Independence Blue Cross

Partners in Health UPDATE℠

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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 recently launched a new physician-to-physician email platform, intended to provide direct and succinct messaging to assist physicians in providing quality care to our members. Future email topics may include policy and billing changes, important upcoming mailings (e.g., QIPS), 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.

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

P **Professional**

F **Facility**

A **Ancillary**

Partners in Health Update℠ is a publication of Independence Blue Cross and its affiliates (IBC), created to provide valuable information to the IBC-participating provider community. This publication may include notice of changes or clarifications to administrative policies and procedures that are related to the covered services you provide in accordance with your participating professional provider, hospital, or ancillary provider/ancillary facility contract with IBC. This publication is the primary method for communicating such general changes. Suggestions are welcome.

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Blue Distinction®: New value-based designation

Blue Distinction is a national designation program, developed in collaboration with the medical community to recognize those facilities that demonstrate expertise in delivering quality specialty care — safely, efficiently, and cost effectively. Blue Distinction Centers are a key part of Blue Plans' efforts to collaborate with physicians and facilities to improve the overall quality, and resulting affordability, of specialty care.

The Blue Distinction Centers for Specialty Care® program is evolving from a quality-focused designation to a more robust, value-based designation that will recognize those facilities that demonstrate expertise in delivering quality specialty care – safely, but also efficiently, and cost effectively.

The value-based designation is awarded to facilities that meet stringent quality measures, focused on patient safety and outcomes, as well as cost-of-care criteria, which will further differentiate Blue Distinction Centers from other facilities. This may result in a fewer number of facilities who are able to maintain their designation.

The Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, is scoring the Requests For Information (RFI) that facilities recently submitted for the Blue Distinction Spine Surgery and Knee and Hip Replacement programs applying the value-based criteria. The other designations currently offered include Cardiac Care, Bariatric Surgery, Complex and Rare Cancers, and Transplants. Eligible facilities may apply during the RFI cycle, when offered, for a particular designation. For the next RFI cycle for these designations, the value-based criteria will be applied.

For those facilities that meet the quality metrics, new cost criteria have been added to address market demand for affordable health care amid significant cost variation for the specialty care areas addressed by Blue Distinction programs.

On a national level, Blue Plans are active in marketing Blue Distinction Centers to nearly 100 million members through national public relations, recognition in a National Provider Directory, and other promotional efforts.

For more information regarding the Blue Distinction Program, please contact Phil Gehman at *phil.gehman@ibx.com* or 215-640-7694.

IBC study shows that integrating medical and pharmacy benefits offers advantages to members

In the February 2012 issue of *Benefits Magazine*, IBC published a study indicating that employers who choose integrated medical and pharmacy benefits for their employees are more likely to have lower medical costs. Members with integrated benefits saved an average of $19.76 per month per member.

In addition, employees are able to achieve better overall health. The study's findings show that an integrated benefits approach results in lower use of hospital and emergency room (ER) services. For members with integrated benefits, the number of hospital admissions was 19 percent lower and the number of ER visits was 28.6 percent lower than members with only medical or pharmacy benefits.

Through IBC's integrated benefits program, we are able to analyze employers' medical and prescription drug claims together to:

- identify members who have gaps in care;
- provide timely intervention;
- perform targeted member outreach through disease management and wellness programs.

Our integrated benefits program also works to maximize the value of our customers' health care dollars by offering key cost-saving controls, such as highly effective formulary and other utilization management programs and continued promotion of generic prescription drugs over brand name drugs. The value of the program may be especially important for members with chronic conditions for whom the right care management relies on them adhering to appropriate medication regimens.

Read the complete article by going to *www.ifebp.org/pdf/webexclusive/12feb.pdf*.

ICD-10 Spotlight:
Know the codes

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

Each month, this section 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.

CONDITIONS: DIABETES AND PRESSURE ULCER

This example demonstrates how to code diabetes and pressure ulcers using “combination codes.” A combination code is a single code used to clarify one of the following:

- two diagnoses;
- a diagnosis with an associated secondary process (manifestation);
- a diagnosis with an associated complication.

The combination code should be documented only if the code fully identifies the diagnostic conditions involved. All of the diagnostic conditions must be clearly documented.

The tables below show how multiple ICD-9 codes translate to new ICD-10 combination codes.

ICD-10 ***diabetes mellitus*** codes are combination codes that include:

- type of diabetes mellitus;
- body system affected;
- the complication/manifestion affecting the body system.

ICD-9 coding table	ICD-10 coding table
• 250.52 Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled • 362.05 Moderate nonproliferative diabetic retinopathy • 362.07 Diabetic macular edema	• E11.331 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema

ICD-10 ***pressure ulcer*** codes are combination codes that include:

- the site (lower back) of the pressure ulcer;
- the location (right/left) of the pressure ulcer;
- the stage of the pressure ulcer.

ICD-9 coding table	ICD-10 coding table
• 707.03 Pressure ulcer, lower back • 707.22 Pressure ulcer stage II	• L89.132 Pressure ulcer of right lower back, stage 2 OR • L89.142 Pressure ulcer of left lower back, stage 2 OR • L89.152 Pressure ulcer of sacral region, stage 2*

**The sacral region (coccyx and sacrum) is uniquely identified in ICD-10. In ICD-9, that region is included in the code for the lower back (707.03).*

For additional information related to IBC’s transition to ICD-10, please visit *www.ibx.com/icd10*.

ICD-10

P F A

IBC invited to present during the Pennsylvania Medical Society's ICD-10 webinar

On February 1, 2012, the Pennsylvania Medical Society (PAMED) hosted a webinar about ICD-10 and the impact on providers. IBC was invited to Harrisburg to present to PAMED members via webinar about steps that many payers are currently taking to prepare for the transition. Approximately 289 sites joined the webinar.

Joan Jennerjahn, VP Provider Network Operations and ICD-10 program lead at IBC presented about what providers can expect from payers during the transition, and touched on what IBC is doing to prepare.

PAMED members can login at *www.pamedsoc.org/ICD10webinar2* to view the webinar and PDF presentation. For more information about IBC's transition to ICD-10, visit *www.ibx.com/icd10*.

BILLING

P F A

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

Effective April 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 April 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.

ADMINISTRATIVE

P F A

IBC to introduce new urgent care benefit

On April 1, 2012, IBC will introduce a new urgent care benefit designed to provide members with a lower cost alternative to emergency rooms, when appropriate. This new benefit will allow members to receive services for urgent medical issues when they cannot access their physician's office but do not require the advanced medical services of an emergency department.

Generally, urgent care is considered medically necessary treatment for an unexpected illness or accidental injury that is not life- or limb-threatening, where immediate services are required in order to prevent a serious deterioration in the member's health.

In order to be recognized as an approved IBC urgent care provider, **centers must meet specific criteria (including network need) and be credentialed and contracted as an urgent care center by IBC**. Approved providers will be identified in the IBC provider directory as such and will be eligible to treat members without the need for a referral or authorization.

Look for future communications concerning details surrounding the new urgent care member benefit. If you have any questions about this new urgent care network, please call 1-800-ASK-BLUE.

P F A

CFID continues to keep down health care costs

Insurance fraud, waste, and abuse are major factors in the rising cost of health care in America today — costing consumers as much as $1 out of every $7 spent on health care. The Corporate and Financial Investigations Department (CFID) at IBC is doing its part to address this problem by identifying, investigating, and reporting suspicious cases of abusive practices to law enforcement authorities. In addition, recovery of overpaid claim dollars is pursued, regardless of the reasons.

2011 in review

Last year the CFID received 986 allegations of fraud, waste, abuse, or aberrant billing practices, with 116 of these allegations coming from providers or members. Because of these allegations, 106 fraud and abuse investigations were initiated. Additionally, audits of 116,106 hospital claims and over 247 professional and ancillary service provider audits were conducted, as well as over 3,550 pharmacy drug utilization desk audits and 549 pharmacy retail site audits. Evidence gathered in 2011 resulted in 42 referrals to law enforcement or regulatory authorities. Of this number, five pertained to members, 13 to doctors, and eight related to prescription fraud.

Trends and results

Through the use of sophisticated data mining software tools, the CFID analyzes all claims submitted by medical providers, facilities, and pharmacies and compares them against member enrollment data and overall provider information. Trends, patterns, and aberrant billing practices are selected for in-depth audits or investigations. The most often used fraud schemes were:

- billing for services not rendered;
- "up-coding" procedure codes on claims submitted in order to receive a higher reimbursement;
- prescription fraud.

Because of the investigations and audits performed by the CFID, over $58.9 million was recovered with an additional $6.8 million in overpaid claims identified but not yet recovered. Grand jury indictments and criminal information filings were brought against 23 individuals last year. Eleven individuals pled guilty or were convicted of health care fraud violations and received probation or incarceration ranging from six to 120 months in prison.

We need your help

Although the CFID continues its efforts to ensure that health care costs are appropriate, we still need your help. The data mining software tools and fraud hotline both provide valuable leads, but there is no substitute for your own vigilance. Allegations received from our provider community are extremely valuable, and we ask you to contact the CFID if you are suspicious of any health care activity. To do so, please call our toll-free Fraud and Compliance Hotline at 1-866-282-2707 or go to our website at *www.ibx.com/antifraud*.

P F A

Reminder: Medicare Advantage PPO network sharing billing procedures

Claims for Blue Cross® Blue Shield® Medicare Advantage PPO members who travel or reside in our 5-county Philadelphia service area should be submitted to IBC for processing.

For dates of service beginning January 1, 2011, IBC was required by the Blue Cross and Blue Shield Association (BCBSA) to participate in the BCBSA national Medicare Advantage PPO Network Sharing Program. This program mandates that we accept Medicare Advantage PPO enrollees from other Blue Cross Blue Shield Plans who travel or reside in our 5-county Philadelphia service area as our local members. Claims for these members should be submitted to IBC for processing for dates of service on or after January 1, 2011.

We previously communicated these procedures in a letter sent to participating providers in September 2010, as well as in *Partners in Health Update* from September 2010 through December 2010; however, Highmark continues to receive these claims in error. These claims will continue to be rejected and returned to providers with direction to resubmit claims to IBC for proper handling.

If you have any questions regarding this claims submission process, please contact your Network Coordinator.

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
- 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.

P F A

HIPAA 5010 troubleshooting tips

As HIPAA 5010 claims submissions come in, IBC has been identifying the most common reasons for claims rejections. Please review the following information carefully to avoid 5010 claims rejections:

- **Invalid Payer Code/NAIC in loop 2010BB, NM109:** There is additional information being placed in this field along with the 5-position Payer Code/NAIC value. As stated in the HIPAA 5010 Companion Guides, only the 5-position Payer Code/NAIC value should be placed in NM109 (where NM101 = PR and NM108 = PI).

  Correct: NM1*PR*2*IBC TRADITIONAL*****PI*54704

  Incorrect: NM1*PR*2*IBC TRADITIONAL*****PI*54704<DIV>0001202000~

- **Invalid Claim Filing Indicator in loop 2000B, SBR09:** In this loop and segment, the value "HM" is being listed as the Claim Filing Indicator. As stated in the HIPAA 5010 Companion Guides, IBC only accepts the following Claim Filing Indicators:

  BL for IBC/KHPE Products (including Select Advantage)

  MA or MB for Medicare Crossover Claims

  MC for Family Planning Claims only

- **Invalid CN1 segment:** As stated in the HIPAA 5010 Implementation Guides, 5010 transactions containing the CN1 segment will be rejected as the CN1 segment is not HIPAA compliant. This may occur if 4010 transactions are converted to the 5010 format prior to being submitted to NaviNet.

HIPAA 5010 Companion Guides can be found on the IBC website at *www.ibx.com/edi*. If you have any questions concerning your HIPAA 5010-compliant transactions, please contact your trading partner (clearinghouse/vendor).

If you are not prepared to submit 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.

P F A

Reminder: Authorization submission requirements through NaviNet

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

- medical/surgical procedures
- 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

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.

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.

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Policy notifications posted as of February 21, 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 February 21, 2012.

Policy effective date	Policy No.	Notification title	Notification issue date
March 2, 2012	11.03.02m	Bariatric surgery	February 1, 2012
March 7, 2012	08.09.11n	Medicare Part B vs. Part D Crossover Drugs	January 6, 2012
March 20, 2012	11.08.03h	Lipectomy and Liposuction	December 21, 2011
March 21, 2012	10.01.01i	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Programs	January 18, 2012
April 4, 2012	11.17.06h	Surgical and Minimally Invasive Treatments for Urinary Outlet Obstruction due to Benign Prostatic Hyperplasia (BPH)	January 5, 2012
April 4, 2012	10.06.01e	Speech Therapy	January 5, 2012
April 4, 2012	07.13.07e	Corneal Pachymetry Using Ultrasound	January 5, 2012
April 4, 2012	10.04.01j	Pulmonary Rehabilitation	January 5, 2012
April 4, 2012	11.08.12g	Surgery for Gynecomastia	January 5, 2012
April 4, 2012	05.00.09e	Bone Growth Stimulators	January 5, 2012
April 4, 2012	05.00.37d	Compression Garments	January 5, 2012
April 5, 2012	07.03.09h	Electromyography (EMG) Studies: Needle EMG, Surface EMG (SEMG)	January 6, 2012
April 5, 2012	07.03.18g	Nerve Conduction Studies (NCS) and Related Electrodiagnostic Studies	January 6, 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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Clarification on the use of Modifier 52

In the October 2011 edition of *Partners in Health Update*, we ran an article regarding the use of Modifier 52: Reduced Services. The article was designated for all provider types — professional, facility, and ancillary providers. However, the article was intended for **professional providers only**. We apologize for any issue or confusion this may have caused.

Complete policy information is available on our medical policy website at *www.ibx.com/medpolicy* by entering the policy number 03.00.32 in the Search box. If you have questions regarding this policy, please contact your Network Coordinator.

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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
Amethia Lo, Camrese Lo	LoSeasonique™	11. Female, Hormone Replacement, Birth Control	December 12, 2011
atorvastastin/amlodipine	Caduet®	4. Heart, Blood Pressure, & Cholesterol	November 12, 2011
eprosartan	Teveten®	4. Heart, Blood Pressure, & Cholesterol	December 23, 2011
flucytosine	Ancobon®	1. Antibiotics & Other Drugs Used for Infection	November 4, 2011
lamivudine	Epivir®	1. Antibiotics & Other Drugs Used for Infection	December 12, 2011
lamivudine/zidovudine	Combivir®	1. Antibiotics & Other Drugs Used for Infection	December 30, 2011
methylphenidate ER	Ritalin LA®	3. Pain, Nervous System, & Psych	December 23, 2011
morphine extended-release	Kadian®	3. Pain, Nervous System, & Psych	November 11, 2011
olanzapine	Zyprexa®	3. Pain, Nervous System, & Psych	October 21, 2011
olanzapine ODT	Zyprexa Zydis®	3. Pain, Nervous System, & Psych	October 21, 2011
tramadol ER	Ryzolt®	3. Pain, Nervous System, & Psych	December 23, 2011
trimipramine	Surmontil®	3. Pain, Nervous System, & Psych	November 18, 2011

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:

Brand drug	Formulary chapter	Effective date
Complera™	1. Antibiotics & Other Drugs Used for Infection	January 1, 2012
Lotemax® opthalmic ointment	12. Eye Medications	January 1, 2012
Tamiflu® 6mg/ml suspension	1. Antibiotics & Other Drugs Used for Infection	January 1, 2012

Brand deletions

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

Effective April 1, 2012.

Brand drug	Generic drug	Formulary chapter
Combivir®	lamivudine/zidovudine	1. Antibiotics & Other Drugs Used for Infection
Epivir®	lamivudine	1. Antibiotics & Other Drugs Used for Infection
Zyprexa®	olanzapine	3. Pain, Nervous System, & Psych
Zyprexa Zydis®	olanzapine ODT	3. Pain, Nervous System, & Psych

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

PFA

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 drugs
was effective at the time the drugs became available in the marketplace:

Brand drug	Generic drug	Drug category	Effective date
Ferriprox®	Not available	Miscellaneous	November 23, 2011
Jakafi™	Not available	Cancer	November 18, 2011

The following 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 April 1, 2012.

Brand drug	Generic drug	Drug category
Copegus®	ribavarin	Stomach, Ulcer, & Bowel Meds
Peg-Intron®	Not available	Stomach, Ulcer, & Bowel Meds
Pegasys®	Not available	Stomach, Ulcer, & Bowel Meds
Rebetol®	ribavarin	Stomach, Ulcer, & Bowel Meds
RibaPak®	ribavarin	Stomach, Ulcer, & Bowel Meds
Ribasphere®	ribavarin	Stomach, Ulcer, & Bowel Meds
RibaTab®	ribavarin	Stomach, Ulcer, & Bowel Meds

Drugs with quantity limits

Quantity limits will be added for the following drugs:

Effective April 1, 2012.

Brand drug	Generic drug	Quantity limit (per 30 days)
Aciphex®	Not available	30 tabs
Dexilant™	Not available	30 caps
Nexium®	Not available	30 caps, packets
Prevacid®	lansoprazole	30 caps, tabs
Prilosec®	omeprazole	30 caps, tabs, packets
Protonix®	pantoprazole	30 tabs, packets
Zegerid®	Not available	30 caps, packets

Strong bones, improved quality of life for women: Controlling osteoporosis after a fracture

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An estimated 55 percent of Americans over age 50 (44 million individuals) currently have osteoporosis or are at risk for the condition due to dangerously thinning bones (osteopenia).[1] Over 2 million fractures of the hip, wrist, or spine were attributed to osteoporosis in 2005 — a number that is expected to rise 50 percent within the next two decades. For individuals in the 65 to 74 age group, the increase is projected to top 87 percent.[2] The price tag for direct medical care for osteoporotic fractures is also steep, approaching $15 billion annually[3], but the cost in individual pain, disability, and reduced quality of life can be immeasurable.[2]

Especially vulnerable are women over 50, who account for 80 percent of osteoporosis cases. Plummeting hormone levels during the five to seven years following menopause can result in a 20 percent loss of bone density during this period.[1] Since early-stage bone thinning produces no obvious symptoms, a fracture is often the first indicator of a problem. By this time, the condition can be quite advanced. For example, women who suffer a hip fracture have a four times greater risk of subsequent osteoporotic fractures.[1]

Tracking intervention after a fracture

Despite this evidence, many women do not receive bone mineral density (BMD) testing or osteoporosis treatment in the months following a fracture.[3] In an effort to shed light on this disparity, the National Committee for Quality Assurance (NCQA) reports the percentage of women over age 67 who receive a BMD test or are prescribed osteoporosis medication within six months following a fracture. Exceptions include women who have had BMD testing within the last year or who already take osteoporosis drugs.[4]

In order to receive a 4-star rating from the Centers for Medicare & Medicaid Services (CMS), a health plan must fulfill the above NCQA measure at least 60 percent of the time. However, only four CMS contracts achieved this goal for 2012. The majority provided screening and intervention to less than 24 percent of patients for whom it was appropriate, earning only a 1- or 2-star rating.[5] Keystone 65 HMO and Personal Choice 65℠ PPO currently have a 2-star rating for this measure, with both plans at 14 percent.

Treatment of osteoporosis and osteopenia

The National Osteoporosis Foundation (NOF) guidelines recommend that women age 50 and older receive pharmacological therapy for bone loss if they have a history of hip or spine fracture or have experienced another type of fracture and show reduced bone mass (a T-score between -1.0 and -2.5) when tested using dual-energy X-ray absorptiometry (DXA).[6]

A bisphosphonate drug is the primary medication choice for most women. Multiple studies confirm the effectiveness of bisphosphonates in preventing vertebral, non-vertebral, and hip fractures. The drug alendronate, now available in generic form, has been shown to cut in half the number of hip and spine fractures over three years in women who have had a previous fracture. It is also approved for use in women with early bone loss.

Additional medications are also available, but the choice of drug ultimately depends on the individual patient's risk profile and preference. When possible, physicians should consider formulary options so members can maximize their health plan benefits. For more information about coverage and precertification requirements for treatment options, please refer to our medical policy website at *www.ibx.com/medpolicy*. Select *Accept and Go to Medical Policy Online*, and then type "osteoporosis" in the Search box.

To supplement the medication regimen, physicians may wish to counsel their patients on the importance of diet and exercise in maintaining bone health:

- **Calcium.** All adults need at least 1,200 mg of calcium a day. Since people age 50 and older often do not consume more than 600 to 700 mg in their daily diets, calcium supplements are recommended.
- **Vitamin D.** Vitamin D is equally important. The NOF advises regular daily intake of 800 to 1,000 IU of vitamin D daily for most adults, but individuals who have health conditions that limit vitamin D absorption may need as much as 2,000 IU a day to maintain adequate levels. Following a fracture, patients should be tested for vitamin D deficiency and treated with therapeutic doses of the vitamin until blood levels reach a normal range.
- **Exercise.** Since weight-bearing exercise is critical in preserving bone mass, rehabilitation is often recommended following a fracture to help patients resume activities of daily living and establish a regular exercise routine. Improvement in strength and balance can also help prevent falls and future fractures.

continued on next page

Strong bones, improved quality of life for women: Controlling osteoporosis after a fracture (continued)

- **Alcohol and tobacco cessation.** Physicians should discourage health habits that are linked to bone loss, such as tobacco use and heavy alcohol consumption. Efforts should be made to steer the patient to smoking cessation programs or other suitable treatment options.[8]

Physicians may also wish to review the patient's current medication list to see if they can eliminate drugs that increase the risk of osteoporosis, such as corticosteroids, heparin, aromatase inhibitors, and some anti-epilepsy medications. The patient should also be evaluated for conditions that exacerbate bone loss, including hyperparathyroidism, hyperthyroidism, malnutrition, malabsorption, and liver disease. In addition, the question of whether to perform routine DXA testing on patients taking bisphosphonate medications has been the subject of controversy. Analysis from the Fracture Intervention Trial, however, indicates that there is no benefit to repeating scans within the first three years of treatment.[7]

It is important for physicians to follow up after therapy is initiated to ensure that patients continue their treatment regimen. One of the major obstacles to osteoporosis treatment is patients' failure to take their medication due to restrictive dosing schedules or unpleasant side effects. Medication adherence can be markedly improved by regular phone calls or direct contact with the patient to address these problems.[8] Patients may also benefit from health coaching to support healthful diet, exercise, and lifestyle choices and assess ongoing fracture risk.

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

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