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PARTNERS IN HEALTH UPDATE

September 2008

Working Together For Quality Health Care



Call one number for your needs

In an effort to improve your calling experience, Independence Blue Cross has enhanced its toll-free number, **1-800-ASK-BLUE**, to provide a convenient, “one-stop shop” for all of your inquiries. This unique and identifiable telephone number can be used for many service needs, such as:

- Interactive Voice Response (IVR) system
- ConnectionsSM Health Management Programs
- Precertification/Preauthorization*
- Provider Services (claim status, eligibility, and benefits)

These changes have been made to the *Important Resources* section of *Partners in Health Update* and will also be reflected on the back of member ID cards, starting in October.

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

**For behavioral health services, providers should still call the number listed on the back of the member's ID card under mental health/substance abuse.*

For articles specific to your area of interest, look for the appropriate icon:

- Professional
- Facility
- Ancillary

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Claims submitted without a valid, registered NPI will reject



NPIs must be registered with IBC

As has been communicated in this publication numerous times, claims submitted to Independence Blue Cross (IBC) without a registered NPI began rejecting as of May 23, 2008, per the Centers for Medicare & Medicaid Services mandate. NPIs can 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 IBC's 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 IBC's *National Provider Identifier (NPI) Toolkit: Tips for Proper Electronic and Paper Claims Submission*, located 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.

BCBSA-mandated ID card style change



Beginning this fall, ID cards for some Independence Blue Cross 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 upon benefit renewal, is made to their coverage. Until such a change is made, members will continue to use their current cards.

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 the member's name and identification number, PCP information, and cost-sharing information.

The back of the card will provide important telephone numbers. To make it easier to obtain information about 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.

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

NaviNet® is a registered trademark of NaviMedix, Inc.

Step out and walk for diabetes!



Be sure to mark Saturday, October 4, 2008, on your calendar. Round up your colleagues, patients, family, and friends; grab your walking shoes; and head for the Philadelphia Museum of Art to take part in *Step Out*SM: *Walk to Fight Diabetes*, the American Diabetes Association's (ADA) new, family-friendly 5K fundraising walk.

Independence Blue Cross is pleased to be the presenting sponsor for *Step Out*. This event is an opportunity to combine the benefits of walking with a chance to make a difference in the fight against diabetes — the seventh leading cause of death by disease in the United States. Diabetes is also taking a devastating toll on our region, with about 11 percent of area residents having diabetes, nearly 3 percent higher than the national average. If current health trends continue, one in three Americans born today will develop diabetes in his or her lifetime.

We would appreciate your help in spreading the word about *Step Out*. We invite you to participate by forming a corporate team or serving as team captain or team

champion for your hospital or office. And, of course, you can also join the walk as an individual participant. Even if you are unable to walk in *Step Out*, you can still help by encouraging your patients to join the walk and participate in the fight against diabetes.

Our sponsorship of *Step Out*, in addition to the diabetes education and support we offer our members through the ConnectionsSM Health Management Program, is another demonstration of how we are here for you and our members every step of the way. By raising awareness of diabetes and helping to raise diabetes research funds, together we can strive towards eradicating diabetes. The 5K walk, with optional outdoor stairs along the way, begins and ends at the Philadelphia Art Museum and is expected to raise \$400,000 for the fight against diabetes. To register your participation, go to www.diabetes.org/stepout, or call **1-888-DIABETES**.

Tips for submitting claims adjustments



When submitting adjustment requests electronically to your Network Coordinator or our Adjustment department using Microsoft Excel® or Microsoft Access™ files, please include the following fields:

IBC Claim ID Number	Performing Provider Name
Member ID	Modifier
Date of Service From	Modifier
Date of Service To	Modifier
Procedure/Service Code	Revenue Code
Patient Last Name	Units Billed
Patient First Name	Charged (billed) Amount
Patient Insured ID number	Allowed Amount
Vendor (billing) Provider Number	Payment Amount
Vendor (billing) Provider Name	Expected Amount
Performing Provider Number	

Submitting your adjustment requests with the above information, especially the highlighted fields, enables us to improve turn-around time and maintain a higher level of service while processing the claim.

If you have additional questions, please contact your Network Coordinator.

Home infusion drug billing reminder



Here are some points to keep in mind when deciding whether a patient's infusion drug should be billed under Medicare Part B (medical) or Part D (pharmacy).

Generally, the method of infusion determines whether the infusion drugs are covered under Part B or Part D:

- Bill Part B if the drug is administered with an infusion pump or an implantable pump.
- Bill Part D if the drug is administered without an infusion pump, such as an IV push.

If the drugs are infused at the patient's home, the following guidelines apply:

- Infusion drugs administered with an infusion pump are not covered unless specifically covered under the applicable Medicare policy.

- Infusion drugs administered without an infusion pump must be submitted by the patient's Part D carrier. If you are not a Part D provider, the member must pay in full for the drugs, then seek reimbursement from the Part D plan.

Please note that we will be making changes to the preauthorization process and the preauthorization form on NaviNet® that will require you to note each drug's route of administration.

For further details, please refer to the Medicare Part B vs. Part D Medical Policy on our website at www.ibx.com/medpolicy.

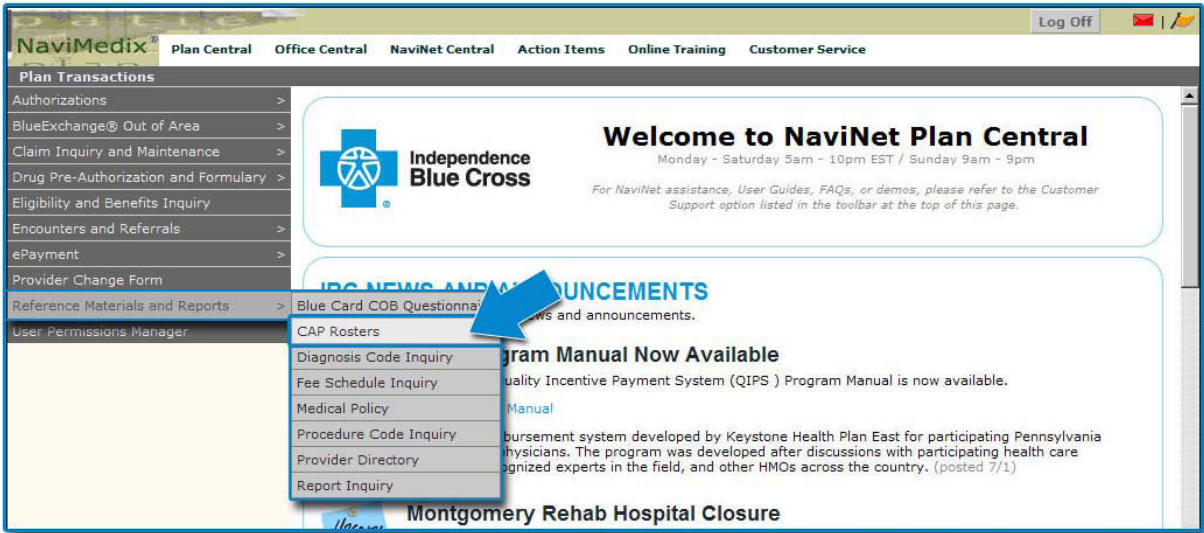
NaviNet® is a registered trademark of NaviMedix, Inc.

NaviNet and capitation roster report



Primary care physicians (PCPs) can view, print, and download electronic copies of their capitation rosters through NaviNet.

To access your capitated roster list, select *Reference Materials and Reports* from the Plan Transactions drop-down menu and then select *CAP Rosters*.



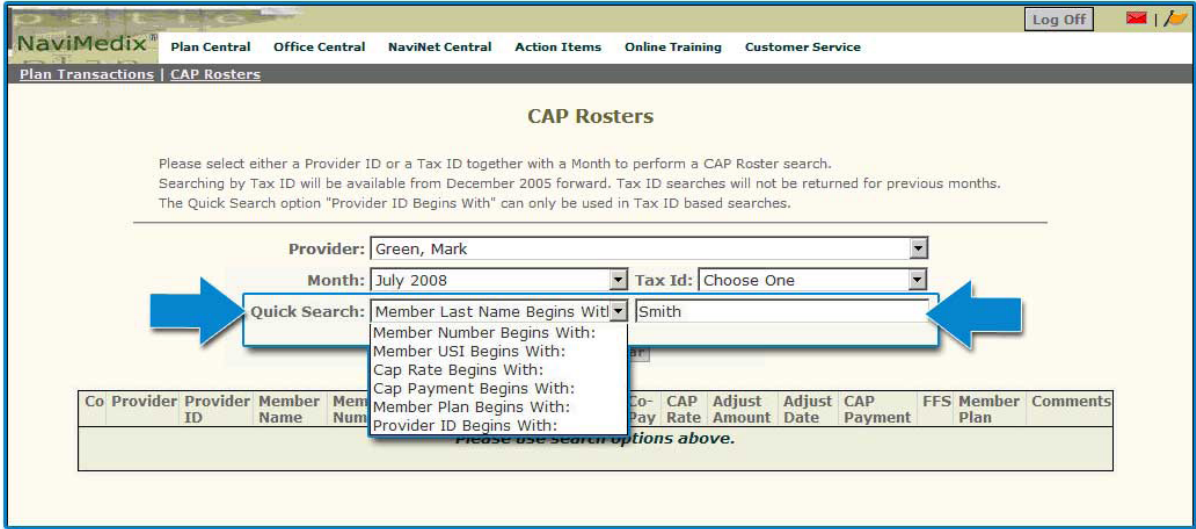
Next, fill out either the *Provider* or *Tax ID* field in combination with a specific month. This will generate an accurate CAP Report for the specified month. *Note:* Once generated, all rosters will be accessible for a period of 13 months.



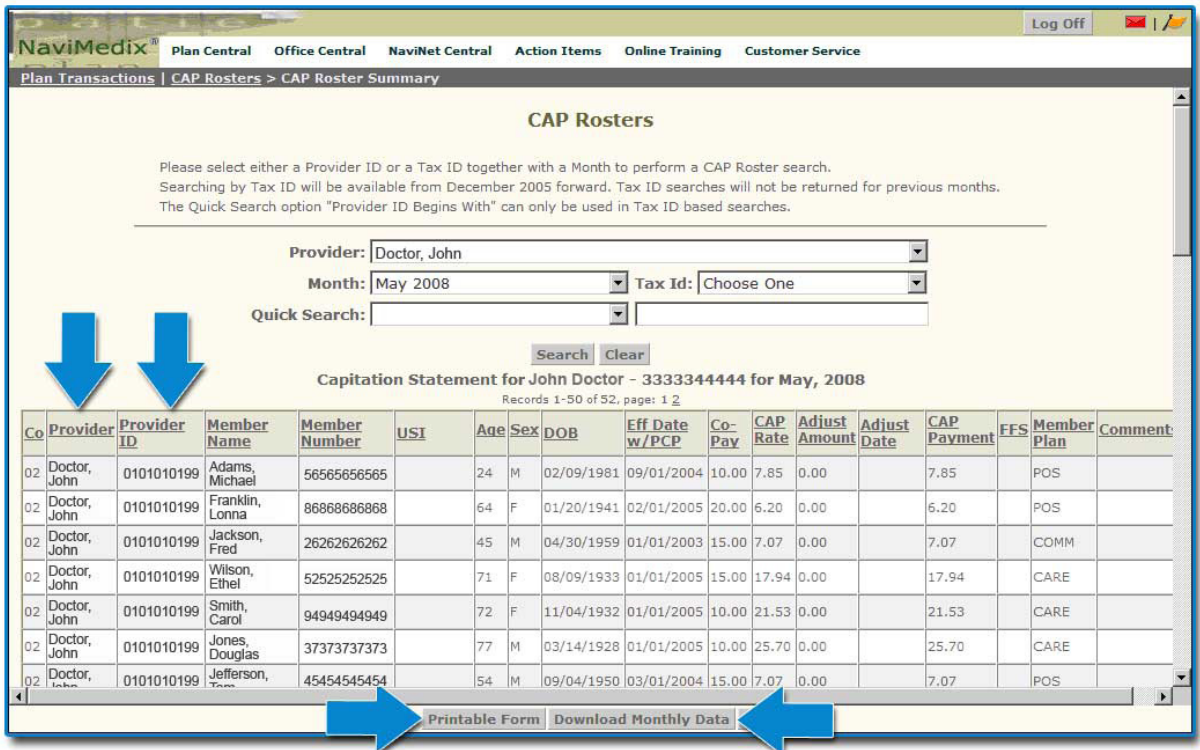
continued on page 6

NaviNet and capitation roster report (continued)

Additionally, you can narrow your search by using the *Quick Search* drop down as displayed below. After selecting the *Quick Search* category, enter a corresponding value (e.g., the patient's last name, USI number, etc.), and select the *Search* button.



These results can be sorted by selecting the column headers. You can also print or download the capitated roster list by selecting the appropriate button along the bottom of the screen.





Medicare Private Fee-for-Service: how to submit a claim

On January 1, 2008, Independence Blue Cross 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.

To file a claim for local Select Advantage PFFS plan members, please use the following guidelines:

- Select Advantage PFFS plans process claims following Original Medicare billing rules, including all prospective payment system requirements. Claims should be submitted using the same coding rules as Original Medicare and use the Medicare CPT® codes and defined modifiers. Diagnosis codes should be billed to the highest level of specificity. Remember to use the CMS-approved HCPCS codes and CMS-approved modifiers.
- Claims for Select Advantage PFFS members should be sent to QCC Insurance Company only, not to a Medicare carrier or fiscal intermediary. However, claims for Medicare-approved clinical trials should be sent to the Medicare carrier or fiscal intermediary.
- Claims should be submitted as soon as possible after a service is provided using the standard CMS-1500 or the UB-04 form. All Medicare billing guidelines must be followed when submitting claims.

All Select Advantage claims must include the following:

- National Provider Number/Medicare Provider Number
- Federal Tax Identification Number
- QCC Insurance Company PFFS Member ID Number, which consists of a 3-position alpha prefix, an 8-position ID number, and a 2-position suffix.

Use the following guidelines when submitting all Select Advantage claims:

- Electronic claims should be submitted using the EDI 837 billing form.
- Paper claims should be submitted to QCC Insurance Company at the following address:
Select Advantage Claims
P.O. Box 69350
Harrisburg, PA 17110
- Claims for routine eye exams and eyewear for Davis Vision providers should be submitted using

the standard Davis Vision process. Claims for non-Davis Vision providers should be submitted on CMS-approved claim forms and with CMS-approved CPT and HCPCS codes to the following address:

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

- Facility paper claims should be submitted on a CMS-1450 claim form. Facilities must include the 6-digit Medicare number in field 51 (PROVIDER NO.).
- Professional paper claims should be submitted on a CMS-1500 claim form.
- When submitting bills on a UB-04, facilities must include the 6-digit Medicare number in field 57 (PROVIDER NO.).
- Laboratories should send claims directly to QCC Insurance Company using the CLIA number.
- The National Provider Identification (NPI) must be included on all claims submissions (paper or electronic) to QCC Insurance Company.
- Hospice providers should file claims using their current process.
- For coordination of benefits, all Medicare secondary payer rules apply. Providers should obtain information on primary payer coverage and bill accordingly.

For Select Advantage *out-of-area* member claims, please use the following guidelines:

- For Medicare covered services, submit claims to QCC Insurance Company at the address below. Do not bill Medicare directly for any services rendered to a PFFS member. Payment will be made directly by the Blue plan.

Select Advantage Claims
P.O. Box 69350
Harrisburg, PA 17110

- Claims for routine eye exams and eyewear for Davis Vision providers should be submitted using the normal Davis Vision process. Claims for non-Davis Vision providers should be submitted on a CMS-approved claim form and with CMS-approved CPT and HCPCS codes to the following address:

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

PRODUCTS

Medicare Private Fee-for-Service: how to submit a claim (continued)

- When filing claims with the local Blue plan, the Blue plan should submit the PFFS claims as it does for a local member from that plan.
- The NPI must be included on all claims submissions (paper or electronic) to the local Blue plan.
- Claims for out-of-area PFFS members should be filed with the local Blue plan using the same CMS billing guidelines, forms, and codes as Original Medicare as well as the unique billing variations identified below:
 - Report the member's PFFS ID number with the alpha prefix (not the Health Insurance Claim Number).
 - If a provider currently submits claims electronically to the local Blue plan, he or she may submit PFFS claims using the source of payment (facility = x; professional = y) and payer ID (facility = a; professional = b).
 - Provider name and credentials should be reported in Box 31 on paper CMS-1500 claims or in the equivalent field on the EDI 837.

Hospice providers should file claims using their current process.

For additional claims and payment methodology information, visit our website at www.ibx.com/providers. Be sure to check future editions of *Partners in Health Update* for additional information on this new Medicare Advantage PFFS plan.

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MEDICAL

Modifier 57 and Modifier 59



In August 2008, Independence Blue Cross posted two notifications on www.ibx.com/medpolicy regarding medical policies that define the documentation and reporting requirements for Modifier 57 and Modifier 59. The notifications are as follows:

For claims processed on or after September 22, 2008, providers will notice ClaimCheck® editing being applied to services that are reported with Modifiers 57 and 59. The additional editing is the result of automation in the application of standard editing in the processing system for these modifiers. To review the company's policies on the appropriate use of Modifier 57 and 59, please review

medical policies 03.00.16d Modifier 57 and 03.00.08c Modifier 59 in the Policy Notification section of www.ibx.com/medpolicy prior to September 22, 2008, or look in the Policy Bulletins section after September 22, 2008.

In addition, specific code editing results for procedure codes reported with Modifiers 57 and 59 will be available beginning September 22, 2008, via Clear Claim Connection™ in the Claims and Billing Information section on www.ibx.com/providers.

Please contact your Network Coordinator if you have any questions.

Transition to all-electronic inquiry and submission — Part II



Enhancements to the provider interactive voice response (IVR) system continue to progress. The new enhancements to the system will provide you with the ability to submit an authorization or precertification request for outpatient and office medical and/or surgical procedures.* This service will be directly accessible through Customer Service at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE), [prompt 2 for Provider Services](#).

This updated system will be available in the near future as part of our phased approach toward the electronic authorization mandate project.

Additional details and a tutorial will be available in future editions of *Partners in Health Update*.

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

Policy Notifications available online



To better communicate updates to our medical and claim payment policies, we will be posting notifications online prior to the policy's effective date. The notifications will be listed by the intended effective date, and we will provide the policy for you to become familiar with it in advance. To read these notifications, please 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.
5. Select the date under Policy Effective Date for the policy notification you wish to view.

Notifications will be posted frequently, so please check the site often.



Policy Notifications posted as of August 8, 2008



In order to better inform providers, Independence Blue Cross has developed a Policy Notification 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 August 8, 2008:

Policy Effective Date	Notification Title	Notification Issue Date
October 1, 2008	08.00.75 Erythropoiesis Stimulating Agents (ESAs)	July 1, 2008
October 1, 2008	06.02.01c Lyme Disease: Diagnosis and Intravenous (IV) Antibiotic Treatment	July 3, 2008
October 21, 2008	11.17.01d Bulking Agents for the Treatment of Stress Urinary Incontinence (SUI) due to Intrinsic Sphincter Deficiency (ISD) and for the Treatment of Vesicoureteral Reflux (VUR)	July 23, 2008
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 4, 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

Visit the Policy Notifications web page on www.ibx.com/medpolicy to view these policies in their entirety, and be sure to check back often, as the site is updated frequently.

Annual Synagis® (palivizumab) distribution program



Independence Blue Cross (IBC) is pleased to announce the Synagis® (palivizumab) distribution program for the 2008-09 respiratory syncytial virus (RSV) season, which is November through April in the U.S. According to the Centers for Disease Control and Prevention, RSV is the most common cause of bronchiolitis and pneumonia among children younger than one year of age. During RSV season, we will approve the monthly administration of Synagis® (palivizumab) for at-risk children younger than two years of age.

How does Synagis® (palivizumab) work?

Synagis® (palivizumab), a humanized monoclonal antibody, provides passive immunity against RSV and is intended to decrease the morbidity and mortality associated with RSV infection in at-risk children younger than two years of age. It is licensed for the prevention of RSV lower respiratory tract disease in at-risk children, which includes children who have:

- chronic lung disease of prematurity (CLD, formerly called bronchopulmonary dysplasia)
- history of preterm birth (<35 weeks gestation)
- congenital heart disease

During RSV season, Synagis® (palivizumab) is administered to at-risk children intramuscularly once every 30 days for a maximum of five doses, according to the medically necessary criteria as outlined in our medical policy available on www.ibx.com/medpolicy. The policy was developed based on the recent guidelines for the use of palivizumab from the American Academy of Pediatrics (AAP) and expert consultant input (*American Academy of Pediatrics 2006 Red Book*, pp 563-565).

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

How can Synagis® (palivizumab) be obtained for office use?

This year, IBC has coordinated with ACRO Pharmaceutical Services to be the sole vendor for Synagis® (palivizumab) during the 2008-09 season. Note that this is a change from the 2007-08 season. It is mandatory that all participating providers obtain Synagis® (palivizumab) through ACRO Pharmaceutical Services (a direct ship vendor), who will ship the agent directly to the health

care provider. ACRO Pharmaceutical Services will provide Synagis® (palivizumab) exclusively for IBC during the 2008-09 season.

In order to facilitate requests as efficiently as possible, all referrals should be sent directly to ACRO Pharmaceutical Services to coordinate shipment and the delivery of Synagis® (palivizumab) to your office. Do not forward referrals to MedImmune, LLC, as IBC is not participating in the RSV Connection™ Program.

If you have questions about the Synagis® (palivizumab) distribution program, please contact Customer Service. Look for more information regarding the shipment and facilitation of Synagis® (palivizumab) in next month's issue of *Partners in Health Update*.

**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 may be verified through 1-800-ASK-BLUE, prompt 2 for Provider Services.*

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 the IBC Synagis® (palivizumab) medical policy criteria, which is based on recommendations from AAP.

Tobacco smoke will not be accepted as an environmental pollutant. This guideline is based on the AAP Committee on Infectious Diseases' indication 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. (American Academy of Pediatrics 2006 Red Book, pp 563-565).

Fee-for-service providers will be reimbursed for the evaluation and management procedure codes that correspond to the patient's office visit. You will not 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 2008-09 season will begin on Wednesday, October 29, 2008. Shipping will end on Wednesday, April 15, 2009. Up to five doses will be shipped per patient (one shipment every 30 days).

Select Drug Program® Formulary updates



The Select Drug Program Formulary is a list of FDA-approved medications that were chosen for their medical effectiveness, safety, and value. The list changes periodically as the FutureScripts® 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 copayment.

Generic drug	Brand drug	Formulary chapter	Effective date
acarbose	Precose®	7. Diabetes, Thyroid, Steroids & Other Miscellaneous Hormones	May 9, 2008
bupropion XL 150 mg	Wellbutrin XL® 150mg	3. Pain, Nervous System, & Psych	May 30, 2008
calcipotriene topical solution 0.005%	Dovonex® Solution	5. Skin Medications	May 9, 2008
dronabinol	Marinol®	8. Stomach, Ulcer, & Bowel Meds	July 3, 2008
ethinyl estradiol/drospirenone	Yasmin®	11. Female, Hormone Replacement, Birth Control	July 2, 2008
paroxetine hcl extended-release	Paxil CR®	3. Pain, Nervous System, & Psych	May 16, 2008
risperidone	Risperdal®	3. Pain, Nervous System, & Psych	July 1, 2008
ropinirole	Requip®	3. Pain, Nervous System, & Psych	May 9, 2008
zaleplon	Sonata®	3. Pain, Nervous System, & Psych	April 11, 2008

Brand additions

These brand drugs are covered at the appropriate brand formulary copayment based on the effective date indicated.

Brand drug	Formulary chapter	Effective date
Actonel® 150 mg	10. Bones, Joints, & Muscles	August 1, 2008
AZOR™	4. Heart, Blood Pressure, & Cholesterol	May 12, 2008
Bystolic™*	4. Heart, Blood Pressure, & Cholesterol	October 1, 2008
Crestor®	4. Heart, Blood Pressure, & Cholesterol	October 1, 2008

Once a brand drug becomes available in the marketplace and is approved by the FutureScripts Pharmacy and Therapeutics Committee as a formulary drug, it will be added to the formulary and will be available at the brand formulary copayment.

*Please note that prior authorization is no longer necessary when prescribing Bystolic. In the future, providers may prescribe Bystolic without first obtaining prior authorization as necessary.

Select Drug Program® Formulary updates (continued)

Brand deletions

These brand drugs will be covered at the appropriate non-formulary copayment.

Effective October 1, 2008

Brand drug	Generic drug	Formulary chapter
Dovonex® Solution	calcipotriene topical solution 0.005%	5. Skin Medications
Risperdal®	risperidone	3. Pain, Nervous System, & Psych
Sonata®	zaleplon	3. Pain, Nervous System, & Psych
Wellbutrin XL® 150mg	bupropion XL 150 mg	3. Pain, Nervous System, & Psych

The generic drugs for the brand drugs listed above are on our formulary and available at the generic formulary copayment.

Prescription drug updates



The drugs listed below now require prior authorization for members enrolled in an Independence Blue Cross prescription drug program. The prior authorization requirement ensures that drugs are used appropriately and guards against drug overuse. Updates to the prior authorization requirement are reflected below.

Drugs requiring prior authorization

The prior authorization requirement for the following drug was effective at the time the drug became available in the marketplace.

Effective May 23, 2008

Brand drug	Generic drug	Drug Category
Taclonex Scalp® Suspension	Not available	Skin Medications

The following drugs will be added to the list of drugs requiring prior authorization for new prescriptions.

Members taking these drugs before the effective date are not affected.

Effective October 1, 2008

Brand drug	Generic drug	Drug category
Alodox™	Not available	Antibiotics & Other Drugs Used for Infection
AMRIX™	Not available	Pain, Nervous System, & Psych
Crestor®	Not available	Heart, Blood Pressure, & Cholesterol
Vytorin®	Not available	Heart, Blood Pressure, & Cholesterol

Please note that prior authorization is no longer necessary when prescribing Bystolic. In the future, providers may prescribe Bystolic without first obtaining prior authorization as necessary.

The ConnectionsSM Health Management Programs 2008 Annual Update now available



The Connections Health Management Programs 2008 Annual Update is included with this issue of *Partners in Health Update*. Learn how you and your patients can benefit from these programs. Also, see what changes have been made to the Connections programs over the past year. The programs are designed to work with your patients

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 our Connections programs, visit www.ibx.com/providers/resources/connections.html.

ConnectionsSM Health Management Programs: supporting our members, your patients



CONNECTIONSSM HEALTH MANAGEMENT PROGRAM

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

- asthma
- diabetes
- heart failure
- chronic obstructive pulmonary disease (COPD)
- hypertension
- coronary heart disease (CHD)
- migraine

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

CONNECTIONSSM ACCORDANTCARETM PROGRAM

Call the Connections AccordantCare Program at [1-866-398-8761](tel: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](tel:1-800-313-8628) to refer a patient with end-stage renal disease on outpatient dialysis.



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

Davis Vision, an independent company, administers vision benefit services.



IMPORTANT RESOURCES

View our online provider directories on www.ibx.com

CARE MANAGEMENT AND COORDINATION	215-567-3570
Case Management	1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Healthy Lifestyles SM Keys to Wellness	215-567-3570 1-800-313-8628*
CONNECTIONSSM HEALTH MANAGEMENT PROGRAMS	
Connections SM Health Management Program Provider Support Line	1-866-866-4694
Connections SM AccordantCare TM Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT	1-866-282-2707
Anti-Fraud and Corporate Compliance Hotline	www.ibx.com/anti-fraud
CREDENTIALING	www.ibx.com/credentials
Credentialing Hotline	215-988-6534
Credentialing Violation Hotline	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	1-888-678-7012
Fax	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 SM	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

2008 ANNUAL UPDATE

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2008 ConnectionsSM Programs Annual Update summary

The 2008 Connections Annual Update highlights the accomplishments of our Connections Health Management Programs during the past year. Our Connections Program is a comprehensive disease management and decision-support program — which includes both the ConnectionsSM Health Management Program and the ConnectionsSM AccordantCareTM Program. Member participation in both programs is high — 98 percent of eligible members take part in the Connections Health Management Program and 90 percent in the Connections AccordantCare Program. Both programs are intended to improve the quality and reduce the cost of health care through more informed patient-physician communication. This is accomplished by providing individually tailored Health Coaching and support material to patients and by giving physicians clinical information that they can apply to their treatment plan.

These are robust programs covering a variety of chronic conditions and offering decision support and health information. The Connections Health Management Program focuses on common, chronic diseases such as asthma, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), diabetes, and heart failure. The AccordantCare Program supports members with one or more of 16 more complex, chronic conditions. Interventions include outreach phone calls, interactive voice messaging, and mail campaigns. Providers with patients in the Connections Health Management Program receive a semiannual SMART[®] Registry, a tailored medical report that aids physicians in better treating patients with specific health care needs.

This year's annual update provides general information on the Connections programs as well as information about new initiatives, new outreaches, and new tools to help you provide support to your patients, our members, with chronic conditions.

ConnectionsSM Health Management Program

The Connections Health Management Program, offered in partnership with Health Dialog, an independent company, provides disease management and decision support to eligible members 24 hours a day, seven days a week, through Health Coaches and online resources. For providers, it is a resource to help you and your patients better manage their asthma, CHD, COPD, diabetes, heart failure, migraines, hypertension, gastroesophageal reflux disease (GERD), and peptic ulcer disease (PUD).

The SMART[®] Registry

Independence Blue Cross (IBC) distributed two releases of the SMART Registry in 2008. The SMART Registry tracks important evidence-based aspects of care for patients with one or more of the following conditions:

- asthma
- CHD
- COPD
- diabetes
- heart failure

The SMART Registry is received by 3,938 IBC primary care practices and includes information on more than 263,966 IBC members. These reports offer practical, relevant information about your patients in a convenient format to help you stay informed about your patients and to monitor their care plans.

The June 2008 SMART Registry introduced the medication persistence report, an enhanced medication monitoring tool. This new report:

- helps you manage your patients with diabetes and cardiac conditions who are using ACEi/ARBs, beta blockers, and lipid-lowering drugs;
- tells you if your patients have ever filled a prescription for the recommended medication and if they are getting their refills.

A new report titled the *Medication Persistence Report* is located on the tab after the *Network Report* on the June SMART Registry. This new report provides you with the names of your patients with CHD, diabetes and heart failure, and their persistence rates — if these drugs are indicated — for ACEi/ARBs, beta blockers, and lipid-lowering medications. Only members with pharmacy claims information in our databases will be included in this report.

SMART[®] is a registered trademark of Health Dialog Services, Incorporated.

Patients with prescription fill rates of 80 percent or more are labeled as persistent. Patients with lower prescription fill rates are labeled as nonpersistent and may be flagged for follow-up. Poorly persistent patients are often good candidates for Health Coaching. Health Coaches are specially trained health care professionals, such as nurses, dietitians, and respiratory therapists, who provide support and health care information over the phone. This coaching benefit is provided at no additional cost to IBC members eligible for the Connections Program.

Please refer to your most recent SMART[®] Registry to update the clinical care your patients have received and to refer your patients who may benefit from Health Coaching to the Connections Program.

Provider Service Specialists support provider offices

Provider Service Specialists (PSSs) are local clinical professionals who provide support and offer information about the Connections Program. Your PSS 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 PSS can help you or to schedule a visit from a PSS.

Asthma targeted provider outreach

In February 2008, the Connections Health Management Program began a targeted clinical initiative to address the needs of providers caring for patients with asthma. This initiative will run until January 2009 and focuses on patients who appear to have controller medication gaps and/or excessive use of rescue medication. As part of this initiative:

- PSSs meet with physicians and other clinical care practitioners to discuss the use of the SMART Registry and to provide clinical resources and referral tools for use by providers and patients.
- The PSSs provide practices with a printout of the practice's Registry, filtered to focus on patients fitting the initiative's criteria.

Many providers have found this initiative useful because the SMART Registry identifies patients who have not followed through with the recommended medication plan and the doctors are able to implement strategies to address this.

Tools and resources for providers who treat patients with asthma and other chronic conditions

A series of asthma management materials are now available to help support you and your patients with asthma — including customizable symptom response plans and controller medication information.

Tools and resources for your patients with asthma or other chronic conditions are available for your office. Visit www.ibx.com/providers/resources/connections.html to find tools such as the PHQ-9 depression screening questionnaire, diabetes and kidney disease brochure, the BMI card, diabetes and asthma template letters, a list of Shared Decision-Making[®] videos, and more. Paper copies of these materials are available by contacting your PSS at [1-866-866-4694](tel:1-866-866-4694).

Connections Health Management Program provider satisfaction survey

The fourth annual provider satisfaction survey for the Connections Health Management Program was conducted by an independent research company in the fourth quarter of 2007. For the first time, providers were able to respond to the survey online through a link in the *Partners in Health Update* (now available online). A follow-up survey was then mailed to nonrespondents. The survey found that awareness of the program was high among respondents. Other important results:

- Nearly 50 percent said patients had talked with them about the program.
- More than 75 percent said the program improved communication with their patients.
- Sixty-four percent found the SMART Registry to be a helpful resource.
- Sixty-six percent found the support from the PSSs to be helpful.
- Sixty-nine percent found the program helpful for their chronic patients who have used it.
- More than 50 percent said the program provided a more positive image of the health plan.

Member satisfaction survey

Each year, IBC surveys 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 2007 survey sample population included members with and without one of the five managed chronic conditions, (asthma, CHD, COPD, diabetes, and heart failure), members who have had telephone contact with a Health Coach, and members who have never spoken to a Health Coach. The survey found that:

- Ninety percent of the respondents indicated that their impression of IBC was positively affected by Connections.
- More than 94 percent of the respondents would recommend Connections to family and friends.
- More than 85 percent of the respondents indicated that it is important that IBC continue to offer Connections.

The most frequently cited reasons for using Connections include:

- 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 AccordantCareTM Program

The Connections AccordantCare Program is offered through a partnership with Accordant Health Services, an independent company, that is a specialized health management organization. The program provides resources to assist you and your eligible IBC patients who live with one or more of the 16 complex chronic conditions that the program supports.

The goal of the program is to work with you to improve the clinical outcomes for these patients. Prevention of complications is the cornerstone of the program. Healthy behaviors that address the whole person, including comorbidities, are promoted, and a support system is developed around each individual's unique needs. Accordant interventions are evidence-based, and the program has earned full accreditation from the National Committee for Quality Assurance (NCQA).

Knowledgeable, licensed AccordantCare nurses offer support to your patients through frequent assessments and 24/7 availability. Nurses emphasize and reinforce your treatment plan. Conversations are designed to detect changes in the member's health status. Nurses notify you of any important changes in your patient's health status.

Members receive customized educational mailings, specific to their conditions, that cover topics from preventive strategies to acute management. Social workers locate specialized resources, such as financial assistance and local support groups. Exclusive online health resources are provided for both members and their caregivers.

As with our other health management program, the Connections AccordantCare Program is designed to improve patients' compliance and self-management skills and to support your treatment plans.

More than 10,500 members were participating in the Connections AccordantCare Program as of April 30, 2008. More than 60 percent participated at an "interactive status" (active communication with an AccordantCare nurse and completion of quarterly assessments). Disease-specific mailings and access to an extensive web library are available to all participants.

Program diseases

The diseases covered by this program are:

- 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
- chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- amyotrophic lateral sclerosis (ALS)
- dermatomyositis
- Gaucher disease

The Connections AccordantCare Program assists you by:

- offering support to your patients who have questions about their condition 24 hours a day, seven days a week;
- educating your patients through AccordantCare's informative website, www.accordant.com, monthly newsletters, and contact with AccordantCare nurses;
- improving patient compliance with your prescribed

treatment plan through educating patients and notifying you of pertinent changes in health status;

- conducting routine health evaluations with your patients by telephone or email to detect early warning signs of complications;
- providing you with access to AccordantCare's nationally recognized medical advisers who are available to discuss complex patient or treatment issues at no cost to you;
- offering specialized care coordination services to coordinate the care of critically ill patients;
- coordinating care among all members of the patient's health care team.

For more information, visit the AccordantCare website at www.accordant.net. If you have questions, call the Connections AccordantCare Program at 1-866-398-8761, 8 a.m. to 9 p.m., Monday through Thursday, or 8 a.m. to 5 p.m. on Friday, EST. Messages left after hours will be returned the next business day.

ConnectionsSM Kidney Program

Since 2004, IBC, in collaboration with RMS, Inc., an independent company, has offered the Connections Kidney Program to provide disease management services to our members with end-stage renal disease on dialysis.

Based on ongoing evaluations, we decided to discontinue the Connections Kidney Program effective April 30, 2008. Members enrolled in the program were assigned to case managers in IBC's Care Management and Coordination department to ensure that these members continue to receive the appropriate support.

To refer a patient on dialysis to the IBC Care Management and Coordination department, call 1-800-313-8628.