Independence Blue Cross®

Partners in Health UPDATE℠

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Toolkit offers help for a successful flu vaccine campaign

Each year, anywhere between 5 and 20 percent of the U.S. population gets the flu, while complications from the flu send more than 200,000 Americans to the hospital annually. The best way to prevent the flu is by getting an annual seasonal influenza vaccine.

To help you get the message about flu vaccination out to your patients, a new online toolkit is available from the W. Montague Cobb/NMA Health Institute. The Immunization Toolkit provides an overview of the U.S. Department of Health & Human Services' "Protecting All from the Flu" campaign, includes information about gaps in vaccination rates among diverse populations, and provides tips and resources for a successful vaccination campaign.

Visit *http://cobb.nmanet.org/cobbEE/toolkit/tk_index.html* to download the toolkit.

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*.

Please allow up to two weeks for us to process your request. 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.

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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.

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Changes to referral requirements for certain nutrition counseling services

Our commercial managed care members have benefits for up to six fully covered nutrition counseling visits per year and for medically necessary diabetic education. Currently, a referral is required for HMO members to use these benefits.

Effective December 1, 2011, however, HMO members will no longer need a referral for these services. This change is an effort to make it easier for all of our members to use their nutrition counseling and diabetic education benefits.

For all members, copayments do not apply when using an in-network provider for these nutritional counseling services. HMO members must use an in-network provider to take advantage of these benefits; PPO and POS members may use an out-of-network provider subject to applicable deductibles and coinsurance.

In order to schedule an appointment for nutrition counseling, members should contact their primary physician or a participating registered dietitian. To locate a network provider, members can log on to ibxpress.com or call Customer Service at 1-800-ASK-BLUE.

Note: Only certain providers (i.e., primary care physicians or registered dietitians) are eligible to provide nutrition counseling services. Appointments with nutritionists are not a covered benefit.

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.

Reminder: Upcoming changes to the Provider Automated System

We will be updating our interactive Provider Automated System, available through 1-800-ASK-BLUE, to make it easier for you to obtain the information you need quickly and efficiently. You will have the option to "speak" with our automated service 24 hours a day, 7 days a week, through enhanced voice-recognition capability. Starting in mid-November, we will begin to transition provider calls to the new system, with all calls on the new system by December 1, 2011.

Through the enhanced Provider Automated System, the following self-service capabilities will be available:

- **Provider authorization inquiry.** The following can be done for authorization inquiries:
  - search for existing authorizations by date or reference number;
  - search by single date or entire month;
  - search 60 days in the past and 180 days in future.

  Please note that authorizations may be retrieved only by the provider associated with the authorization. Also, behavioral health inquiries should continue to be directed to Magellan Behavioral Health, Inc.
- **Claims.** Search member claims within two years from current date.
- **Member eligibility and benefits.** The phone service continues to offer this information.
- **Referral and encounter submissions.** Submit referrals and encounters using the member ID number located on his or her member ID card.
- **Referral inquiry.** Search for existing referrals within 90 days from the current date.

Please be sure to have your NPI, corporate ID number, and last four digits of your tax ID number ready before you call in order to complete the listed transactions.

For more tips and information about the Provider Automated System, a guide will be available on our website at *www.ibx.com/providerautomatedsystem* by mid-November.

Magellan Behavioral Health, Inc., an independent company, manages mental health and substance abuse benefits for most IBC members.

P F A

Reminder: Provider self-service requirements now in effect

As of September 15, 2011, we began enforcing our policy that requires providers to use the NaviNet® web portal or the Provider Automated System when requesting member eligibility.

In addition, providers must use NaviNet or call the Provider Automated System to check claims status information. The claim detail provided through either system includes specific information, such as:

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

Providers can view a webinar at *www.navinet.net/intro_pss_ibc* for more information on these requirements. The presentation offers guidance on where to obtain member eligibility and claims status information through NaviNet.

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 assistance with accessing member or claims information, please call the eBusiness Provider Hotline at 215-640-7410.

Providers without access to NaviNet must obtain eligibility and claims status information through the Provider Automated System by calling 1-800-ASK-BLUE and following the voice prompts.

Billing

P A

Claims Preprocessing Edits Claims Resolution Document updated for HIPAA 5010

Due to the upcoming implementation of the HIPAA 837P 5010 transaction, a new version of the *Claims Preprocessing Edits Claims Resolution Document (10/2011)* has been added to ibx.com. The document should be used when trying to resolve business edit rejections for HIPAA 837P 5010 transactions.

To view or print a copy of this revised worksheet, please visit *www.ibx.com/ediforms*.

If a HIPAA 837P 4010 transaction or paper claim has been submitted and rejected, use the existing *Claims Preprocessing Edits Claims Resolution Document (11/2010*) to help determine why it was rejected and provide a basis for resubmitting a clean claim.

Please note that the worksheet may be updated on a regular basis to reflect new error codes and claims resolution instructions. This document is intended to provide guidance on current billing submission errors we have encountered.

For additional assistance, contact the EDI Business Help Desk at 215-241-2305.

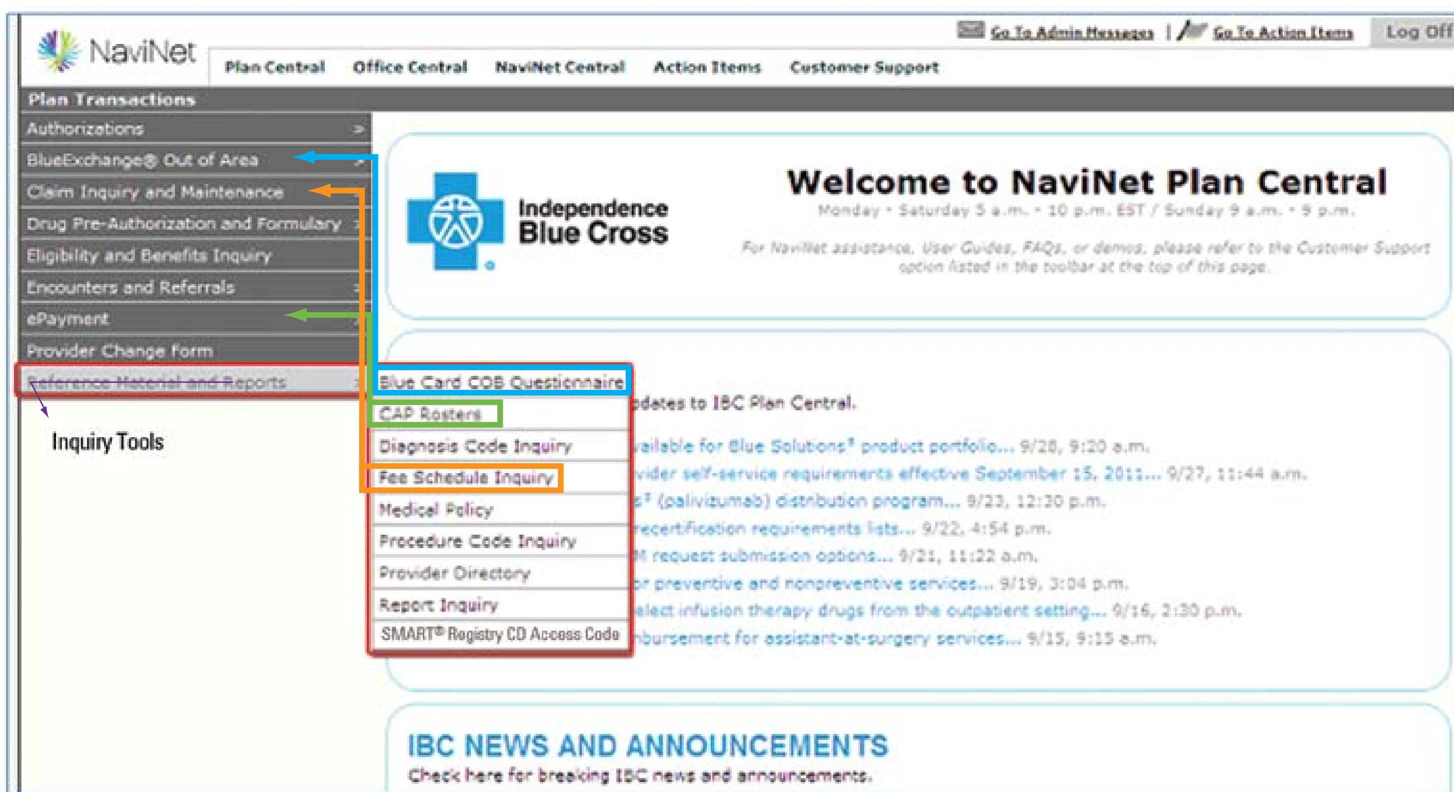
PFA

NaviNet Plan Transactions menu options to change

In an effort to enhance usability, **effective December 10, 2011,** we are making the following modifications to the *Reference Material and Reports* transaction on IBC Plan Central:

- *Reference Material and Reports* will be renamed *Inquiry Tools.*
- *BlueCard® COB Questionnaire* will be moved under *BlueExchange® Out of Area.*
- *CAP Rosters* will be moved under *ePayment.*
- *Fee Schedule Inquiry* will be moved under *Claim Inquiry and Maintenance.*

The screenshot below shows where the existing options, all currently available under *Reference Material and Reports*, will be located.



We hope that these changes will make it easier for you to locate these important transactions. If you have any questions, please contact NaviNet customer service at 1-888-482-8057 or our eBusiness Provider Hotline at 215-640-7410.

The transition to ICD-10 and the impact on providers

a message from the

Independence Blue Cross Network Medical Directors

Dear Valued Provider and Office Staff:

The mandated transition to ICD-10 represents one of the biggest challenges in health care history, as the change is far-reaching and affects a number of entities in the health care industry. Increasing the number of codes from approximately 24,000 ICD-9 codes to over 140,000 new ICD-10 codes will not be an easy task and will require significant upgrades to systems and processes for payers and providers. Therefore, it is important that preparation begin now to comply with the mandated ICD-10 implementation date of October 1, 2013.

Beyond the ability to diagnose diseases on a more granular level, increasing the number of diagnosis codes has many additional benefits for providers, including reducing payment errors, speeding up the reimbursement process throughout the industry, and the possibility of enhancing quality measurement and research to inform changes in health care.

A number of negative scenarios could potentially affect the workflow of providers who are not prepared to implement ICD-10 codes by October 1, 2013. Examples include:

- rejection of claims payments;
- coding and billing backlogs;
- inaccurate/incomplete clinical metrics and pay-for-performance reporting that does not meet peer standards.

Providers can prepare for the transition and avoid being negatively affected by taking inventory of changes required at their practice, such as evaluating business and IT efforts that are involved (e.g., required upgrades to practice management software). The Centers for Medicare & Medicaid Services (CMS) has established recommended timelines for small and large provider offices to comply with the ICD-10 implementation date of October 1, 2013. Visit *www.cms.gov/ICD10/03_ICD-10andVersion5010ComplianceTimelines.asp* to review these CMS timelines. Providers are encouraged to use these timelines to gauge their readiness level.

IBC is committed to sharing information with providers about the mandatory transition to the ICD-10 code sets. As part of that effort, we will continue to publish articles in upcoming editions of *Partners in Health Update* that focus on various transition-related requirements and our plans to comply with the mandated transition. Providers can also find information about the ICD-10 transition by visiting *www.ibx.com/icd10*. If you have any questions about our transition to ICD-10, please email them to *ICD10@ibx.com*.

Thank you for your participation in our network and your efforts to prepare for this transition.

Sincerely,

Ronald J. Brooks, M.D. Senior Medical Director	Steven J. Brown, M.D. Medical Director	Dale M. Mandel, M.D. Medical Director

PFA

Policy notifications posted as of October 27, 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 October 27, 2011.

Policy effective date	Notification title	Notification issue date
October 26, 2011	**11.08.14f** Removal of breast implants	September 26, 2011
October 27, 2011	**00.10.18g** Modifiers for Assistant-at-Surgery Services: 80, 81, 82, and AS	July 29, 2011
October 28, 2011	**07.00.21d** Allergy Immunotherapy	September 28, 2011
October 28, 2011	**11.02.17c** Endovascular Stent-Graft Repair of the Thoracic Aneurysm and Dissection	September 28, 2011
October 28, 2011	**06.02.01d** Lyme Disease: Diagnosis and Intravenous (IV) Antibiotic Treatment	September 28, 2011
October 28, 2011	**12.04.02b** Nonemergency Ambulance Transport Services	September 28, 2011
November 9, 2011	**05.00.21h** Durable Medical Equipment (DME)	October 10, 2011
November 9, 2011	**05.00.42d** Patient Lifts	October 10, 2011
November 9, 2011	**05.00.71** Standing Frames	October 10, 2011
November 11, 2011	**10.00.02a** Day Rehabilitation	October 12, 2011
November 11, 2011	**07.05.07** Drug-Eluting Beads and Bland Embolization for the Treatment of Hepatic Malignancies	October 12, 2011
November 11, 2011	**07.03.03d** Medical Evaluation and Management for Attention-Deficit Hyperactivity Disorder (ADHD)	October 12, 2011
November 16, 2011	**03.00.32** Modifier 52 Reduced Services	August 18, 2011
January 1, 2012	**07.03.14e** Inoperative Neurophysiological Monitoring (INM)	October 3, 2011
January 10, 2012	**05.00.56e** Hospital Beds and Accessories	October 14, 2011
January 11, 2012	**08.01.04** Preventive Immunization	October 13, 2011
January 24, 2012	**08.00.62d** Abatacept (Orencia®) for injection for intravenous use	October 26, 2011
January 24, 2012	**11.08.15m** Reconstructive Breast Surgery	October 26, 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.

P

Specialists needed to assist in developing medical policies

IBC is currently recruiting physicians to participate in the review of medical policies related to a number of medical specialties. These physicians would be responsible for evaluating and providing feedback on the scientific evidence and local standards of care addressed in our medical policies. Medical policies are research-based documents that allow us to evaluate the medical necessity of services, devices, drugs and biologics, and procedures for our members. In addition, medical policies provide guidelines for obtaining benefits and reimbursement in accordance with the member's benefits plan.

As a consultant, you will evaluate proposed medical policies based on your areas of expertise and be paid a consulting fee. Your contributions will significantly impact the medical policies that IBC establishes, which affect the delivery of health care in our region.

At this time, IBC is seeking physician consultants in the following specialties:

- cardiology
- interventional radiology
- medical genetics
- pain management
- radiation and medical oncology

Qualifications

To qualify as a consultant, you must:

- maintain board certification in each specialty for which you wish to consult;
- maintain an active clinical practice in each specialty for which you wish to consult;
- understand and agree to our conflict of interest statement, which is available upon request prior to participation and is reviewed and reaffirmed annually;
- understand and agree to our confidentiality statement;
- maintain a high ethical standard, evidenced by the absence of any IBC investigation into personal or group claims practices.

Become a consultant

If you meet these criteria and are interested in sharing your expertise as a consultant, please submit your curriculum vitae by email to *medical_policy@ibx.com* or by mail to:

George S. Fenimore, MSN, RN
Director, Medical & Claim Payment Policy
Independence Blue Cross
1901 Market Street, 32nd floor
Philadelphia, PA 19103

PFA

Benefits changes and clarifications for commercial members

Effective January 1, 2012, unless otherwise noted, the following member benefits changes and clarifications will be implemented for several commercial programs for Pennsylvania members:

Type of service	Plans affected	Change/clarification
Air or ground ambulance	All HMO, All POS, All DPOS	Language is being added to this benefit to permit HMO/POS members to be transferred back into the service area via air or ground ambulance for covered rehabilitative care after an out-of-area emergency.
Appeals	All HMO, All POS, All DPOS, All PPO, Traditional	Language is being revised to comply with Health Care Reform.
Benefit period calendar year vs. contract year	All HMO, All POS, All DPOS, All PPO	Language is being clarified to clearly state whether the group's benefit period is the contract year or calendar year in the group and member's Schedule of Benefits and that a calendar year is from January 1 through December 31.
Capitated laboratory services	All HMO, All POS, All DPOS	Language is being added to clarify that laboratory services are covered capitated services.
Dependents to 26	All HMO, All POS, All DPOS, All PPO, Traditional	Language is being revised in our policy for removing dependents who have reached the maximum age.
Discretionary language	All HMO, All POS, All DPOS, All PPO, Traditional	Language is being added to clarify that IBC has the discretion to interpret benefit plans and to determine whether or not a member is entitled to benefits.
Durable medical equipment — safety equipment	All HMO, All POS, All DPOS, All PPO	Language is being added to clarify that "equipment for safety" is not considered durable medical equipment because it is not primarily medical in nature and is not covered.
Genetic testing	All HMO, All POS, All DPOS, All PPO	Language is being clarified to bring it into alignment with the evolving field of genetic testing.
Medical Policy defined	All HMO, All POS, All DPOS, All PPO	Language is being added to clarify that Medical Policy is used to determine whether covered services are medically necessary.
Nutrition counseling and diabetic education *Effective December 1, 2011*	All HMO	Language is being revised to state that HMO referral requirements for nutrition counseling and diabetic education are being removed.

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Benefits changes and clarifications for commercial members (continued)

Type of service	Plans affected	Change/clarification
Preventive care immunizations	All HMO, All POS, All DPOS, All PPO	Language is being added to state that a full list of pediatric and adult immunization schedules can be found by accessing the Advisory Committee on Immunization Practices website.
Reliable Evidence	All HMO, All POS, All DPOS, All PPO	Language is being added to clearly identify what is considered appropriate Reliable Evidence in determining whether a drug, biological, product, device, medical treatment, or procedure is Experimental/Investigational.
Retroactive terminations *Effective March 1, 2012*	All HMO, All POS, All DPOS, All PPO, Traditional	Language is being revised to reflect the changes to the period of time in which IBC will retroactively terminate members.
Rosa's Law — Federal mandate	All HMO, All POS, All DPOS, All PPO, Traditional	Language will comply with Federal law that requires that the terms "mental retardation" and "retarded" be replaced with the term "intellectual disability."

If you have questions regarding these benefits changes and clarifications, please call Customer Service at 1-800-ASK-BLUE.

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 can be verified by calling Customer Service at 1-800-ASK-BLUE.

PFA

Reminder: Introducing Keystone 65 Select HMO

In 2012, we are introducing a new Medicare Advantage plan — Keystone 65 Select HMO. This new plan will be offered in addition to Keystone 65 Preferred HMO and Personal Choice 65℠ PPO (in Philadelphia and Bucks counties only). Keystone 65 Advantage HMO will no longer be offered after December 31, 2011.

Members currently enrolled in the discontinued Keystone 65 Advantage HMO plan were recently sent an Annual Notice of Change/Evidence of Coverage (ANOC/EOC) explaining that they will be moved into the Keystone 65 Preferred HMO plan starting January 1, 2012. These members, like all Medicare beneficiaries, can enroll in a new plan for 2012 any time between October 15 and December 7. We encourage these Keystone 65 Advantage HMO members to consider the new lower-cost Keystone 65 Select HMO for their 2012 health care needs.

Keystone 65 Select HMO benefits highlights

Service	Cost to member
Primary care physician	$20 copayment
Specialist	$45 copayment
Emergency room	$50 copayment (not waived if admitted)
Outpatient surgery (performed in an ambulatory surgical center)	$100 copayment (per date of service)
Outpatient surgery (performed in a hospital setting)	$350 copayment (per date of service)
Inpatient hospital	$215 copayment/day for days 1-8 ($1,720 per stay maximum); $0 copayment/day for 9+ days; unlimited days each benefit period
Hearing, dental, vision	Benefits package available for additional $10 per month in plan premiums

Note: All Keystone 65 HMO and Personal Choice 65 PPO plans will include the SilverSneakers® fitness benefit in 2012.

Please contact your Network Coordinator if you have any questions.

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

PFA

Upcoming Medicare Advantage HMO and PPO benefits changes

Effective January 1, 2012, there will be several changes to our current Medicare Advantage HMO and PPO plans in addition to the introduction of our new limited network HMO plan, Keystone 65 Select HMO. The following tables highlight some of these changes. Please note that this is a list of our significant benefits changes, not a comprehensive list of all benefits changes.

Keystone 65 Preferred HMO benefits changes

Benefit	Keystone 65 Preferred HMO	
	Current	Changes for 2012
Smoking and tobacco use cessation	Not covered	No copayment
Diabetes screening	Not covered	No copayment
Inpatient hospital care	$175 copayment per day, days 1-8; $1,400 maximum per stay	$190 copayment per day, days 1-8; $1,520 maximum per stay
Skilled nursing facility care	$20 copayment per day for days 1-20 $100 copayment per day for days 21-100	$30 copayment per day for days 1-20 $110 copayment per day for days 21-100
Physician services, including doctor's office visit	$15 copayment for each primary care physician office visit	$10 copayment for each primary care physician office visit.
Outpatient hospital services	$150 copayment in ambulatory surgical center $300 copayment in outpatient hospital facility	$100 copayment in ambulatory surgical center $350 copayment in outpatient hospital facility
Urgently needed care	$15 - $40 copayment	$10 - $40 copayment
Radiation therapy	$25 copayment	$40 copayment
Complex radiology	$80 copayment for complex radiology, which includes MRI/MRA, CTA/CT scans, PET scans, and nuclear cardiology studies	$100 copayment for complex radiology, which includes MRI/MRA, CTA/CT scans, PET scans, and nuclear cardiology studies

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Upcoming Medicare Advantage HMO and PPO benefits changes (continued)

Personal Choice 65℠ PPO benefits changes

Benefit	In-network		Out-of-network	
	Current	Changes for 2012	Current	Changes for 2012
Smoking and tobacco use cessation	Not covered	No copayment	Not covered	No copayment
Diabetes screening	Not covered	No copayment	Not covered	No copayment
Primary care visit	$20 copayment	$10 copayment	Member responsible for 30% of charges after $500 deductible is met	Member responsible for 30% of charges after $500 deductible is met
Outpatient hospital services	$125 copayment in ambulatory surgical center $250 copayment in outpatient hospital facility	$100 copayment in ambulatory surgical center $350 copayment in outpatient hospital facility	Member responsible for 30% of charges after $500 deductible is met	Member responsible for 30% of charges after $500 deductible is met
Ambulance services	$100 copayment	$75 copayment	$100 copayment	$75 copayment
Urgently needed care	$20 - $40 copayment	$10 - $40 copayment	$20 - $40 copayment	$10 - $40 copayment

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Upcoming Medicare Advantage HMO and PPO benefits changes (continued)

Optional supplemental benefits package available to Keystone 65 Select HMO members

Our new Keystone 65 Select HMO members will have the option to purchase the Choice Program, an optional supplemental benefits package, for an additional $10 a month. The optional supplemental benefits package will cover vision, dental, and hearing, as these benefits are no longer included for Keystone 65 Select HMO members. See the table below for details about the supplemental benefits package.

Covered services	Member pays
Dental services — Preventive dental	
One exam and cleaning every six months	$15 copayment
Hearing services	
Non-Medicare-covered routine hearing exams, including fitting and evaluation for two hearing aids, covered every three years	$45 copayment for non-Medicare-covered hearing exams and evaluation
Medicare-covered hearing exams	$45 copayment for Medicare-covered hearing exams and evaluations
Hearing aids, covered every three years	Up to $500 for two hearing aids
Vision care	
Non-Medicare-covered routine eye exams, every two years	$0 copayment for routine eye exams, once every two years
Eyewear not covered by Medicare, every two years	$100 for eyewear

Note: Vision, dental, and hearing are still included in the benefits packages for Keystone 65 Preferred HMO and Personal Choice 65 PPO members.

Please contact your Network Coordinator if you have any questions about these 2012 benefits changes for Medicare Advantage HMO and PPO members.

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2011–2012 Clinical Practice Guideline Summary now available

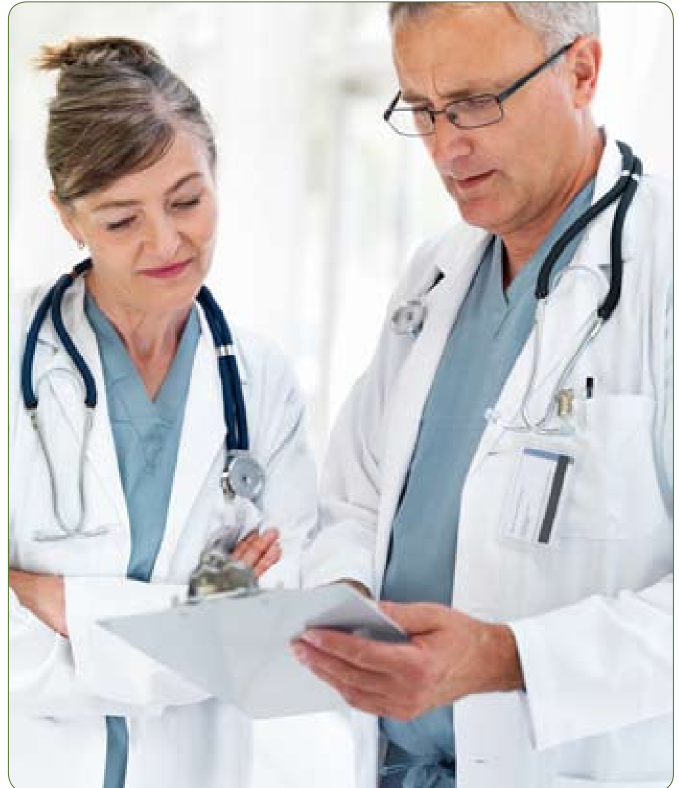
We recently posted the *2011–2012 Clinical Practice Guideline Summary,* which replaces the previous version. The new summary includes a listing of all Clinical Practice Guidelines adopted by IBC that are considered the accepted minimum standard of care in the medical profession. Adherence to these guidelines may lead to improved patient outcomes.

Individual clinical decisions should be tailored to specific patient medical and psychosocial needs. As national guideline recommendations evolve, please update your practice accordingly. The summary provides the reference for each condition and links directly to the guidelines.

We update the guidelines annually based on changes made to nationally recognized sources. Changes are reviewed by internal and external consultants, as appropriate, and by the IBC Quality Committee, which is comprised of network physicians.

In comparison to guidelines from the previous year, the *2011–2012 Clinical Practice Guideline Summary* focuses more on disease management in accordance with the National Committee for Quality Assurance (NCQA) standards. Preventive health guidelines, which were previously included, can be found in our Member Wellness Guidelines. Also, the *Spirometry Guide for Health Care Professionals*, as provided by the Global Initiative for Chronic Obstructive Lung Disease (GOLD), has been added to the summary.

You can access the *2011–2012 Clinical Practice Guideline Summary* at *www.ibx.com/clinicalguidelines*, or you can call the Provider Supply Line at 1-800-858-4728 to request a hard copy of the summary or any of the individual guidelines.



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2011–2012 Clinical Insights now available

The *2011–2012 Clinical Insights: Effective Care for Patients with Chronic Conditions (Clinical Insights)* was recently posted. *Clinical Insights* highlight topics that Health Coaches from the Connections^{SM} Health Management Program may discuss with members who have the following conditions:

- asthma
- permanent (chronic) atrial fibrillation
- chronic obstructive pulmonary disease
- coronary heart disease
- diabetes mellitus
- heart failure
- primary and secondary stroke prevention

Information for each condition is extracted directly from the Clinical Practice Guidelines.

You can access *Clinical Insights* on our website at *www.ibx.com/clinicalguidelines*, or you can call the Provider Supply Line at 1-800-858-4728 to request a hard copy.

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Connections℠ Program Provider Satisfaction Survey available November 4

The Connections℠ Health Management Program is pleased to announce that the annual Connections Program Provider Satisfaction Survey will be available November 4, 2011.

We've updated the survey to ask your opinion of the program's impact on patients' use of services, including emergency department services, inpatient hospital services, tests and procedures, and physician visits. The annual survey gives you the opportunity to tell us what you think of Connections, which may help us improve program services in the future.

Other questions will assess:

- your overall satisfaction with access to and interactions with the Connections staff;
- how Connections affects your patients' health status relative to their target condition;
- how Connections affects your patients' health status and treatment plan adherence;
- your satisfaction with the frequency of communication from Connections.

Visit *http://providersurveys.com/IBC2011* starting November 4 to take the survey online. If you have any problems with the online survey or need a paper copy, please contact a Connections Provider Specialist at 1-866-866-4694.

We encourage you to take the Connections survey, and thank you in advance for your participation.

Connections℠ 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 prior authorization Fax	1-888-678-7012 1-888-671-5285
Direct Ship Specialty Pharmacy Program Fax	1-888-678-7012 1-888-671-5285
Mail order program toll-free fax	1-877-228-6162
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
Mail order program toll-free fax	1-877-344-1318
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