Q4082	Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP)
Q4096	Injection, von Willebrand factor complex human, ristocetin cofactor (not otherwise specified), per I.U. VWF:RCO
S5000	Prescription drug, generic
S5001	Prescription drug, brand name

**These codes are subject to change pending routine updates.*

Listing of these codes on the table does not imply that a separate payment will be made for the code; that all current and future coding edits apply, and that these codes should only be reported when there is not a more specific code.

Please submit an NDC in the following fields:

- **Electronic professional claims:** 837P Loop 2410/Data Element LIN02 = N4 qualifier and Data Element LIN03 = NDC
  - Example: LIN**N4*00093723106~
- **Paper professional claims:** field 24A in the shaded area above the date of service.

  Report the N4 qualifier in the first two positions left-justified followed by the 11-digit NDC with no spaces in between.
  - Example:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
N400026064871					

- **Electronic institutional claims:** 837I Loop 2410/Data Element LIN02 = N4 qualifier and Data Element LIN03 = NDC
  - Example: LIN**N4*00093723106~
- **Paper institutional claims:** box 43 (revenue code description)

  Report the N4 qualifier in the first two position left-justified followed by the 11-digit NDC with no spaces in between.
  - Example: N400093723106

If you have questions, please contact your Network Coordinator.

NAVINET®

NaviNet and Electronic Funds Transfer

NaviNet allows you to create a convenient, time-saving Electronic Fund Transfer (EFT) account. An EFT account is designed to allow for the transfer of funds by electronic means, rather than conventional, sometimes time-consuming paper-based payment methods. EFT account transactions often result in faster payments and eliminate the need for manual deposits.

Appropriate levels of security can be set by the security officer to restrict the ability to register, view, and edit an EFT account.

Detailed information is accessible on the *ePayments* screen under *Plan Transactions*. Additional information, including instructions about how to manage EFT accounts, can be found in the *User Guides* on NaviNet Plan Central by selecting *Click Here for NaviNet Customer Support* under the *Customer Support* menu.

You may also contact NaviNet Customer Care at 1-888-482-8057 for assistance.

Medicare Private Fee-for-Service: requirements for deemed providers

On January, 1 2008, we launched Select Advantage, a new Medicare Private Fee-for-Service (PFFS) plan. This Medicare Advantage PFFS plan is a non-network, non-managed care product that does not include utilization management or require referrals. However, all services must meet Original Medicare guidelines for coverage and are subject to retrospective review audit.

Providers are considered to be "deemed" providers when the provider is aware that the member is covered under a PFFS health plan, accepts the plan's Terms and Conditions, and provides care to the member. If a provider does not agree to the Terms and Conditions, the provider should not provide services to the PFFS member, except in emergencies.

Providers have the right to decide whether to treat Select Advantage PFFS members, on a patient-by-patient and visit-by-visit basis. A decision to treat a specific member does not require the provider to treat other Select Advantage PFFS members.

Providers who treat Select Advantage PFFS members must comply with all applicable Medicare and other federal health care program laws, regulations, and program instructions that apply to the services furnished to members. Any services or other activity performed by a provider in accordance with these Terms and Conditions must be consistent and comply with QCC Insurance Company's contractual obligations to the Centers for Medicare & Medicaid Services (CMS).

- Providers treating Select Advantage PFFS members must be licensed or certified by the state for the services being provided, comply with any other applicable state or federal requirements, and have or be eligible to obtain a Medicare billing number.
- Providers must not have opted out of Medicare or been prohibited from participating in the Medicare program.
- Provider must not be a federal health care provider, such as a Veteran's Administration provider. Under federal regulations, these providers are not eligible for reimbursement under a PFFS plan except when providing emergency care to non veterans.
- Institutional/facility providers treating Select Advantage PFFS members must be Medicare certified to treat Medicare beneficiaries.
- Providers may not hold a member liable for payment of any fees that are the obligation of the plan.
- Providers must comply with all Medicare and other federal health care program laws, regulations, and program instructions that apply to the services furnished to members. This includes inspections and audits in addition to audits by the plan or its designees.
- Providers will permit CMS, the Department of Health and Human Services, the Comptroller General, or their designees (the plan) to inspect, evaluate, and audit any and all provider financial records, contracts, medical records, patient care documentation, documents, papers, and other records pertaining to any covered services provided under these Terms and Conditions. The right to inspect, evaluate, and audit will extend ten years from the expiration of the Terms and Conditions or from completion of final audit, whichever is later, unless otherwise required by applicable law.
- Provider must not discriminate against Select Advantage PFFS Medicare Advantage members based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Providers must follow the standards of confidentiality and patient privacy rights outlined in HIPAA regulations.

Providers shall make medical records available to the Select Advantage PFFS plan, the Quality Improvement Organization (QIO), or a designated vendor in accordance with CMS appeals and grievance timeframes without charge to the member, Select Advantage PFFS, the QIO, or its designated vendor for purposes of the plan handling member appeals and grievances. Providers also agree to comply with the plan's requests for member medical records, and their submission to the QIO, as part of the appeals process.

For additional information, please visit our website at *www.ibx.com/providers.* Also, be sure to check future editions of *Partners in Health Update* for additional information about this Medicare Advantage PFFS plan.

Robotic surgical system not eligible for separate reimbursement consideration

We consider the use of a robotic surgical system to be an integral part of the primary surgical procedure and is, therefore, not eligible for separate reimbursement consideration. A separate precertification is not required for the use of the robotic surgical system; however, other precertification requirements may apply based on product rules.

Use the following code to report the use of a robotic surgical system:

S2900 – Surgical techniques requiring use of robotic surgical system. (List separately in addition to the code for the primary procedure.)

About robotic surgery

Robotic surgery allows surgeons to use robotic devices to perform minimally invasive surgical procedures requiring precision and control. With robotic surgery, a three-dimensional magnification of the surgical site is obtained via a tiny camera inserted into the patient's body. The surgeon uses voice activation software or remote control technology to direct the movement of the surgical instruments as they perform the procedure.

If you have any questions, contact your Network Coordinator.

Updated reporting requirements for anesthesia services performed by providers in anesthesia specialties for a cancelled or discontinued procedure

Effective December 19, 2008, we are updating our reporting requirements for anesthesia services performed by providers in anesthesia specialties for a cancelled or discontinued procedure.

The following requirements are also available in policy #01.00.02b, Anesthesia Services for a Cancelled or Discontinued Procedure, which is currently available in the *Policy Notifications* section of *www.ibx.com/medpolicy.*

- If the procedure is cancelled due to the assessment of the patient's condition *during* the anesthesia provider's presurgical/preanesthetic evaluation and *before* induction of regional or general anesthesia:
  - Report an evaluation and management (E&M) code that reflects the type and level of service performed.

  Note: We apply CPT® (Current Procedural Terminology) E&M service reporting guidelines that are current on the date of service to all E&M (e.g., consultation E&M) codes.
- If the procedure is cancelled *following* the anesthesia provider's presurgical/preanesthetic assessment and the patient's preparation for surgery, and *before* induction of regional or general anesthesia:
  - Report CPT code 01999.
- If the procedure is cancelled or discontinued *after* general or regional anesthesia induction has occurred:
  - Report the appropriate anesthesia (ASA) code corresponding to the surgical procedure plus the time, in minutes, expended providing the anesthesia services.

  Note: If reimbursement for the ASA code is considered by IBC at a flat rate, time is not applied and should not be reported. Individual provider fee schedules apply.

Additional billing requirements

Providers must adhere to the following additional billing requirements:

- The primary diagnosis(es) *and*, as a secondary diagnosis, either V64.1 or V64.3 are necessary to identify that the procedure was cancelled or discontinued.
- A description of and an indication that the procedure was cancelled or discontinued are required.
- Providers must not report base units in association with anesthesia services.

For additional information, refer to the full policy, which is available at *www.ibx.com/medpolicy.*

New look for member ID cards

Beginning this fall, identification cards for some Pennsylvania members will have a new look. The new cards will be issued to members when a change, such as choosing a new primary care physician (PCP), adding a dependent, or renewing benefits, is made to their coverage. Until such a change is made, members will continue to use their current card.

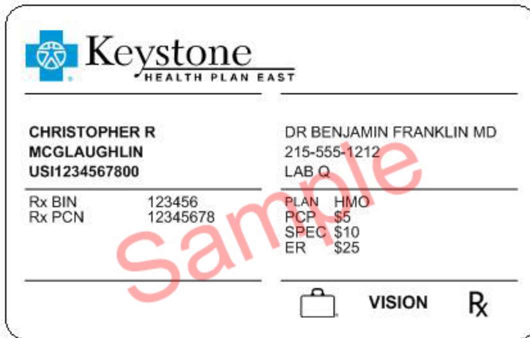
The new design divides the front of the card into four quadrants, each separated by a horizontal line. Each quadrant will contain information specific to the member, such as member name and identification number, PCP information, and cost-sharing information.

The back of the card provides important telephone numbers. To simplify the process of obtaining information on our members, providers can now use one number, 1-800-ASK-BLUE, to request precertification for covered services and obtain eligibility information. NaviNet® is also available to confirm member eligibility.

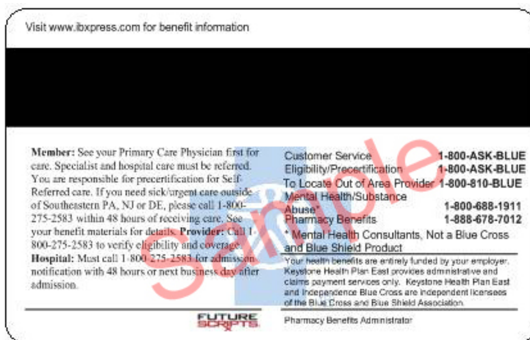
If you have questions about the new ID cards, please contact your Network Coordinator.

Note: For behavioral health services, providers should still call the number on the back of their ID card under Mental Health/Substance Abuse.

Keystone Health Plan East

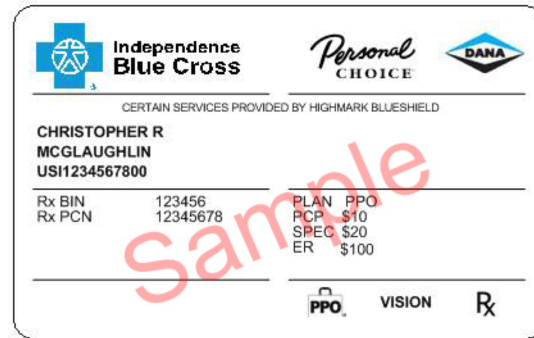


front

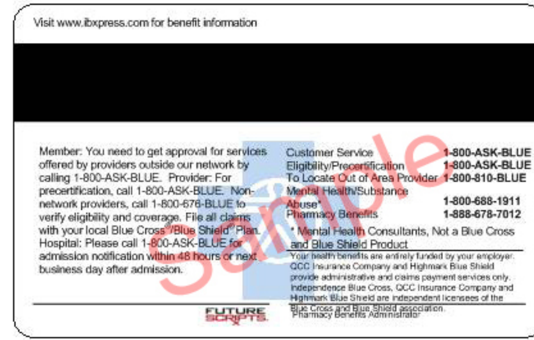


back

Personal Choice®



front



back

Policy notifications posted as of October 15, 2008

In order to better inform providers, we have developed a *Policy Notifications* web page where our policies are posted prior to their effective date. Below is a listing of the policy notifications we have posted to the site as of October 15, 2008:

Policy Effective Date	Notification Title	Notification Issue Date
November 1, 2008	**03.00.12** Modifier 78: Unplanned Return to the Operating/ Procedure Room by the Same Physician Following the Initial Procedure for a Related Procedure During the Postoperative Period	August 14, 2008
November 1, 2008	**03.00.31** Modifiers for Split or Shared Surgical Services (Modifiers 54, 55, and 56)	August 4, 2008
November 4, 2008	**05.00.61c** Cervical Traction for In-home Use	August 6, 2008
November 14, 2008	**11.01.02g** Cochlear Implant	October 15, 2008
November 14, 2008	**11.02.20d** Maze Procedure(s)	October 15, 2008
December 16, 2008	**01.00.02b** Anesthesia Services for a Cancelled or Discontinued Procedure	September 17, 2008
December 16, 2008	**06.02.24d** Preimplantation Genetic Diagnosis (PGD) Testing	September 17, 2008
December 30, 2008	**07.13.01d** Orthoptic/Pleoptic Training	October 1, 2008
December 30, 2008	**11.15.17b** Paravertebral Facet Joint Nerve Block	October 1, 2008
January 1, 2009	**08.00.26h** Botulinum Toxin Type A and Type B	October 1, 2008
January 1, 2009	**04.00.05b** Extraction of Bony Impacted Teeth and Exposure of Impacted Teeth	October 1, 2008
January 1, 2009	**08.00.76** Oxaliplatin (Eloxatin®)	October 1, 2008
January 14, 2009	**05.00.25e** Cranial Remolding Orthoses (Helmets)	October 15, 2008
January 14, 2009	**05.00.21c** Durable Medical Equipment (DME)	October 15, 2008

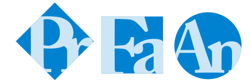
To access these notifications and view the policies in their entirety, follow these instructions:

1. Visit *www.ibx.com/medpolicy.*
2. Select *Accept and Go to Medical Policy Online*.
3. Select the *Commercial and Other Medicare Advantage policies* link.
4. Select *Policy Notifications* from the Medical Policy column on the left sidebar.

Be sure to check back often as the site is updated frequently.

MEDICAL

Stay tuned — Transition to all-electronic authorization inquiry and submission continues



New enhancements to the provider interactive voice response (IVR) system will launch in the near future. These enhancements will provide you with the ability to submit electronic authorization or precertification requests for outpatient and office medical and/or surgical procedures.* This service will be directly accessible through Customer Service at 1-800-ASK-BLUE, prompt 2 for Provider Services.

The updated system will be available soon as part of our phased approach toward the electronic authorization mandate project. Prior to completing an authorization or precertification request for outpatient and office medical and/or surgical procedures using the enhanced system, please have the following *required* pieces of information ready to ensure your success:

- provider's ID number;
- the last four digits of your tax ID *or* your national provider identification (NPI) number;
- member's ID number;
- member's name and date of birth;
- date of service;
- setting, procedure code;
- diagnosis code;
- the name, address, and telephone number of both the servicing provider/facility and the requesting provider.

A tutorial for using the new IVR system will be included in a future edition of *Partners in Health Update*.

**For behavioral health services, providers should still call the number listed on the member's ID card under Mental Health/Substance Abuse.*

CREDENTIALING

Reassessment for ancillary providers

As a reminder, all participating Durable Medical Equipment (DME), Home Infusion, and Hospice providers are required to be accredited by an Independence Blue Cross recognized accrediting body, as described below. In 2009, we will be conducting a reassessment of our network providers to ensure compliance with this requirement. Should you have any questions concerning this information, please contact Theresa Sawyer, contract data coordinator, at 215-241-3846.

Provider type	Recognized accrediting organizations
DME providers	Any approved accrediting organization "deemed" by CMS for DME providers including but not limited to: ▪ Accreditation Commission for Health Care ▪ Community Health Accreditation Program ▪ The Exemplary Provider Accreditation Program (a.k.a The Compliance Team) ▪ Joint Commission
DME – providers for Orthotics & Prosthetics only	▪ American Board for Certification in Orthotics and Prosthetics ▪ The Board of Orthotist/Prosthetist Certification ▪ The Exemplary Provider Accreditation Program (a.k.a The Compliance Team)
Home Infusion providers Hospice providers	▪ Accreditation Commission for Health Care ▪ Community Health Accreditation Program ▪ Joint Commission

Reminder for Medicare Part D formulary changes

As has been the case in previous years, benefits may change for Keystone 65, Personal Choice 65SM, Select Advantage, and Selection Option members on January 1. For example, as of January 1, 2009, there will be a four-tier formulary in place for some members serviced by FutureScripts® Secure.

For updated benefit information, visit *www.site65.com,* contact your Network Coordinator, or call Customer Service at 1-800-ASK-BLUE, prompt 2 for Provider Services.

Expanded Blood Glucose Meter Program offered to members

We offer an expanded Blood Glucose Meter Program with a free Accu-Chek® System or OneTouch® System to patients enrolled in one of our prescription drug programs who are currently using another brand of blood glucose meter or are new to blood glucose testing.

Accu-Chek family of products

The Accu-Chek family of products contains meters to help your patients meet daily challenges related to diabetes. Please ask your patient to consider the options below when choosing which blood glucose meter to use.

- Accu-Chek Advantage® System is a lightweight, portable meter that provides accurate results in seconds.
- Accu-Chek Active™ System allows patients to obtain a blood sample from a location other than their fingers.
- Accu-Chek Compact™ System eliminates the need to carry a vial of test strips.
- Accu-Chek Complete™ System is designed for active management by recording blood sugar, insulin, carbohydrates, exercise, stress, ketones, HbAlc, and much more.

To request a free Accu-Chek System meter for patients who are new to blood glucose testing or are currently testing with another meter:

1. Call the Accu-Check Fulfillment Center at 1-888-744-3671 between 8 a.m. and 8 p.m. EST to order an Accu-Chek System. The Accu-Chek System will be delivered to the patient within five business days.
2. Write a prescription for the member for Accu-Chek test strips that correspond to the member's meter and Accu-Chek Softclix® lancets.

Learn more about Accu-Chek products, including product demonstration videos, at *www.accu-chek.com.*

OneTouch family of products

The OneTouch family of products contains meters to help your patients meet daily challenges related to diabetes. Please ask your patient to consider the options below when choosing which blood glucose meter to use.

- OneTouch UltraMini™ Meter is a small and sleek meter designed to fit in your pocket or purse, has a large and easy-to-read screen, and makes testing simple and discreet with three steps.
- OneTouch Ultra®2 Meter flags results as before or after meal so that a user can see the impact of food choices and can view before- or after-meal averages to see the impact of food portions over time. Two-way scrolling buttons with backlighting make it easy to read and operate.

Learn more about OneTouch products at *www.OneTouch.orderpoints.com.*

To request a free OneTouch Meter for patients who are new to blood glucose testing or are currently testing with another meter:

1. Call 1-800-991-4252 between 8 a.m. and 8 p.m. EST to order a OneTouch Meter. The OneTouch Meter will be delivered to the patient within five business days.
2. Write a prescription for the member for OneTouch Meter test strips that correspond to the member's meter and OneTouch Meter lancets.

For more information, please contact Customer Service at 1-800-ASK-BLUE, prompt 2 for Provider Services.

New Clinical Practice Guidelines now available

The *2008-2009 Clinical Practice Guideline Summary* is now available and replaces the 2007 version. The new grid includes a listing of all Independence Blue Cross (IBC) Clinical Practice Guidelines. These Clinical Practice Guidelines are considered the accepted minimum standard of care in the medical profession. Adherence to these guidelines may lead to improved patient outcomes. Individual clinical decisions should be tailored to specific patient medical and psychosocial needs. As national guideline recommendations evolve, please update your practice accordingly.

We update the guidelines annually based on changes made to nationally recognized sources. Changes are reviewed by internal and external consultants, as appropriate, as well as by IBC quality committees, and then are incorporated into the guidelines. Our guidelines for 2008-2009 include the adoption of the *Recommendations for Preventive Pediatric Health Care* from the American Academy of Pediatrics and Bright Futures™, a national pediatric health care promotions and disease prevention initiative.

The guidelines are not a statement of benefits. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), or employer group. Individual member coverage will need to be verified with us. If you have any questions or concerns regarding member coverage, or if you would like more information on specific benefits coverage, please contact Customer Service at 1-800-ASK-BLUE, prompt 2 for Provider Services.

You may view the Clinical Practice Guidelines on our website at *www.ibx.com/providers;* the grid includes the URL of each guideline and will link directly to the guideline. To obtain a printed copy of the guideline grid or any of the individual guidelines, please call the Provider Supply Line at 1-800-858-4728.

Clinical Insights now available

The 2008-2009 *Clinical Insights: Effective Care for Patients with Chronic Conditions* is now available. *Clinical Insights* highlights topics that Health Coaches from the Connections℠ Health Management Program may discuss with members for the following conditions: asthma, coronary heart disease, chronic obstructive pulmonary disease, diabetes, and heart failure. Key points are derived from the Clinical Practice Guidelines.

View *Clinical Insights* on our website at *www.ibx.com/pdfs/providers/policies_guidelines/clinical_guidelines/clinical_insights.pdf,* or call the Provider Supply Line at 1-800-858-4728 to obtain a printed copy.

Improving Medicare members' health with SilverSneakers®

We are pleased to announce the positive response it has received from members regarding the SilverSneakers Fitness Program available to Keystone 65, Personal Choice 65℠, and Select Advantage members. Members are improving their fitness and enjoying themselves in the process. We've had an overwhelmingly positive response to our signature SilverSneakers fitness classes in which members feel the instructors are knowledgeable, friendly, and fun.

This program is provided at no cost to members beyond their monthly premium and offers members a free fitness membership at a participating SilverSneakers or Silver Access by SilverSneakers location.

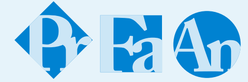
In addition, the SilverSneakers participating locations offer individuals access to amenities such as treadmills, weights, pool, and fitness classes included in a basic membership. Members can take advantage of the signature SilverSneakers classes taught by certified instructors. Classes can include SilverSneakers® – Muscular Strength & Range of Movement, SilverSneakers® – Cardio Circuit, SilverSneakers® Yoga Stretch, and SilverSplash®. Class offerings vary by location.

Enrollment is easy. Members simply choose a participating fitness center that is conveniently located, present their health plan ID card at the front desk, and ask to join SilverSneakers. Members can then tour the facility and see all the amenities available to them as new SilverSneakers members.

To learn more or find a convenient location, visit *www.silversneakers.com/ibc.*

Notes: Security 65® and 65 Special members are not eligible for SilverSneakers. SilverSneakers® is a registered mark of Healthways Health Support, Inc., an independent company.

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



Connections℠ Health Management Program

Call the Provider Support Line at 1-866-866-4694 to refer a patient for Health Coaching with any of the following conditions:

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

Health Coaches provide disease management and decision support for numerous health-related issues.

Connections℠ AccordantCare™ Program

Call the Connections AccordantCare Program at 1-866-398-8761 to refer a patient with any of the following diseases:

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

Call our Care Management and Coordination department at 1-800-313-8628 to refer a patient with end-stage renal disease on outpatient dialysis.

Visit our enhanced provider website at *www.ibx.com/providers/resources/connections.html.* This information is also available through NaviNet®.

Partners in Health Update is a publication of the Provider Communications department for the exchange of information and ideas among the IBC provider community. Suggestions are welcome.

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

Not all benefit plans use Magellan Behavioral Health, Inc. to administer behavioral health benefits. Please check the back of the member's ID card for the telephone number to contact for behavioral health services, if applicable.

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 presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefit plans. Members should refer to their benefit contract for complete details of the terms, limitations, and exclusions of their coverage.

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IMPORTANT RESOURCES

View our online provider directories on www.ibx.com

CARE MANAGEMENT AND COORDINATION Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Healthy Lifestyles℠ Keys to Wellness	215-567-3570 1-800-313-8628*
CONNECTIONS℠ HEALTH MANAGEMENT PROGRAMS Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ AccordantCare™ Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/anti-fraud
CREDENTIALING Credentialing Hotline Credentialing Violation Hotline	www.ibx.com/credentials 215-988-6534 215-988-1413
CUSTOMER SERVICE (Policies/Procedures/Claims) HMO and PPO	1-800-ASK-BLUE, prompt 2 for Provider Services
eBUSINESS Help Desk	215-241-2305
FutureScripts® Prescription Drug Authorization Toll Free Fax	1-888-678-7012 1-888-671-5285
Direct Ship Injectable Fax	1-888-678-7012 215-761-9165
Blood Glucose Meter Hotline	1-888-678-7012
FutureScripts® Secure Medicare Part D	1-888-678-7015
HEALTH RESOURCE CENTER Healthy Lifestyles℠	215-241-3367 1-800-ASK-BLUE*
Precertification	1-800-ASK-BLUE
NAVINET® PORTAL REGISTRATION	www.ibx.com/providers/navinet/index.html
PROVIDER MEDICAL POLICY WEB PAGE	www.ibx.com/medpolicy
PROVIDER PHARMACY WEB PAGE	www.ibx.com/provider_rx
PROVIDER SUPPLY LINE	1-800-858-4728

* Outside 215 area code

Visit our website: *www.ibx.com/providers/communications*