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Clarification on the use of modifier -50

In the September edition of *Partners in Health Update*, we ran an article regarding the use of modifier -50. The article was designated for all provider types — professional, facility, and ancillary providers. However, the article was intended for professional providers only. We apologize for any issue or confusion this may have caused.



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 member's ID card under Mental Health/Substance Abuse.*

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).

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

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

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Precertification is required for select procedures



This is a reminder that certain services require preapproval/precertification from IBC prior to being performed.

If your patient needs services that require preapproval/precertification, call 1-800-ASK-BLUE. You can also visit our website at www.ibx.com/providers/preapproval for a complete list of services that are subject to preapproval/precertification.

The Care Management and Coordination (CMC) department will evaluate your request and will notify your office once a decision has been reached for those cases that require clinical review. You will be provided with a preapproval/precertification reference number

based on the determination of your request. Failure to obtain preapproval/precertification may result in provider penalties or denials of payment regardless of medical necessity.

For detailed information on preapproval/precertification requirements, please refer to the CMC section of the *Provider Manual for Participating Professional Providers* or the *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers*.

Note: Providers registered with the NaviNet® web portal may submit requests electronically for services to be rendered at an acute-care facility or ambulatory surgical center.

Elimination of authorization approval letters for NaviNet®-enabled providers



In an effort to streamline your administrative processes, we are changing the way we notify you of authorization approvals. **Effective November 6, 2009**, separate letters confirming an approved authorization request will no longer be sent through the mail for most providers. However, the status regarding authorization requests is available through the NaviNet web portal and the Interactive Voice Response (IVR) system — written confirmation is also available through NaviNet.

NaviNet-enabled providers

If you already have access to NaviNet, you can view *all* of your authorization requests through the *Authorization Status Inquiry* transaction by selecting the Transaction Detail. Printer-friendly and electronic versions will be available for your records. These requests can be viewed for up to two years from the date of service through NaviNet.

Even if you do not submit your request for authorization through NaviNet (i.e., by telephone or through the IVR), you can still view the status on NaviNet through the *Authorization Status Inquiry* screen. A separate authorization approval letter will no longer be sent, as one can be printed from this site.

This change only affects letters that were previously sent to confirm an *approved* authorization. All providers, including those who are NaviNet-enabled, will continue to receive letters through the mail notifying them of denied authorization submissions.

This notification process change also applies to providers who are NaviNet-enabled but delegate their access to a third-party representative.

Providers who are not NaviNet-enabled

Although we strongly encourage our providers to become NaviNet-enabled, there will be no change in process for providers who are not. You will continue to receive letters through the mail notifying you of the authorization approval.

All providers can still obtain the status of an authorization request through the IVR system. Call 1-800-ASK-BLUE and follow the voice prompts to the IVR.

If you have any questions about this new process, please contact your Network Coordinator. If you would like to get direct access to NaviNet at your office location, visit www.ibx.com/providers/navinet or call 215-640-7410 for more information.

Process changes for Baby BluePrints® prenotification and inpatient routine maternity services status letters

As previously communicated, Baby BluePrints prenotification letters are no longer being sent. In addition, the inpatient routine maternity services status letters, formerly concurrent review approval letters, are no longer being mailed.

Rather than receive letters, you will now be able to verify a member's enrollment in Baby BluePrints, obtain her maternity prenotification reference number, and get the inpatient routine maternity services status by using the NaviNet® web portal or the Interactive Voice Response (IVR) system (see detailed instructions below).

Please note that the *Initial Maternity Patient Questionnaire* form should still be completed and mailed back to us immediately following the first prenatal visit. This process is not changing.

Using NaviNet

To verify a member's enrollment in Baby BluePrints, submit a delivery notification, obtain a maternity prenotification reference number, or obtain an inpatient routine maternity services status through NaviNet, follow the steps below:

- Log in to NaviNet and select *Authorizations* from the Plan Transactions menu, and then select *Authorization Status Inquiry*.
- Enter the member's ID number. Then enter the member's estimated date of confinement (EDC) in the "Service Date From" field. Leave the "Service Date To" field blank. Click on *Search*.
- If the member is enrolled, a 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.
- 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 authorization.

Using the IVR system

If you are an OB/GYN provider, hospital, or birthing center and you wish to verify a member's enrollment in Baby BluePrints, obtain a maternity prenotification reference number, get an inpatient routine maternity services status, or submit a delivery notification using the IVR system, follow these steps:

- Call 1-800-ASK-BLUE, and select prompt 2 for Provider Services.
- Select prompt 3 for authorizations.
- Select prompt 3 for other authorizations.
- Select prompt 3 for authorization submission.
- Select prompt 2 for delivery notification and prenotification, and follow the voice prompts.

OB/GYN providers. To verify a member's enrollment in Baby BluePrints, obtain a maternity prenotification reference number, or get an inpatient routine maternity services status, follow the prompts above. By using the delivery notification or prenotification prompt, you will receive a verification and reference number for the prenotification of services. This process validates the member's enrollment into Baby BluePrints. You will receive a verification and reference number at the end of the call for the prenotification of services, which validates the member's enrollment into Baby BluePrints.

Hospitals and birthing centers. To submit a delivery notification and/or receive inpatient routine maternity services status, follow the prompts above. Upon validation of the maternity record, you will be prompted to report the notification of services. You will also be able to obtain a reference number for the prenotification of services as well as a confirmation of routine maternity inpatient status.

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



Precertification changes effective January 1, 2010

Beginning January 1, 2010, IBC will require precertification for varicose veins procedures and certain injectable drugs.

Varicose veins procedures

Precertification will be required for all varicose veins procedures in all settings. For correct billing codes and additional information, please refer to Policy #11.02.01f: Treatment of Varicose Veins of the Lower Extremities, which is available on our website at www.ibx.com/medpolicy.

Injectable drugs

Precertification will be required for Mozobil® and Temodar®. Precertification will also be required for Ampligen®, pending approval from the U.S. Food and Drug Administration. This precertification information will be published in future medical policies that will be effective on January 1, 2010.

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

Your CMS compliance training must be completed by December 31, 2009



In accordance with a requirement from the Centers for Medicare & Medicaid Services (CMS), all network providers and their staff 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, where you will find the training materials. To confirm with IBC that you have completed the training, you will need to provide your electronic signature.

Already completed compliance training?

We recognize that many providers may have already completed this training requirement through another organization. If you have completed your CMS compliance training for 2009, your electronic signature is still needed for confirmation — go to www.ibx.com/compliancetraining to provide it.

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 for 2009.

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



No separate fee for surgical trays

Our Corporate and Financial Investigations Department (CFID) routinely reviews claims, medical records, and billing records of professional providers to analyze unusual billing patterns and the potential presence of improper charges and/or incorrect payments. These reviews are part of our corporate commitment to contain health care costs and improve service efficiencies.

CFID recently audited the use of the “ST” modifier and found that several providers are billing their surgical CPT® code on a separate line with the ST modifier for billing supplies. We have notified these providers and are working to make sure this incorrect billing does not occur in the future. *Note:* Podiatrists can still report with the “SU” modifier in accordance with the Claim Payment Policy #00.03.01: Podiatry Services Included in Capitation.

Effective January 1, 2003, the ST modifier became a national HCPCS modifier defined as “Related to Trauma or Injury.” Prior to this date, the billing of surgical tray fees in the office setting was reported by adding a separate line using the surgical procedure with the ST modifier. HMO claims billed with dates of service on or after January 1, 2003, for a surgical tray fee in the office setting were to be reported with a SU modifier. This

billing requirement did not apply to PPO claims. For PPO claims, neither a separate claim line nor the use of the SU modifier was required.

As a reminder, the office- or facility-based fee is paid automatically based on the place of service indicated on your CMS-1500 form. In January 2003 a letter was sent regarding the implementation of a new fee schedule increase in Pennsylvania. Each of the fee schedules — for about 1,150 CPT codes — contained a different fee for covered services provided in an office setting rather than a facility setting. Office-based fees were higher than facility-based fees. The site-of-service differential pricing reflected the usually higher overhead costs incurred in an office setting. This office/facility site-of-service differential fully replaced tray fees. As a result, no tray fee modifiers (ST or SU) were required on HMO claims with dates of service beginning March 1, 2003.

To report any suspicion of fraud, waste, or abuse, please visit www.ibx.com/antifraud or call our toll-free Corporate Compliance and Fraud Hotline at 1-866-282-2707.

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.

Updated billing requirements for Avastin® in ophthalmological use



In the June 2009 edition of *Partners in Health Update*, we announced that precertification requirements for Avastin in ophthalmological use had changed. The article also listed the appropriate codes for billing. Since then, a new HCPCS code has been made available and should be used when billing for Avastin in ophthalmological use.

Effective October 1, 2009, intravitreal injection of Avastin for ophthalmological use must be reported with *both* of the following codes:

- Q2024: Injection, bevacizumab, 0.25 mg
- the specific ICD-9 diagnosis code that represents any of the following vascular diseases of the eye (please refer to the coding table in the policy for the specific codes):
 - wet, age-related macular degeneration (AMD);
 - ischemic retinal vein occlusions;
 - proliferative diabetic retinopathy, when used to decrease vascularity prior to vitreous surgery.

For more information about the precertification changes for Avastin, refer to Policy #08.00.66c: Bevacizumab (Avastin®), which is available on our website at www.ibx.com/medpolicy. This new billing requirement will be included in the updated version of the policy, #08.00.66d, which will be posted to our website in October.

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



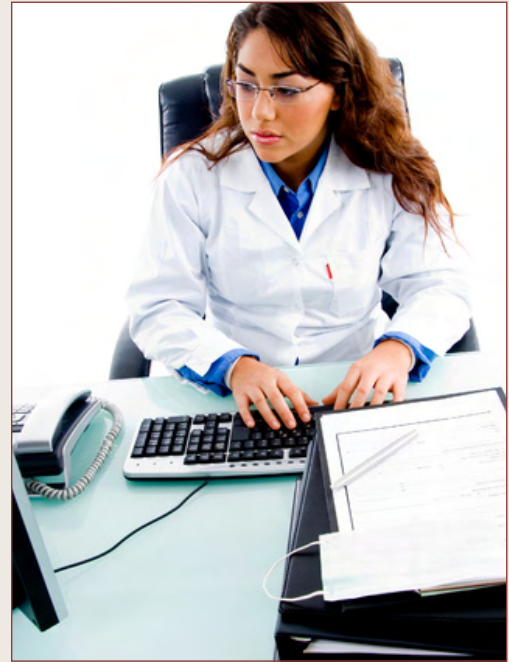
Our Medical Policy website is your source for all information regarding our medical and claim payment policies. Visit www.ibx.com/medpolicy often for news and announcements as well as recently released policy information.

Balance billing and cost-sharing requirements for Keystone 65 Complete members

According to federal law, Medicare Advantage members eligible for both full Medicare and Medicaid benefits (also known as QMB/QMB+ or dual eligibles) are not responsible for Medicare cost-sharing and cannot be balance billed. Rather, the provider must bill Medicaid for any cost-sharing. This requirement applies to all Medicare providers, even those who do not participate in the Medicaid program.

Please be aware that Medicaid is not required to provide any cost-sharing payment when the amount paid by Medicare exceeds the State's rates on its fee schedule. In such instances, the provider is prohibited from balance billing the member for anything that Medicaid does not pay, including cost-sharing.

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



New hospice benefits for all standard Medicare Supplement plans

Effective June 1, 2010, hospice benefits will be added to our Security 65[®] Plans A, B, and C in accordance with the Medicare Improvements for Patients and Providers Act (MIPPA). In addition, to be compliant with MIPPA, IBC will no longer offer Security 65 Plan H to new enrollees. Members currently enrolled may either remain in Plan H or enroll in another plan. Members who remain enrolled in Plan H will *maintain* their current benefits; however, they will *not* be eligible to receive the new hospice benefits.

MIPPA, which applies to all Standard Medicare Supplement Plans, requires that specific hospice benefits be offered to all Medigap members. Currently, Medicare pays 100 percent for hospice care while the members pay \$5 for each prescription drug for pain relief and symptom control and 5 percent of the Medicare-approved amount for inpatient respite care. Currently, the standardized Medicare Supplement Plans offered by IBC do not pay for any hospice benefits.

The new MIPPA-mandated hospice benefits require that:

- Medicare will continue to pay its amount;
- standard Medicare Supplement plans will now pay the \$5 prescription drug cost and 5 percent inpatient respite care;
- the member will still be responsible for any hospice charges incurred that are not paid by Medicare if he or she does not purchase a Standard Medicare Supplement Plan.

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

Medicare Advantage plan offerings for 2010

IBC is making some changes to the products it is offering in 2010. We are pleased to continue to offer a diverse array of products and services for Medicare beneficiaries, and we are committed to working closely with members and eligible beneficiaries to help them choose a plan that best suits their needs. However, as we have stated in previous editions of *Partners in Health Update*, unprecedented decreases in government reimbursement for Medicare Advantage plans have led to our decision to not renew some plans for 2010.

The following is a list of the products that we will continue to offer in 2010, as well as a list of those being discontinued:

Products offered in 2010	Products not being renewed in 2010
Keystone 65 Advantage HMO	Keystone 65 Complete
Keystone 65 Preferred HMO	Keystone 65 Value
Personal Choice 65 SM PPO — <i>individual product in Bucks and Philadelphia counties*</i>	Select Advantage
Security 65 [®] (Medicare Supplement)	Personal Choice 65 SM — <i>individual product in Chester, Delaware, and Montgomery counties*</i>
Select Option [®] PDP	

*The group product will remain in place in all five counties. All members in the Personal Choice 65 PPO plan may continue to use any provider in the 5-county service areas.

Due to new guidelines from the Centers for Medicare & Medicaid Services, we are changing the plan names of the products we will offer in 2010, which are listed above. Please note that members will receive new ID cards with the new product information and logos.

Included with this edition of *Partners in Health Update* is a flyer for you to print and hang in your office. It shows the new names and logos that will appear on our Medicare Advantage ID cards.

Note: Providers who have patients enrolled in one of the discontinuing plans will receive a separate letter with details on how they can assist their patients on finding a new health plan.

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



The Provider Satisfaction Survey coming soon to the NaviNet® web portal

We will be conducting our annual Provider Satisfaction Survey in the coming weeks. This year the survey will be available on NaviNet instead of being mailed to your office. Your response helps us to evaluate our performance and improve the way we do business with you.

This survey is your opportunity to tell us about your experiences with us over the past year with regard to:

- care management and coordination
- claims processing
- communications
- peer-to-peer process
- prior authorization
- provider relations and network services
- reimbursement
- technology

The survey will be available to office-based physicians, nurses, billing offices, office managers, and other office staff through NaviNet. A *Provider Satisfaction Survey* transaction button will appear at the bottom of the Plan Transactions menu in early October. We look forward to learning about your experiences with us and hope you will complete our survey.

We have contracted with Morpace Inc., an independent research firm, to help conduct our 2009 Provider Satisfaction Survey. If you do not have access to NaviNet, but would like to participate in the survey, contact Morpace at [1-866-786-0343](tel:1-866-786-0343) to request a paper copy.

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

Quality ranking for primary care physician offices



This year we are recognizing practices that have demonstrated excellence by achieving the highest Practice Quality Assessment Score (PQAS) rank in 2009 based on 2008 data. This ranking is given to the top 10 percent based upon membership of eligible primary care physician (PCP) offices.

PQAS is a comprehensive ranking system of quality measures and member satisfaction for primary care offices with 75 or more HMO members.

We want to congratulate the practices listed on the following page for achieving excellence in aggregate in the following areas of preventive care:

- childhood immunization;
- cancer prevention in the areas of cervical cancer screening, colon and rectal cancer screening, and breast cancer screening;
- diabetes care (HbA1c testing, LDL testing, eye exam rates, and nephropathy screening);
- heart care (LDL testing after a heart attack);
- asthma care (use of anti-inflammatory medicines for people with chronic persistent asthma);
- well-child visits;
- member satisfaction regarding multiple aspects of office practice.

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Quality ranking for primary care physician offices (continued)

Congratulations to the PCP offices listed below for demonstrating excellence by achieving the highest PQAS rank in 2009 based on 2008 data.

- Romeo S. Abella, M.D., PC
- Abington Pediatric Associates
- Abington Plaza Medical Associates, Inc.
- Abington Springhouse Internal Medicine
- Ackroyd Pediatrics, PC
- Andorra Pediatrics
- ARIA Physician Services — Commodaro
- ARIA Physician Services — Northeast Internal Medicine
- ARIA Physician Services — Oxford Internal Medicine
- ARIA Physician Services — Palat
- Associated Family Practice Professionals
- Vicky P. Berberian, M.D.
- Bishnu Charan Borah, M.D.
- Bucks County Family Practice, PC
- Bucks County Pediatrics
- Bucks Family Medical Associates
- Buxmont Medical Associates
- William T. Chain, Jr., M.D.
- Cheltenham Internal Medicine
- Marina Cherkassky, M.D.
- Chester County Primary Care
- Peter N. Christie, D.O.
- Stephanie A. Chuipek, M.D.
- Luigi A. Cianci, M.D.
- City Line Family Medicine
- Complete Physicians Services
- Cowpath Pediatrics
- M. Cramer and A. Cramer, M.D.s
- Alfonso Cuozzo, M.D.
- Delphi Family Health Center
- Usha B. Desai, M.D.
- Marcelino Desantos, M.D., PC
- Doylestown Family Health Care
- Doylestown Family Medicine
- Lisa M. Ducker, D.O.
- Einstein Internal Medicine Associates
- Elkins Park Medical Associates
- Elliott Internal Medicine
- Ellis and Sitkoff, PC
- Family Care Medical Center, PC
- Feasterville Family Practice, LLP
- Richard M. Finkelstein, M.D.
- Frankford Avenue Family Practice, PC
- Elefant Galante, PC
- Gateway Internal Medical Associates
- Gateway Medical Associates, PC
- Joel Goldberg, D.O.
- Patricia C. Johnston, M.D.
- Great Valley Family Medicine
- G. S. Peter Gross, D.O., PC (732 S. 8th Street)
- G. S. Peter Gross, D.O., PC (2240 S. 3rd Street, Whitman Medical Center)
- HAN Glenn R. Ortle, D.O.
- HAN Howland, Jenkins, and Trinkley
- Susan D. Hoffman, M.D.
- Horsham Pediatric Association, PC
- Yehchiu Hsieh, M.D.
- Arlene P. Imber, D.O.
- Jefferson Medical Care — Chinatown
- Jefferson Medical Care, PC — Harry A. Frankel, M.D.
- Ronda Karp, D.O.
- George Kenis, D.O.
- Kids First — Highpoint
- Kids First — Paoli
- Kids First — Roxborough
- Kids First — Springfield
- Wonhee Kim, M.D.
- Gordon Klinow Pediatric Associates
- Min-Hsiung Ko, M.D.
- Kressly Pediatrics, PC
- E. Gary Lamsback, M.D.
- Lawndale Medical Associates
- Harvey N. Lisgar and Associates
- Luxembourg Medical Associates
- LVPG ABC Family Pediatrics
- Michael Lyons, M.D.
- Anna C. Lysiak, M.D.
- Main Line Family Medicine
- Main Line Healthcare Primary Care
- Joseph F. Mambu, M.D., PC
- Margiotti and Kroll Pediatrics, PC (4829 E. Street Road)
- Margiotti and Kroll Pediatrics, PC (2861 S. Eagle Road)
- Meadowbrook Pediatrics, PC
- Meadowloft, LLC
- Murray Brand Associates
- New Falls Medical Center
- Northeast Medical Practice Limited
- Northwest Internal Medicine
- P.I.M. Associates, PC (Old York Road)
- P.I.M. Associates, PC (6404 Roosevelt Blvd.)
- Paoli Pediatrics
- Peace Valley Internal Medicine
- Pediatric Associates of Plymouth
- Pediatric Medical Associates
- Alexander Pedicino, M.D.
- Penncare Adolescent Young Adult Associates
- Personal Physician Services, PC
- David M. Petro, D.O.
- Prime Health Network
- Radnor Medical Associates
- Vincent S. Reina, D.O.
- Rockledge Medical Associates
- Keith S. Rothman, M.D.
- John L. Sabatini, D.O.
- Senior Health Association
- Arthur K. Smith, M.D.
- J. Andrew Solis, M.D., PC
- Edward P. Spiegel, M.D.
- Stonybrook Medical Center
- Simon Y. Su, M.D.
- TPI Baiocchi and Rosenberg
- TPI Wyndmark Medical Associates
- Trappe Pediatric Care
- Trivalley Primary Care — Upper Perkiomen Office
- Trivalley Primary Care — Lower Salford Office
- Upper Dublin Internal Medicine
- Upper Merion Family
- P. D. Vassaluzzo, M.D.
- Joseph M. Valloti, M.D.
- M. Louis Vandebek, M.D.
- Village Family Health Center at Chester Springs
- Village Shires Family Medicine
- Gregory D. Williams, M.D.
- John P. Woodward, M.D.
- Wyncote Family Practice
- Christine Zabel, D.O.
- Zweiback Medical Associates

New credentialing procedure effective January 1, 2010

Beginning January 1, 2010, IBC will mandate the use of the Council for Affordable Quality Healthcare (CAQH) electronic credentialing application for new providers. Providers already participating in our network will also be required to use the CAQH electronic application for the re-credentialing process. The CAQH electronic credentialing application is free to providers and available on the CAQH website at <https://upd.caqh.org/oas>.

Providers interested in participating in our network should call the Network Credentialing Support Services Hotline at 215-241-4120. A credentialing packet that includes a

contract and a billing registration information form will then be sent to the provider. These forms must be signed and returned to IBC. It is the provider's responsibility to notify IBC upon completion of the CAQH form.

Note: The credentialing process will not continue unless all three documents are received.

For more information regarding our credentialing process, please contact Customer Service at 1-800-ASK-BLUE.

BLUECARD®

Fall 2009 edition of *Inside IPP* now available

Inside IPP: An Inter-Plan Programs Publication is our publication for facility and ancillary providers to increase provider awareness of and satisfaction with the BlueCard Program. The publication introduces new initiatives related to BlueCard processing and highlights plans for improvement.

The fall 2009 edition of *Inside IPP* is now available and features the following articles:

- Inside IPP survey findings and suggestions
- Aged claims affect plans and their partner plans
- BlueSquared® facilitates Inter-Plan business processes and messaging services for Home and Host plans
- NDC submission changes for institutional providers
- New federal Mental Health Parity and Addiction Equity Act effective October 3, 2009

Visit www.ibx.com/insideipp where you can read the latest edition as well as find a complete archive of past issues of *Inside IPP*. Paper copies of *Inside IPP* are available through the Provider Supply Line upon request.



New federal mental health and substance abuse parity mandate effective October 3, 2009

The Federal Mental Health Parity and Addiction Equity Act was signed into law on October 3, 2008. The law becomes effective October 3, 2009, and applies to groups when either the group contract renews or upon issuance of a contract to a new group. It is important for you to understand these changes so you can answer questions that your patients may have.

The law applies to members who are covered by group health plans with 51 or more employees, and it requires that mental health and substance abuse benefits, if they are provided, be in parity with (or equal to) medical and surgical benefits.

As a result of the new law, members may experience some benefits changes, including the removal of limits on inpatient days and outpatient visits as well as differences in cost-sharing (e.g., deductibles, copayments, coinsurance, and out-of-pocket expenses) for mental health and substance abuse services. Please note that current medical management (e.g., precertification) will not be affected by the law. Members were notified about how the law may affect them.

The law applies to all commercial managed care (HMO, POS, Direct POS, and PPO) and Traditional (Blue Cross Hospitalization, Blue Shield Medical Surgical, Major Medical, and Comprehensive Major Medical/CompSelect®) plans.

If you have questions about the Mental Health Parity and Addiction Equity Act, please contact Customer Service at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE). If your patients have questions, please refer them to Customer Service.



Autism law reminder and provider list now available

On July 3, 2008, the Commonwealth of Pennsylvania passed a law that requires health insurers to cover services for the diagnosis and treatment of autism spectrum disorders (ASD) for members under 21 who are in commercial groups with 51 or more employees. ASD includes autistic disorder, Asperger's Syndrome, Rett Syndrome, childhood disintegration disorder, and pervasive development disorder.

The law became effective July 1, 2009, and applies to groups when either the group contract renews or upon issuance of a contract to new groups. Benefits will be provided for services set forth in a treatment plan, which we may request and review for approval.

Locating participating providers

A list of participating providers who specialize in services related to ASD, including applied behavioral analysis, psychiatric, psychological, and physical, occupational, and speech therapy services, has been posted on our website as a reference for members and providers. You can view this list by visiting www.ibx.com/find_a_provider. Then open the PDF file posted under the first heading, Find Participating Doctors, Hospitals, and Ancillary Providers.

For more detailed information about ASD coverage for eligible Pennsylvania group members, refer to Policy #07.03.07c: Medical Evaluation and Management of Autistic Spectrum Disorders (ASD), which is available on our website at www.ibx.com/medpolicy.

Coverage under Michelle’s Law effective October 9, 2009



In 2008, Congress passed Michelle’s Law, which requires coverage for full-time students insured under their parents’ policies to be extended for up to one year if the student is injured or becomes seriously ill and must take a medically necessary leave of absence from a college or other post-secondary educational institution. To qualify for this extension, the student’s physician must submit written documentation to IBC stating the need for a medically necessary leave of absence.

This law does not allow college students to extend coverage beyond their policy’s maximum age limits, nor does it guarantee coverage if their parents’ coverage is terminated. Michelle’s Law becomes effective October 9, 2009, and applies to group and non-group contracts when either the group or non-group contract renews or upon issuance of a contract to new groups or to new non-groups.

For more information regarding Michelle’s Law, please call Customer Service at 1-800-ASK-BLUE.

Policy notifications posted as of September 17, 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 September 17, 2009.

Policy effective date	Notification title	Notification issue date
October 2, 2009	05.00.14d High-Frequency Chest Wall Oscillation Devices	September 2, 2009
October 6, 2009	11.03.02f Bariatric Surgery	July 8, 2009
October 16, 2009	08.00.13g Immune Globulin: Intravenous (IVIG), Subcutaneous (SCIG)	September 16, 2009
December 1, 2009	05.00.29d Automatic External and Wearable Cardioverter Defibrillators	September 2, 2009
December 1, 2009	05.00.58c Home Oxygen Therapy	September 2, 2009
December 1, 2009	11.14.20c Metal-on-Metal Total Hip Resurfacing	September 2, 2009
January 1, 2010	08.00.78 Self-Injectable Drugs	July 22, 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.

New preferred diabetic test strips effective October 1, 2009

Effective October 1, 2009, Bayer HealthCare LLC and Abbott Laboratories, both independent companies, are 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[®].

Please note that as of October 1, 2009, Accu-Chek[®] and OneTouch[®] 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. A letter was sent to affected members explaining this change.

Free meters for 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. To order a free meter, you or your patient should contact Abbott or Bayer directly using the information listed for each manufacturer. Our members can also get a free meter through their pharmacy using the manufacturer coupons that were sent with the member notification. Along with the coupon, your patient will also need two prescriptions — one for the test strips and one for the corresponding meter — in order to receive a free meter at the pharmacy.

Abbott Diabetes Care products

The Abbott Diabetes Care products include the following blood glucose meters:

- 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 offers the following blood glucose meters:

- 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.

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.



Upcoming changes to self-injectable drug coverage

We are changing the way we cover self-injectable drugs in an effort to provide our commercial HMO, POS, Direct POS, and PPO members access to self-injectable drugs in the right setting at the right time for a good value. These changes are part of our evolving approach to managing specialty pharmaceutical benefits.

Upcoming changes for self-injectable drugs

Effective January 1, 2010, we will no longer provide benefits for most self-injectable drugs under our medical benefits program. However, HMO, POS, Direct POS, and PPO members who have IBC pharmacy coverage will continue to be covered for self-injectables under their pharmacy benefits. Members who have pharmacy coverage from another carrier should check their benefits to determine whether their prescription drug plan includes coverage for self-injectable drugs.

Self-injectables through our pharmacy benefits program

The self-injectable drugs that are available under our pharmacy benefits program are those that patients typically administer themselves and do not require physician monitoring. A current list of drugs is maintained in our medical policy. Please note that self-injectable growth hormones have been added to the pharmacy benefits program and require prior authorization.

We will continue to cover the following types of injectables under our medical benefits program at the appropriate levels of cost-sharing:

- injectables that cannot be administered without medical supervision;
- injectables that are mandated by law to be covered (e.g., insulin);
- injectables that are required for emergency treatment under the medical benefits program, such as self-injectable drugs that effectively counteract allergic reactions (e.g., EpiPen®).

Direct ship option available

We coordinate with our pharmacy benefits manager, FutureScripts®, an independent company, to offer the FutureScripts Direct Ship Specialty Pharmacy Program to members with IBC pharmacy* coverage. You can use this program to order self-injectables, and have them shipped either directly to the member or to your office, and coverage for these self-injectable drugs is provided under the pharmacy benefit.

Your patients can benefit from key features of this program, including:

- free shipping;
- educational information and pharmacists available to answer questions about their therapies and possible side effects;
- proactive refill service, providing your patient with a phone call the week before the prescribed refill date to schedule the next delivery.

To enroll a patient in the FutureScripts Direct Ship Specialty Pharmacy Program, call FutureScripts at 1-888-678-7012, option 3, or go to www.futurescripts.com/priorauthorization and download the *Direct Ship Injectable Form*. FutureScripts will coordinate the shipment and delivery of the self-injectables.

If you have any questions about these changes, please call Customer Service at 1-800-ASK-BLUE. You can also refer to the notification for Policy #08.00.78: Self-Injectable Drugs on our website at www.ibx.com/medpolicy.

Please note that the FutureScripts Direct Ship Specialty Pharmacy Program is available for members who have either medical or pharmacy coverage through IBC. However, as of January 1, 2010, self-injectables through the FutureScripts Direct Ship Specialty Pharmacy Program will **only be available for members who have pharmacy coverage through IBC. Accessing the FutureScripts Direct Ship Specialty Pharmacy Program under the medical benefit after January 1, 2010, is only for non-self-injectable specialty drugs that are typically administered in a provider's office.*

Note: Some members are not affected by the change of coverage of self-injectable drugs to the pharmacy benefit. 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.



Annual Synagis® (palivizumab) distribution program

As announced in our last edition, we will once again offer the Synagis® (palivizumab) distribution program for the 2009-10 respiratory syncytial virus (RSV) season, which is November through April in the United States. According to the Centers for Disease Control and Prevention, RSV is the most common cause of bronchiolitis and pneumonia among children younger than 1 year.

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

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

Note: Please refer to the September edition of *Partners in Health Update* for the new criteria for premature infants, which derives from updated guidelines published in the 2009 American Academy of Pediatrics Red Book®. These criteria are a change from the previous RSV season.

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?

Synagis® is a medical benefit that is managed by the FutureScripts® Direct Ship Specialty Pharmacy Program and facilitated by ACRO Pharmaceutical Services, an independent company. ACRO Pharmaceutical Services will provide Synagis® (palivizumab) exclusively for IBC during the 2009-10 RSV season, and it is mandatory that all participating providers obtain Synagis® (palivizumab) through the FutureScripts Direct Ship Specialty Pharmacy Program. Through this program, ACRO Pharmaceutical Services will ship the agent directly to your office.

Synagis® (palivizumab) can be requested directly from ACRO Pharmaceutical Services by completing the RSV Enrollment Form, which can be obtained by calling FutureScripts at 1-888-678-7012, option 3, or ACRO Pharmaceutical Services at 1-800-906-7798.

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.

We are **not** participating in RSV Connection™, a voluntary program through MedImmune, LLC, the makers of Synagis® (palivizumab). Please do **not** forward referrals to MedImmune, LLC.

View our medical policy for Synagis® (palivizumab) at www.ibx.com/medpolicy and search for Policy #08.00.22g: Immune Prophylaxis for Respiratory Syncytial Virus (RSV).

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

- Synagis® (palivizumab) will generally be approved for office administration only, unless a patient is receiving home nursing services for a separate indication.
- The RSV enrollment form must include sufficient clinical information to meet our Synagis® (palivizumab) medical policy criteria, which are based on recommendations from the American Academy of Pediatrics (AAP).
- Tobacco smoke will not be accepted as an environmental pollutant. This guideline is based on the indication from the AAP Committee on Infectious Disease that, while at-risk infants should never be exposed to tobacco smoke, passive household exposure to tobacco smoke has not been associated with an increased risk of RSV hospitalization on a consistent basis.¹

- Fee-for-service providers will be reimbursed for the evaluation and management procedure codes that correspond to the patient's office visit. Since FutureScripts will pay ACRO Pharmaceutical Services directly, you will neither pay for doses ordered through the FutureScripts Direct Ship Specialty Pharmacy Program nor receive reimbursement for the actual pharmaceutical.
- Upon approval of your request, Synagis® (palivizumab) will be shipped to your office monthly during RSV season. Overnight shipping for the 2009-10 RSV season will begin on Wednesday, October 28, 2009. Shipping will end on April 14, 2010. Up to five doses will be shipped per patient (one shipment every 30 days).

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.

¹American Academy of Pediatrics, 2006 Red Book, pp 563-565.

Two vaccines for the upcoming influenza season

As the H1N1 (swine flu) outbreak grows in our region, we are monitoring the current pandemic flu outbreak, taking our lead from the Centers for Disease Control and Prevention (CDC) and state and local health departments. The 2009-10 flu season may be particularly severe due to the new H1N1 flu virus. The best way to protect patients and staff this season is to get *both* the seasonal flu vaccine and the H1N1 flu vaccine as soon as it is available. The Advisory Committee on Immunization Practices (ACIP) has released recommendations for each vaccine.

Seasonal flu vaccine recommendations

We encourage our members to get vaccinated against the seasonal flu and ask that you advise your patients to receive a vaccination as soon as possible. ACIP recommends the seasonal flu vaccination for the following individuals:

- all children ages 6 months to 18 years;
- anyone 50 years or older;
- children and adolescents (ages 6 months to 18 years) who are receiving long-term aspirin therapy and who might be at risk for experiencing Reye Syndrome after influenza virus infection;
- women who will be pregnant during the influenza season;
- adults and children who have chronic pulmonary (including asthma) or cardiovascular (except hypertension), renal, hepatic, neurological/neuromuscular, hematologic, or metabolic disorders (including diabetes mellitus);
- adults and children who have immunosuppression (including immunosuppression caused by medications or by HIV);
- residents of nursing homes and other long-term care facilities;
- health care providers;
- household contacts (including children), caregivers of children \leq 59 months (i.e., younger than 5 years), and adults \geq 50 years;
- household contacts (including children) and caregivers of persons with medical conditions that put them at higher risk for severe complications from influenza.

The seasonal flu vaccine is unlikely to provide protection against novel H1N1 flu. The H1N1 flu vaccine is not intended to replace the seasonal flu vaccine — it is intended to be used in addition to the seasonal flu vaccine.

Please visit the *News and Announcements* section of www.ibx.com/medpolicy to view our coverage of the standard seasonal influenza vaccine for 2009-10.

H1N1 flu vaccine recommendations

The ACIP met to make recommendations on who should receive the new H1N1 flu vaccine when it becomes available. Novel H1N1 flu vaccine is being purchased by the federal government and will be made available to vaccinators at no cost. The vaccine will be allocated across states proportional to population. While a shortage of the H1N1 flu vaccine is not expected, vaccine supply and demand may be unpredictable. Therefore the ACIP made recommendations on which groups should be prioritized.

The ACIP is recommending the H1N1 flu vaccine for the following groups:

- pregnant women;
- household contacts and caregivers for children younger than 6 months;
- health care and emergency medical services personnel;
- children between ages 6 months and 18 years;
- young adults between ages 19 and 24 years;
- persons 25 through 64 who have health conditions associated with higher risk of medical complications from influenza.

According to recent studies, the risk for infection is lower for persons 65 or older than for younger age groups. Based on this information, after the prioritized groups have been vaccinated, programs and providers should begin vaccinating everyone 25 through 64, then those 65 and older.

Please visit the *News and Announcements* section of www.ibx.com/medpolicy to view our coverage for the administration of novel H1N1 flu vaccine for 2009-10.

If you have any questions concerning flu or benefits coverage, please contact Customer Service at **1-800-ASK-BLUE**.

For flu information for specific groups as well as the latest vaccine recommendations, go to the CDC website at www.cdc.gov, or call 1-800-CDC-INFO.

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.

ConnectionsSM AccordantCareTM Program assists physicians in providing evidence-based care for complex conditions

The primary goal of the Connections AccordantCare Program is to help IBC members improve the quality of their lives through improved adherence to provider treatment plans. Connections AccordantCare members have complex, chronic conditions, and many are on immunosuppressive medications. Therefore, these members are at increased risk of complications due to pneumococcal infections and influenza. In addition, many members with chronic disease must receive preventive care and immunizations based on disease-specific guidelines. The Connections AccordantCare Program works with physicians and other caregivers to help them improve their ability to provide specialized preventive care to our members, their patients.

Pneumonia vaccination

The Centers for Disease Control and Prevention (CDC) has certain guidelines for vaccination against pneumococcal pneumonia that emphasize the importance of the vaccine for high-risk children, adolescents, and adults. Most Connections AccordantCare members fall into the high-risk category because they have chronic illness and diseases associated with immunosuppressive therapy (including corticosteroids). For example, members with amyotrophic lateral sclerosis (ALS) should receive a pneumonia vaccine and be familiar with the symptoms of pneumonia.

However, special considerations may apply for members with certain illnesses. The clinical practice guidelines for multiple sclerosis (MS), for example, recommend that people with MS who meet the CDC criteria for any particular vaccination should receive it. But members who are experiencing a serious MS relapse that affects their ability to carry out activities of daily living should defer vaccination until four to six weeks after the onset of the relapse.

Some members are not even aware of the pneumonia vaccine or are not sure whether they should receive a vaccination. The Connections AccordantCare Program offers personalized education to members during telephone assessments in the fall and winter. Members are asked whether they have received the pneumococcal vaccine, and they are reminded of the importance of speaking with their physicians about the vaccine. Also,

telephone on-hold messages speak to the importance of receiving the pneumonia vaccine, explain its benefits, and invite members to speak directly with their Connections AccordantCare nurse. The nurses can assist with patient questions, such as:

- What about someone with my disease? Should I get the vaccine?
- What kinds of infections can the pneumonia vaccine prevent?
- Are there different types of pneumonia vaccines? Which vaccine should I get?
- Should pregnant women get the pneumonia vaccine?
- How many times do I have to get a pneumonia vaccine?
- What are the side effects of the pneumonia vaccine?

The program also mails information about the vaccination to members. Mailings include articles such as “Pneumococcal Polysaccharide Vaccine: What You Need to Know” (also available in Spanish) from the CDC.

Influenza vaccination

The primary method for preventing seasonal flu and its associated complications is the influenza vaccine. The CDC recommends a flu vaccination for all persons who want to reduce their chances of catching or spreading the flu — but especially for those with chronic medical problems, those with any condition that compromises their respiratory system, or those with a suppressed immune system. Many Connections AccordantCare members with chronic illnesses are especially at risk for complications of the flu, and each chronic illness may require specialized information about the immunization.

For example, flu shots are highly recommended for people with ALS or cystic fibrosis because the flu can cause them to experience serious respiratory problems. People with ALS who experience even a weak cough may have a problem removing the thick mucus caused by the flu, which can lead to a feeling of choking. Likewise, members with systemic scleroderma — a condition covered by the Connections AccordantCare Program — should receive an influenza immunization, especially those with restrictive lung disease.

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Connections AccordantCare Program assists physicians in providing evidence-based care for complex conditions (continued)

Another instance in which disease-specific information can be very important is with members who have hemophilia. Flu shots are generally recommended for people with hemophilia; however, flu shots should be given subcutaneously rather than intramuscularly. If this is not possible, members with hemophilia should be infused with factor before the shot to prevent a bleed in the muscle. After the shot, the area should be iced.

The flu can be especially dangerous for anyone whose immune system has been suppressed by drug therapy, which is often the case with Connections AccordantCare members. The CDC recommends that patients with autoimmune diseases on disease-modifying antirheumatic drugs (DMARDs) receive an annual flu shot of trivalent inactivated influenza vaccine.

The Connections AccordantCare Program serves members by helping to keep them informed about preventive health measures. For example, the influenza vaccination reminder initiative provides significant, additional support to help physicians and other caregivers deliver the appropriate, disease-specific message about flu vaccinations. The reminder initiative:

- educates members about the importance of the flu vaccination;
- empowers members to discuss the flu vaccination with their physicians and other health care providers;
- encourages members to seek out the flu vaccination when it's appropriate.

In addition, information about the symptoms, prevention, and treatment of flu — along with the CDC recommendations for vaccination — is mailed to members in a special issue of Accordant's *CareConnections*SM newsletter during the flu season. This special issue also addresses the differences between the nasal spray and the flu shot. Education emphasizes that the nasal spray is contraindicated for our members with compromised immune systems. The mailings encourage members to speak with their physicians about the flu vaccination.

Based on its policy of supporting physicians, Connections AccordantCare communicates frequently with members about the importance of receiving pneumococcal and flu vaccinations. This level of intervention assists physicians in providing our members the personalized care they need. It provides an additional health care resource for members and their physicians. To refer a patient or to obtain additional information about the Connections AccordantCare Program, call toll-free at [1-866-398-8761](tel:1-866-398-8761).



October is breast cancer awareness month

The Centers for Disease Control and Prevention (CDC) recommend mammography screening as the best available method to detect breast cancer in its earliest, most treatable stage. However, according to a study published in the June 15 issue of *Cancer*, the proportion of U.S. women 40 and older who report having a mammogram in the previous two years declined from 70 percent to 66 percent from 2000 to 2005. The drop in mammography screening was most pronounced for women over 50.

Although the number of breast cancer cases has dropped in the past few years, this decline in mammography adherence may mean that some women with early-stage disease will not be diagnosed until later.

We recognize the importance of this screening and have made mammograms more accessible to our members by:

- eliminating copayments, deductibles, and coinsurance for mammograms performed in-network;
- allowing members to go anywhere in the radiology network for screening and diagnostic mammograms*;
- enabling HMO members who require a follow-up breast ultrasound to receive the ultrasound at any participating radiology site.

IBC programs and resources

Mammography screening reminder program. This year IBC is mailing mammography screening reminders to female members turning 40 during their birth month and to female members age 42 - 69.

IBC's consumer website. Our consumer website, www.ibxpress.com, includes breast cancer information and email reminders to schedule a mammogram. Members can also register for a reminder from the American Cancer Society's "Once Is Not Enough" email program.

Decision support videos from the ConnectionsSM Health Management Program^{}.** Five breast cancer videos are available on topics ranging from early-stage breast cancer to breast reconstruction. A complete listing of decision support videos and other Connections Health Management Program information and tools can be found at www.ibx.com/providerconnections.

Providers can call the Connections Program Provider Support Line at 1-866-866-4694 for information about the Connections Program or to refer members to the program.

Oncology Case Management Program. The Oncology Case Management Program is specially designed for members with cancer who are undergoing treatment. The program is designed to provide additional support and information to help members better understand and self-manage their condition. Trained registered nurses work with you and your patient to develop individualized care plans. The Oncology Case Management Program is a service provided by IBC to its members at no charge. Participation in the program is voluntary.

If you are interested in referring any of your IBC patients to the Case Management Department, please call 1-800-313-8628, prompt 1.

Resources from the American Cancer Society

The following American Cancer Society programs are available on www.cancer.org or by calling 1-800-ACS-2345:

- "Reach to Recovery." Helping breast cancer patients cope with breast cancer for more than 30 years, this program matches a trained volunteer breast cancer survivor with a newly diagnosed person to offer support and hope.
- "Look Good...Feel Better." This free, community-based program teaches female cancer patients beauty techniques to help restore their appearance and self-image while they are undergoing radiation and chemotherapy treatments.
- "tlc, Tender Loving Care[®]." This magazine/catalog includes informative articles as well as information on products designed for women coping with cancer, such as wigs, head coverings, and mastectomy forms.
- I Can Cope[®]. This is an educational program that offers information, support, and coping skills for those dealing with cancer themselves or as a caregiver.

*All commercial and Medicare Advantage HMO members may obtain screening and/or diagnostic mammography, provided by an accredited in-network radiology provider, without obtaining a referral. HMO members must go to a participating radiology provider.

**The decision support videos are available for members eligible for the Connections Health Management Program.



Resources and tools available to help manage cholesterol

According to the American Heart Association (AHA) and the American Stroke Association, cardiovascular disease is the leading cause of death of both men and women in the U.S. The major controllable risk factor for cardiovascular disease is high cholesterol. The AHA showed that in 2009, 98.6 million Americans 20 and older had blood cholesterol levels over 200 mg/dl. The National Heart, Lung, and Blood Institute's Adult Panel III guidelines state that the ideal total cholesterol level is less than 200 mg/dl.

The Institute recommends cholesterol screening (fasting lipid profile) every five years, starting at age 20. Health care professionals can promote healthy lifestyle approaches for reducing the risk of heart disease by reviewing the following with their patients:

- a diet low in saturated fat and cholesterol;
- importance of regular physical activity;
- healthy weight maintenance;
- tobacco cessation for those who smoke or chew tobacco.

Prevention tools for members

Prevention is the best defense against cardiovascular disease. A variety of resources and tools are available for providers and their eligible IBC members. The tools can be used to educate patients on the risk factors and preventive measures of cardiovascular disease and promote healthy lifestyle changes.

Health Coaches. Providers can refer members to a Health Coach through the ConnectionsSM Health Management Program. Health Coaches are available 24 hours a day, seven days a week, and can help members learn about proper cholesterol management and other prevention measures. To refer a patient for health coaching, complete the Connections Physician Referral Form and fax it to the Connections Health Management Program at 1-800-276-3075. The form is available at www.ibx.com/providerconnections or by calling the Provider Support Line at 1-866-866-4694. Members can call 1-800-ASK-BLUE to speak directly with a Health Coach.

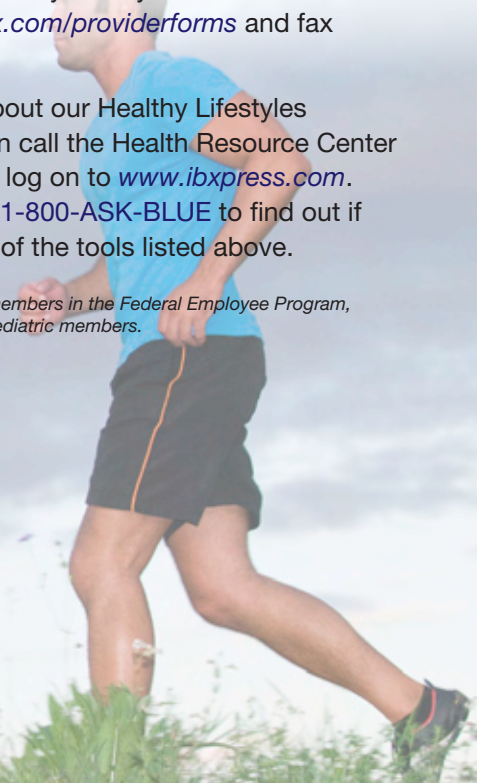
Nutrition counseling. Providers are reminded that IBC members are eligible for six free nutrition counseling visits with their primary care physician or a participating network registered dietitian to help them establish good eating habits that will contribute to a healthier lifestyle. There is no out-of-pocket expense for members utilizing the services of a network physician or a participating registered dietitian. Members can find a list of participating providers and registered dietitians on www.ibxpress.com.

Healthy LifestylesSM Programs. Our Healthy Lifestyles Programs are designed to encourage healthy behavior through incentives and active member participation. Healthy Lifestyles offers discounts and reimbursements to eligible members who participate in programs for weight management, fitness, safety, smoking cessation, and alternative health.

Healthy LifestylesSM Keys to Wellness*. Registered nurses are available to work with members who have multiple gaps in preventive services. The nurses assist members in identifying how they can make healthier lifestyle choices to improve their chances of staying well. To have a registered nurse contact one of your patients, please call 1-800-313-8628 and leave a message containing the patient's name and member ID number, or access our Healthy Lifestyles Keys to Wellness referral form at www.ibx.com/providerforms and fax it to 215-238-7063.

For more information about our Healthy Lifestyles Programs, members can call the Health Resource Center at 1-800-ASK-BLUE, or log on to www.ibxpress.com. Members may also call 1-800-ASK-BLUE to find out if they are eligible for any of the tools listed above.

*The program is not available to members in the Federal Employee Program, Keystone 65 Complete, and for pediatric members.



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* www.ibx.com/providerkeystowellness
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
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
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

New ID cards will be issued to our Medicare Advantage members in December and will go into effect January 1, 2010. Look for these new logos on your patients' ID cards:



Member eligibility can be verified by using the NaviNet® web portal or the provider Interactive Voice Response system or by calling Customer Service at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE).

Please note that these changes are in addition to the following products that will not be renewed in 2010:

- Keystone 65 Complete
- Personal Choice 65SM
(only for individual plans in Chester, Delaware, and Montgomery counties)*
- Keystone 65 Value
- Select Advantage

*The group product will remain in place in these three counties as well as Bucks and Philadelphia counties. All members in the Personal Choice 65 PPO plan may continue to use any provider in the 5-county service area. NaviNet® is a registered trademark of NaviNet, Inc.

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