Partners in Health UPDATE℠

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Reminders....

Early extension of dependent care coverage begins June 1, 2010

Beginning June 1, IBC will extend health insurance coverage for young adults up to age 26 who are currently covered by their parents' individual or employer-sponsored health plans.

By allowing these young adults to remain on their parents' plans starting June 1, IBC is helping families avoid a potential gap in coverage until the new federal healthcare reform provision takes effect.

For more information about this new coverage, please read the press release at *www.ibx.com/news_events/press_releases*.

Get important information delivered right to your email

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

Please allow up to two weeks for us to process your request and remember to add IBC (*provider_communications@ibx.com*) to your email address book. We respect your privacy and will not make your email address available to third parties. For more information about our privacy policy, go to *www.ibx.com/privacy*.

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

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

Professional

Facility

Ancillary

Partners in Health Update℠ is a publication of Independence Blue Cross and its affiliates (IBC), created to provide valuable information to the IBC-participating provider community. This publication may include notice of changes or clarifications to administrative policies and procedures that are related to the covered services you provide in accordance with your participating professional provider, hospital, or ancillary provider/ancillary facility contract with IBC. This publication is the primary method for communicating such general changes. Suggestions are welcome.

Contact Information:

Provider Communications
Independence Blue Cross
1901 Market Street
35th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

John Shermer
Managing Editor

Charleen Baselice
Production Coordinator

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

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

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

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

Requirements for submitting changes to your office information

It is extremely important that you submit timely and accurate updates of your office information to IBC. This helps ensure prompt payment of claims, delivery of critical communications, seamless recredentialing, and accurate listings in our provider directories.

In fact, you are contractually obligated to notify us in a timely manner when changing key elements of your practice information. Please note the following requirements:

- **30-day** prior written notice for all updates of provider information;
- **60-day** prior written notice for closure of a primary care physician (PCP) practice to additional patients;
- **90-day** prior written notice for resignation/termination from our network.

Many updates may be submitted electronically through the *Provider Change Form* transaction on the NaviNet® web portal. Please note that the specific change requests available to you on NaviNet vary depending on your provider type as well as on the lines of business in which you participate.*

To submit a change, select *Provider Change Form* from the Plan Transactions menu on NaviNet.

Physicians can:

- change address, office hours, total hours, and phone or fax numbers;
- change selection of capitated providers (for HMO PCPs only);
- add newly credentialed providers or participating providers to a participating group (applicable to group practices only);
- add hospital affiliation.

You may also download copies of the form from our website at *www.ibx.com/providerforms*, and fax the form and accompanying documents to Network Administration at 215-988-6080. Be sure to retain the transmission confirmation from your fax machine.

Forms may also be mailed to:

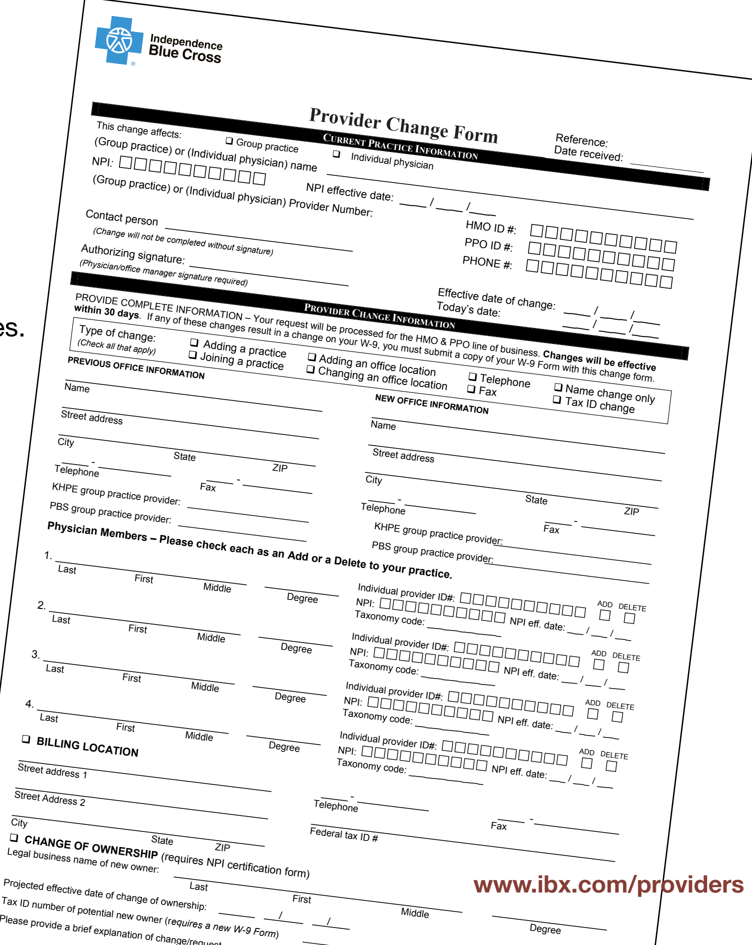
Network Administration
Independence Blue Cross
P.O. Box 41431
Philadelphia, PA 19101-1431

Note: If a change also represents a change to your W-9 form (e.g., new name, new tax ID number, new billing vendor, new "pay to" address, or new ownership), the provider's signature and the W-9 form *must* be provided. An office manager's signature will suffice for any other changes.

For more information, please refer to the *Administrative Procedures* section of the *Provider Manual for Participating Professional Providers*.

Please call your Network Coordinator with any questions.

**Providers contracted with Magellan Behavioral Health, Inc. should continue to contact their Magellan Network Coordinators at 1-800-866-4108.*



Independence Blue Cross

Provider Change Form

Reference:
Date received: ______

CURRENT PRACTICE INFORMATION

This change affects: ❑ Group practice ❑ Individual physician

(Group practice) or (Individual physician) name ______

NPI: ☐☐☐☐☐☐☐☐☐☐ NPI effective date: ___ / ___ / ___

(Group practice) or (Individual physician) Provider Number: ______

HMO ID #: ☐☐☐☐☐☐☐☐☐☐
PPO ID #: ☐☐☐☐☐☐☐☐☐☐
PHONE #: ☐☐☐☐☐☐☐☐☐☐

Contact person ______

Authorizing signature: ______
(Change will not be completed without signature)
(Physician/office manager signature required)

Effective date of change: ___ / ___ / ___
Today's date: ___ / ___ / ___

PROVIDER CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION – Your request will be processed for the HMO & PPO line of business. **Changes will be effective within 30 days.** If any of these changes result in a change on your W-9, you must submit a copy of your W-9 Form with this change form.

Type of change: *(Check all that apply)*
❑ Adding a practice ❑ Joining a practice ❑ Adding an office location ❑ Changing an office location ❑ Telephone ❑ Fax ❑ Name change only ❑ Tax ID change

PREVIOUS OFFICE INFORMATION

Name ______
Street address ______
City ______ State ______ ZIP ______
Telephone ___ - ______ Fax ___ - ______
KHPE group practice provider: ______
PBS group practice provider: ______

NEW OFFICE INFORMATION

Name ______
Street address ______
City ______ State ______ ZIP ______
Telephone ___ - ______ Fax ___ - ______
KHPE group practice provider: ______
PBS group practice provider: ______

Physician Members – Please check each as an Add or a Delete to your practice.

1. Last First Middle Degree
Individual provider ID#: ☐☐☐☐☐☐☐☐☐☐ ADD ☐ DELETE ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI eff. date: ___ / ___ / ___
Taxonomy code: ______

2. Last First Middle Degree
Individual provider ID#: ☐☐☐☐☐☐☐☐☐☐ ADD ☐ DELETE ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI eff. date: ___ / ___ / ___
Taxonomy code: ______

3. Last First Middle Degree
Individual provider ID#: ☐☐☐☐☐☐☐☐☐☐ ADD ☐ DELETE ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI eff. date: ___ / ___ / ___
Taxonomy code: ______

4. Last First Middle Degree
Individual provider ID#: ☐☐☐☐☐☐☐☐☐☐ ADD ☐ DELETE ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI eff. date: ___ / ___ / ___
Taxonomy code: ______

❑ **BILLING LOCATION**

Street address 1 ______
Street Address 2 ______
City ______ State ______ ZIP ______
Telephone ___ - ______ Fax ___ - ______
Federal tax ID # ______

❑ **CHANGE OF OWNERSHIP** (requires NPI certification form)

Legal business name of new owner: Last First Middle Degree
Projected effective date of change of ownership: ___ / ___ / ___
Tax ID number of potential new owner (requires a new W-9 Form)
Please provide a brief explanation of change/request

ClaimCheck®: Upgrade scheduled and edit clarification

ClaimCheck® is a comprehensive code-auditing tool that we use to evaluate the relationships between procedure codes submitted on the CMS-1500 claim form (or equivalent electronic format). Claims are edited by ClaimCheck® to ensure that correct coding rules and guidelines are used. Please note the following information.

Upcoming upgrade scheduled

In an effort to maintain an enhanced level of transparency, the ClaimCheck® software will be upgraded from version 9.0.44 to 9.0.45 effective June 28, 2010. This upgrade applies to all contracted providers who deliver professional services to members by way of the CMS-1500 claim form or equivalent electronic format.

Upgrades to ClaimCheck® are scheduled twice yearly, typically in the spring and fall. The release schedule for ClaimCheck® upgrades is subject to modification for business reasons. Edits are sourced to various nationally accepted authorities, including the American Medical Association, CPT® (Current Procedure Terminology), Centers for Medicare & Medicaid Services, and national specialty societies.

Clarifying edits for reprocessed or adjusted claims

ClaimCheck® and Clear Claim Connection™ are updated regularly for consistency with Medical and Claim Payment Policy, new procedure codes, current health care trends, and/or medical and technological advances. ClaimCheck® clinical relationship logic is applied based on the date a claim is processed, reprocessed, or adjusted in our claims processing system. Clinical relationship logic is not applied based on the date the service was performed. Therefore, claims that are reprocessed or adjusted for any reason may receive a different editing outcome from ClaimCheck® based on the clinical relationship logic that is in effect at the time the claim adjustment occurs.

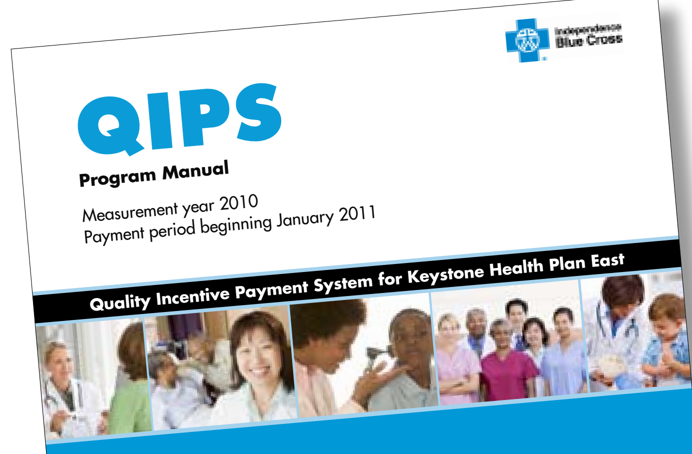
Notwithstanding the foregoing, it is understood that a specific claim payment policy may supersede the terms of this policy with respect to the subject of that claim payment policy only.

Detailed disclosures of all ClaimCheck® code edits are available through Clear Claim Connection™, which is accessible through the NaviNet® web portal 24 hours a day, 7 days a week. If you have any questions about ClaimCheck® or Clear Claim Connection™, please contact your Network Coordinator.

REIMBURSEMENT

2010 performance incentive program revisions for PCPs

As communicated in the April edition of *Partners in Health Update*, significant revisions were made to the Quality Incentive Payment System (QIPS) program for the measurement year 2010 for participating Pennsylvania primary care physicians (PCPs). Revisions include changes to quality measures and terms, as well as the addition of new medical cost management and administrative measures. The program provides a balanced rewards model for delivering high-quality, cost-effective care to our HMO and POS members.



QIPS Program Manual

The *QIPS Program Manual – Measurement year 2010*, available on the NaviNet web portal, highlights the new measurements. To assist you in identifying the revisions to the program, a QIPS Program Comparison Chart is also posted on NaviNet. Paper copies of the *QIPS Program Manual* are available by calling the Provider Supply Line at 1-800-858-4728.

For additional information regarding QIPS, please contact your Network Coordinator.

Billing

Professional Injectable and Vaccine Fee Schedule updates effective July 1, 2010

Effective July 1, 2010, we will be implementing a quarterly update to our Professional Injectable and Vaccine Fee Schedule.

These updates reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables. You will be able to view these changes on July 1, 2010, through the NaviNet® web portal. To do so, select *Reference Material and Reports* from the Plan Transactions menu, and then select *Fee Schedule Inquiry*.

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

Inpatient facility condition code change for Federal Employee Program claims

Effective July 1, 2010, a new condition code, P7, must be submitted for Federal Employee Program (FEP) claims when a patient is transferred and/or admitted to an inpatient facility from an emergency room (ER). Currently, condition code 7 is used to identify patients who are admitted as inpatient from an ER on facility claims.

The new condition code, P7, should be reflected on your UB-04 claim form or in your electronic claim submission. This change will affect inpatient facility claims for FEP members with both the Standard and Basic options.

For FEP claims with a service date *prior* to July 1, 2010, please submit with source of admission/point of origin code 7 for admission to an inpatient facility when a patient is admitted through the ER. All FEP claims with a service date *on or after* July 1, 2010, should be submitted with the new condition code P7.

If you have any questions about this condition code change, please contact your Network Coordinator.

Products

Medicare Advantage PPO claims processing changes for 2011

Effective January 1, 2011, IBC will be required by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield plans, to participate in the BCBSA national Medicare Advantage PPO Network Sharing program and accept Medicare Advantage PPO enrollees from other BCBSA plans who travel or reside in our 5-county service area as our local members. Similar to the current BlueCard® program for commercial BCBSA PPO plans, this national BCBSA initiative enables enrollees in one BCBSA Medicare Advantage Plan to obtain health care service benefits while traveling or living in another BCBSA plan's service area.

As a Participating Provider, you will be expected to provide services to these BCBSA national Medicare Advantage PPO plan members who present to you for treatment.

IBC will process these BCBSA plan Medicare Advantage PPO enrollee claims for covered professional, facility, and ancillary services (ambulance, DME, and home infusion) in the 5-county service area in accordance with your contracted rates.

Please be advised that if you are a Professional Provider, you currently do not participate in the commercial BlueCard program. Your contract will be amended to cover your provision of services to these Medicare Advantage PPO enrollees. Under the commercial BlueCard program, Professional Provider services are provided by Highmark's PremierBlue Shield network and this will not change.

We will provide you with more information in the upcoming months about how these changes may affect your Provider Agreement with IBC and your practice.

Medical

Policy notifications posted as of May 20, 2010

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 May 20, 2010.

Policy effective date	Notification title	Notification issue date
June 11, 2010	**11.08.05f** Application and Removal of Tattoos	May 12, 2010
June 11, 2010	**00.01.48** Marijuana for Medical Use	May 12, 2010
June 18, 2010	**11.17.07d** Radiofrequency Micro-remodeling (by transurethral, transvaginal, or paraurethral approach) for Urinary Stress Incontinence	May 19, 2010
July 13, 2010	**05.00.30d** Noninvasive Respiratory Assist Devices (RADs): Continuous Positive Airway Pressure (CPAP) Devices and Bi-Level Devices	April 16, 2010
July 27, 2010	**11.08.08e** Chemical Peels	April 28, 2010

To view these notifications, as well as 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.

Pharmacy

Reminder: New prior authorization requirements for members taking insulin

Effective July 1, 2010, members who are currently taking Humulin®, Humalog®, ReliOn®/Novolin®, and Apidra® insulin will be required to obtain prior authorization.

As previously communicated, Novolin®, Novolog®, Lantus®, and Levemir® are now the preferred brands of insulin for all prescription drug programs and are the only insulins available on the Select Drug Program® Formulary. In addition, all new prescriptions for Humulin®, Humalog®, ReliOn®/Novolin®, and Apidra® insulin require prior authorization. These changes became effective April 1, 2010.

Prior authorization requests will be reviewed in accordance with our established criteria, and, if approved, non-preferred insulin will be covered at the highest level of cost-sharing. If denied, non-preferred insulin will not be a covered benefit. To learn more about our pharmacy policy and prior authorization criteria for insulin, visit the Pharmacy Policy section of our website at *www.ibx.com/rxpolicy*.

Refer to the March edition of *Partners in Health Update* for the original notification regarding these changes. If you have any questions, please contact FutureScripts®, our independent pharmacy benefits management company, at 1-888-678-7012.

Select Drug Program® Formulary updates

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

Generic additions

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

Generic drug	Brand drug	Formulary chapter	Effective date
budesonide	Pulmicort Respules®	13. Allergy, Cough & Cold, Lung Meds	April 3, 2010
cefditoren	Spectracef®	1. Antibiotics & Other Drugs Used For Infection	February 8, 2010
clindamycin phosphate	Evoclin®	5. Skin Medications	April 5, 2010
diltiazem HCl	Cardizem® LA	4. Heart, Blood Pressure, & Cholesterol	March 19, 2010
epinephrine pen injector	AdrenaClick™	13. Allergy, Cough & Cold, Lung Meds	April 5, 2010
epinephrine pen injector	EpiPen®	13. Allergy, Cough & Cold, Lung Meds	April 5, 2010
hydrocortisone/pramoxine kit	Analpram E™ Kit	8. Stomach, Ulcer, & Bowel Meds	January 26, 2010
imiquimod cream	Aldara®	5. Skin Medications	February 25, 2010
losartan	Cozaar®	4. Heart, Blood Pressure, & Cholesterol	April 9, 2010
losartan — HCTZ	Hyzaar®	4. Heart, Blood Pressure, & Cholesterol	April 9, 2010
metaxalone	Skelaxin®	10. Bones, Joints, & Muscles	April 5, 2010
prutect topical emulsion	Biafine®	5. Skin Medications	February 17, 2010
tamsulosin	Flomax®	14. Urinary & Prostate Meds	March 3, 2010

Brand additions

These brand drugs were previously added to the formulary and are covered at the appropriate brand formulary level of cost-sharing:

Brand drug	Formulary chapter	Effective date
Suboxone®	16. Diagnostics & Misc Agents	May 1, 2010
Trilipix®	4. Heart, Blood Pressure, & Cholesterol	April 1, 2010

This brand drug will be added to the formulary and will be covered at the appropriate brand formulary level of cost-sharing:

Brand drug	Formulary chapter	Effective date
Besivance™	12. Eye Medications	July 1, 2010

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Select Drug Program® Formulary updates (continued)

Brand deletions

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

Effective July 1, 2010.

Brand drug	Generic drug	Formulary chapter
AdrenaClick™	epinephrine pen injector	13. Allergy, Cough & Cold, Lung Meds
Biafine®	prutect topical emulsion	5. Skin Medications
EpiPen®	epinephrine pen injector	13. Allergy, Cough & Cold, Lung Meds
Pulmicort Respules®	budesonide	13. Allergy, Cough & Cold, Lung Meds
Skelaxin®	metaxalone	10. Bones, Joints, & Muscles

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

Prescription drug updates

There are several updates for members enrolled in an IBC prescription drug program. A drug will be excluded from coverage because it is available over the counter; typically, over-the-counter medications are excluded from all IBC prescription drug programs. Also, prior authorization and quantity limit requirements will be applied to additional drugs. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. Quantity level limits are designed to allow a sufficient supply of medication based upon the maximum daily dose and length of therapy approved by the U.S. Food and Drug Administration for a particular drug. These most recent updates are reflected below.

Over-the-counter exclusion

This brand drug will no longer be covered under the prescription drug program because it is available over the counter:

Effective June 1, 2010.

Brand drug	Generic drug	Drug category
Zegerid® 20mg	Not available	Stomach, Ulcer, & Bowel Meds

Drugs requiring prior authorization

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

Brand drug	Generic drug	Drug category	Effective date
Ampyra™	Not available	Bones, Joints, & Muscles	February 19, 2010
Cayston™	Not available	Antibiotics & Other Drugs Used for Infection	February 26, 2010
Exalgo™	Not available	Pain & Nervous System	April 2, 2010
Mirapex ER®	Not available	Pain & Nervous System	February 26, 2010
Pennsaid®	Not available	Pain & Nervous System	April 2, 2010
Victoza®	Not available	Diabetes	March 5, 2010

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Pharmacy

Prescription drug updates (continued)

The following non-formulary drugs require prior authorization for new prescriptions as of the date indicated below. Members taking these drugs immediately prior to the effective date are not affected:

Brand drug	Generic drug	Drug category	Effective date
Samsca™	Not available	Bones, Joints, & Muscles	April 1, 2010
Zipsor™	Not available	Bones, Joints, & Muscles	July 1, 2010

Drugs requiring prior authorization and quantity level limits

The following drugs will be added to the list of drugs requiring prior authorization and will also be subject to quantity limits: *Effective August 1, 2010.*

Brand drug	Generic drug	Drug category
Suboxone®	Not available	Opioid Withdrawal
Subutex®	buprenorphine*	Opioid Withdrawal

**Prior authorization also applies to the generic formulation.*

Health and Wellness

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

Call the Provider Support Line at 1-866-866-4694 to refer a member to a Health Coach 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)
- issues with medication persistence
- peptic ulcer disease (PUD)

Health Coaches also provide decision support for numerous health-related issues, including chronic pain, weight loss surgery, depression, breast or prostate cancer, and end-of-life decisions.

Visit *www.ibx.com/providerconnections* for more information about the Connections Health Management Programs.

Connections℠ Complex Care Management Program seeks panelists for Physician Advisory Board

As reported in the December 2009 and April 2010 editions of *Partners in Health Update*, IBC is currently transitioning the care management of members with complex, chronic conditions from an outside vendor to our own in-house nurse care managers. As part of this transition, IBC will create a Physician Advisory Board comprised of rheumatologists, neurologists, hematologists, gastroenterologists, and pediatric pulmonologists.

Key tasks of the Physician Advisory Board will include:

- conducting quarterly educational sessions, clinical updates, and/or case rounds with IBC care managers;
- providing consultation by phone or secure email to care managers regarding specific members;
- assisting with the development and review of clinical tools and clinical guidelines.

The ideal Physician Advisory Board member would be a provider who is practicing in his or her specialty and who supports population health principles and managed care.

Doctors on the Physician Advisory Board will receive an hourly stipend for their work. For more information or to apply for a position, please contact Esther Nash, M.D. at 215-241-4653 or *Esther.Nash@ibx.com*.

SMART® Registry release for June 2010

The next release of the SMART Registry will be mailed to IBC providers in June 2010. The SMART Registry provides information on doctors' patients who are eligible for the Connections℠ Health Management Program with any of the following chronic conditions: asthma, diabetes, heart failure, coronary heart disease, and chronic obstructive pulmonary disease.

The SMART Registry CDs include a security measure to protect our members' health information. Practices with more than 11 Connections-eligible patients with a chronic condition automatically receive the SMART Registry on CD, which is password-protected. Letters that provide the password will be mailed to practices approximately one week before the SMART Registry is mailed. Practices can also look up their password through the NaviNet® web portal. To do so, select *Reference Material and Reports* from the Plan Transactions menu and then select *SMART Registry Password*.

If you have any questions about the SMART Registry CD or the encryption process, please contact a Connections Program Specialist (CPS)* by calling the Connections Program Provider Support Line at 1-866-866-4694. A CPS can help you and your staff to navigate the CD to locate the most important information.

You can also schedule an appointment with a CPS to meet with you and your staff to review the SMART Registry reports and to help with making referrals to the Connections Health Management Program.

To speak with a CPS about the SMART Registry or any other aspect of the Connections Program, call the Provider Support Line at 1-866-866-4694.

**Connections Program Specialists were previously known as Provider Service Specialists.*

SMART® is a registered trademark of Health Dialog Services Corporation, an independent company.

Healthways SilverSneakers® Fitness Program proven to reduce health care costs of members with diabetes

Study: Health care cost and utilization associated with use of a health club membership benefit in older adults with diabetes

According to a recent study published in *Diabetes Care*, the journal of the American Diabetes Association, older adults with diabetes who are enrolled in the SilverSneakers Fitness Program are admitted to the hospital less often, have lower inpatient care costs, and have significant reductions in their overall health care costs after only the first year of participation.[1]

The study, funded by the Centers for Disease Control and Prevention and conducted by Group Health and the University of Washington, extends a January 2008 study that looked at nearly 5,000 SilverSneakers participants during a two-year period. Researchers examined whether the impact of SilverSneakers participation on health care costs and utilization also applies to older adults with chronic conditions such as diabetes.[2]

The health care costs from SilverSneakers members with diabetes (study group) were compared to costs from diabetic members of the same age and gender who were not enrolled in SilverSneakers (control group).

Key conclusions

Lower total health care costs. During the first year of the program, the study group generated $1,600 less per member in total health care costs than the control group. During the second year, the health care costs for the study group continued to decline. Reductions of $1,230 per member were seen for the study group compared to the control group during the second year.

Lower hospitalization rates. Study group members had 29 percent fewer hospital admissions than the control group members. Costs per member for inpatient care were similar for study and control group members.

The SilverSneakers® Fitness Program

Greater savings with more participation. Participants who averaged two or more visits per week in the first year of the study had significantly lower health care costs in the second year than those members who visited the fitness center fewer than two times per week in year one. Members who participated more frequently generated $2,141 less per member in total health care costs than members with lower participation.

The study suggests that the health care cost reductions associated with participation in an exercise program for older adults in general also apply to older adults with diabetes. In fact, the impact on total health care cost is seen earlier and is three times greater in this higher-risk group.

For more information about this study, please visit *www.healthways.com*.

Note: SilverSneakers is offered to IBC Medicare Advantage HMO members at no additional cost. To enroll in the program, members can simply bring their health plan ID card to any participating SilverSneakers location. For a complete list of locations, members can visit the SilverSneakers website at *www.silversneakers.com* or call 1-866-584-7685.

[1]Huong, H.Q., Maciejewski, M.L., Gao, S., Lin, E, Williams, B., & LeGerfo, J.P. (2008). Health Care Use and Costs Associated with Use of a Health Club Membership Benefit in Older Adults with Diabetes. Diabetes Care, 31(8), 1562-1567. http://care.diabetesjournals.org/content/vol31/issue8.

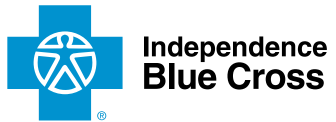
[2]www.cdc.gov/pcd/issues/2008/jan/07_0148.htm.

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

Important Resources

Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/antifraud
Care Management and Coordination Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Healthy Lifestyles℠ Keys to Wellness	215-567-3570 1-800-313-8628* www.ibx.com/providerkeystowellness
Connections℠ Health Management Programs Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ Complex Care Management Program	1-800-313-8628
Credentialing Credentialing Hotline	215-988-6534 www.ibx.com/credentials
Credentialing Violation Hotline	215-988-1413
Customer Service/Provider Services • Provider Automated System (eligibility/claims status/referrals) • Connections Health Management Programs • Precertification/maternity requests — Imaging services (CT, MRI/MRA, PET, and nuclear cardiology) — Authorizations	1-800-ASK-BLUE
Provider Services user guide	www.ibx.com/providerautomatedsystem
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
Pharmacy website (formulary updates, prior authorization)	www.ibx.com/rx
FutureScripts® Secure Medicare Part D	1-888-678-7015
Formulary updates	www.site65.com
Medical Policy website	www.ibx.com/medpolicy
NaviNet® portal registration	www.ibx.com/navinet
Provider Supply Line	1-800-858-4728

* Outside 215 area code



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