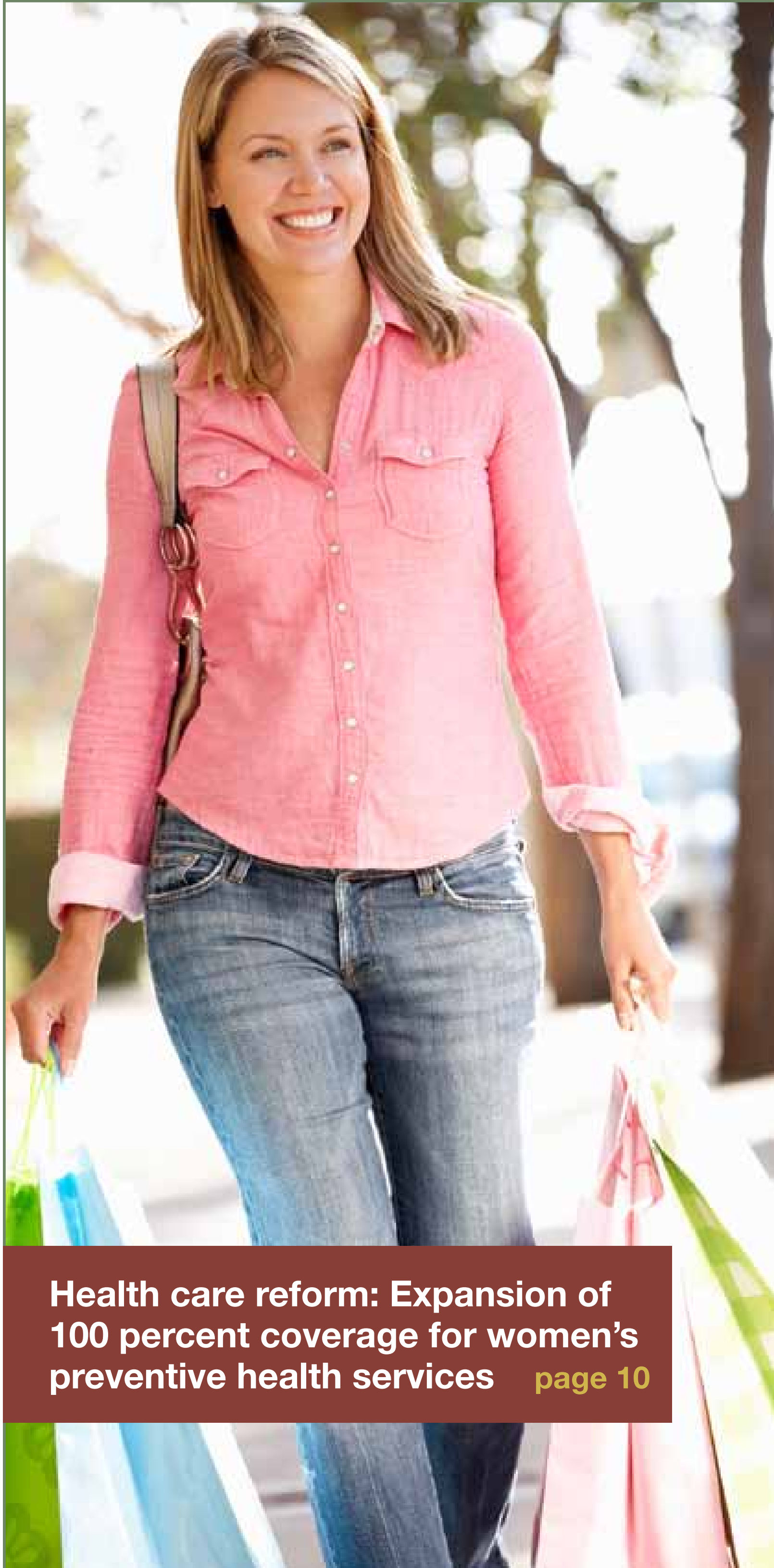
Independence
Partners in Health UPDATE℠



Health care reform: Expansion of 100 percent coverage for women's preventive health services page 10

Inside this edition

ICD-10
- ▶ ICD-10 Spotlight: Know the codes (Coding Convention/Guideline: Mental and Behavioral Disorders)

CONSUMERISM
- Look for the new Find a Doctor tool this month

ADMINISTRATIVE
- Reminder: Provider self-service requirements

BILLING
- ▶ Professional Injectable and Vaccine Fee Schedule updates effective January 1, 2013
- ▶ Nutrition counseling not eligible for payment in group setting
- ▶ Significant changes in 2013 to CPT® codes for behavioral health services

MEDICAL
- ▶ Policy notifications posted as of November 30, 2012
- ▶ Health care reform: Expansion of 100 percent coverage for women's preventive health services
- ▶ Updated policy for Never Events and Preventable Adverse Events
- Reminder: Coverage change for Plan B One-Step® (Levonorgestrel, Next Choice®)

PHARMACY
- ▶ Changes to growth hormone prescribing procedures
- ▶ Prescription drug updates
- ▶ Select Drug Program® Formulary updates

NAVINET®
- Reminder: Authorization submission requirements through NaviNet

QUALITY MANAGEMENT
- Our Quality Management Program promotes quality of care and service

HEALTH AND WELLNESS
- The importance of lead screening and lead safety
- Resolution solution: The SilverSneakers® Fitness Program
- *2012-2013 Clinical Practice Guideline Summary* now available
- Case management: Help for your patients when they need it

▶ Articles designated with an orange arrow include notice of changes or clarifications to administrative policies and procedures.

Reminder…

Sign up to receive IBC news and announcements via email

If you and your office staff would like to receive email providing you with the latest information of interest to participating IBC providers, including *Partners in Health Update* and breaking news alerts, simply complete the sign-up form located on our website.

Email sign-up: *www.ibx.com/providers/email*

All requests are processed within 48 hours. To prevent your firewall from marking our email messages as spam, please add IBC (*provider_communications@ibx.com*) to your email address book and provide your information services or information technology contacts with the domains and IP addresses listed on our website.

For professional providers only

Additionally, the IBC Network Medical Directors offer a physician-to-physician email platform, intended to provide direct and succinct messaging to assist physicians in providing quality care to our members. Email topics have included information on the Quality Performance Measure (QPM) score program, announcements of new initiatives, fee schedule reminders, and more.

Participating professional providers are encouraged to join the Network Medical Directors Physician-to-Physician email list.

Physician-to-Physician email sign-up: *www.ibx.com/providers/physician_email*

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*.

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

Keystone Health Plan East has an accreditation status of *Commendable* from NCQA.

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, 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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ICD-10 Spotlight:
Know the codes

ICD | 10

More codes • More detail • Improved accuracy℠

Each month, IBC will feature an example of how ICD-9 codes will translate to ICD-10 codes. We will present coding examples from different specialties and popular disease categories to demonstrate the granularity that the new ICD-10 code set will provide.

CODING CONVENTION/GUIDELINE: MENTAL AND BEHAVIORAL DISORDERS

As in ICD-9, the codes for mental and behavioral disorders are located in Chapter 5 of ICD-10. However, in ICD-10, the clinical terminology and classification of many conditions are different. There are also more subchapters, categories, subcategories, and codes that provide greater clinical detail. This includes some changes in names and definitions of disorders to reflect more current clinical terminology and standardization of the terms used to diagnosis mental, behavioral, and substance use disorders.

One difference involves the classification of substance use, abuse, and dependence. In ICD-10, the terms are not interchangeable as they are in ICD-9; they are separate conditions in ICD-10.

Condition: Alcohol-induced psychotic disorder with delusions

Substance	ICD-9		ICD-10	
Use	291.5	Alcohol-induced psychotic disorder with delusions	F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
Abuse	291.5	Alcohol-induced psychotic disorder with delusions	F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
Dependence	291.5	Alcohol-induced psychotic disorder with delusions	F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions

Alcohol dependence, drug dependence, and non-dependent abuse of drugs are classified into three different categories. The ICD-10 codes identify the aspects of use (e.g., withdrawal state), the effects (e.g., dependence), and the manifestations (e.g., with delirium).

Condition: Opioid use, abuse, and dependence

Categories	ICD-10	
Aspects of use	F11.23	Opioid dependence with withdrawal
Effects	F11.10	Opioid abuse, uncomplicated
	F11.20	Opioid dependence, uncomplicated
Manifestations	F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
	F11.282	Opioid dependence with opioid-induced sleep disorder
	F11.921	Opioid use, unspecified with intoxication delirium

In addition to the clinical terminology and classification changes, unlike ICD-9, there are chapter-specific guidelines for mental and behavioral disorders in ICD-10. These consist of pain disorders related to psychological factors and disorders due to psychoactive substance use (i.e., in remission, psychoactive substance use, abuse, and dependence).

continued on next page

ICD-10 Spotlight:
Know the codes

ICD | 10
More codes • More detail • Improved accuracy℠

CODING CONVENTION/GUIDELINE: MENTAL AND BEHAVIORAL DISORDERS (*continued)*

Pain disorders related to psychological factors

There is a distinctive code assignment when the pain is exclusively related or indirectly related to psychological factors.

ICD-10
F45.41 Pain disorder exclusively related to psychological factors
F45.42 Pain disorder with related psychological factors

Mental and behavioral disorders due to psychoactive substance use

In remission: The appropriate code assignments for "in remission" are assigned only on the basis of provider documentation.

Psychoactive substance use, abuse, and dependence: When the provider documentation refers to use, abuse, and dependence of the same substance (e.g., alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse.
- If both abuse and dependence are documented, assign only the code for dependence.
- If use, abuse, and dependence are all documented, assign only the code for dependence.
- If both use and dependence are documented, assign only the code for dependence.

For additional information related to the IBC transition to ICD-10, please visit *www.ibx.com/icd10*. On this site you will also find other examples of how ICD-9 codes will translate to ICD-10 codes in the *ICD-10 Spotlight: Know the codes* booklet.

PFA

Look for the new Find a Doctor tool this month

Mid-month, we will launch our new Find a Doctor tool, which will allow IBC members, including plan members who carry an Independence Administrators ID card, to conduct more efficient online searches for network doctors, specialists, hospitals, and other health care professionals.

Independence

I WANT TO FIND...

Doctors & Medical Professionals *
Need help with your search?
Enter address, city+state or zip *
Location
Within 5 miles
Doctor, Medical Professional, or Practice Name
e.g. John Smith or Internal Medicine Associates
Select a Plan *
Select a Plan
Select Specialty(CTRL + Select for multiple)
Adolescent Medicine
Allergy & Immunology
Anesthesiology
Applied Behavioral Analyst
Audiology
View Glossary
Search for Providers Outside US
Submit

SEARCH TIPS

Narrow your search for physicians by:
Board Certified
Specialty
Language
Narrow your search for hospitals by:
Facility Type
Blue Distinction Center

Already a member?
Log in to view additional provider details.
Log In

CHOOSE THE RIGHT DOCTOR

Get the Facts: Health Care Quality Information
Visit Pennsylvania Health Care Quality Alliance to search and compare infection rates, mortality, readmissions, and other performance measures for hospitals in Pennsylvania. The Hospital Quality Search Tool also provides quality data for hospitals in Pennsylvania and throughout the nation.

Know Your Options: Cost-Saving Tips for Deductibles and Coinsurance
Consider choosing doctors in your plan's network.

For non-emergencies, consider seeking treatment at an Urgent Care Center or Retail Health Clinic.

Consider having blood tests performed at non-hospital-based labs.

For X-Rays, CT scans, or MRIs, consider choosing standalone Diagnostic or Imaging Centers instead of hospitals.

Need Help Navigating Health Care?
Call 1-800-ASK-BLUE for more information.

Members can find this easy-to-use tool at *www.ibx.com* or by logging onto our secure member website at *www.ibxpress.com* (Independence Administrators plan members can access the tool through myIBXTPA.com). Providers can access the tool through the NaviNet® web portal or through the IBC website.

Searching for a network health care professional

To search for a network health care professional, users should select one of the following types of provider from the first drop-down menu:

- Doctors & Medical Professionals
- Hospitals & Facilities
- Diagnostic & Imaging Centers
- Medical Supply & Services Providers
- Urgent Care Centers & Retail Clinics

Once the user selects a provider type, he or she will need to complete the remaining fields to begin the search. Any required fields for the search are marked with a red asterisk. Regardless of the provider type, the user must enter a location (i.e., address; city and state; or ZIP) and select a health plan.

I WANT TO FIND...
Doctors & Medical Professionals *
Need help with your search?
Enter address, city+state or zip *
Location
Within 5 miles
Doctor, Medical Professional, or Practice Name
e.g. John Smith or Internal Medicine Associates
Select a Plan *
Select a Plan
Select Specialty(CTRL + Select for multiple)
Adolescent Medicine
Allergy & Immunology
Anesthesiology
Applied Behavioral Analyst
Audiology
View Glossary
Search for Providers Outside US
Submit

continued on the next page

Look for the new Find a Doctor tool this month (continued)

CUSTOMIZE RESULTS

- Gender
- Accepting New Patients
- Board Certified
- Specialty
- Weekend Hours Available
- Language

Hospital Affiliation

Hospital

Practice Affiliation

Practice

☐ Only Show Providers with Reviews (1)

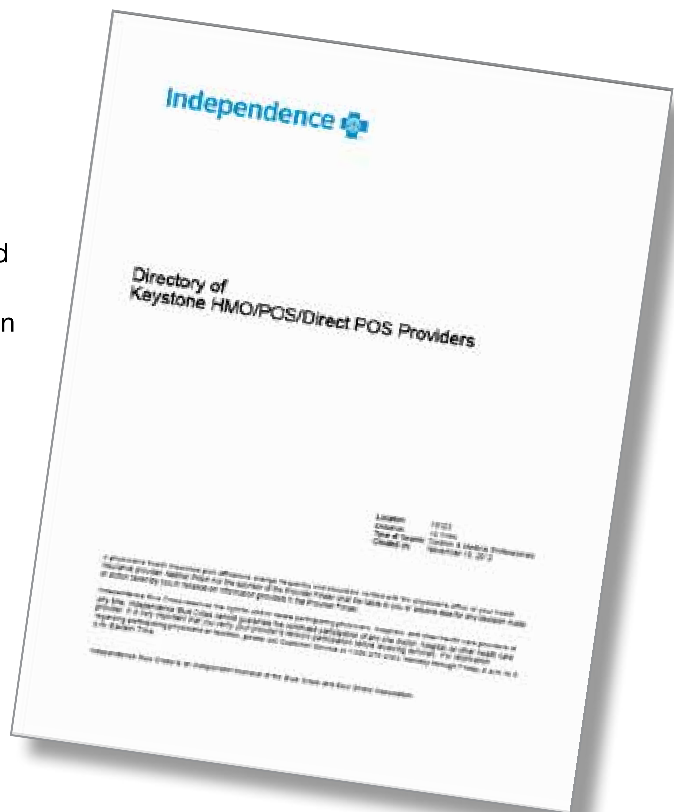
Remove Filters

As with any of the provider type options, the user can further customize the search results after the initial search. For example, when searching for a doctor or medical professional, the search results can be filtered based on the provider's gender, specialty, languages, and whether they are accepting new patients, are board certified, or have weekend hours. Users can also search for providers based on hospital and practice affiliation using the drop-down menus.

Create a customized provider directory

One feature that may be of value to both members and providers is the option to create a customized directory using the "Create Directory" link that appears in the upper right corner of the Search Results screen. When referring a patient to a specialist, providers may wish to create a customized directory specific to that specialty and the member's benefits plan.

Once you've created your customized directory, you can download it in PDF format or email it to yourself or to a member. A cover page will be added automatically to the directory and will include the plan type that it applies to, the terms of the search, and the date it was created.



Independence

Directory of
Keystone HMO/POS/Direct POS Providers

Check out the new Find a Doctor tool!

We aim to be as transparent as possible to our members and providers, and the new Find a Doctor tool is a way for us to increase the availability and accessibility of health information and data. This tool gives our members an opportunity to become better informed and more empowered about their decision-making and health care choices.

If you have any questions about the Find a Doctor tool, please call 1-800-ASK-BLUE.

Administrative

P F A

Reminder: Provider self-service requirements

As previously communicated, providers must 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, and 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 F A

Professional Injectable and Vaccine Fee Schedule updates effective January 1, 2013

Effective January 1, 2013, 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, 2013, through the NaviNet® web portal. 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.

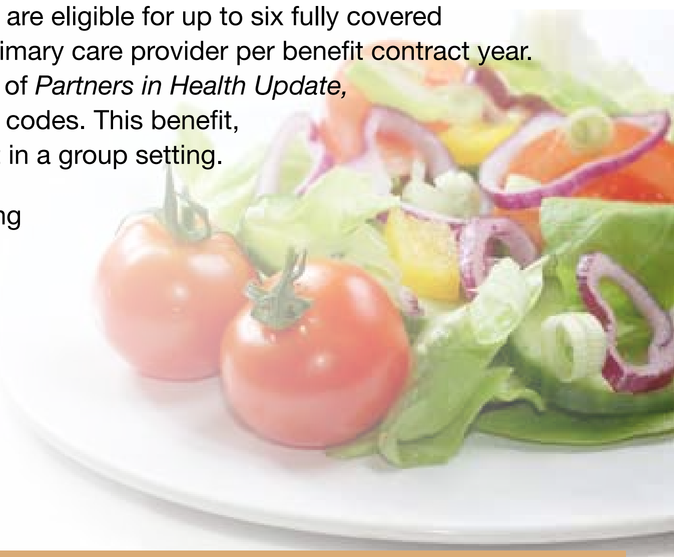
Nutrition counseling not eligible for payment in group setting

P

As previously communicated, most commercial managed care members are eligible for up to six fully covered one-on-one nutrition counseling sessions with a registered dietitian or primary care provider per benefit contract year. In the original communication about this benefit in the June 2007 edition of *Partners in Health Update,* group counseling sessions were mistakenly included in the eligible list of codes. This benefit, however, was intended only to be provided in an individual setting — not in a group setting.

Therefore, **effective March 1, 2013,** nutrition counseling in a group setting will no longer be eligible for payment. Providers should no longer bill for medical nutrition therapy in a group setting with the following codes: 97804, G0271. Only diabetic education services are eligible for payment in a group setting with these codes.

Note: Members do not need to obtain a referral for nutrition counseling services.



Significant changes in 2013 to CPT® codes for behavioral health services

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Effective January 1, 2013, significant changes will be made to CPT codes for psychiatry and psychotherapy services. The American Medical Association makes changes to CPT code sets on an annual basis, but the upcoming changes for psychiatry and psychotherapy services will have a more significant impact than usual.

The following list includes the changes for several commonly used psychiatry and psychotherapy CPT codes:

- removal of evaluation and management (E&M) plus psychotherapy codes from the psychiatry section (90805, 90807);
- deletion of pharmacologic management code 90862 (providers should use appropriate E&M code);
- distinction between psychotherapy and E&M services (i.e., time spent on E&M services is not counted towards psychotherapeutic services, and separate codes can be used in combination with one another);
- inclusion of psychiatry add-on codes, which are services performed in addition to a primary service or procedure and never as a stand-alone service;
- addition of code 90785 for interactive complexity;
- new code for psychotherapy for a patient in crisis.

For more detailed information about these upcoming changes, please refer to the American Psychiatric Association (APA) website at *www.psychiatry.org/practice/managing-a-practice/cpt-changes-2013/current-procedural-terminology-cpt-code-changes-for-2013*. This website includes documents and guides to help you navigate the extensive changes. The APA also encourages behavioral health providers to purchase the 2013 edition of the CPT manual.

If you have any questions, please contact Magellan Behavioral Health, Inc. at 1-800-866-4108.

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

PFA

Policy notifications posted as of November 30, 2012

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 30, 2012.

Policy effective date	Policy No.	Notification title	Notification issue date
November 15, 2012	06.02.14e	In Vitro Chemosensitivity and Chemoresistance Assays	October 16, 2012
November 26, 2012	08.00.95b	Personalized Vaccines (e.g., Provenge)	October 26, 2012
December 7, 2012	11.05.17	Implantable Miniature Telescope (IMT) for the Treatment of End-Stage Age-Related Macular Degeneration (AMD)	November 7, 2012
December 12, 2012	11.00.06d	Treatment of Obstructive Sleep Apnea (OSA) and Primary Snoring for Adults	September 13, 2012
December 21, 2012	05.00.62e	Injectable Dermal Fillers	November 21, 2012
December 21, 2012	11.15.24	Migraine Deactivation Surgery	November 21, 2012
December 31, 2012	06.02.39	Measurement of Serum Antibodies to Infliximab	November 30, 2012
January 1, 2013	00.03.01j	Podiatry Services Included in Capitation for Pennsylvania Based Health Maintenance Organization (HMO) or Health Maintenance Organization Point-of-Service (HMO-POS) Products	October 3, 2012
January 9, 2013	11.01.01g	Otoplasty	October 10, 2012
February 5, 2013	00.01.44e	Never Events and Preventable Adverse Events	November 7, 2012
February 25, 2013	07.08.03	Medical and Surgical Treatment of Temporomandibular Joint Disorder	November 27, 2012

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 Tools* 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.

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Health care reform: Expansion of 100 percent coverage for women's preventive health services

Note: An earlier version of this article was published in the July 2012 edition of Partners in Health Update*. The bolded text indicates new language that was not in the previous version of the article.*

On August 1, 2012, IBC expanded the list of women's preventive health services that are covered at 100 percent (i.e., $0 copayment) for certain members.

In response to the federal health care reform act known as the Patient Protection and Affordable Care Act of 2010, the Department of Health and Human Services (HHS) announced a modification to the August 2011 interim final rule, expanding the list of preventive services with a $0 copayment when performed in-network. As a result, IBC has updated commercial health plans to eliminate member cost-sharing for an expanded list of women's preventive services for all non-grandfathered plans.

The federal rule that took effect on August 1, 2012, impacted all non-grandfathered IBC medical and prescription drug plans. Please note the following groups are exempt from the federal ruling:

- groups that have maintained grandfathered status for their health benefit plans;
- all Medicare Supplement and Medicare Advantage plans;
- for contraceptive services only, groups that meet the definition of a religious employer or that are able to certify for a one-year temporary safe harbor.

Coverage for women's preventive services

As a result of the 2011 HHS modification to the health care reform act, IBC currently provides 100 percent coverage (i.e., $0 copayment) to all commercial health plans for the following six preventive care services for women when they are performed in-network:

- well-woman visits
- counseling for sexually transmitted infections
- screening for gestational diabetes
- screening and counseling for HIV
- screening for human papillomavirus (HPV)
- screening and counseling for interpersonal and domestic violence

As of August 1, 2012, IBC also provides 100 percent coverage for the following two additional preventive services:

- **Contraception methods and counseling.** All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling will be available to women at a $0 copayment when performed in-network. Medical procedures such as contraceptive devices and injectable contraceptives will also be eligible for $0 copayment when performed in-network. All generic oral contraceptives will be covered at 100 percent at retail and mail-order pharmacies. Cost-sharing will continue to apply to brand and non-formulary prescription drugs; there is no change in current state for non-generic tiers.
- **Breastfeeding support, supplies, and counseling.** Women will have access to comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period. Current coverage provides for lactation support received during an inpatient maternity stay as part of an inpatient admission or postpartum home care visits. Support is also available at the mother's postpartum office visits and well-baby visits. The in-network cost-sharing will be removed. **Breast pump rental and breastfeeding equipment are available to women without cost-sharing subject to approval for medical necessity.**

As always, continue to check the NaviNet® web portal for member eligibility and copayment amounts. To do so, select *Eligibility and Benefits Inquiry* from the Plan Transactions menu, enter the search criteria for the member, and click *Select* next to the appropriate member. In the Copays section, select *Preventive Services* to view Medical Policy #00.06.02e: Preventive Care Services, which lists all preventive services that have a $0 copayment and are covered at 100 percent.

If you are not NaviNet-enabled, visit *www.ibx.com/medpolicy*. Select *Accept and Go to Medical Policy Online* and then type the policy name or number in the Search box.

Updated policy for Never Events and Preventable Adverse Events

Never Events and Preventable Adverse Events are considered adverse events or errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients. They address injuries caused by errors in medical and surgical management and errors that occur as a result of a failure to follow standards of care or hospital policies and procedures.

Based on recent regulations published by the Centers for Medicare & Medicaid Services (CMS), our Claim Payment Policy #00.01.44e: Never Events and Preventable Adverse Events will be updated as outlined below and will be effective February 5, 2013.

The following Hospital Acquired Conditions and associated diagnosis and procedure codes will be added to the section of the policy addressing preventable adverse events:

Preventable Adverse Event	Diagnosis code	Associated procedure codes
Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED) Procedures	**996.61** Infection and inflammatory reaction due to cardiac device, implant and graft **998.59** Other postoperative infection	00.50 – 00.54; 37.74 – 37.77; 37.79; 37.80 – 37.83; 37.85 – 37.87; 37.89; 37.94; 37.96; 37.98
Iatrogenic Pneumothorax With Venous Catheterization	**512.1** Iatrogenic Pneumothorax	38.93

The following two diagnoses codes will be added to Vascular Catheter-Associated Infection:

999.32 Bloodstream infection due to central venous catheter

999.33 Local infection due to central venous catheter

For questions or additional information related to Never Events and Preventable Adverse Events, please contact your Network Coordinator.

Reminder: Coverage change for Plan B One-Step® (Levonorgestrel, Next Choice®)

Effective January 1, 2013, IBC will apply age restrictions to the corresponding National Drug Codes (NDCs) for Plan B One-Step® (Levonorgestrel, Next Choice®). As a result, Plan B One-Step® and generic versions will not be covered for women age 17 and older. Claims for women age 17 and older will deny since Plan B One-Step® is available over the counter without a prescription, and IBC's prescription drug programs exclude coverage for drugs dispensed without a prescription. This change will not impact other emergency contraception options available by prescription, which will continue to be covered with no cost-sharing as required by the Affordable Care Act. The requirement to cover contraceptives is effective for plan years on or after August 1, 2012.*

To verify eligibility, please use the NaviNet® web portal or call the Provider Automated System at 1-800-ASK-BLUE. For additional information, please contact your Network Coordinator.

**For members with an IBC prescription drug plan, generic prescription oral contraceptives are covered with no cost-sharing at retail and mail-order participating pharmacies. Cost-sharing applies to brand and non-formulary prescriptions. For customers who are eligible for a temporary safe harbor, the effective date for contraceptive services is for plan years on or after August 1, 2013. If a customer is a "religious employer" as defined by the interim final rules issued by the Departments of Health and Human Services, Labor, and Treasury, they may be exempt from the requirement of providing contraceptive coverage in their medical and/or prescription drug plans.*

P

Changes to growth hormone prescribing procedures

Effective January 1, 2013, for coverage under the terms of our commercial health plans*, prior authorization will not be issued for Humatrope® in the absence of a documented trial and failure of therapy with, or contraindication to, Norditropin®.

As of January 1, 2013, a new prior authorization will be required in order for members to receive Humatrope®. In addition, any existing authorizations for Humatrope® will no longer be valid as of January 1, 2013. Members who are currently taking Humatrope®, but who have a documented history of trial and failure of Norditropin®, will not be considered an exception. For members who have previously tried and failed Norditropin®, the documentation of such failure should be submitted along with your prior authorization request for coverage of Humatrope®. All coverage requests and prescription drug claims for Humatrope® for commercial members will be denied in the absence of a new prior authorization. This requirement for Humatrope® prior authorization applies to members starting, as well as those currently taking, Humatrope®.

Please note that even in circumstances where prior authorization is obtained for Humatrope®, members will be responsible for the highest non-formulary level of cost-sharing available under the terms of their plan.

Effects on existing Humatrope® prescriptions

Prescriptions now on file for commercial members on Humatrope® will require prior authorization effective January 1, 2013.

Recent approvals for Humatrope®

We recognize that certain members may have recently had a prior authorization issued for Humatrope®. Those prior authorizations are valid for one year. To reduce the administrative burden on you and your patients and to avoid disruption in therapy, Norditropin® will not require authorization for the period of coverage prior to January 1, 2013, that Humatrope® was authorized. However, patients will require a new prescription for Norditropin® in order for Norditropin® to be dispensed by the pharmacy. Submission of additional clinical information will not be necessary. Your IBC commercial patients will not experience a change to their cost-sharing obligation for Norditropin® (i.e., copayment, coinsurance, or deductible) as a result of this change.

If you have any questions related to this change, please call FutureScripts at 1-888-678-7012.

**Does not include Medicare Advantage HMO and PPO or other government programs.*

P F A

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:

Brand drug	Generic drug	Drug category	Effective date
Bosulif®	Not available	Cancer	September 14, 2012
Xtandi®	Not available	Cancer	September 7, 2012
Zetonna™	Not available	Ear, Nose, Throat Medications	June 8, 2012

The following drugs will be added to the list of drugs requiring prior authorization for new prescriptions. Members taking these drugs immediately prior to the effective date are not affected.

Effective January 1, 2013.

Brand drug	Generic drug	Drug category
Extavia®	Not available	Biotechnology
Rebif®	Not available	Biotechnology
Zioptan™	Not available	Eye Medications

Drugs with quantity limits

Quantity limits will be added for the following drugs:

Brand drug	Generic drug	Drug category	Quantity limit (per 30 days)	Effective date
N/A	codeine 30mg/5ml solution	Pain, Nervous System, & Psych	1800 ml	December 1, 2012
Binosto™	Not available	Bone, Joint, & Muscle	5 tabs	October 15, 2012

PFA

Select Drug Program® Formulary updates

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

Generic additions

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

Generic drug	Brand drug	Formulary chapter	Effective date
calcipotriene	Dovonex® cream	5. Skin Medications	June 1, 2012
ciprofloxacin	Cetraxal®	6. Ear, Nose, Throat Medications	August 3, 2012
clindamycin/benzol peroxide	Duac®	5. Skin Medications	June 29, 2012
clozapine ODT	Fazaclo®	3. Pain, Nervous System, & Psych	September 7, 2012
desloratadine	Clarinex®	13. Allergy, Cough & Cold, Lung Meds	July 6, 2012
levalbuterol	Xopenex®	13. Allergy, Cough & Cold, Lung Meds	August 24, 2012
levonorgestrel	Plan B One-Step®	11. Female, Hormone Replacement, & Birth Control	July 20, 2012
montelukast sodium	Singulair®	13. Allergy, Cough & Cold, Lung Meds	August 10, 2012
pioglitazone	Actos®	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones	August 20, 2012
pioglitazone hcl/ metformin hcl	Actoplus Met®	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones	August 20, 2012
spinosad	Natroba™	5. Skin Medications	August 3, 2012
tolterodine tartrate	Detrol®	14. Urinary and Prostate Meds	June 29, 2012

Brand additions

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

Brand drug	Formulary chapter	Effective date
Betaseron®	9. Biotechnology	October 1, 2012
Travatan Z®	12. Eye Medications	July 13, 2012
Xifaxan 550mg®	1. Antibiotics & Other Drugs Used for Infection	August 1, 2012

continued on the next page

Select Drug Program® Formulary updates (continued)

Brand deletions

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

Effective January 1, 2013.

Brand drug	Generic drug	Formulary chapter
Actoplus Met®	pioglitazone hcl/metformin hcl	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones
Actos®	pioglitazone	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones
Dovonex® cream	calcipotriene	5. Skin Medications
Singulair®	montelukast sodium	13. Allergy, Cough & Cold, Lung Meds

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

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

Effective January 1, 2013.

Brand drug	Formulary therapeutic alternative	Formulary chapter
Humatrope®	Norditropin®	7. Diabetes, Thyroid, Steroids, & Other Miscellaneous Hormones

PFA

Reminder: Authorization submission requirements through NaviNet

As previously communicated, providers must use the NaviNet® web portal in order to initiate the following authorization types:

- medical/surgical procedures
- chemotherapy/infusion therapy
- 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

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 and would like training on how to submit authorizations, please call the eBusiness Provider Hotline at 215-640-7410.

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.

P F A

Our Quality Management Program promotes quality of care and service

Information about the IBC Quality Management Program is accessible on our website at *www.ibx.com/qualitymanagement*. IBC is dedicated to maintaining the highest standard of care and service for our members, providers, and the communities we serve. The following information about our Quality Management Program is available on our website to promote our standards of care:

- **Quality Management Program.** The description of the IBC Quality Management Program includes program goals, objectives, and activities to improve clinical, network, and service quality.
- **Member rights and responsibilities.** All IBC members have defined rights and responsibilities.
- **Medical record-keeping standards.** Well-maintained medical records are critical to facilitate communication, continuity, coordination, and an effective plan of care. Accordingly, IBC standards require that medical records are maintained in a manner that is current, detailed, and organized as required by applicable regulatory requirements.
- **Access and availability standards.** IBC standards ensure that our managed care networks are adequate to meet the needs of our members with respect to location and appointment accessibility for primary and specialty care as well as urgent and emergency care in accordance with applicable regulatory requirements.
- **Privacy and confidentiality.** IBC, our contractors, and our affiliates are required to protect the privacy and confidentiality of our members' personal and health information in accordance with state and federal regulatory requirements.

Information about our Quality Management Program and these standards can also be found in the *Provider Manual for Participating Professional Providers* (*Provider Manual*), which is available through the NaviNet® web portal. A paper copy of the *Provider Manual* can be ordered by submitting an online request at *www.ibx.com/providersupplyline* or by calling the Provider Supply Line at 1-800-858-4728.

Please review the standards listed in this article to ensure that your office maintains the required access, documentation, and quality care expected of our network providers.

For more information about our Quality Management Program and our progress in meeting program goals, please visit our website or contact Customer Service at 1-800-ASK-BLUE. Members may request the same information by calling Customer Service.

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The importance of lead screening and lead safety

According to the Centers for Disease Control and Prevention (CDC), about 500,000 U.S. children ages 1 to 5 have lead levels greater than 5 micrograms per deciliter (µg/dL) of blood.[1] Problems that can be attributed to even a small amount of lead in the blood include learning disabilities, attention deficit disorder, decreased muscle and bone growth, as well as behavioral problems.[2]

To help raise awareness of the importance of lead screenings, IBC is educating the parents and guardians of children ages 2 and older for whom there is no record of a lead screening. Parents will receive information in the mail regarding the importance of lead screening and lead safety, and they will be encouraged to discuss screening and education with their child's health care provider.

Lead screening recommendations

According to the United States Environmental Protection Agency (EPA), children's blood levels tend to increase from 6 to 12 months of age, and tend to peak at 18 to 24 months of age.[3] The CDC has recently updated its recommendations on children's blood lead levels and recommends that health care providers try to prevent the occurrence of blood lead levels of **5 µg/dL and above** instead of 10 µg/dL and above in children by[4]:

- screening children younger than age 6, preferably by ages 1 and 2, if they had not yet been tested;
- screening children and their family members who have been exposed to high levels of lead;
- screening children who should be tested under their state and local health screening plan.

The new blood lead level value means that more children will likely be identified as having lead exposure — allowing parents, doctors, public health officials, and communities to take action earlier to reduce the child's future exposure to lead. The new recommendation does not change the guidance that chelation therapy be considered when a child has a blood lead test greater than or equal to 45 µg/dL.

What your practice can do

Physicians can try to prevent lead poisoning in children by:

- discussing recommendations for lead screening with the parents/guardians of their pediatric patients;
- screening children starting at age 12 months and again at 24 months;
- discussing additional follow-up screening with parents and guardians;
- discussing lead safety and prevention with parents and guardians.

Resources

The following resources may assist you and your staff in effectively educating parents and guardians regarding the importance of lead screening:

- **The National Lead Poisoning Prevention Week Campaign Toolkit.** The CDC along with the EPA and the Department of Housing and Urban Development developed the National Lead Poisoning Prevention Week Campaign Toolkit to encourage information sharing, collaboration, and promotion of lead poisoning prevention activities. To download the toolkit, please visit *www.cdc.gov/nceh/lead/nlppw.htm*.
- **Lead Safe Babies Program.** 215-731-7148 (Philadelphia residents)
- **National Lead Information Center.** 1-800-424-LEAD (non-Philadelphia residents)

Additional resources on patient management can be found on our website at *www.ibx.com/providers/resources*.

[1]Centers for Disease Control and Prevention. Childhood Lead Poisoning. www.cdc.gov/nceh/lead.

[2]United States Environmental Protection Agency (EPA). Basic Information, Facts about lead. http://epa.gov/lead.

[3]United States Environmental Protection Agency (EPA). Basic Information, Facts about lead. http://epa.gov/lead.

[4]Centers for Disease Control and Prevention. www.cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm.

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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 2013. 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 Medicare-eligible members 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 2011, 58 percent of SilverSneakers participants reported their health as "excellent" or "very good"* compared to only 30 percent of Medicare-eligible members 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 Medicare-eligible members 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 Select, Keystone 65 Preferred HMO, and Personal Choice 65℠ 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, 2011 (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.

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2012-2013 Clinical Practice Guideline Summary now available

We recently posted the *2012-2013 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.

Changes in the *2012-2013 Clinical Practice Guideline Summary* include:

- the use of proton pump inhibitors to reduce gastrointestinal risks of antiplatelet therapy and NSAID use in coronary heart disease;
- aspirin for primary prevention of cardiovascular events in people with diabetes;
- recommendations for transition from pediatric to adult diabetes care systems;
- new obesity guidelines.

You can access the *2012-2013 Clinical Practice Guideline Summary* at *www.ibx.com/clinicalguidelines*. Paper copies of the Summary, or any of the individual guidelines, can be ordered by submitting an online request at *www.ibx.com/providersupplyline* or by calling the Provider Supply Line at 1-800-858-4728.

Case management Help for your patients when they need it

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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*.

Important Resources

Resource	Contact
Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/antifraud
Care Management and Coordination Case Management	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
Connections℠ Provider Portal	www.hdproviderportal.com/ibc
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

Independence

Visit our website: www.ibx.com/pnc