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Partners in Health Update

January 2008

Working Together For Quality Health Care

Register your NPI online with provider registration web form

Providers may now register their NPIs with IBC online by submitting an NPI provider registration web form.

Please visit *www.ibx.com/providers/npi/provider_registration.html* to register your NPI information with us.

SMART® Registry release date changed

In the December 2007 issue of *Partners in Health Update,* we announced that the next issue of the SMART® Registry would be mailed in early January 2008. Due to a production delay, providers can now expect to receive the SMART Registry in early February 2008. If you have any questions, please contact the Connections℠ Health Management Program Provider Support Line at 1-866-866-4694.

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

- Professional
- Facility
- Ancillary

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IBC's NPI contingency plan to continue through May 23, 2008

After careful assessment of provider readiness, we have determined that a significant percentage of providers have either not yet registered their NPIs with IBC, or have not begun submitting their NPIs on claims. Therefore, IBC's NPI contingency plan will continue through May 23, 2008 — the latest date allowed by the Centers for Medicare & Medicaid Services (CMS). Unless CMS announces an extension, providers must use their NPI on all claims as of May 23, 2008.

IBC's contingency plan: Dual use

The dual use strategy allows providers to submit all electronic and paper claims with NPIs and 10-digit legacy provider identifiers (IBC-assigned IDs providers use to identify themselves as an IBC-participating health care provider). If providers have registered their NPI with IBC or submitted an NPI with a CMS certification, they may continue to submit claims with their NPI and 10-digit legacy identifier, consistent with our dual use strategy.

Our dual use strategy is intended to ensure that IBC is NPI compliant, but in a manner that maintains operations, recognizes providers' varying states of readiness, and avoids unnecessary disruption in providers' cash flow.

More information about IBC's NPI dual use claims submission, including the entire IBC NPI contingency plan, electronic and paper claim submission instructions, and relevant FAQs, is available on *www.ibx.com/providers/npi.*

NPIs must be registered with IBC

NPI-only claims will reject if NPI is not registered with IBC

As previously stated in our NPI contingency plan, NPI-only claims will reject if providers have not registered their NPIs with us. IBC has the ability to accept claims with an NPI as the primary identifier if providers have registered their NPI with us. However, providers must register their NPI with IBC prior to submitting NPI-only claims.*

Once you have registered your NPI with us, please submit claims with the NPI and 10-digit legacy identifier, consistent with our dual use strategy.

In addition to all providers currently participating with IBC, NPIs will be required for new practitioners who request participation with IBC. The NPI, if not already registered, will also be requested as part of the recredentialing process.

**IBC will receive contracted Behavioral Health Providers' NPI information directly from Magellan Behavioral Health, Inc. For further information, please contact Magellan National Provider Services Center at 1-800-788-4005, or visit Magellan at www.MagellanHealth.com.*

Registering your NPIs with IBC

When providers register their NPIs with IBC, we are able to link the NPIs to existing data in our internal processing systems. To mitigate any potential impact in a provider's cash flow, we have requested that providers register their NPIs with us prior to submitting an NPI claim.

Registering your NPI with IBC is easy. Once you have obtained your NPI, you may register using either of the following methods:

- **Online.** Register your NPI online by submitting the appropriate NPI provider registration web form on *www.ibx.com/providers/npi/provider_registration.html.*
- **Paper.** Participating providers may also register their NPIs with us by mailing their completed custom NPI Submission Form. This form has been included in mailings to participating provider offices.

Contact your Network Coordinator with questions regarding the new provider registration web form or your custom NPI Submission Form.

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NATIONAL PROVIDER IDENTIFIER (NPI)

NPIs must be registered with IBC (continued)

How to obtain an NPI

National Plan and Provider Enumeration System (NPPES) is currently accepting applications for NPIs. Providers who have not yet obtained an NPI may apply for it in one of the following ways:

- **Online.** Complete the web-based application on *https://nppes.cms.hhs.gov.* It takes approximately 20 minutes to complete and is the most time-efficient method of obtaining an NPI.
- **Paper.** Providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator. The form will be available only upon request through the NPI Enumerator. Providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of the following ways:
  - Phone: 1-800-465-3203 or TTY/TDD 1-800-692-2326
  - Email: *customerservice@npienumerator.com*
  - Mail:
    NPI Enumerator
    P.O. Box 6059
    Fargo, ND 58108-6059

NPI web resources

IBC provider NPI website
www.ibx.com/providers/npi
Contains NPI background, FAQs, registration forms, web links, and other information.

CMS main NPI website
www.cms.hhs.gov/NationalProvIdentStand/
Contains NPI Final Rule, FAQs, fact sheets, tip sheets, NPI Viewlet, Medicare MedLearn articles, and enumeration statistics.

NPI enumerator website
https://nppes.cms.hhs.gov/NPPES/Welcome.do
Main site to enter an NPI application.

WEDI NPI outreach initiative
www.wedi.org/npioi/index.shtml
NPI Resource Center with information resources, industry readiness assessment survey, etc.

BILLING

Paper claims submission guidelines

Effective March 1, 2008, we will no longer accept paper claim submissions on which information has been covered with correction fluid or has been scratched out. Using correction fluid or manually scratching out information causes concerns with auditing and processing procedures and is not compliant with HIPAA regulations. Beginning March 1, 2008, any such submissions will be returned to you, and a new clean claim submission will be required.

Although not preferred, if a correction is necessary, you may line out the incorrect data, neatly print the corrected data, and initial the correction. Please be sure the correction is legible.

Please contact your Network Coordinator if you have any questions about proper paper claim submissions.

IBC rejecting paper claims submitted on forms CMS-1500 (12/90) and UB-92

IBC will no longer accept paper claims submitted on forms CMS-1500 (12/90) and UB-92. All paper claims received after December 17, 2007, must be submitted on revised forms CMS-1500 (08/05) and UB-04. Paper claims submitted on forms CMS-1500 (12/90) and UB-92 will reject after December 17, 2007.

KHPE commercial HMO/POS and PA PPO claims address changes for paper claim submissions

A change was made to the claims mailing addresses for Keystone Health Plan East commercial HMO/POS and Personal Choice®, effective November 1, 2007. The new claims mailing addresses are as follows:

Keystone Health Plan East commercial HMO/POS
P.O. Box 69353
Harrisburg, PA 17106-9353

Personal Choice
P.O. Box 69352
Harrisburg, PA 17106-9352

Please begin to use these new addresses for all your future paper claim submissions and share this information with the person that handles billing for your office.

You may contact your Network Coordinator with any questions.

Modifier 51 overpayments identified

Recently, we discovered that professional surgical claims have been erroneously overpaid for certain services. These overpayments are due to a system processing error regarding the use of Modifier 51. We are currently evaluating the issue and plan to correct the system in first quarter 2008.

What is Modifier 51?

Modifier 51 (as defined by the American Medical Association Current Procedural Terminology [CPT®*]) is used when multiple procedures — other than evaluation and management services — are performed at the same session by the same provider for the same patient. Additional procedures or services beyond the primary service should be reported with Modifier 51. Multiple surgical procedures appended with Modifier 51 are subject to standard multiple surgical reduction guidelines. Please see Claim Payment Policies *11.00.10c Multiple Surgical Reduction Guidelines* and *03.00.07d Modifier 51: Multiple Procedures* for more information on this topic.

Description of the error

Surgical procedures billed with Modifier 51 are not always following multiple surgical reduction logic. This logic should apply, which may result in these surgical services billed with Modifier 51 being reimbursed at 50 percent of the professional fee schedule allowance amount.

Next steps

We are currently reviewing the steps necessary to correct this processing error and plan to implement a fix in the first quarter of 2008. We will communicate the status of this fix in a future edition of *Partners in Health Update*.

Once we have corrected the system, we will contact impacted providers to address overpayments related to this issue.

We apologize for this processing error and are working to prevent such errors in the future.

BILLING

New payment rationale for Medicare-eligible commercial members without Medicare Part B

IBC will soon coordinate benefits for commercial members who are Medicare eligible, have not enrolled in Medicare Part B, and for whom Medicare would be the primary payer.

If a member is eligible to enroll in Medicare Part B and has not done so, IBC will pay as the secondary payer for services covered under an IBC commercial group benefit program (e.g., Personal Choice®, Keystone Health Plan East), even if the member does not enroll for, pay applicable premiums for, maintain, claim, or receive Medicare Part B benefits. This change affects any member who is Medicare eligible and for whom Medicare would be the primary payer.

It is important that you routinely ask your Medicare-eligible members to show their Medicare identification cards. If you have identified a member who is eligible to enroll in Medicare Part B, but has not done so, you may collect the amount under "Member Responsibility" on the SOR, which includes any cost-sharing (copayment, coinsurance, deductible) plus the amount Medicare would have paid as the primary payer.

Please contact Provider Services with any questions.

NAVINET®

Enhancements to NaviNet® home infusion and chemotherapy/infusion transactions

We are pleased to announce several enhancements to the NaviNet® home infusion and chemotherapy/infusion transactions, effective December 15, 2007.
The enhancements include:

- real-time approvals of transaction requests;
- the ability to request services for the duration of therapy (for chemotherapy/infusion);
- the addition of continuity of care/extension of care requests for existing authorizations (for chemotherapy/infusion).

Approvals for all requests will be dependent upon both the submission of all required information and meeting our medical policy criteria. Requests that do not include all required information or that do not meet our medical policy criteria will be forwarded to the Care Management and Coordination (CMC) department. If the request is not authorized, or requires additional information, CMC will notify you verbally and in writing.

You may continue to verify determinations and the status of authorization requests by using the *Authorization Status Inquiry* transaction. You may view our policies on *www.ibx.com/medpolicy,* or select the *Medical Policy* link on NaviNet under *Reference Material and Reports.*

Note the following:

- Please have all clinical information available when submitting authorizations.
- Home infusion providers should continue to use the applicable contracted home infusion codes.
- Use the applicable HCPCS/CPT®* code(s) when submitting requests for chemotherapy or infusion therapy authorizations. When administered in the office/outpatient settings, the applicable HCPCS code must be used for the following drugs: Aldurazyme® (J1931), Aredia® (J2430), Avastin® (J9035), Boniva® (J1740), Ceredase® (J0205), Cerezyme® (J1785), Elaprase™ (J1743), Erbitux® (J9055), Fabrazyme® (J0180), Herceptin® (J9355), Intravenous Immunoglobulin (IVIG) (J1566, J1569), Flebogamma® (J1572), Gammagard (J1569), Gamunex® (J1561), Octagam® (J1568), Rho(D) (J2791), Myozyme® (J0220), Orencia® (J0129), Remicade® (J1745), and Tysabri® (J2323).

If you have any questions regarding NaviNet, or if you need to register for its use, please contact the eBusiness Provider Inquiry line at 215-640-7410, or complete an online inquiry form on *www.ibx.com/providers/navinet.*

Medicare Private Fee-for-Service now available

Select Advantage, a Medicare Advantage Private Fee-for-Service plan (PFFS), is now available. Select Advantage is a Medicare Advantage plan being offered as an alternative product for Medicare beneficiaries to receive Medicare benefits. The Medicare Advantage PFFS plan is a non-network, non-managed care product that does not include utilization management or require referrals. However, all services must meet Original Medicare guidelines for coverage and are subject to retrospective review/audit.

Select Advantage covers the same benefits as Original Medicare but also covers additional services that are not covered by Original Medicare. As such, the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations and Medicare Local Coverage Determination contractor policies from the state of Pennsylvania apply to this product.

Among the added benefits, members covered under this product are eligible for the Connections℠ Health Management Program. Connections offers information and decision support to members living with common chronic conditions, such as diabetes, heart disease, and respiratory disorders as well as for significant medical decisions, such as those involving joint pain and men's and women's health issues.

For your convenience, the plan's terms and conditions, reimbursement grid, and payment methodology information are now available on our website. In addition, the IBC *Companion Guides* have been updated to reflect the payor codes for Select Advantage PFFS. To view these materials and to learn more about Select Advantage, please visit *www.ibx.com/providers.*

For additional information regarding CMS National Coverage Determinations, please visit *www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd.* For information regarding Medicare Local Coverage Determination contractor policies from the state of Pennsylvania, please visit *www.cms.hhs.gov/mcd/index_lmrp_bystate.asp.*

To refer members for the Connections Health Management Program, please call the Provider Support Line at 1-866-866-4694.

IBC introduces new Personal Choice® Flex High Deductible Health Plan (HDHP) flexibility for large group customers

New high deductible health plan (HDHP) options and enhancements to existing Health Savings Account (HSA)-qualified HDHPs for large group customers (100+ employees) will be available starting **January 1, 2008.** The new plans provide a single high deductible platform for large group customers to custom design a plan that best meets their needs. The same benefit structure, precertification list, and exclusions will be used for all HDHPs.

New plans: Flex High Deductible Health Plans (Flex HDHPs)

Flex HDHPs are not HSA qualified. Instead, they can be offered with a Health Reimbursement Account (HRA), Flexible Spending Account (FSA), or as a stand-alone medical plan. Flex HDHPs will include the *Flex Precertification*, *Exclusion,* and *Biotech/Specialty Injectable Lists.* These plans do not have to be offered with an integrated drug plan. Instead, they can be offered with a freestanding or PPO Rider program.

Enhancements to existing HSA-qualified HDHPs

If an employer chooses to offer an HSA, they must offer a HSA-qualified HDHP. Our existing portfolio of HDHPs has been enhanced to give large group employers additional flexibility in creating an HSA-qualified HDHP. As a reminder, HSA-qualified HDHPs also include the *Flex Precertification, Exclusion,* and *Biotech/Specialty Injectable Lists.*

A note to physicians regarding billing. The member's actual financial responsibility may not be available at the time of service. Therefore, claims (other than the copayments associated with preventive office visits and routine gynecological exams) should be submitted for adjudication by IBC before the member is billed to ensure that members are billed correctly.

For more information, or for questions about HDHPs, contact your Network Coordinator.

MEDICAL

30-Day advance policy change notifications available online

To better communicate policy changes to providers, advance notification articles regarding changes to medical policies are now published on *www.ibx.com/medpolicy.* These notification articles will be available at least 30 days in advance of the proposed changes to policy.

Please follow these instructions to read notifications:

1. Visit *www.ibx.com/medpolicy.*
2. Select *Accept and Go to Medical Policy Online.*
3. Select the *Commercial and Other Medicare Advantage policies* link.
4. Select *News & Announcements* from the Medical Policy column on the left sidebar.
5. Select links to 30-day notice articles.

Another new enhancement to the *News & Announcements* section is a listing of recently published policies to the website ordered by month. These listings are updated daily, so please check back frequently to view what's new.

PHARMACY

No Pay Copay wrap-up

The No Pay Copay program is coming to an end. The last day of the program is December 31, 2007. **Beginning January 1, 2008**, members will pay their plan's lowest copay for generic drugs.

We want to thank you for talking to our members, your patients, about using generic drugs where appropriate. We recently conducted a survey with 805 members who have IBC drug coverage to better understand their opinion about generic drugs. We asked specific questions regarding No Pay Copay and generic awareness. The survey results show members have increased awareness of generics and are willing to use them.

- Seventy-five percent said that they believe generic drugs are as safe and effective as their brand-name equivalents and 87 percent are likely to ask for generics after the end of No Pay Copay.
- Forty-seven percent of those who inquired about generic drugs throughout 2007 were influenced to inquire because of No Pay Copay.
- Thirteen percent said that the money they saved through No Pay Copay allowed them to fill other prescriptions that they would not have been able to fill otherwise.
- Only 31 percent claimed their doctors or pharmacists have ever proactively recommended they use a generic alternative.

We understand that you know best how to care for your patients. We encourage you to continue prescribing generic equivalents and generic therapeutic alternatives, where appropriate. By doing so, you may help reduce patients' out-of-pocket costs.

Again, we thank you for your consideration and assistance in making the No Pay Copay program a success.

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

Enhanced Facility Peer-to-Peer Reconsideration and new Inpatient Appeal process

IBC is introducing an enhanced Facility Peer-to-Peer Reconsideration and a revised Inpatient Appeal process **effective January 1, 2008,** for acute care hospitals, acute rehab hospitals, and long-term acute care hospitals. These changes will not affect skilled nursing facilities. The processes will apply to inpatient facility days that have been denied for lack of Medical Necessity. Additional information about these changes was mailed to you in November 2007. Highlights of the changes are outlined below:

Facility Peer-to-Peer Reconsideration

The enhanced Facility Peer-to-Peer Reconsideration process expands the time frames in which a hospital may initiate a Facility Peer-to-Peer Reconsideration and broadens the modes of communication and documentation in support of the hospital's request. The enhancements to the current process were developed with input from the provider community and offer hospitals a streamlined process, along with opportunities to discuss denial decisions and resolve inquiries prior to initiating a formal appeal. IBC conducted pilot programs of this enhanced Facility Peer-to-Peer Reconsideration process with three participating hospitals, which responded very favorably.

Features of this enhanced program are as follows:

- **Timing of Facility Peer-to-Peer request.** The Facility Peer-to-Peer process should be initiated prior to a member's discharge from the hospital; however, hospitals will now have up to two business days from the date the member is discharged to initiate the Facility Peer-to-Peer Reconsideration process.
- **Initiation of process.** The attending physician, ordering physician, hospital utilization management department physicians, or their designated physician representative (e.g., hospital medical director) may contact a Medical Director by telephone, fax, or email or may call the Physician Phone Line at 1-888-814-2244 or locally 215-241-4079 in Pennsylvania. For those providers in New Jersey, call 1-877-585-5731, option 1.
- **Submission of pertinent information.** The requesting physician has the option to submit additional documentation in support of the request. This may generally include:
  - pertinent parts of the medical record, which will usually consist of progress notes and orders; and
  - written rationale for the approval request. Whenever possible, this should include justification citing specific InterQual criteria or an explanation that supports exemption from such guidelines.
- **Discussion and determination.** The request for reconsideration will be responded to within one business day of receipt. The reconsideration discussions are heard at prescheduled meetings via telephone twice a week. At this time, the physician will have the opportunity to support his or her position with additional supporting documentation.

The Facility Peer-to-Peer Reconsideration process will be completed within ten business days of the member's discharge date. If, after the reconsideration process is complete, the decision is to uphold all or a portion of the initial adverse determination, the hospital may initiate the Inpatient Appeal process for lack of Medical Necessity.

Single-Level Facility Inpatient Appeal Process

In conjunction with the introduction of the enhanced Facility Peer-to-Peer Reconsideration process, the current two-level Inpatient Appeal process will be consolidated into a single-level process. *Beginning with denial decision (adverse determination) notices for Medical Necessity dated January 1, 2008, and thereafter, there will be a single level of formal facility appeal available for denials for lack of Medical Necessity.*

Under the new, single-level Facility Inpatient Appeal Process following an initial adverse determination notice, the hospital may formally appeal the adverse determination. The hospital must submit the appeal in writing within *180* calendar days of the adverse determination notice. The written appeal request must contain the complete medical record for the case being appealed.

Appeals are reviewed by an external, independent, licensed physician who is of the same or similar specialty that typically manages the care under review and who was not involved in the initial adverse determination.

The decision to uphold or overturn all, or a portion of, the initial adverse determination is made and communicated in writing to the hospital within 30 calendar days of receipt of the written appeal and the complete medical record.

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APPEALS

Enhanced Facility Peer-to-Peer Reconsideration and new Inpatient Appeal process (continued)

The written determination of the appeal will include the rationale for the determination where all, or a portion of, the adverse determination is upheld. This decision is final and binding.

For questions regarding the enhanced Facility Peer-to-Peer Reconsideration process or the single-level Inpatient Appeal process, please contact your Network Coordinator or Hospital Service Coordinator.

PREVENTIVE HEALTH

SilverSneakers®: A new program offered by IBC

We are pleased to announce that **effective January 1, 2008**, IBC will offer the SilverSneakers® Fitness Program, designed exclusively for Medicare-eligible members. This leading program is provided at no cost to members beyond their monthly premium and offers members a free fitness membership at a participating SilverSneakers and Silver Access by SilverSneakers location. Medicare members eligible for the SilverSneakers program will no longer be able to participate in the Healthy Lifestyles℠ Fitness Reimbursement Program.

The SilverSneakers participating locations offer individuals access to amenities such as treadmills, weights, pool and fitness classes included in a basic membership. Members can also take advantage of the signature SilverSneakers classes taught by certified instructors. Classes can include SilverSneakers® - Muscular Strength & Range of Movement, SilverSneakers® - Cardio Circuit, SilverSneakers® Yoga Stretch, and SilverSplash® class offerings will vary by location.

The Silver Access by SilverSneakers participating locations offer individuals access to amenities, such as treadmills, weights, and pool, included in a basic membership. Members utilizing Silver Access locations can also participate in instructor-led classes at any SilverSneakers location.

Enrollment is easy. Members simply choose a participating fitness center that is conveniently located, present their membership ID card at the front desk, and ask to join SilverSneakers. Members can then tour the facility and see all the amenities available to them as new SilverSneakers members.

To learn more or find a convenient location online, visit *www.silversneakers.com/ibc.*

Note: *Security 65® and 65 Special members are not eligible for SilverSneakers.*

®SilverSneakers is a registered mark of Healthways Health Support, Inc.

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

Connections℠ Health Management Program

To refer a patient for Health Coaching for the following chronic diseases or for general health support, or to obtain additional information for your office, call the Connections Health Management Program Provider Support Line at 1-866-866-4694.

Diseases:

- asthma
- heart failure (HF)
- coronary heart disease (CHD)
- chronic obstructive pulmonary disease (COPD)
- diabetes

Connections℠ AccordantCare™ Program

To refer a patient or obtain additional information concerning the following diseases, call the Connections AccordantCare Program at 1-866-398-8761.

Diseases:

- seizure disorders
- rheumatoid arthritis
- multiple sclerosis
- Crohn's disease
- Parkinson's disease
- systemic lupus erythematosus (SLE)
- myasthenia gravis
- sickle cell disease
- cystic fibrosis
- hemophilia
- scleroderma
- polymyositis
- dermatomyositis
- chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- amyotrophic lateral sclerosis (ALS)
- Gaucher disease

Connections℠ Kidney Program

To refer a patient who is on renal dialysis or obtain additional information, call the Connections Kidney Program at 1-866-303-4CKP (4257).

Disease:

- end-stage renal disease

Medical decision aids help patients make the right choices

What are medical decision aids and are they effective?

Compared with patients who receive "usual care," patients who use medical decision aids are more informed about their treatment options, have a better grasp of the benefits and harms of each of their options, and are more comfortable with the choices they make, according to a recent Cochrane review.[1]

Decision aids take the form of pamphlets, videos, audio presentations, and interactive electronic tools. They typically focus on medical conditions that respond to a variety of treatment options and for which there is no single "right" treatment approach. These educational tools describe the different treatment options for a given condition and then provide details about the risks and benefits of each option. After presenting that information, most decision aids go on to pose a series of questions that are designed to guide the decision-making process.

Example of a decision aid

A decision aid for people with back and leg pain caused by a herniated disc, for example, might explain that in most people the condition can be managed either with surgery or with more conservative approaches, such as pain medications and physical therapy. It would then outline the risks of each approach, describing the possible complications from surgery and the possible side effects from medications. It would also offer statistics on the chances of recovery with each approach and on the speed with which pain might subside with each approach.

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Medical decision aids help patients make the right choices (continued)

Finally, it might ask them to consider how much their pain limits them, how they feel about the risks of surgery, and whether they think they could wait to give their back time to heal without surgery.

Decision aids have become increasingly common. The authors of the Cochrane review identified more than 200[2] decision aids, most of which were developed by hospitals, patient education organizations, and health consulting companies in the U.S. and Canada. Still, despite their apparent popularity, few rigorous studies have codified the effects these tools have on patients.

Effects of decision aids on patients

To tackle that issue, the Cochrane Consumers and Communication Review Group systematically reviewed 35 high-quality, published, randomized, controlled trials examining the effects of decision aids. According to the authors, "trials indicate that decision aids improve knowledge and realistic expectations; enhance active participation in decision making; lower decisional conflict; decrease the proportion of people remaining undecided; and improve agreement between values and choice." Even so, the authors caution that most available decision aids do not conform to the "CREDIBLE" criteria for quality. The acronym stands for:

C= competent developers and development
R= recent
E= evidence-based
DI= devoid of conflicts of interest
BL= balanced presentation of options, benefits, harms
E= efficacious

In particular, the authors mention that few of the existing decision aids describe the degree of uncertainty surrounding the medical evidence cited in the aids, and, of course, few have been studied for efficacy.

That being said, several of the decision aids that are available to IBC members do receive high quality ratings. In particular, decision aids created by Health Dialog are consistently evaluated favorably according to the criteria used by the Cochrane authors.[3]

Medical conditions addressed by decision aids

Below is a list of the medical conditions that are addressed in decision aids produced by Health Dialog. These aids, which consist of videos supplemented by booklets, are available without charge to your patients eligible for the Connections℠ Health Management Program. Members receive supportive Health Coaching to determine whether their clinical situation is the right one for each video, as well as follow-up Health Coaching. The decision aids provide evidence-based information and are designed to promote an informed dialog between individuals and their physicians. All videos are based on medical evidence researched and evaluated by the Foundation for Informed Medical Decision Making and are regularly reviewed and updated to ensure they contain the most current and accurate information. The videos feature perspectives of people who have made important decisions about their health. These interviews help viewers understand the key issues involved in making clinical choices. The goal is to help them understand their options and gain confidence to discuss their treatment options and their preferences with their health care providers.

The decision aids available through Health Dialog include the following conditions:

- back pain
- breast cancer
- colon cancer
- chronic pain
- depression
- end of life
- heart disease
- major joint arthritis
- menopausal symptoms
- prostate health
- obesity surgery
- uterine conditions

To find out more about the Connections Health Management Program videos and other Shared Decision-Making® services, contact the Connections Health Management Program Provider Support Line at 1-866-866-4694. A Provider Service Specialist will return your call within two business days.

Note: The Connections Health Management Program is available to most members. Members should refer to their member materials for the terms, limitations, and exclusions of their health care coverage. They can also call Customer Service at the telephone number listed on their ID card to check eligibility.

[1] *O'Connor AM, Stacey D, Entwistle V, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2003; 1: CD001431. http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001431/frame.html*

[2] *http://decisionaid.ohri.ca/index.html*

[3] *http://decisionaid.ohri.ca/AZlist.html*

Partners in Health Update is a publication of the Provider Communications department for the exchange of information and ideas among the IBC provider community. Suggestions are welcome.

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IMPORTANT RESOURCES

View our online provider directories at www.ibx.com

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℠ Kidney Program	1-866-303-4CKP (4257)
Connections℠ AccordantCare™ Program	1-866-398-8761
CORPORATE AND FINANCIAL INVESTIGATIONS DEPARTMENT Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/anti-fraud
CREDENTIALING VIOLATION HOTLINE	215-988-6534 www.ibx.com/credentials
eBUSINESS Help Desk	215-241-2305
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