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Suggestions?

Do you have suggestions on how we can improve your experience with our website? We are in the process of redesigning the provider section of ibx.com and value your input.

Please email your ideas to us at provider_communications@ibx.com. Our goal is to make the site easier to navigate so you can quickly find the information you need.

We appreciate and welcome your feedback.

Partners in Health UpdateSM 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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For articles specific to your area of interest, look for the appropriate icon:

- P** Professional
- F** Facility
- A** Ancillary



Keystone Health Plan East, Personal Choice[®], Keystone 65, and Personal Choice 65SM have an accreditation status of *Excellent* from the National Committee for Quality Assurance (NCQA).

Healthy LifestylesSM Rewards: A new approach to wellness by incenting members

Findings from our recent research show that most health care consumers are taking an active role in changing behaviors to optimize their health. The same study revealed that more than two-thirds of those surveyed would participate in a member rewards program if offered by their employer.*

Motivating your patients — our members — to be more active in their health care has been an ongoing priority at IBC, which is why we launched the Healthy Lifestyles Rewards program earlier this year. Healthy Lifestyles Rewards is an incentive-based program that encourages members to engage in the right balance of activities, ranging from physical fitness and education to preventive screenings and services. The program has been enhanced as of July 1, 2009; employer groups with 100 or more employees have the option of adding this incentive program to their employees' Personal Choice[®] or Keystone Health Plan East (KHPE) coverage.



How Healthy Lifestyles Rewards works

With Healthy Lifestyles Rewards, HealthPoints are awarded when milestones are reached. One HealthPoint equals \$1. Employers may select one of two ways to provide rewards to their enrolled members:

- **Gift cards.** An employer group may offer their employees the option of redeeming HealthPoints for gift cards to a wide selection of restaurants and retailers.
- **Health account deposits.** An employer group may combine its Healthy Lifestyles Rewards program with a consumer-driven health care program, allowing points to become additional deposits into employees' health savings accounts (HSAs) or health reimbursement accounts (HRAs). Deposits will be made into the employees' accounts for every HealthPoint earned.

How employees can earn HealthPoints

There are many ways that participating employees can earn their HealthPoints, including:

- completing an online health assessment;
- visiting their primary care physician;
- getting a mammogram (women 40 or older);
- receiving a colorectal cancer screening (members 50 or older);
- making two calls to a ConnectionsSM Health Management Program Health Coach;
- completing a smoking cessation program;
- receiving an annual flu vaccine.

Who is eligible?

For employees to be eligible for Healthy Lifestyles Rewards, their employer must purchase the program. It's then available for any employee covered under the group's Personal Choice or KHPE plan. Additionally, covered spouses and dependents 18 and older may participate.

We want our members to be as healthy as possible and to utilize every opportunity given to them to adopt a healthy lifestyle. We believe that encouraging your eligible patients to join this program can lead to overall improved health and long-term behavior change.

For more information about the Healthy Lifestyles Rewards program, call 1-800-ASK-BLUE.

*The study was conducted online in August 2008 with 1,011 insured consumers in the 5-county Philadelphia area. Data was also obtained from The Healthcare Trends Study, which was conducted continuously throughout 2008 with 600 consumers in group plans.



Medicare Advantage Private Fee-for-Service: Provider payment dispute resolution process

On January 1, 2008, we launched Select Advantage, a Medicare Advantage Private Fee-for-Service (PFFS) plan. This plan is a non-network, nonmanaged 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 a retrospective review audit.

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

If you chose to treat Select Advantage PFFS members and believe that the payment you received for a service is less than the amount indicated in our Terms and Conditions of Payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with Select Advantage, take one of the following actions:

- Mail a written dispute to:
Independence Blue Cross
Select Advantage PFFS Provider Appeals Administration
P.O. Box 37653
Philadelphia, PA 19101-0653
- Fax a dispute to 1-888-223-0592.

A copy of our Select Advantage PFFS Provider Appeal Form is available at www.site65.com/pdfs/plan_finder/pffs/appeals_form.pdf. Please provide appropriate documentation to support your payment dispute. For example, a remittance advice from a Medicare carrier would be considered such documentation. You must dispute claims within 120 days from the date you initially received payment.

We will review your dispute and respond to you within 30 days. We will inform you in writing if your payment dispute is denied.

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



Discontinuation of the Keystone 65 Complete plan for special needs members

Effective January 1, 2010, IBC will no longer be offering its Keystone 65 Complete plan. This plan for special needs members is currently available in the following Pennsylvania counties: Bucks, Chester, Delaware, Montgomery, and Philadelphia. Keystone 65 Complete will continue through December 31, 2009, and members who are enrolled in this plan will receive their standard benefits until that date.

IBC is working to ensure that all affected members receive adequate time and information to assist them in selecting new health insurance coverage by January 1, 2010. Additional information will be provided in future editions of *Partners in Health Update* and through other communication vehicles.

Additional changes to Medicare Advantage plans

Due to increased medical costs and decreased federal funding to all Medicare Advantage plans, we need to make some difficult decisions. These decisions include making significant changes to our plan benefits and plan offerings for 2010. Look for more information in future editions of *Partners in Health Update*.

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

Easy online access to new and updated policy information

Our medical policy website, www.ibx.com/medpolicy, provides updated information about our policies, news, and notifications, all in one convenient location. You can check for the most up-to-date policy information in two distinct areas, *Policy Notifications* and *Recently Released*, both of which you can access directly from the homepage.

Policy Notifications: A listing of new and updated policies scheduled for release

The notifications on the *Policy Notifications* page represent new and updated policies that are scheduled to become active on the intended effective date. These notifications, listed by scheduled effective date, allow providers to become familiar with the new policy version in advance of its release.

Recently Released: Monthly lists of everything published on our site

Our *Recently Released* policy page is updated daily with a listing of everything that has changed on the site, grouped by month. The list includes news and announcements, policy notifications, and policies that have been published and archived, as well as any other updates to the Medical Policy site.

Both of these resources help you easily find our latest policy information. To ensure that you are informed, visit our site often, as our pages are updated frequently.

MEDICAL

Policy notifications posted as of July 20, 2009

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 July 20, 2009.

Policy effective date	Notification title	Notification issue date
August 19, 2009	11.14.19d Artificial Intervertebral Disc Insertion	July 20, 2009
August 26, 2009	11.08.20e Wound Care: Bioengineered Skin Substitutes	May 28, 2009
October 6, 2009	11.03.02f Bariatric Surgery	July 8, 2009

To access these notifications and then 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 *Policy Notifications*.

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



Change and opportunity when converting hospital payments to a DRG reimbursement method

When converting to a Medicare model, Diagnosis Related Group (DRG) reimbursement method, payers and providers are given the opportunity to tailor payment to the intensity of service and resource utilization.

We are committed to working closely with you to make a smooth transition to the DRG payment system. However, there can be some questions when converting to a DRG reimbursement method. The staff of private payer billing companies are often unfamiliar with many of the DRG concepts and the effect on inlier rates. However, the transition can be seamless with education and communication. Medicare billing providers and the Health Information Management Department within hospitals can prove to be an invaluable resource to explain the principles of “present on admission,” “post acute transfer policy,” and “cost outliers,” as well as the related impact to payment.

Additionally, any contract provisions that affect payment should be communicated to your billing staff so they understand your facility’s financial agreements.

Your billing staff should also be made aware of any contract exceptions to the DRG model, along with the DRG version being utilized to calculate the reimbursement.

Your Network Coordinator can help answer your payment questions and your claims processing queries and will assist with your and your staff’s educational needs. Our Corporate and Financial Investigations Department’s Facility Provider Audit area is conducting DRG validation and focused DRG audits. In addition, any questions dealing with issues of potential fraud or abuse should be referred directly to the Anti-Fraud and Corporate Compliance Hotline at 1-866-282-2707.

Together, we can minimize the questions and explain the process, leading to a better understanding of how the DRG model works and smoothing out some of the bumps along the road of change.

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

Reminder: Mandated coverage for autism spectrum disorders



On July 3, 2008, the Commonwealth of Pennsylvania passed a law that requires health insurers to cover the diagnosis and treatment of autism spectrum disorders (ASD) for members under 21 enrolled in commercial groups with 51 or more employees. ASD includes autistic disorder, Asperger’s Syndrome, Rett Syndrome, childhood disintegration disorder, and pervasive development disorder. Coverage for ASD in accordance with this mandate was effective July 1, 2009. We began to include coverage for eligible new members who begin coverage on or after July 1, 2009. We will also apply this coverage

over the next year to eligible existing members on their contract anniversary date. Benefits will be provided for services set forth in a treatment plan, which we may request and review for approval.

For more detailed information about ASD coverage for eligible Pennsylvania group members, refer to the June issue of *Partners in Health Update*. You can also refer to Policy #07.03.07c: Evaluation and Management of Autistic Spectrum Disorders (ASD), which is available on our website at www.ibx.com/medpolicy.

CMS compliance training required for all providers

In accordance with a new requirement from the Centers for Medicare & Medicaid Services (CMS), all IBC network providers who treat our Medicare Advantage members must complete annual Medicare Advantage and Part D compliance training in an effort to combat fraud, waste, and abuse. Under this new regulation, you must complete the initial training by December 31, 2009.

Completing the training requirement

To complete this required training, visit www.ibx.com/compliancetraining. There, you will find training materials that you can download and review.

To confirm that you have completed the training, you will need to provide your electronic signature. To do so, click the link for the Compliance Certification form and select *I have completed CMS compliance training*. Be sure to enter in all required information. You will receive a confirmation that your compliance requirement for 2009 has been fulfilled. Please print a copy for your records.

Already completed compliance training?

We recognize that many providers may have already completed this training requirement through another organization. If you have completed CMS compliance training for 2009, your electronic signature is needed for confirmation. To provide it, visit www.ibx.com/compliancetraining, and click the link for the Compliance Certification form. Then select *I have completed similar training*, and enter the name of the organization that provided the training. You will receive a confirmation that your 2009 compliance requirement has been fulfilled. Please print a copy for your records.

If you do not have access to the Internet, call the Provider Supply Line at 1-800-858-4728 for a paper copy of the training materials and/or Compliance Certification form. Please note that you will be responsible for mailing or faxing the form to us by December 31, 2009, in order to fulfill your training requirement.

If you have questions about this required training, please contact your Network Coordinator.

Reminder: Timely submission of Initial Maternity Patient Questionnaire important for early outreach



Registering maternity members into our Baby BluePrints® high-risk perinatal program is imperative for early outreach. The *Initial Maternity Patient Questionnaire* form should be mailed to IBC following the first prenatal visit to ensure timely registration into this program. In some instances, questionnaires are being combined and mailed at a later date; our goal, however, is to reach out to members identified as having risk factors within the first trimester of pregnancy.

The program offers many benefits to members, such as educational materials and reimbursements for parenting classes, lactation consultants, and breast pumps. Additionally, our obstetric nurses offer case management to members who need help with such diagnoses as:

- gestational diabetes mellitus
- pregnancy-induced hypertension
- preterm labor
- hyperemesis gravidarum

Please remind your staff to send in the registration questionnaires immediately after the first prenatal visit. Member registration into the program and prenatalization for delivery will be completed at the same time.

The image shows a detailed 'Initial Maternity Patient Questionnaire' form. At the top, it features the 'Baby BluePrints' logo and a title. Below the title, there are instructions: 'By completing this questionnaire, you will be enrolled in the Baby BluePrints® program. You may be contacted by your health plan regarding the program.' The form contains numerous fields for personal information, including First Name, Middle Initial, Last Name, Insurance ID#, Your Social Security #, Insurance Plan (with options like Personal Choice, Keystone, HMO/POS, Traditional Blue Cross/Blue Shield, and Other), Policyholder's Name, State of Policyholder's employment, Your Date of Birth (MM/DD/YY), Your Age, Age of baby's father, Your Address (City, Home Telephone, Work Telephone), Your Occupation, Primary Language (English, Spanish, Sign Language, or Other), Marital Status (Married, Single, Divorced, Separated, Widowed), Emergency Contact, and a list of questions regarding pregnancy history and current health. The form is numbered '0686411736' in the top right corner.

Baby BluePrints® goes green

We recognize the volume of mail that our providers receive daily. In our continued efforts to reduce waste and streamline your administrative processes, we are changing the prenotification process for Baby BluePrints.

Effective September 18, 2009, maternity prenotification letters will no longer be mailed to facilities and obstetric providers. Instead, you will be able to verify our members' enrollment into Baby BluePrints and obtain their maternity prenotification reference number by using the NaviNet® web portal or the provider Interactive Voice Response (IVR) system at 1-800-ASK-BLUE.

Please note that, as always, the Initial Maternity Patient Questionnaire form should be completed and mailed to us immediately following the first prenatal visit. That process is not changing.

Using the NaviNet web portal

To verify our members' enrollment into Baby BluePrints, submit a delivery notification, and/or obtain a maternity prenotification reference number using the NaviNet web portal, use the following instructions:

1. Log in to the NaviNet web portal and select *Authorizations* from the Plan Transactions menu. Then select *Authorization Status Inquiry*.
2. Enter the member ID number. Then enter the estimated date of delivery in the "Service Date From" field. Leave the "Service Date To" field blank. Click *Search*.
3. If the member is enrolled, the prenotification will display. Click *Select* to view the maternity prenotification reference number in the "Transaction Number" field in the upper right corner of the screen.
4. Hospitals and birthing centers can submit a delivery notification using the Transaction Detail screen. Change the admission date to reflect when the member was admitted, and complete the delivery information. Click *Submit* to update the prenotification.



Using the IVR system

To verify our members' enrollment into Baby BluePrints, submit a delivery notification, and/or obtain a maternity prenotification reference number using the IVR system, call 1-800-ASK-BLUE, prompt 2 for Provider Services. Then select prompt 1 to connect to the IVR system, and use the following instructions:

- **OB/GYN providers.** Select *Authorization Inquiry* from the menu options and follow the voice prompts.
Note: For the date of service, enter the estimated date of delivery. You will receive a verification and reference number for the prenotification of services, which validates the member's enrollment into Baby BluePrints.
- **Hospitals/birthing centers.** Select *Delivery Notification* from the menu options, and follow the voice prompts. If you have not already been provided with the maternity reference number, you will be guided through steps to validate your services related to the member's care to ensure her privacy. Upon validation of the maternity record, you will be prompted to report the notification of services and will receive a reference number for those services.

The maternity prenotification reference number should be used on all communications, including billing for the member's maternity services through the term of her pregnancy. If you have any questions, please contact your Network Coordinator.





Reminder: Check precertification requirements for durable medical equipment

We want to remind you to check member benefits for precertification requirements for durable medical equipment (DME). For most members, precertification is required for all rental items except oxygen when the billed amount is \$500 or more per line item. Precertification is also generally required for all purchased items except diabetic supplies and unit dose medications for nebulizers.

While the threshold for most members is \$500, certain Medicare groups have a threshold of \$100. Please check the benefits for each member to whom you supply DME to verify the appropriate precertification threshold.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Plan (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage maybe verified by calling Customer Service.



The Preventable Serious Adverse Events Act update



Pennsylvania House Bill 84, which prohibits facilities and professional providers from seeking reimbursement related to preventable serious adverse events, will take effect on August 9, 2009.

On January 1, 2009, IBC published claim payment policy #00.01.44: Never Events and Preventable Adverse Events. Under this policy, the company will not provide coverage for Never Events or the incremental costs associated with Preventable Adverse Events.

For more details, please view the policy in its entirety at www.ibx.com/medpolicy.

If you have questions, please contact your Network Coordinator.

Call 1-800-ASK-BLUE One number for all of your needs



Our toll-free number, 1-800-ASK-BLUE, is a convenient way to access the following services:

- Provider Services
- Interactive Voice Response (IVR) system
- ConnectionsSM Health Management Programs
- Precertification/preauthorization*

Please use 1-800-ASK-BLUE for all of your needs. The former telephone numbers for the services listed above will eventually be disconnected.

*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.



Providers must use the NaviNet web portal or the IVR system for all member eligibility inquiries

This is a reminder that participating providers are required to use either the NaviNet web portal or the Interactive Voice Response (IVR) system to obtain member eligibility information.

The NaviNet web portal

In addition to member eligibility information, providers using the NaviNet web portal have access to many other resources, including submission and inquiry functionality for authorizations, encounters, and referrals.

Please note that the NaviNet web portal is available only to participating providers. To get started using the NaviNet web portal, please contact the eCommerce Provider Hotline at 215-640-7410 or complete an *Online Inquiry Form* at www.ibx.com/navinet.

IVR

Providers may also use the IVR system, our speech-enabled automated phone service, to retrieve member eligibility information for HMO and PPO members.

Please note that requested information can be faxed to your office through the IVR system. Call 1-800-ASK-BLUE, prompt 2 for Provider Services, and then prompt 1 to connect to the IVR system, which is available 24 hours a day, 7 days a week.

We are making enhancements to the IVR system regarding authorization services. These enhancements are intended to improve your experience when contacting our Health Resource Center.

When calling for authorization-related services, please have the following information ready:

- your NPI or corporate provider ID number;
- the last four digits of your tax ID number.

Authorization services are available Monday through Saturday, 5 a.m. to 11 p.m. and Sunday from 9 a.m. to 11 p.m.

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

Announcing new preferred diabetic test strips effective October 1, 2009

We will soon be changing our preferred diabetic test strips in our Blood Glucose Meter Program. **Effective October 1, 2009**, Bayer and Abbott products will become the preferred brands of test strips for all of our prescription drug programs. In addition, they will be the only preferred test strips on the Select Drug Program[®] Formulary. Both of these brands offer your patients simple and accurate testing strips and monitoring systems.

We recognize that you are best qualified to choose the most appropriate medical devices for your patients, but we ask you to discuss the new preferred brands with them. For Abbott monitors, the new preferred test strips include FreeStyle[®], FreeStyle Lite[®], and Precision Xtra[®]. For Bayer monitors, the new preferred test strips include Contour[®], Breeze[®]2, Elite[®], and Autodisc[®].

Our current preferred test strip brands, Accu-Chek[®] and OneTouch[®], will remain as the preferred brands until September 30, 2009. You may prescribe these test strips without a prior authorization through September 30, 2009. As of October 1, 2009, these test strips will be non-preferred and therefore no longer included on our formulary.

New prior authorizations

Effective October 1, 2009, we will also require prior authorization for any test strips that we consider non-preferred. In other words, if a member chooses to use a test strip that is not FreeStyle[®], FreeStyle Lite[®], Precision Xtra[®], Contour[®], Breeze[®]2, Elite[®], or Autodisc[®], you will need to fill out a prior authorization form on your patient's behalf. If the prior authorization is not approved, the non-preferred test strips will not be a covered pharmacy benefit for your patient, and he or she will be responsible for the entire cost of the test strips. If the request for the non-preferred test strips is approved, your patient will be charged the highest level of cost-sharing.

Free meters for new preferred test strips

To help ease the transition to our new preferred test strips, both Abbott and Bayer glucose meters are available at no cost to our members who are switching to one of the new preferred test strips. The following information provides details about these brands and the products they offer. You will also find contact information for requesting a free meter as well as links to the manufacturers' websites.

Abbott Diabetes Care products

The Abbott Diabetes Care products include meters that can help your patients meet their daily challenges related to diabetes. Your patients can consider the products below when choosing a blood glucose meter from this manufacturer:

- FreeStyle Lite[®] Blood Glucose Monitoring System
- FreeStyle Freedom[®] Lite Blood Glucose Monitoring System
- Precision Xtra[®] Blood Glucose and Ketone Monitoring System

More information about these products is available at www.abbottdiabetescare.com/products. To obtain an Abbott meter at no cost, you or your patient should call Abbott Diabetes Care at 1-866-224-8892 or visit their website at www.meters.abbottdiabetescare.com.

Bayer Diabetes Care products

The Bayer family of products also offers meters that can help your patients meet their daily challenges related to diabetes. Your patients may want to consider the options below when choosing a Bayer blood glucose meter:

- Contour[®] Meter
- Breeze[®]2 Meter

Learn more about these products at www.bayerdiabetes.com/sections/ourproducts.aspx. To obtain a Bayer meter at no cost, you or your patient should call Bayer Diabetes Care at 1-877-229-3777.

Note: You can still request Accu-Chek[®] and OneTouch[®] brand meters through September 30, 2009, by calling 1-888-678-7012, prompt 3, then prompt 5.

For more information

If you have questions about the new preferred test strips or the Blood Glucose Meter Program, please contact FutureScripts[®], our pharmacy benefits management company, at 1-888-678-7012, prompt 3.

FutureScripts is an independent company that provides pharmacy benefits management services.

Shared decision-making legislation may shape informed consent and help doctors collaborate with patients

This article was prepared by and reprinted with permission of Health Dialog and the Foundation for Informed Medical Decision Making, based in Boston. The Foundation provides evidence-based decision-support content to the IBC ConnectionsSM Health Management Program. To find out more about shared decision-making and the Foundation, visit www.informedmedicaldecisions.org.

Shared decision-making enters primetime with new legislation

Physicians practicing throughout the United States may soon face legislation encouraging their participation in shared medical decision-making. That's already true of physicians in the state of Washington,^{1,2} and will probably soon be true for physicians in Minnesota, Maine, and Vermont. Other state legislatures are also contemplating codifying shared decision-making, which is a process by which the physician shares with the patient all relevant risk and benefit information on all treatment options, and the patient shares with the physician all relevant personal information that might make one treatment or side effect more or less tolerable than another.

Shared decision-making facilitates communication between patients and their doctors and improves patient satisfaction with care.^{3,4} These are reasons enough to implement the practice, but if Washington State's approach to shared decision-making legislation models how it will be done elsewhere, physicians will have one more incentive to become shared decision-makers. According to the Washington State bill, if a patient signs an acknowledgement of shared decision-making, "such acknowledgement shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered, and the patient has the burden of rebutting this by clear and convincing evidence."²

"That means," says Benjamin Moulton, J.D., M.P.H., executive director emeritus of the American Society of Law, Medicine and Ethics, "that physicians who implement shared decision-making may have a greater degree of protection from litigation than physicians who do not — if an adverse event occurs during treatment — because of the detailed information about risks and benefits disclosed during the [shared decision-making] process."⁵

Communicating the risks and benefits to your patients

Upon hearing the definition of shared decision-making, many physicians worry that they don't have enough time to sit with each of their patients to explain all of the risks and benefits of every treatment approach for a given condition. The Washington State bill offers a solution to this time-crunch problem by encouraging the use of patient decision aids, "written, audio-visual, or online tools that provide a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes, [that are] certified by one or more national certifying organizations."²

Decision aids like those described in the Washington State bill have grown in popularity because they save physicians time while also offering patients standardized, thorough, and easy-to-understand explanations of their options. For this reason, the ConnectionsSM Health Management Program offers your eligible patients access to Shared Decision-Making[®] videos, booklets, and Web modules. The certification process for medical-decision aids has yet to be ironed out, but the materials provided by the Connections Program fulfill the other criteria outlined in the Washington State legislation.

The decision aids available to your Connections-eligible patients are based on medical evidence researched and evaluated by the Foundation for Informed Medical Decision Making, a nonprofit organization dedicated to improving the quality of medical decisions. These decision aids are regularly reviewed and updated to ensure that they contain the most current and accurate information. They cover such topics as:

- back pain
- breast cancer

continued on page 13

¹ <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5930&year=2007>

² <http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Senate%20Bills/5930.pdf>

³ O'Connor AM, Bennett CL, Stacey D, Barry M, Col NF, Eden KB, Entwistle VA, Fiset V, Holmes-Rovner M, Khangura S, Llewellyn-Thomas H, Rovner D. Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews* 2003, Issue 1. Art. No.: CD001431. DOI: 10.1002/14651858.CD001431.

⁴ Charles C, Gafni A and Whelan T. Shared decision making in the medical encounter: What does it mean? (or it takes at least two to tango). *Social Science & Medicine* 44.5 (1997): 681-92.

⁵ www.informedmedicaldecisions.org/ask_moulton.html

Shared decision-making legislation may shape informed consent and help doctors collaborate with patients (continued)

- colon cancer screening
- chronic pain
- depression
- end-of-life care
- heart disease
- major joint arthritis
- menopausal symptoms
- prostate health
- obesity
- uterine conditions

Patient support also available through our Connections Program

We understand that you provide your patients with the information they need, but we want to remind you that your patients may also have access to Health Coaches — health care professionals such as nurses, dietitians, and respiratory therapists. These professionals are trained in

decision support and can help your patients prepare for the discussions they must have with you. Your patients can call a Health Coach from the Connections Program at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE), 24 hours a day, seven days a week.

To learn more about the Shared Decision-Making[®] services available to your practice, call a Connections Program Provider Service Specialist at [1-866-866-4694](tel:1-866-866-4694).

Please visit www.informedmedicaldecisions.org for more information about the Foundation for Informed Medical Decision Making.

Suggested reading

Rethinking Informed Consent: The Case for Shared Decision Making. The American Journal of Law & Medicine. 2006;32(4): 429-501.

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Recommendations from the CDC on adolescent immunization

According to the Centers for Disease Control and Prevention (CDC), immunizations are the single most effective protection against diseases during childhood, adolescence, and even later in life. Vaccination programs that focus on infants and children have decreased the occurrence of many preventable childhood diseases, but adolescents still need the additional protection that immunizations provide. Boosters continue to protect them from diseases against which they were immunized during infancy and early childhood.

IBC believes that routine office visits with health care providers gives providers the opportunity to assess the vaccination status of our adolescent population.

2009 adolescent immunization recommendations

Practitioners can ensure that children 11 through 13 receive age-appropriate immunizations by following recommendations for adolescent immunization from the CDC's Advisory Committee on Immunization Practices (ACIP). Providers should consult the relevant ACIP statement for detailed recommendations, including those for high-risk conditions, at www.cdc.gov/vaccines/recs/acip/default.htm.¹

The CDC states that this schedule indicates the recommended ages for routine administration of vaccines licensed as of December 1, 2008, for children 7 through 18. Any dose not administered at the recommended age should be administered at a subsequent visit when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other

components are not contraindicated, and the combination is approved by the U.S. Food and Drug Administration for that dose of the series.²

Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone at 1-800-822-7967.³



Boosters can continue to protect adolescents from diseases against which they were immunized during infancy and childhood.

Temporary shortages of vaccines may lead to delays in scheduled immunizations. Parents should be advised of the need to “catch up” on any necessary vaccinations when the vaccines become available.

Immunization reminders

IBC recently sent a reminder to the parents of adolescents regarding the importance of immunization. Parents were reminded to schedule their adolescents' immunizations and to visit our youth website, www.ibx.com/gen-y.

For more information on immunizations, preventive care, obesity, and other important adolescent health topics, parents can visit www.ibx.com/gen-y or call 1-800-ASK-BLUE to talk with a Health Coach from the ConnectionsSM Health Management Program.

Note: This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Plan (HMO, PPO, etc.), and/or employer group. HMO and PPO member coverage may be verified by calling Customer Service.

¹CDC, “Recommended childhood and adolescent immunization schedule - United States,” 2009, <www.cdc.gov/nip/acip>, accessed on March 1, 2009.

²*ibid.*

³*ibid.*



ConnectionsSM Health Management Programs: Supporting your patients, our members

ConnectionsSM Health Management Program

Call the Provider Support Line at **1-866-866-4694** to refer a member for Health Coaching if the member has any of the following conditions:

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

Health Coaches also provide decision support for numerous health-related issues, including chronic pain, migraines, depression, and breast or prostate cancer.

ConnectionsSM AccordantCareTM Program

Call the Connections AccordantCare Program at **1-866-398-8761** to refer a member if the member has 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's disease

Connections Health Management Program information is available by visiting www.ibx.com/providerconnections.

Important resources

American Imaging Management (AIM) Call for CT, MRI/MRA, PET, and Nuclear Cardiology	1-800-ASK-BLUE
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 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 Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/antifraud
Credentialing Credentialing Hotline	215-988-6534 www.ibx.com/credentials
Credentialing Violation Hotline	215-988-1413
Customer Service (policies/procedures/claims) HMO and PPO	1-800-ASK-BLUE, prompt 1 for Member Services 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 Specialty Pharmacy Program 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
Formulary updates	www.site65.com
Health Resource Center Healthy Lifestyles SM	1-800-ASK-BLUE
Precertification	1-800-ASK-BLUE
Interactive Voice Response (IVR) system	1-800-ASK-BLUE, prompt 2
NaviNet® Portal Registration	www.ibx.com/navinet
Provider Medical Policy website	www.ibx.com/medpolicy
Provider Pharmacy website	www.ibx.com/rx
Provider Supply Line	1-800-858-4728

* Outside 215 area code



Visit our website: www.ibx.com/providercommunications