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Articles designated with an orange arrow include notice of changes or clarifications to administrative policies and procedures.
Expanded infant sleep guidelines from the AAP

The American Academy of Pediatrics (AAP) has expanded the guidelines for infant sleep safety and sudden infant death syndrome (SIDS) risk reduction. The expanded recommendations include a series of 18 guidelines for parents, health care providers, and other caregivers to create a safe sleep environment for infants.

The complete list of recommended guidelines is available at www.healthychildren.org/safesleep.

New ACIP guidelines for pertussis vaccine

The Advisory Committee on Immunization Practices (ACIP) has recently changed its recommendation for Tdap and pregnancy. The ACIP recommendations now include administering Tdap after 20 weeks gestation instead of postpartum, since pregnancy registries have determined that there is no adverse effect and that fewer newborns contract pertussis if their mothers are vaccinated antepartum.

The complete list of recommended guidelines is available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6041a4.htm?s_cid=mm6041a4_w.
**Announcements**

**IBC network medical directors launch physician-to-physician email platform**

Many participating providers have expressed an interest in receiving direct physician-to-physician communications on behalf of IBC. Based on this feedback, we are excited to announce that the IBC Network Medical Directors (Ronald Brooks, M.D., Steven Brown, M.D., and Dale Mandel, M.D.) have recently launched a new physician-to-physician email platform.

This new platform will provide direct, clear, and succinct messaging that will assist physicians in providing quality care to our members. Email topics may include policy and billing changes, important upcoming mailings (e.g., QIPS), notifications regarding future fee schedule updates, details about our Quality Performance Measure score program, and more. In addition, emails will also include useful resources, including important IBC contact information, links to the NaviNet® web portal, and the most recent editions of *Partners in Health Update*.

The Network Medical Directors will only send an email when there is significant information of value to IBC-participating physicians. The physician-to-physician emails serve to highlight recent mailings/postings or changes that are pertinent to our participating providers.

Please note: The Network Medical Directors email platform is intended for IBC-participating physicians. IBC maintains a broader email distribution list for both providers and office staff for general IBC-related news and announcements. Participating providers and office staff can sign up for this separate email list by going to the Contact Information page at [www.ibx.com/providers](http://www.ibx.com/providers).

The process for joining the IBC Network Medical Directors email list is quick and easy. All participating providers are welcome to join, and providers can opt out at any time. We encourage you to pass this information along to all interested IBC-participating colleagues.

Visit [http://tinyurl.com/ibc-email](http://tinyurl.com/ibc-email) to join the Network Medical Directors Physician-to-Physician Email list or simply click the image to the left and enter the required information.

**Change to mass adjustments for outpatient fee schedule changes for IBC member claims**

In accordance with direction from the Blue Cross and Blue Shield Association (BCBSA), mass adjustments for outpatient fee schedule changes for IBC member claims will no longer directly crossover from the Centers for Medicare & Medicaid Services to IBC.

When you receive the remittance advice from Medicare, you will be able to confirm whether the claim has been automatically forwarded (crossed over) to IBC. If the remittance indicates that the claim was not crossed over, submit the claim to IBC electronically with Frequency Code 7 to indicate the claim is a replacement of a prior claim.

The following are additional frequency codes that you may need when submitting a claim:

- Frequency Code 5: For late charges only
- Frequency Code 8: Void/cancel a prior claim

Please contact your Network Coordinator if you have any questions about this change.
ClaimCheck® upgrade 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.

Recent upgrade

In an effort to maintain an enhanced level of transparency, the ClaimCheck® software was upgraded from version 9.0.47 to 9.0.48 effective November 14, 2011. This upgrade applies to all contracted providers who deliver professional services to members and bill 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. Edits are based on recommendations (sourced) by 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. This 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 ClaimCheck® with respect to the subject of that claim payment policy.

Detailed disclosures of all ClaimCheck® code edits are available through Clear Claim Connection™, which is accessible through the NaviNet® web portal Monday through Saturday from 5 a.m. to 10 p.m. and Sunday from 9 a.m. to 9 p.m. If you have any questions about ClaimCheck® or Clear Claim Connection™, please contact your Network Coordinator.

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.
Information about Keystone 65 Select HMO available online

Resources are available online for providers with questions about the new Keystone 65 Select network.

IBC is now offering Keystone 65 Select HMO to Medicare Advantage members. The Keystone 65 Select HMO product, which is effective January 1, 2012, does not include all hospitals or providers participating in our current Medicare Advantage HMO network.

For more information on the Keystone 65 Select network, visit www.ibx.com/providers/k65select. This website includes information on the new network, including:
- eligibility requirements for participation in the Keystone 65 Select network;
- a list of the Keystone 65 Select participating hospitals;
- a list of the Keystone 65 Select capitation sites;
- a link to the Keystone 65 Select Network Hospital Privileges Attestation form.

For more specific information about the Keystone 65 Select HMO product, visit www.ibxmedicare.com.

Attention: Changes to the Provider Automated System postponed until mid-December

In the November edition of Partners in Health Update, we announced that we would be updating our interactive Provider Automated System, available through 1-800-ASK-BLUE.

Please note that these updates have been delayed until mid-December due to the need for further testing. We will update you on our progress in the IBC News & Announcements section on the NaviNet® web portal as well as in the next edition of Partners in Health Update.

Rest assured that we’re working hard towards the finalization of the updated system, which will help you to obtain the information you need quickly and efficiently. Thank you for your understanding during this transition.

Professional Injectable and Vaccine Fee Schedule updates effective January 1, 2012

Effective January 1, 2012, 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 January 1, 2012, through NaviNet®. To do so, select Claim Inquiry and Maintenance from the Plan Transactions menu, and then select Fee Schedule Inquiry.

If you have any questions about the updates, please contact your Network Coordinator.
Reminder: Authorization submission requirements through NaviNet

As previously communicated in Partners in Health Update, all provider groups were to have all site locations NaviNet-enabled by January 1, 2011, in order to initiate the following authorization types through the NaviNet® web portal:

- medical/surgical procedures
- cardiac rehabilitation*
- chemotherapy/infusion
- durable medical equipment
- emergency hospital admission notification
- home health
  - dietitian
  - home health aide
- occupational therapy
- physical therapy
- skilled nursing
- social work
- speech therapy
- home infusion
- outpatient speech therapy
- pulmonary rehabilitation*
- sleep studies*

Please note that the representatives at the Health Resource Center are no longer able to initiate the authorizations listed above.

Tips for submitting authorizations

NaviNet submissions that result in a pended status can take up to two business days to be completed. These may include requests for additional clinical information as well as requests that may result in a duplication of services. If the authorization remains pended beyond two business days, or if the authorization request is urgent, providers should call 1-800-ASK-BLUE for assistance.

Requests for medical/surgical procedures can be made up to six months in advance on NaviNet, and in most cases, requests for medically necessary care are authorized immediately.

In some instances, providers can modify the date of service previously approved by selecting Authorizations from the Plan Transactions menu and then Authorization Status Inquiry.

About NaviNet

For your convenience, NaviNet is available to all participating providers Monday through Saturday, 5 a.m. to 10 p.m., and Sunday, 9 a.m. to 9 p.m. If your office location has not yet registered for NaviNet, go to 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 submit authorizations, please call the eBusiness Provider Hotline at 215-640-7410.

*As of January 1, 2012, these services will no longer require authorization.

Note: This information does not apply to providers contracted with Magellan Behavioral Health, Inc. Magellan-contracted providers should contact their Magellan Network Coordinator at 1-800-866-4108 for authorizations.

Magellan Behavioral Health, Inc., an independent company, manages mental health and substance abuse benefits for most IBC members.
ICD-10 readiness for IBC-participating facilities

IBC is keeping providers informed about our transition to the new ICD-10 code sets and is actively looking to obtain feedback from facilities and providers about their plans to comply with the mandate.

On October 5 and October 11, 2011, IBC hosted focus groups to discuss the ICD-10 transition. ICD-10 representatives from IBC-participating facilities were invited to participate in a lunchtime discussion where they shared their plans and challenges while preparing for the transition.

There were a number of common challenges discussed among the focus group attendees that each facility is facing while preparing for the transition to the new code sets. A few of those challenges include:

- Assessment and implementation of staff resources needed for various ICD-10 work streams;
- Assessment of the financial impact involved with upgrading systems and processes;
- Physician education and adoption of increased specificity for clinical documentation;
- Coder retention, training, and certification in ICD-10.

Feedback received from the focus groups determined that IBC facilities are in various stages of ICD-10 readiness, ranging from assessing the impact of ICD-10 to systems and processes (e.g., working with a vendor to perform gap analyses), to beginning work on the required changes (e.g., working with a practice management software vendor to ensure systems are ICD-10 compliant).

IBC plans to host follow-up ICD-10 focus groups in early 2012 to monitor the progress of facility ICD-10 readiness and to continue to share information that may be helpful for overcoming additional challenges.

ICD-10 cash flow tips by Wells Fargo

The financial impact of ICD-10 is one of the many shared concerns of facilities and providers. In an effort to address some of the financial impacts of the transition, Wells Fargo created ICD-10 cash flow tips for the Healthcare Information and Management Systems Society (HIMSS). Visit www.himss.org and search “Wells Fargo” for a PDF of the tip sheet.

Countdown to ICD-10

Begin the countdown to the ICD-10 implementation date of October 1, 2013, by downloading an ICD-10 countdown clock to your facility or provider office website. Visit www.aapc.com/ICD-10/widgets/add-countdown-widget.aspx to download the free ICD-10 countdown clock created by the American Association of Professional Coders (AAPC). You can also download an ICD-10 timeline widget by visiting www.cms.gov/ICD10/03_ICD-10andVersion5010ComplianceTimelines.asp. The timeline widget, created by the Centers for Medicare & Medicaid Services, is available for free download to your desktop or mobile device. The timeline widget also can be shared by email, social media channels, and/or embedded on your office website.

For more information about IBC’s transition to ICD-10, visit www.ibx.com/icd10.

HIPAA 5010

IBC follows CMS lead with HIPAA 5010 90-day enforcement grace period

Consistent with the recent statement issued by the Centers for Medicare & Medicaid Services (CMS), IBC will be observing a 90-day grace period for enforcement of the new HIPAA 5010 transaction standards.

The original rule from the United States Department of Health and Human Services (HHS) stipulated that any health care entity that submits electronic standard transactions must comply with HIPAA 5010 (errata version) by January 1, 2012. IBC will comply with the HHS rule to move to 5010 standards. However, IBC will continue to accept and remit 4010A transactions past the original compliance date of January 1, 2012, through the recommended 90-day enforcement grace period. This grace period will expire on March 31, 2012. In addition, we will accept HIPAA 5010 (errata version) transactions beginning with the original compliance date of January 1, 2012.

If you are not prepared to issue and accept HIPAA 5010 compliant transactions by March 31, 2012, you may be adversely affected by conversion activities initiated by IBC and/or your trading partners. We encourage you to continue working with your trading partners to ensure your preparedness and to avoid any negative outcomes during this transition.

If you have any questions concerning your preparedness for the transition to 5010, please contact your trading partners.
## Policy notifications posted as of November 23, 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 November 23, 2011.

<table>
<thead>
<tr>
<th>Policy effective date</th>
<th>Policy No.</th>
<th>Notification title</th>
<th>Notification issue date</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 16, 2011</td>
<td>03.00.32</td>
<td>Modifier 52 Reduced Services</td>
<td>August 18, 2011</td>
</tr>
<tr>
<td>December 9, 2011</td>
<td>00.01.47a</td>
<td>Inpatient Hospital Readmission</td>
<td>November 9, 2011</td>
</tr>
<tr>
<td>December 9, 2011</td>
<td>05.00.43d</td>
<td>Seat Lift Mechanisms</td>
<td>November 9, 2011</td>
</tr>
<tr>
<td>December 22, 2011</td>
<td>05.00.14f</td>
<td>High Frequency Chest Wall Oscillation Devices</td>
<td>November 22, 2011</td>
</tr>
<tr>
<td>December 23, 2011</td>
<td>00.01.25m</td>
<td>PPO Network Rules for Provision of Specialty Services for Durable Medical Equipment and Laboratory, Radiology, and Physical Medicine and Rehabilitative Services</td>
<td>November 23, 2011</td>
</tr>
<tr>
<td>January 1, 2012</td>
<td>07.03.14e</td>
<td>Intraoperative Neurophysiological Monitoring (INM)</td>
<td>October 3, 2011</td>
</tr>
<tr>
<td>January 10, 2012</td>
<td>05.00.56e</td>
<td>Hospital Beds and Accessories</td>
<td>October 14, 2011</td>
</tr>
<tr>
<td>January 11, 2012</td>
<td>08.01.04</td>
<td>Preventive Immunization</td>
<td>October 13, 2011</td>
</tr>
<tr>
<td>January 24, 2012</td>
<td>08.00.62d</td>
<td>Abatacept (Orencia®) for injection for intravenous use</td>
<td>October 26, 2011</td>
</tr>
<tr>
<td>January 24, 2012</td>
<td>11.08.15m</td>
<td>Reconstructive Breast Surgery</td>
<td>October 26, 2011</td>
</tr>
</tbody>
</table>

To view the policy notifications, go to [www.ibx.com/medpolicy](http://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.

### Reminder: Change to anesthesia claims payment methodology calculation

As previously communicated, for claims processed on or after July 1, 2011, anesthesia time units reported in minutes are divided by fifteen minutes and rounded to one decimal place (e.g., 16 minutes = 1.1 units), replacing the previous process of rounding to the next whole number (e.g., 16 minutes = 2 units).

This change is reflected in Claim Payment Policy #00.01.14i: Reporting and Documentation Requirements for Anesthesia Services. This policy has been available for review by providers and their office staff since it was posted on our website as a notification on April 1, 2011, and became effective on July 1, 2011. The claim payment policy for reporting and documentation requirements for anesthesia services is available at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).
Precertification process change for certain infusion therapy drugs

As part of our continuing efforts to improve the quality and affordability of health care, we are making important changes to the precertification process for our members who receive the following infusion therapy drugs:

- alglucerase (Ceredase®)
- imiglucerase (Cerezyme®)
- velaglucerase alfa (VPRIV®)
- eculizumab (Soliris®)

Effective January 1, 2012, all precertification requests for these drugs will be reviewed to determine if members are receiving them in the setting that is cost-effective, safe, and clinically appropriate for their medical needs. This decision is based on factors such as, but not limited to:

- the setting that has been determined to be both cost-effective and safe for the member;
- the level of care required by the member based on his or her medical history and current health status;
- recommendations from the drug manufacturer;
- current standards in medical practice.

Typically, administration of the infusion therapy drugs listed above should only occur in an outpatient facility or hospital when patients are receiving an initial dose of one of these drugs, or for those who have a history of treatment-related adverse effects that require monitoring. Aside from these exceptions, most patients can safely receive these drugs in either a provider's office or in their home through a home infusion provider.

Administering drugs in the office or at home

The following options are available for administering these drugs in a provider's office or in the member's home:

- Buy and bill. Providers can buy the drug and bill the health plan for reimbursement once the drug has been given to the member.
- Home infusion therapy. Many members prefer the convenience of receiving infusion therapy drugs in their home through a home infusion provider. Providers should discuss this option with their IBC patients, when appropriate.

Requesting administration in an outpatient facility or hospital

Providers who request coverage for administration of these drugs in an outpatient facility or hospital will be asked during precertification to provide details about the member’s medical history to support the request. A team of IBC medical directors and nurses will review the submitted documentation and determine whether coverage in these settings is approved.

Impacts to coverage

IBC will continue to cover these drugs and all services associated with their administration when both of the following requirements are met:

- The member meets the medical necessity criteria outlined in the applicable medical policy.
- The drug is given in the setting that has been approved by IBC as part of the precertification review process.

Please call Customer Service at 1-800-ASK-BLUE if you have any questions about setting options for these infusion therapy drugs. Customer Service can also assist you with home infusion options.
Upcoming benefits change for progesterone in oil

Progesterone in oil, a standard injectable medication, is currently covered for our members under their pharmacy benefit. Effective January 1, 2012, progesterone in oil will no longer be covered under the pharmacy benefit and will only be covered under the medical benefit. This change is being made because this medication is not considered a self-injectable and therefore should not be covered under the pharmacy benefit.

Our Pharmacy Services department will work with providers who have prescribed this injectable to a member to obtain a new prescription and start the member in the Direct Ship Injectables Program. This voluntary program is available for your patients who have their medical benefits through an IBC managed care program. It facilitates the shipment of injectable medications like progesterone in oil to your office or the member’s home (members may continue to self-administer at your discretion). Providers may also opt to supply the drug and bill the plan directly.

For more information about the direct ship option, go to www.ibx.com/directship. Please call Customer Service at 1-800-ASK-BLUE if you have any questions about this change.

Brand Lipitor® available to members through May 2012

On November 30, 2011, the generic form of Lipitor, called atorvastatin, became available. Through a special program with Lipitor’s manufacturer, IBC commercial members can continue to obtain brand Lipitor at the same level of cost-sharing they pay for generic drugs. This limited time program is in place for a six-month period, from November 30, 2011, to May 31, 2012.

Members who are currently taking Lipitor received a letter in early November that informed them of the program details. These members will also receive a letter in May as the program concludes to remind them of the program’s end date.

Once the program ends

Starting June 1, 2012, members who have been prescribed Lipitor will be encouraged to make the switch to its generic form, atorvastatin. At that time, brand Lipitor will become a non-formulary brand medication and will only be available at the highest non-formulary level of cost-sharing.

As of June 1, 2012, members who are filling prescriptions for Lipitor should be given generic atorvastatin at their pharmacy to continue paying the lowest formulary level of cost-sharing.

Note: From November 30, 2011, to May 31, 2012, generic atorvastatin will not be covered under IBC prescription drug programs.

Our position on generic drugs

This initiative doesn’t change our position on the benefits of generic drugs. IBC remains committed to their use, as they are typically the lowest-cost option and are often prescribed as preferred alternatives to brand-name medications.
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:

<table>
<thead>
<tr>
<th>Generic drug</th>
<th>Brand drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>atovaquone/proguanil</td>
<td>Malarone®</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
<td>September 20, 2011</td>
</tr>
<tr>
<td>metformin ER</td>
<td>Fortamet®</td>
<td>7. Diabetes, Thyroid, Steroids, and Other Misc. Hormones</td>
<td>October 3, 2011</td>
</tr>
</tbody>
</table>

Brand additions

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

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juvisync™</td>
<td>7. Diabetes, Thyroid, Steroids, and Other Misc. Hormones</td>
<td>November 18, 2011</td>
</tr>
</tbody>
</table>

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

Effective January 1, 2012.

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incivek™</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
</tr>
<tr>
<td>Victrelis™</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
</tr>
</tbody>
</table>

Brand deletion

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

Effective January 1, 2012.

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Formulary therapeutic alternatives</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comtan®</td>
<td>Azilect®, amantadine, selegeline</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
</tbody>
</table>

There is no generic equivalent 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.
Prescription drug updates

For members enrolled in an IBC prescription drug program, prior authorization and quantity limit requirements will be applied to certain drugs. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. Quantity 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. The most recent updates are reflected below.

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:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Drug category</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brilinta™</td>
<td>Not available</td>
<td>Heart, Blood Pressure, &amp; Cholesterol</td>
<td>October 4, 2011</td>
</tr>
<tr>
<td>Firazyr®</td>
<td>Not available</td>
<td>Heart, Blood Pressure, &amp; Cholesterol</td>
<td>August 26, 2011</td>
</tr>
<tr>
<td>Gralise™</td>
<td>Not available</td>
<td>Pain, Nervous System, &amp; Psych</td>
<td>August 19, 2011</td>
</tr>
<tr>
<td>Incivek™</td>
<td>Not available</td>
<td>Antibiotics and Other Drugs Used for Infection</td>
<td>August 8, 2011</td>
</tr>
<tr>
<td>Lazanda®</td>
<td>Not available</td>
<td>Pain, Nervous System, &amp; Psych</td>
<td>September 30, 2011</td>
</tr>
<tr>
<td>Orencia® SQ</td>
<td>Not available</td>
<td>Bones, Joints, &amp; Muscles</td>
<td>October 4, 2011</td>
</tr>
<tr>
<td>Vicrelis™</td>
<td>Not available</td>
<td>Antibiotics and Other Drugs Used for Infection</td>
<td>August 8, 2011</td>
</tr>
<tr>
<td>Xalkori®</td>
<td>Not available</td>
<td>Cancer &amp; Organ Transplant Drugs</td>
<td>September 2, 2011</td>
</tr>
<tr>
<td>Xarelto®</td>
<td>Not available</td>
<td>Heart, Blood Pressure, &amp; Cholesterol</td>
<td>August 29, 2011</td>
</tr>
<tr>
<td>Zelboraf®</td>
<td>Not available</td>
<td>Cancer &amp; Organ Transplant Drugs</td>
<td>August 17, 2011</td>
</tr>
</tbody>
</table>

The following non-formulary drugs will be added to the list of drugs requiring prior authorization. Members taking these drugs immediately prior to the effective date are not affected:

*Effective December 1, 2011.*

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Drug category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nexiclon™ XR Suspension</td>
<td>Not available</td>
<td>Heart, Blood Pressure, &amp; Cholesterol</td>
</tr>
<tr>
<td>Tradjenta™</td>
<td>Not available</td>
<td>Diabetes</td>
</tr>
</tbody>
</table>

Drugs with quantity limits

Quantity limits will be added for the following drugs:

*Effective December 1, 2011.*

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Quantity limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dificid™</td>
<td>Not available</td>
<td>20 tablets per 10 days</td>
</tr>
<tr>
<td>Sprix®</td>
<td>Not available</td>
<td>5 bottles per 30 days</td>
</tr>
</tbody>
</table>
Resolution solution: The SilverSneakers® Fitness Program

The end of the year is approaching and your patients may be thinking about New Year’s resolutions for 2012. Among the most common resolutions are to lose weight, get in shape, and be healthier. While these are also some of the more difficult goals to attain, IBC Medicare Advantage HMO and PPO members have an excellent benefit designed to help them keep active and healthy – the SilverSneakers Fitness Program.

SilverSneakers is helping older adults all over the country experience total well-being as they get stronger, gain better balance and coordination, and expand their social network. In fact, in 2010, 57 percent of SilverSneakers participants reported their health as “excellent” or “very good” compared to only 30 percent of older adults nationally who are not enrolled in SilverSneakers.

To help members reach their goals of being healthy, feeling younger, and maintaining independence, SilverSneakers includes:

- a fitness membership at a local participating location with access to nearly 10,000 locations nationwide;
- use of basic amenities plus signature SilverSneakers classes designed specifically for older adults and taught by certified instructors;
- SilverSneakers Online, a secure members-only website with resources and tools for healthier living (www.silversneakers.com/member).

When new members sign up, they receive the SilverSneakers Fitness Program Member Handbook, which includes descriptions of some common goals and the benefits of achieving them, plus suggested SilverSneakers classes to help meet each goal. At www.silversneakers.com/member, members can create exercise and nutrition plans, watch class videos, get expert advice on fitness and nutrition, and track their progress toward goals, as well as find healthy recipes and informative articles on relevant health topics. The camaraderie among SilverSneakers members, both at the participating locations and online, also offers an excellent support system.

Help your IBC Medicare Advantage HMO and PPO patients keep their resolutions and reach their health and fitness goals. Refer them to www.silversneakers.com or 1-888-423-4632 today to find their closest SilverSneakers location and get more information about the program. Signing up is fast and easy, and they’ll be on their way to living more healthy and active years.

Note: SilverSneakers is offered to Keystone 65 Preferred HMO and Personal Choice 65SM PPO members at no 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 1-888-423-4632.

*Healthways SilverSneakers Annual Member Survey, 2010 (based on SF-12 scores)
This is not a statement of benefits. Benefits may vary based on Federal 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.
SilverSneakers is a registered mark of Healthways, Inc., an independent company.

Case management Help for your patients when they need it

Sometimes members need extra support. Registered nurse case managers and social workers from IBC are available to provide telephone support and information to your patients who are experiencing complex health issues or are facing challenges in meeting health care goals. Consider making a referral to case management if any of your patients need help with the following:

- wound care
- cancer treatment education
- complications of pregnancy
- adherence to treatment plan
- community resource information
- coordination of home care services
- complex pediatric medical conditions
- socioeconomic support (medications)
- investigation of benefits for medical equipment
- chronic condition with multiple comorbid conditions

The case manager or social worker will work with your office to find out how best to support the member in following your treatment plan.

To refer a patient to case management, call 1-800-313-8628, or complete an online referral form at www.ibx.com/case_mgmt_ref_form.
Managing bladder control problems

Approximately 13 million Americans are plagued by urinary incontinence. Although bladder control problems are not a normal part of aging, the problem is most common in older adults; in fact, one in three people age 65 and older suffers from some degree of urine leakage. Unchecked, loss of bladder control can lead to complications such as pressure ulcers and urinary tract infections. Psychological ramifications such as depression and social isolation are also common in older adults suffering from urinary incontinence. And, according to the National Quality Measures Clearinghouse, the price tag associated with the direct cost of caring for urinary incontinence is estimated to top $15 billion yearly.\(^1\)

Loss of bladder control is often easily treatable — if the physician is aware of the problem. A survey conducted by the National Association for Continence (NAFC) revealed that patients endured urinary leakage an average of 6 years before bringing the issue to the attention of a health care professional. Women in particular are reluctant to mention the subject.\(^2\) This reluctance makes it extremely important for you to bring up this topic with your older adult patients during regular office visits.

Of the treatments available for bladder control problems — pelvic floor exercises (Kegels), medication, surgery, or a combination of the three — the choice of therapy should be based on the form of urinary incontinence a person has (stress, urge, or mixed), whether the patient is male or female, and the patient's preferences and abilities.\(^3\)

Kegel exercises are effective for stress incontinence in both sexes. A recent trial published in the January 2011 issue of the Journal of the American Medical Association (JAMA) showed that men with stress incontinence following prostatectomy saw significant improvement in urinary leakage after eight weeks of combined behavioral therapy and pelvic floor exercises.\(^4\) Medications such as oxybutynin (Ditropan\(^5\)) and tolterodine (Detrol\(^6\)) that calm strong urinary urges can be used to treat overactive bladder symptoms in both men and women. However, if a man is suffering from urinary leakage due to an enlarged prostate gland, drugs such as tamsulosin (Flomax\(^7\)) and dutasteride (Avodart\(^8\)) may be appropriate for this condition. Similarly, surgery to remove part of the prostate may ease urinary problems in men.

Stress incontinence in women can often be alleviated with surgery (such as the “Burch” and “sling” procedures) to repair the pelvic support muscles.\(^9\) Another option for women with stress incontinence who are not good candidates for surgery is the injection of a bulking agent into the wall of the urethra at the bladder outlet.\(^5\) The bulking material expands the tissue around the bladder neck thus narrowing the opening and preventing urine loss. This is not a permanent solution, however, and may need to be repeated.\(^6\)

Each patient is different with unique preferences, concerns, and needs. There is not one right treatment option for everyone; therefore, it is important to discuss urinary incontinence treatments with your older adult patients. When patients need to discuss these options further, they may seek information and support from a Health Coach. Health Coaches — health care professionals such as registered nurses — from the Connections\(^\text{SM}\) Program are available to speak with your patients about the many options available to treat urinary incontinence. To learn more about the health coaching services available to your practice, call 1-866-866-4694. You can refer a member to the Connections Program by filling out a fax referral form available at www.ibx.com/providers/resources/connections/chmp.html.

References:

\(^1\) National Quality Measures Clearinghouse. Management of urinary incontinence in older adults: percentage of Medicare members 65 years of age and older who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem. www.qualitymeasures.ahrq.gov/content.aspx?id=14984


*This is not a statement of benefits. Benefits may vary based on Federal 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.*
**Important Resources**

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| **Anti-Fraud and Corporate Compliance Hotline** | 1-866-282-2707  
www.ibx.com/antifraud |
| **Care Management and Coordination**         | 215-567-3570  
1-800-313-8628* |
| Case Management                              |                                       |
| **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**                            | 215-988-1413  
www.ibx.com/credentials |
| Credentialing Violation Hotline              |                                       |
| **Customer Service/Provider Services**       |                                       |
| Provider Automated System (eligibility/claims status/referrals) | 1-800-ASK-BLUE (275-2583) |
| Connections Health Management Programs       |                                       |
| Precertification/maternity requests          |                                       |
| — Imaging services (CT, MRI/MRA, PET, and nuclear cardiology) | |
| — Authorizations                             |                                       |
| Provider Services user guide                 | 1-866-282-2707  
www.ibx.com/antifraud |
| **eBusiness Help Desk**                     | 215-241-2305 |
| **FutureScripts® (pharmacy benefits)**       | 1-888-678-7012  
1-888-671-5285 |
| Prescription drug prior authorization       |                                       |
| Fax                                          |                                       |
| Direct Ship Specialty Pharmacy Program       | 1-888-678-7012  
1-888-671-5285 |
| Fax                                          |                                       |
| Mail order program toll-free 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) | 1-888-678-7012  
www.ibx.com/rx |
| FutureScripts® Secure (Medicare Part D)      | 1-888-678-7015 |
| Formulary updates                            | 1-888-678-7015  
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