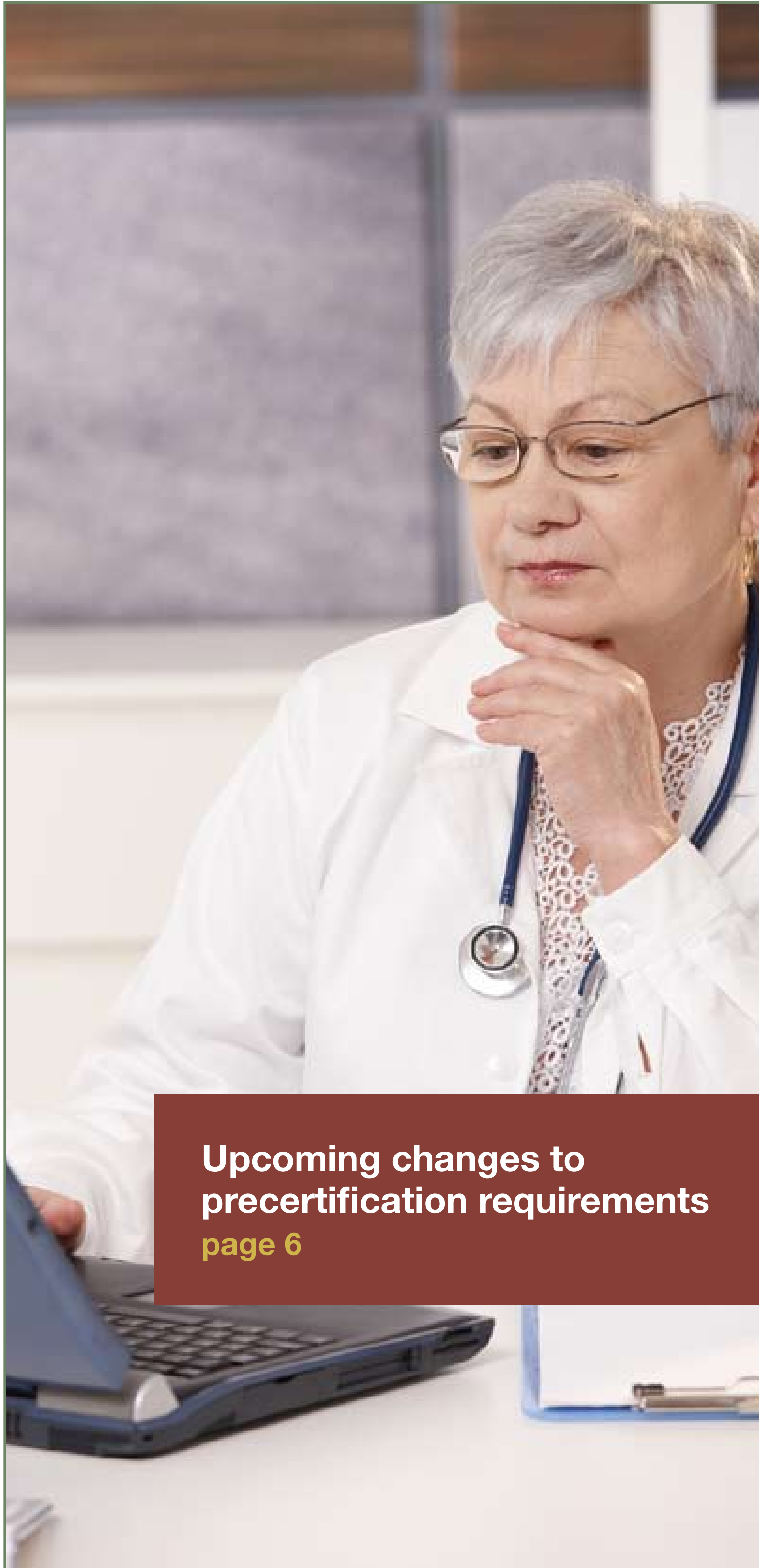
Independence Blue Cross

Partners in Health UPDATE[SM]



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Reminder...

Get important information delivered through 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*.

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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:

P **Professional**

F **Facility**

A **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.

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P

New Delaware chiropractic mandate

On July 1, 2011, a new mandate issued by the state of Delaware for billing chiropractic/spinal manipulation services will go into effect for all Delaware insurers.

To comply with this mandate, beginning July 1, 2011, any member who is insured by a Delaware insurer and who receives chiropractic/spinal manipulation services will be billed for a copayment equal to that of a primary care physician (PCP) visit. Therefore, chiropractors should verify the correct copayment amount through the NaviNet® web portal. To do so, select *Eligibility and Benefits Inquiry* from the Plan Transactions menu, input the member's information, and select the member name from the search results to view the PCP copayment amount.

If you are not NaviNet-enabled, you can register by going to *www.navinet.net* and selecting *Sign up* from the top right.

Member eligibility and copayment information is also available through the Provider Automated System by calling 1-800-ASK-BLUE.

Note: This notice does not apply to Medicare Advantage HMO or PPO members.

P F A

Upcoming provider self-service requirements

In our continuing efforts to provide the most current and reliable information to our network providers, in the near future we will begin to enforce our policy that requires providers to use the NaviNet® web portal or the Provider Automated System when requesting member eligibility. In addition, providers will be directed to use NaviNet or the Provider Automated System when calling for claim status information. The claim detail provided through either system includes specific information, such as:

- check date
- check number
- service codes
- paid amount
- member responsibility

If your office location is not yet registered for NaviNet, please visit *www.navinet.net* and select *Sign up* from the top right. If your office is currently NaviNet-enabled but would like training on how to access member or claim information, please call the eBusiness Provider Hotline at 215-640-7410.

Providers can also obtain this information through the Provider Automated System by calling 1-800-ASK-BLUE and following the voice prompts.

Look for additional information on the effective date and how to use these tools in upcoming editions of *Partners in Health Update*.

Professional Injectable and Vaccine Fee Schedule updates, effective July 1, 2011

Effective July 1, 2011, we will implement a quarterly update to our Professional Injectable and Vaccine Fee Schedule for all Pennsylvania, New Jersey, and Delaware providers.

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 starting July 1, 2011, 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.

Are you ready?: HIPAA 5010 transition

Beginning January 1, 2012, any health care entity that submits electronic standard transactions to IBC must comply with HIPAA 5010 (errata version). After this date, version 4010A will no longer be valid.

IBC is preparing for the transition to 5010 by testing directly with our trading partners. We ask that you speak with your trading partner (or through whomever you submit your claims) in order to ensure that your trading partner is compliant and ready to electronically submit standard transactions using version 5010 by January 1, 2012. Providers should take an active role in ensuring their trading partners are on track with 5010 compliance.

Important billing change

A new 5010 billing requirement stipulates that providers can no longer submit a PO Box or lockbox in the Billing Provider area on professional and institutional claims. A physical street address must be listed for the Billing Provider and the Service Facility location.

Inquiries

If you have specific questions surrounding the transition to 5010, please refer to the HIPAA 5010 Frequently Asked Questions (FAQ) found on our website at *www.ibx.com/hipaa5010*. The FAQ contains the most current information we have at this time. We will continue to update the FAQ as new information becomes available.

Please continue to check *Partners in Health Update*, the NaviNet® web portal, and *www.ibx.com/providers* for important updates and information regarding the conversion to 5010.

MEDICAL

Policy on X-rays associated with fractures in the office setting

All HMO members and most POS members using their referred benefit are required to obtain outpatient diagnostic radiology services at their primary care physician's capitated radiology site.

However, in some acute circumstances, medically necessary X-rays associated with a fracture may be performed in a specialist's office. Hand surgeons, orthopedic surgeons, podiatrists, and sports medicine specialists are eligible for fee-for-service reimbursement consideration for X-rays associated with a fracture that are performed in the office setting.

Claim Payment Policy #00.03.09: X-rays Associated with Fractures in the Office Setting became available in May for providers and their office staff. The noted specialists should read this policy in its entirety by visiting *www.ibx.com/medpolicy* and entering the policy number in the Search box.

PFA

Policy notifications posted as of May 20, 2011

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, 2011.

Policy effective date	Notification title	Notification issue date
May 27, 2011	**00.03.09** X-rays Associated with Fractures in the Office Setting	April 28, 2011
June 8, 2011	**11.02.06g** Catheter Ablation of Cardiac Arrhythmias	May 9, 2011
June 10, 2011	**08.00.81a** Bendamustine Hydrochloride (Treanda®)	May 11, 2011
June 10, 2011	**07.02.04g** Intracoronary Brachytherapy	May 11, 2011
June 10, 2011	**07.00.17b** Ketogenic Diet for Children as a Treatment for Refractory Epilepsy	May 11, 2011
June 10, 2011	**05.00.73** Neuromuscular Electrical Stimulators (NMES) and Functional Electrical Stimulators (FES)	May 11, 2011
June 10, 2011	**08.00.80a** Temozolomide (Temodar®) for Injection	May 11, 2011
June 14, 2011	**08.00.65e** Pamidronate Disodium (Aredia®) for Intravenous Infusion	March 16, 2011
June 20, 2011	**06.02.14d** In Vitro Chemosensitivity and Chemoresistance Assays	May 20, 2011
July 1, 2011	**00.01.25l** PPO Network Rules for Provision of Specialty Services for Durable Medical Equipment and Laboratory, Radiology, and Physical Medicine and Rehabilitative Services	April 1, 2011
July 1, 2011	**00.01.14i** Reporting and Documentation Requirements for Anesthesia Services	April 1, 2011
July 27, 2011	**05.00.70** Mechanical Stretching Devices for the Treatment of Joint Stiffness or Contractures	April 28, 2011

To view the policy notifications, go to *www.ibx.com/medpolicy*, select *Accept and Go to Medical Policy Online,* and click on the *Policy Notifications* box. You can also view policy notifications using the NaviNet® web portal by selecting *Reference Materials and Reports* from the Plan Transactions menu, then *Medical Policy.* Once these policies are in effect, they will be available by using the Search box on the Medical Policy homepage. Be sure to check back often, as the site is updated frequently.

PFA

Upcoming changes to precertification requirements

Effective for dates of service on or after September 1, 2011, we will implement important changes to the list of services and drugs that require precertification. These changes are intended to achieve consistency across product lines with regard to certain precertification requirements as we continue to look for ways to improve and simplify the precertification process.

The new precertification requirements will apply to all commercial products for dates of service on or after September 1, 2011; Medicare Advantage HMO and PPO members will transition for dates of service on or after January 1, 2012.

The following precertification requirements *will be added* for all commercial products in all settings:

- potentially cosmetic procedures (please refer to the detailed list below);
- pain management procedures (paravertebral facet joint injections, transforaminal epidural injections, epidural injections);
- hyperbaric oxygen treatments;
- additional medical infusion/injectable drugs (please refer to the detailed list on the next page);
- cataract surgery;
- cochlear implant surgery;
- uvulopalatopharyngoplasty (UPPP or UP3).

The following precertification requirements *will be removed* for all commercial products in all settings:

- sleep studies
- cardiac rehabilitation
- pulmonary rehabilitation

Providers will continue to have access to the most current lists of precertification requirements on our website at *www.ibx.com/providers/preapproval*. Providers also can log into the NaviNet® web portal and view each member's Benefit Snapshot, which includes a member-specific list of requirements. It is very important for providers to use NaviNet to verify member-specific requirements as we proceed through this transition. Failure to obtain precertification for any of the services or drugs that require it may result in a reduction in payment or nonpayment for the services not precertified.

If you are not NaviNet-enabled, you can register by going to *www.navinet.net* and selecting *Sign up* from the top right.

Please call 1-800-ASK-BLUE if you have any questions about these upcoming changes.

Potentially cosmetic procedures that will require precertification		
Blepharoplasty/ptsosis repair	Hair transplant	Rhinoplasty
Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion, and removal of breast implants	Injectable dermal fillers	Rhytidectomy
Canthopexy/canthoplasty	Keloid removal	Scar revision
Cervicoplasty	Labiaplasty	Skin closures including: skin grafts, skin flaps, and tissue grafts
Chemical peels	Lipectomy, liposuction, or any other excess fat removal procedure	Sex reassignment surgery
Dermabrasion	Orthognathic surgery procedures including, but not limited to: bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies	Surgical treatment of gynecomastia
Excision of excessive skin and/or subcutaneous tissue	Otoplasty	Surgery for varicose veins, including perforators and sclerotherapy
Genetically and bio-engineered skin substitutes for wound care		

continued on the next page

Upcoming changes to precertification requirements (continued)

When a drug class is listed below, all drugs in the class require precertification, including any unlisted trade or generic names, as well as any drugs that are approved by the U.S. Food and Drug Administration (FDA) during the remainder of the benefit year.

Regardless of how the drug is classified below, each drug requires precertification for all indications for which it could be prescribed.

Additional infusion drugs that will require precertification		
Abraxane®	Enzyme replacement (Lumizyme®, Replagal®*, Uplyso®*, VPRIV®)	Istodax®
Alimta®	Flolan®	Jevtana®
Alpha 1 inhibitors (Aralast NP™, Glassia™, Prolastin® C, Zemaira®)	Folotyn®	Provenge®
Arzerra™	Gammaplex® (IVIG)	Psoriasis/rheumatoid arthritis (Actemra®)
Belatacept*	Halaven™	Remodulin®
Benlysta®	Hemophilia factors	Soliris®
C1 esterase inhibitors (Berinert®, Cinryze®)	Herceptin® DM1*	Yervoy™
Corifact™ (factor drug)		

Additional injectable drugs that will require precertification		
Kalbitor®	Makena™	Stelara®
Lucentis®	Omapro™*	Xgeva™
Macugen®	Prolia®	Xolair®

**This drug is pending FDA approval.*

Clinical criteria used for utilization management determinations

Clinical decision support criteria are used to enhance coverage decisions based on medical necessity. Each case is reviewed by a registered nurse care coordinator or an IBC medical director. Nurse care coordinators can approve coverage; however, only medical directors can deny coverage.

Clinical decision support criteria are obtained through an externally validated and computer-based system and are used to assist us in determining medical necessity. These evidence-based clinical decision support criteria are nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist our clinical staff in evaluating the medical necessity and appropriateness of coverage based on a member's specific clinical needs. Clinical decision support criteria help promote consistency in our plan determinations for similar medical issues and requests and reduce practice variation among our clinical staff to minimize subjective decision making.

We use clinical decision support criteria from InterQual®, a product of McKesson Corporation, an independent company, and Medicare coverage criteria for Medicare Advantage HMO and PPO members. InterQual updates its criteria annually. To ensure that the criteria developed are in accordance with community standards, the guidelines are reviewed by the Clinical Quality Committee, whose membership is comprised of participating providers.

At a minimum, we review the clinical criteria annually. In addition, updates are made and released as they become available.

Participating providers may give input on the clinical criteria, which is forwarded to McKesson. The participating provider may also contact McKesson through its website at *www.mckesson.com*.

InterQual criteria may be applied for covered services including, but not limited to, the following:

- some elective surgeries and/or settings for inpatient and outpatient procedures (e.g., hysterectomy and sinus surgery)
- inpatient hospitalizations
- inpatient rehabilitation
- skilled nursing facility
- long-term, acute-care facility
- observation

In addition, we apply InterQual acute-care guidelines for all emergency admissions. Admissions that do not meet acute intensity of services and severity of illness are reviewed by an IBC medical director and payment is denied when guidelines are not satisfied. Observation services do not need preapproval but are subject to InterQual criteria for medical necessity, which requires that the treatment and/or procedures include at least six hours of observation.

Information about clinical decision support criteria may be obtained by calling 215-241-3417.

Updated InterQual® guidelines for 2011

McKesson Health Solutions, an independent company, has made significant changes to the Level of Care Criteria for 2011. Starting in July, we will implement the revised InterQual guidelines.

The InterQual Acute Criteria are moving towards a condition-specific focus and have begun a transition away from body-system subsets. This represents a significant change from the intensity of service and severity of illness approach. Providers should note that the new guidelines will require the provision of more detailed information on the treatment plans, including medication administration. The 2011 criteria for which there are condition-specific subsets for adults are:

- Acute Coronary Syndrome
- Asthma
- Epilepsy
- Heart failure
- Pneumonia
- Stroke/TIA

The 2011 criteria with condition-specific subsets for pediatrics are: Asthma, Croup, Epilepsy, and Pneumonia.

For more information on the condition-specific subsets in the 2011 Acute Criteria, please visit *www.McKesson.com* under Providers/Hospitals.

P

Guidelines for contraception in women with medical problems*

The Centers for Disease Control and Prevention (CDC) has adapted the World Health Organization (WHO) Medical Eligibility Criteria for Contraceptive Use, 2010, for the United States. The guidelines recommend contraceptive methods for women with medical problems, based on assessment of health risks. The guidelines state that unintended pregnancy places at risk women with history of bariatric surgery within the past two years, peripartum cardiomyopathy, or women who received a solid organ transplant within two years, among other medical conditions.

Other notable changes to the WHO's Criteria include endorsement of emergency contraception for women with history of bariatric surgery (restrictive or malabsorptive), rheumatoid arthritis, inflammatory bowel disease, and solid organ transplantation.

Recommendations for ongoing oral contraception for post-bariatric surgery patients differ depending on the type of procedure performed. After restrictive procedures, women can still absorb oral medications, and therefore, oral methods are appropriate. However, after malabsorptive surgery, oral methods are not recommended.

Various cancers, history or risk of deep vein thrombosis, rheumatoid arthritis, various cardiac conditions, inflammatory bowel disease, fibroids, and endometrial hyperplasias are among the other conditions addressed.

The full CDC report is available at *www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm?s_cid=rr5904a1_w*.

Recommendations for hormonal or intrauterine methods are summarized by medical condition (Appendix L) and are available at *www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a13.htm*.

Note: Contraceptive medications and devices are subject to individual plan coverage.

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

P

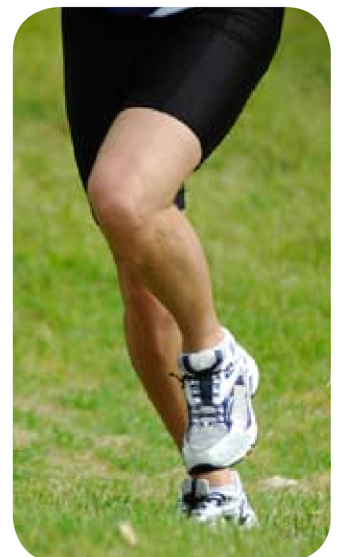
Reminder: Three hyaluronate acid products designated as preferred brands for treatment of osteoarthritis of the knee

Currently there are six hyaluronate acid products that have been approved by the U.S. Food and Drug Administration to treat osteoarthritis of the knee: Euflexxa®, Hyalgan®, Orthovisc®, Supartz®, Synvisc®, and Synvisc-One®.

IBC has designated **Euflexxa®**, **Synvisc®**, and **Synvisc-One®** as our preferred hyaluronate acid products for treatment of osteoarthritis of the knee. These three preferred brands were selected based on their demonstrated cost-effectiveness to the plan. Choosing one of these preferred brands does not affect the member's cost-sharing for the drug.

IBC encourages providers to choose one of these three preferred brands when treating members with osteoarthritis of the knee. The appropriate course of treatment would be one of the following:

- one intra-articular injection of Synvisc-One®;
- three intra-articular injections of Synvisc®;
- three intra-articular injections of Euflexxa®.



IBC will continue to cover all six hyaluronate acid products in accordance with the medical necessity criteria listed in Medical Policy #11.14.07h: Intra-articular Injection of Hyaluronan for the Treatment of Osteoarthritis. All six of these hyaluronate acid products are subject to precertification requirements. One series of injections will be precertified every six months.

The medical policy for hyaluronate acid products is available at *www.ibx.com/medpolicy*. Select *Accept and Go to Medical Policy Online* and then type the policy name or number in the Search box.

PFA

Prescription drug updates

For members enrolled in an IBC prescription drug program, drugs have been excluded from coverage because they are available over-the-counter. Typically, drugs that are available over-the-counter are excluded from IBC prescription drug coverage. In addition, prior authorization requirements have been applied to additional drugs. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. The most recent updates are reflected below.

Over-the-counter exclusions

These brand drugs are no longer covered under the prescription drug benefit because they are available over-the-counter:

Effective March 4, 2011.

Brand drug	Generic drug	Formulary chapter
Allegra®	fexofenadine	13. Allergy, Cough & Cold, Lung Meds
Allegra-D®	fexofenadine-pseudoephedrine	13. Allergy, Cough & Cold, Lung 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	Formulary chapter	Effective date
Amturnide™	Not available	4. Heart, Blood Pressure, & Cholesterol	March 23, 2011
Edarbi™	Not available	4. Heart, Blood Pressure, & Cholesterol	April 8, 2011
Nexiclon™ XR Tablets	Not available	4. Heart, Blood Pressure, & Cholesterol	March 8, 2011
Nuedexta™	Not available	3. Pain, Nervous System, & Psych	March 8, 2011
Sylatron™	Not available	9. Biotechnology	April 22, 2011

The following non-formulary drugs have been added to the list of drugs requiring prior authorization for new prescriptions. Members taking these drugs immediately prior to the effective date were not affected:

Effective May 1, 2011.

Brand drug	Generic drug	Formulary chapter
Abstral®	Not available	3. Pain, Nervous System, & Psych
Tekamlo™	Not available	4. Heart, Blood Pressure, & Cholesterol

PFA

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 formulary coverage based on their medical effectiveness, safety, and value. The list changes periodically as the 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
doxycycline	Doryx®	1. Antibiotics & Other Drugs Used for Infection	January 7, 2011
ethinyl estradiol/ norethindrone	Femcon® Fe	11. Female, Hormone Replacement, Birth Control	April 1, 2011
exemestane	Aromasin®	2. Cancer & Organ Transplant Drugs	April 8, 2011
gabapentin solution	Neurontin® Solution	3. Pain, Nervous System, & Psych	March 14, 2011
letrozole	Femara®	2. Cancer & Organ Transplant Drugs	April 29, 2011
methylphenidate	Concerta®	3. Pain, Nervous System, & Psych	April 29, 2011
norethindrone acetate/ ethinyl estradiol	Femhrt®	11. Female, Hormone Replacement, Birth Control	February 18, 2011
phenelzine	Nardil®	3. Pain, Nervous System, & Psych	December 24, 2010
propafenone	Rythmol® SR	4. Heart, Blood Pressure, & Cholesterol	January 7, 2011
voriconazole	Vfend®	1. Antibiotics & Other Drugs Used for Infection	February 18, 2011

Brand additions

These brand drugs were added to the formulary as of the dates indicated below and are covered at the appropriate brand formulary level of cost-sharing:

Brand drug	Formulary chapter	Effective date
Actos®	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones	April 1, 2011
Actoplus Met®	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones	April 1, 2011
Geodon®	3. Pain, Nervous System, & Psych	April 1, 2011
Lipitor®	4. Heart, Blood Pressure, & Cholesterol	April 1, 2011
Lovaza®	4. Heart, Blood Pressure, & Cholesterol	July 1, 2011
OxyContin®	3. Pain, Nervous System, & Psych	April 1, 2011
Seroquel XR®	3. Pain, Nervous System, & Psych	April 1, 2011

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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, 2011.

Brand drug	Generic drug	Formulary chapter
Concerta®	methylphenidate	3. Pain, Nervous System, & Psych
Femara®	letrozole	2. Cancer & Organ Transplant Drugs
Femhrt®	norethindrone acetate/ ethinyl estradiol	11. Female, Hormone Replacement, Birth Control
Nardil®	phenelzine	3. Pain, Nervous System, & Psych
Neurontin® Solution	gabapentin solution	3. Pain, Nervous System, & Psych
Vfend®	voriconazole	1. Antibiotics & Other Drugs Used for Infection

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

Brand deletions

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

Effective July 1, 2011.

Brand drug	Formulary therapeutic alternative	Formulary chapter
Valturna®	losartan	4. Heart, Blood Pressure, & Cholesterol

There is no generic equivalent on our formulary for the above brand drug; however, there are formulary therapeutic alternative drugs. These therapeutic alternative drugs are available at the appropriate formulary level of cost-sharing.

Health and Wellness

Health Coaches offer support for patients who need diabetic eye care

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

Eye care is an essential part of managing diabetes, a disease that affects approximately eight percent of the American population.[1] Over five million American adults have diabetic retinopathy, the leading cause of blindness among working-age adults. People with diabetes are also more vulnerable to glaucoma and cataracts. Unfortunately, many who are diagnosed with diabetes do not receive the recommended eye care.[1]

There are three critical ways for diabetics to minimize damage to the eyes:

- **Tight blood glucose control.** Results from the Diabetes Control and Complications Trial (DCCT) showed that individuals who kept A1C levels to below 7 percent reduced their risk of retinopathy by 76 percent.[2]
- **Blood pressure management.** Treating high blood pressure so that it stays within target ranges is another key prevention step cited in the American Diabetes Association *Standards of Medical Care in Diabetes*.[1]

continued on the next page

Health Coaches offer support for patients who need diabetic eye care (continued)

- **Comprehensive dilated eye exams.** It is also critical that patients with diabetes get a regular comprehensive dilated eye exam, which allows the eye care provider to inspect the retina for early signs of retinopathy. These signs include leaking blood vessels and retinal swelling. The exam should also screen for glaucoma-related optic nerve damage either through direct ophthalmoscope observation or slit-lamp biomicroscopic examination. Other aspects of a comprehensive eye exam include measurement of intraocular pressures and assessment of the patient's peripheral vision and visual acuity.[3,4,5]

The risk of eye damage increases each year a person has diabetes. Therefore, adults and children with type 1 diabetes should have their first comprehensive dilated eye exam within five years of developing the condition. Patients who have type 2 diabetes should receive an exam soon after diagnosis. If the results of the exam are negative, a person may wait two years before repeating it. If signs of disease are apparent, the exam should be conducted at least yearly.[1]

Women who have diabetes should have a comprehensive dilated exam when planning to become pregnant or soon thereafter and should be advised of the risk of development and/or progression of diabetic retinopathy. The exam should occur during the first trimester and the patient should be followed closely throughout pregnancy and for one year postpartum.[1]

How do you ensure that your patients are thoroughly informed?

Given how common diabetes is, you, as a clinician, may need to spend time talking with your patients about eye care. The Connections[SM] Health Management Program offers your eligible patients access to Health Coaches who are trained in helping patients understand the need for diabetic tests and treatments. What's more, Health Coaches can send your patients a Shared Decision-Making® video and booklet program titled *Living with Diabetes*.

Shared Decision-Making® video and booklet programs are educational tools designed to give patients all of the information they need regarding tests and treatments for their specific conditions. The programs are based on medical evidence researched and evaluated by the Foundation for Informed Medical Decision Making, a non-profit organization dedicated to improving the quality of medical decisions. The programs are regularly reviewed and updated to ensure that they contain the most current and accurate information.

To learn more about the health coaching services available to your eligible IBC patients, call the Connections Provider Support line at 1-866-866-4694. A Connections Program Specialist will return your call within two business days. Additional information about the Connections Program is also available online at *www.ibx.com/providerconnections*.

[1]*American Diabetes Association. Executive Summary: Standards of Medical Care in Diabetes-2011.* Diabetes Care. 2010;34(1):S4-S10. *http://care.diabetesjournals.org/content/34/Supplement_1/S4.full.pdf+html*

[2]*National Diabetes Information Clearinghouse. DCCT and EDIC: The Diabetes Control and Complications Trial and Follow-up Study. NIH Publication No. 08-3874. May 2008. http://diabetes.niddk.nih.gov/dm/pubs/control/*

[3]*Medicare Prevention Services. Glaucoma Screening. Centers for Medicare & Medicaid Services. July 2009. https://www.cms.gov/MLNProducts/Downloads/Glaucoma.pdf*

[4]*National Eye Institute. Facts About Diabetic Retinopathy. National Institutes of Health. www.nei.nih.gov/health/diabetic/retinopathy.asp*

[5]*National Eye Institute. Information for Healthy Vision. National Institutes of Health. www.nei.nih.gov/healthyeyes/eyeexam.asp*

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

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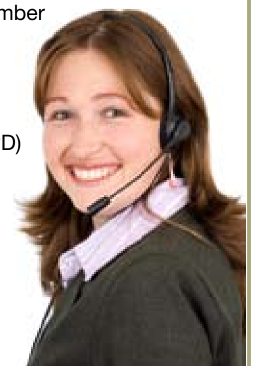
Connections[SM] Health Management Program: Supporting your patients, our members

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



Health Coaches also provide decision support for numerous health-related issues, including back pain, fall prevention, depression, cardiometabolic risk, weight loss surgery, breast or prostate cancer, and chronic pain.

Information about our Connections Health Management Program is available at *www.ibx.com/providerconnections*.

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)*
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 Violation Hotline	215-988-1413 www.ibx.com/credentials
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 (275-2583)
Provider Services user guide	www.ibx.com/providerautomatedsystem
eBusiness Help Desk	215-241-2305
FutureScripts® (pharmacy benefits) 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.ibxmedicare.com
IBC Direct Ship Injectables Program (medical benefits)	www.ibx.com/directship
Medical Policy	www.ibx.com/medpolicy
NaviNet® portal registration	www.navinet.net
Provider Supply Line	1-800-858-4728 www.ibx.com/providersupplyline

* Outside 215 area code

Visit our website:
www.ibx.com/providercommunications