Independence Blue Cross

Partners in Health UPDATE[SM]

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QUALITY MANAGEMENT

- Our Quality Management Program promotes quality of care and service

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

This just in....

Claims preprocessor enhancements

We recently made a change to our claims preprocessor worksheet – specifically to *Error Code P0016B*. The document and the edit have been updated in order for claims to be submitted with the correct data elements. The revised worksheet is available on our website at *www.ibx.com/ediforms*.

The *Claims Preprocessing Claims Resolution Document* highlights rules that will be applied to claims and provides a comment on how to remedy rejected claims. It is intended to provide guidance on current billing submission errors that we have encountered.

Additionally, it helps determine why a claim was rejected and provides a basis for resubmitting a clean claim. The worksheet may be updated on a regular basis to reflect new error codes and claim resolution instructions.

For additional assistance regarding this worksheet, contact the eBusiness Help Desk at 215-241-2305.

Member benefits changes

The November edition of *Partners in Health Update* included an article on upcoming member benefits changes and clarifications. To further clarify the change for outpatient substance abuse providers, language is being revised to include care for outpatient-based opiate detoxification services when performed in an office-setting by an appropriately licensed behavioral health care provider and will require precertification.

If you have questions regarding this change, please call Customer Service at 1-800-ASK-BLUE.

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

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

- **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.

Contact Information:

Provider Communications
Independence Blue Cross
1901 Market Street
35th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

John Shermer
Managing Editor

Charleen Baselice
Production Coordinator

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

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FutureScripts® and FutureScripts® Secure are independent companies that provide pharmacy benefits management services.

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

Administrative

P

ClaimCheck® update and edit clarification scheduled

Please be aware of upcoming changes being made to ClaimCheck, the comprehensive code-auditing tool that we use to evaluate the relationships between procedure codes submitted on the CMS-1500 claim form (or equivalent electronic format). Claims are edited by ClaimCheck to ensure that correct coding rules and guidelines are used.

Upgrade scheduled

In an effort to maintain an enhanced level of transparency, the ClaimCheck software will be upgraded from version 9.0.45 to 9.0.46, **effective December 13, 2010.** This upgrade applies to all contracted providers who bill for professional services for IBC members by way of the CMS-1500 claim form (or equivalent electronic format).

Upgrades to ClaimCheck are scheduled twice yearly, typically in the spring and fall. The release schedule for ClaimCheck upgrades is subject to modification for business reasons. Edits are sourced to various nationally accepted authorities, including the American Medical Association, CPT® (Current Procedure Terminology), Centers for Medicare & Medicaid Services, and national specialty societies.

Clarifying edits for reprocessed or adjusted claims

ClaimCheck and Clear Claim Connection™ are updated regularly for consistency with medical and claim payment policy, new procedure codes, current health care trends, and/or medical and technological advances. ClaimCheck clinical relationship logic is applied based on the date a claim is processed, reprocessed, or adjusted in our claims processing system. Clinical relationship logic is *not* applied based on the date the service was performed; therefore, claims that are reprocessed or adjusted for any reason may receive a different editing outcome from ClaimCheck based on the clinical relationship logic that is in effect at the time the claim adjustment occurs.

Notwithstanding the foregoing, it is understood that a specific claim payment policy may supersede the terms of this policy with respect to only the subject of such specific claim payment policy.

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

Products

P F A

New product portfolio for small group customers

Recently, IBC introduced the Blue Solutions® product portfolio, 25 newly created health care plans for small businesses (customers with 2 – 50 employees). These new plans are based on the most popular products offered by IBC in the past, but they've been further enhanced to comply with health care reform provisions. All of the plans also include prescription and vision coverage.

Effective January 1, 2011, all small group customers will be required to choose a plan from the Blue Solutions product portfolio upon the group's renewal date; therefore, it is possible that a high number of your patients will have different cost-sharing or copayment amounts when they move to their new benefits plan. For this reason, it is important that you check your members' ID cards for the most current information. Providers can also check the NaviNet® web portal to verify member eligibility and cost-share information.

Please contact Customer Service if you have questions about these new plans.

Note: *Some plans may exclude prescription drug coverage.*

BLUEsolutions®
FOR SMALL EMPLOYERS

Reminder: The new Blue Cross® Blue Shield® Medicare Advantage PPO Network Sharing program starts January 1

Effective for dates of service beginning January 1, 2011, IBC will be required by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield plans, to participate in the BCBSA national Medicare Advantage PPO Network Sharing program and 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. Similar to the current BlueCard® Program for commercial Blue Cross Blue Shield PPO Plans, this national BCBSA initiative enables enrollees in one Blue Cross Blue Shield Medicare Advantage PPO Plan to obtain health care benefits and services from participating Blue Cross Blue Shield Plan providers while traveling or living in another Blue Cross and/or Blue Shield Plan's service area.

How this affects participating providers

As a participating provider, you will be expected to provide services to these Blue Cross Blue Shield Medicare Advantage PPO enrollees who present to you for treatment as you would any other Blue Cross Blue Shield Medicare Advantage PPO member.

Facility providers

IBC will continue to process participating provider claims for covered facility services (e.g., hospitals, skilled nursing facilities, ambulatory surgery centers, renal dialysis) for these Blue Cross Blue Shield Medicare Advantage PPO enrollees. For admissions on or after January 1, 2011, you will be paid the contracted rates for covered services for these members. For more information on claims submission, please refer to the Facility Payer ID grid on our website at *www.ibx.com/edi*.

Professional and ancillary providers

For professional and ancillary providers who submit claims on the CMS-1500 claim form or through the 837P transaction, your contract will be amended to cover your provision of services to these Blue Cross Blue Shield Medicare Advantage PPO enrollees and claims for services rendered to them. You should continue to submit commercial BlueCard claims to Highmark Blue Shield, as this process will not change. IBC will process only Blue Cross Blue Shield Medicare Advantage PPO claims.

For Blue Cross Blue Shield Medicare Advantage PPO claims that span dates of service from 2010 into 2011, you will be required to split the claim for billing purposes. Claims with dates of service up to December 31, 2010, should continue to be submitted to Highmark Blue Shield. For information on where to submit claims for dates of service on or after January 1, 2011, please refer to the Professional Payer ID grid on our website at *www.ibx.com/edi*.

All providers

The ID cards for these Blue Cross Blue Shield Medicare Advantage PPO enrollees will contain "MA" in the suitcase logo. These enrollees have been instructed to provide their Blue Cross Blue Shield Medicare Advantage PPO ID card — not their standard Medicare ID card — when presenting to your office/facility for services.

The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) and the Local Coverage Determinations (LCD), as well as select IBC Reimbursement Policies, will be applied to claims for a Blue Cross Blue Shield Medicare Advantage PPO plan enrollee by IBC as a Host Plan. Home Plan Medical Policy may still be applied. For CMS-1500 or 837P claims received, the National Correct Coding Initiative edits of CMS will be applied during claims adjudication.

All claims submissions for Blue Cross Blue Shield Medicare Advantage PPO enrollees to the Host Plan IBC must be completed in accordance with Personal Choice 65℠ PPO guidelines.

Resources

Visit *www.ibx.com/medpolicy* for more detailed information regarding NCDs and LCDs or to view a list of the applicable IBC Reimbursement Policy documents. Be sure to visit the site often, as it is updated regularly.

If you have any questions about Blue Cross Blue Shield Medicare Advantage PPO, please contact your Network Coordinator.

Note: Behavioral health providers can expect to receive communications regarding this initiative directly from Magellan Behavioral Health, Inc., an independent company; however, all other aspects of this product apply.

New $25 copayment option and PCP capitation rate for Medicare Advantage HMO members

IBC will offer a new copayment option to HMO members enrolled in our Medicare Advantage Benefits Program, **effective January 1, 2011**. Medicare Advantage members who select this HMO benefit plan option will receive new ID cards with the new $25 copayment listed. Your capitation payment for members with this benefit option will be based on new rates that are actuarially equivalent to your current capitation rates.

If you have any questions regarding member eligibility, visit the NaviNet® web portal and select *Member Eligibility and Benefits Inquiry* from the Plan Transactions menu. If you are not NaviNet-enabled, go to *www.navinet.net* and select *Sign up* from the top right. You can also register for NaviNet by calling the IBC eBusiness Provider Hotline at 215-640-7410.

Billing

Mental health and substance abuse benefit changes for Federal Employee health program

Effective January 1, 2011, the following changes will be made to the mental health and substance abuse benefits for the Federal Employee Program (FEP):

Copayment waiver for pre- and post-partum depression visits

The copayment will be waived for up to four visits for members who are seeking treatment for pre- and post-partum depression. This applies to both the Standard and Basic Option for outpatient facility services incurred on or after January 1, 2011. Up to four copays will be waived when claims are billed with one of the following primary diagnosis codes:

- 648.40
- 648.41
- 648.42
- 648.43
- 648.44

Residential Treatment Centers

Residential Treatment Centers (RTCs) will no longer be treated as covered providers. Changes will be put in place to discontinue Preferred Mental Health/Substance Abuse benefits for facility claims submitted by RTCs unless they are provided under the case management process. This applies to both the Standard and Basic Option for claims incurred on or after January 1, 2011 with a Residential Treatment revenue code equal to 1001 or 1002.

Obtaining prior approval

The requirement that prior approval must be obtained before payment is made for any outpatient facility mental health/ substance abuse benefit is being removed. This includes partial hospitalization programs and intensive outpatient programs at preferred or non-preferred facilities. This applies to both the Standard and Basic Option for services incurred on or after January 1, 2011.

If you have any questions regarding these changes, please contact your Network Coordinator

Policy notifications posted as of November 17, 2010

PFA

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 17, 2010.

Policy effective date	Notification title		Notification issue date
December 8, 2010	**08.00.78c**	Self-Injectable Drugs	November 8, 2010
December 8, 2010	**11.09.02**	Sex Reassignment Surgery (SRS) for Gender Identity Disorder (GID)	November 8, 2010
December 10, 2010	**08.00.06d**	Inpatient Administration of Intravenous Dihydroergotamine Mesylate (D.H.E. 45®)	November 10, 2010
December 10, 2010	**08.00.08d**	Radioimmunotherapy with Ibritumomab Tiuxetan (Zevalin®)	November 10, 2010
December 15, 2010	**08.00.94**	Denosumab (Prolia™)	September 16, 2010
December 29, 2010	**08.00.82a**	Ustekinumab (Stelara™) for Subcutaneous Injection	September 29, 2010
January 1, 2011	**08.00.66f**	Bevacizumab (Avastin®)	September 30, 2010
January 1, 2011	**08.00.26l**	Botulinum Toxin Agents	September 30, 2010
January 1, 2011	**08.00.67e**	Cetuximab (Erbitux®)	September 30, 2010
January 1, 2011	**08.00.86**	Ecallantide (Kalbitor®)	September 30, 2010
January 1, 2011	**08.00.84**	Eculizumab (Soliris®)	September 30, 2010
January 1, 2011	**08.00.51c**	Enzyme Replacement for the Treatment of Gaucher's Disease (e.g., Alglucerase [Ceredase®], Imiglucerase [Cerezyme®], Velaglucerase Alpha [VPRIV™])	September 30, 2010
January 1, 2011	**08.00.25f**	Epoprostenol (Flolan®) and Treprostinil (Remodulin®)	September 30, 2010
January 1, 2011	**08.00.13h**	Immune Globulin: Intravenous (IVIG), Subcutaneous (SCIG)	September 30, 2010
January 1, 2011	**08.00.76b**	Oxaliplatin (Eloxatin®)	September 30, 2010
January 1, 2011	**08.00.50h**	Rituximab (Rituxan®)	September 30, 2010
January 1, 2011	**08.00.85**	Tocilizumab (Actemra®)	September 30, 2010
January 1, 2011	**08.00.33h**	Trastuzumab (Herceptin®)	September 30, 2010
January 1, 2011	**08.00.91**	Alpha 1-Proteinase Inhibitor Therapy (e.g., Prolastin, Aralast, Aralast NP, Glassia, Zemaira)	October 1, 2010
January 1, 2011	**08.00.93**	C1 Esterase Inhibitors (Human): Cinryze® and Berinert®	October 1, 2010
January 1, 2011	**08.00.92**	Coagulation Factors for Hemophilia	October 1, 2010
January 1, 2011	**11.14.13e**	Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions	October 1, 2010
January 1, 2011	**08.00.34e**	Infliximab (Remicade®)	October 1, 2010
January 1, 2011	**08.00.88**	Ofatumumab (Arzerra™)	October 1, 2010
January 1, 2011	**08.00.95**	Sipuleucel-T (Provenge®)	October 1, 2010
January 1, 2011	**08.00.90**	Paclitaxel Protein-bound Particles for Injectable Suspension (Albumin-bound)/(Abraxane® for Injectable Suspension)	October 1, 2010
January 1, 2011	**08.00.87**	Pemetrexed (Alimta®)	October 1, 2010

continued on next page

Policy notifications posted as of November 17, 2010 (continued)

Policy effective date	Notification title	Notification issue date
January 11, 2011	**11.14.06e** Autologous Chondrocyte Implantation (ACI)/Carticel® and Other Cell-based Treatments of Focal Articular Cartilage Lesions	October 13, 2010
January 11, 2011	**08.00.68c** Ibandronate Sodium (Boniva®) for Intravenous Injection	October 13, 2010
January 11, 2011	**11.14.12b** Osteochondral Allograft Transplantation	October 13, 2010
January 11, 2011	**11.14.09d** Osteochondral Autograft Transplantation (OAT) Procedure	October 13, 2010
January 11, 2011	**08.00.97** Romidepsin (Istodax®)	October 13, 2010
January 12, 2011	**00.01.25j** PPO Network Rules for Provision of Specialty Services for Durable Medical Equipment and Laboratory, Radiology, and Physical Medicine and Rehabilitative Services	October 14, 2010
January 25, 2011	**11.02.06f** Catheter Ablation of Cardiac Arrhythmias	October 27, 2010
January 26, 2011	**07.03.07f** Evaluation and Management of Autism Spectrum Disorders (ASD)	October 28, 2010
February 9, 2011	**11.14.11d** Arthroscopic Electrothermal Joint Repair	November 11, 2010

To view the policy notifications, go to *www.ibx.com/medpolicy*, select *Accept and Go to Medical Policy Online,* and then click on the *Policy Notifications* box. You can also view policy notifications using the NaviNet® web portal by selecting *Reference Materials and Reports* from the Plan Transactions menu and then *Medical Policy.* Once these polices 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.

Changes to our self-injectable drugs policy

Effective January 1, 2011, two changes will be made to Medical Policy #08.00.78: Self-Injectable Drugs, as detailed below.

Removing Intron A®

Intron A®, which includes Intron A Pen® will be removed from the policy because there are clinical scenarios when health care providers must directly administer this product to patients. As a result, this drug will only be available under the **medical benefit** and will no longer be available under the pharmacy benefit. Note, however, that providers may begin billing for Intron A® under the medical benefit effective December 8, 2010.

This change should not affect your patients' ability to receive coverage for this drug. However, your patients can now have this drug shipped directly to their home or your office through the Direct Ship Pharmacy Program. To set up delivery of either product, please complete and submit a Direct Ship injectable form, which can be found at *www.ibx.com/providerforms*.

Adding tesamorelin (Egrifta)

In anticipation of approval from the U.S. Food and Drug Administration (FDA), tesamorelin (Egrifta) will be added to the Self-Injectable Drugs policy. Tesamorelin (Egrifta) will only be made available under the **pharmacy benefit**; it will not be available under the medical benefit. Please note that tesamorelin (Egrifta) is not eligible for coverage until the drug receives FDA approval.

To view the policy notification for Self-Injectable Drugs, go to *www.ibx.com/medpolicy*, select *Accept and Go to Medical Policy Online*, and then type the policy name or number in the Search box.

P

Prescription and documentation requirements for physical and occupational therapy services

This is a reminder to providers, especially physical therapy (PT) and occupational therapy (OT) providers, that according to Claim Payment Policy #10.03.01a: Physical Medicine and Rehabilitation Services, a prescription/order must be received from a physician prior to a member receiving therapy services.

Even though certain providers who have been issued certificates (referred to as Direct Access by the American Physical Therapy Association [APTA]*) by their state regulatory agency which may permit the ability to treat a patient for 30 calendar days without a prescription/order from a physician, IBC requires a prescription from a physician for our member's coverage. In addition to other criteria, only PT services ordered by a physician are eligible for reimbursement. As the policy states:

> "Benefits for physical therapy (PT) and occupational therapy (OT) evaluation and management (E&M) services, modalities, and therapeutic procedures, along with tests and measurements, are considered eligible for reimbursement by the Company when...the service is prescribed by a physician...For reimbursement, the Company requires that a physician must prescribe the service, even though Direct Access is available to licensed practitioners in designated states."

In addition to a prescription, IBC may also request documentation for therapy services rendered and conduct audits that investigate proper documentation. As the policy states:

> "Documentation should be available for review upon request from the Company. The medical record should include the plan of care that has been written and developed by the eligible health care provider. The plan of care must be established prior to the initiation of therapy and signed by the provider...
> The Company conducts reviews and audits of services provided to our members, regardless of the participation status of the treating provider. This process will include, but is not limited to, the review of all services related to the claim prior to payment and post-payment review/audit of paid claims. Reviews may initially focus on adequate documentation, the proper usage of CPT® and Healthcare Common Procedure Coding System (HCPCS) codes according to the appropriate level of service provided, and the utilization of rehabilitation services."

Please visit our Medical Policy website at *www.ibx.com/medpolicy* for IBC's full coverage and billing requirements for physical medicine and rehabilitation services.

**Please be advised that the APTA's Direct Access has no relation to IBC's Direct Access℠ OB-GYN benefit for HMO and POS members.*

PFA

New requirements for precertification and user guide available

IBC requires that certain drugs receive precertification before coverage is available for our members. Precertification ensures that members meet the medical necessity criteria listed in our policies. **Effective January 1, 2011,** there will be two new requirements for precertification:

- For *all drugs* covered under the medical benefit that require precertification, providers must report additional member data, such as height and weight.
- For the following eight drugs, Dosing and Frequency Requirements will be applied during precertification:
  - cetuximab (Erbitux®)
  - trastuzumab (Herceptin®)
  - onabotulinumtoxinA (Botox®)
  - bevacizumab (Avastin®)
  - rituximab (Rituxan®)
  - oxaliplatin (Eloxatin®)
  - intravenous immune globulin (IVIG)
  - infliximab (Remicade®)

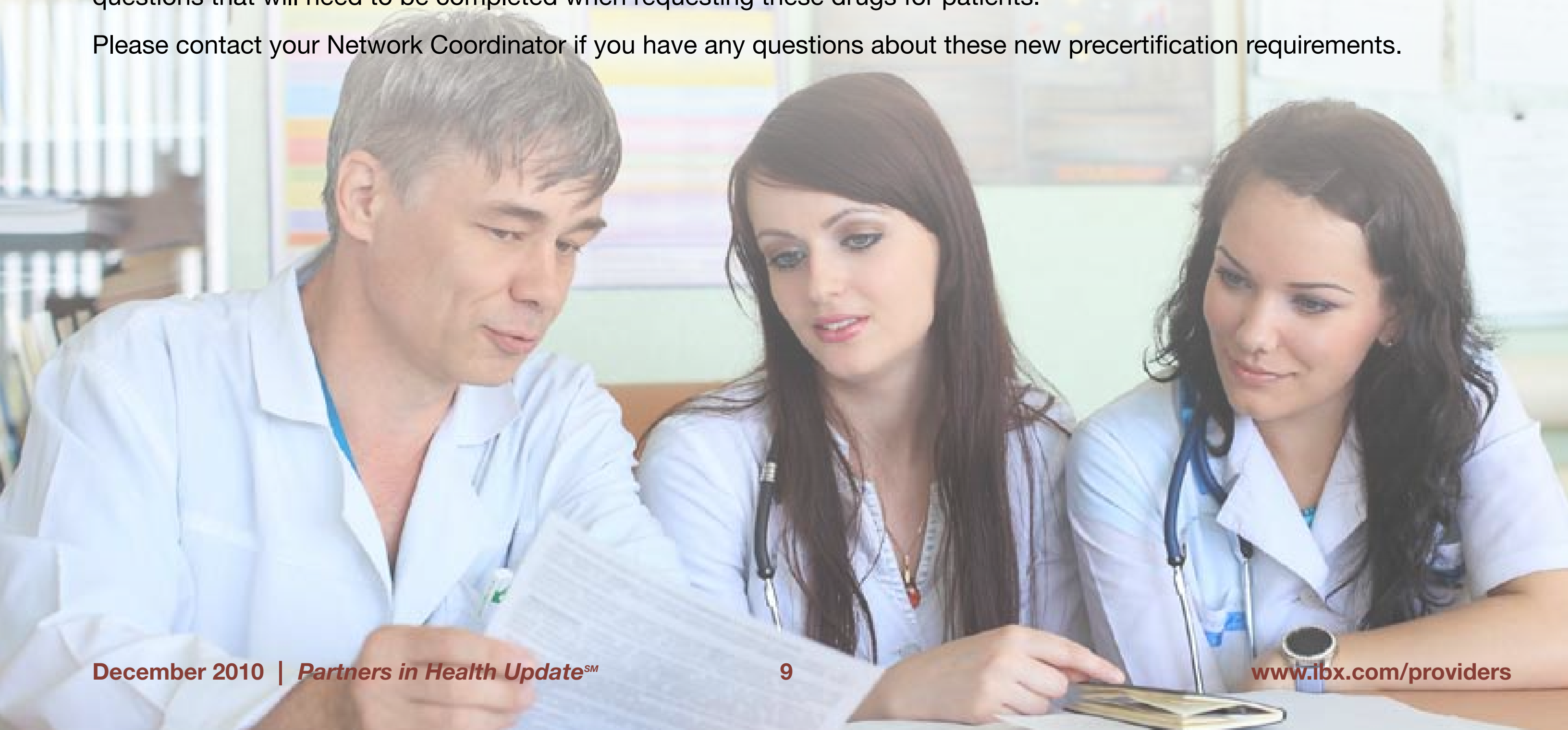
Dosing and Frequency Requirements

The Dosing and Frequency Requirements will be included in the medical policies for the eight drugs listed above. To view the policy notifications for these eight drugs, go to *www.ibx.com/medpolicy*, select *Accept and Go to Medical Policy Online,* and then click on the *Policy Notifications* box. You can also view policy notifications using the NaviNet® web portal by selecting *Reference Materials and Reports* from the Plan Transactions menu and then *Medical Policy.* Once these polices become effective, they will be available by typing the drug names into the Search box on the Medical Policy homepage.

The Dosing and Frequency Requirements help IBC verify that our members' drug regimens are in accordance with national prescribing standards. They are based on current U.S. Food and Drug Administration approval, drug compendia (e.g., American Hospital Formulary Service Drug Information®, Micromedex®), industry-standard dosing templates, drug manufacturers' guidelines, published peer-reviewed literature, and pharmacy and medical consultant review. Requests for coverage outside these requirements will need documentation (i.e., published peer-reviewed literature) to support the request.

A user guide on the Dosing and Frequency Requirements will be available in December for providers and their office staff through the NaviNet® web portal in the Administrative Tools & Resources section as well as in the medical policies for the eight drugs above as an attachment. The user guide explains how the Dosing and Frequency Requirements for these eight drugs are being implemented as part of the precertification process, and it gives examples of the clinical logic questions that will need to be completed when requesting these drugs for patients.

Please contact your Network Coordinator if you have any questions about these new precertification requirements.



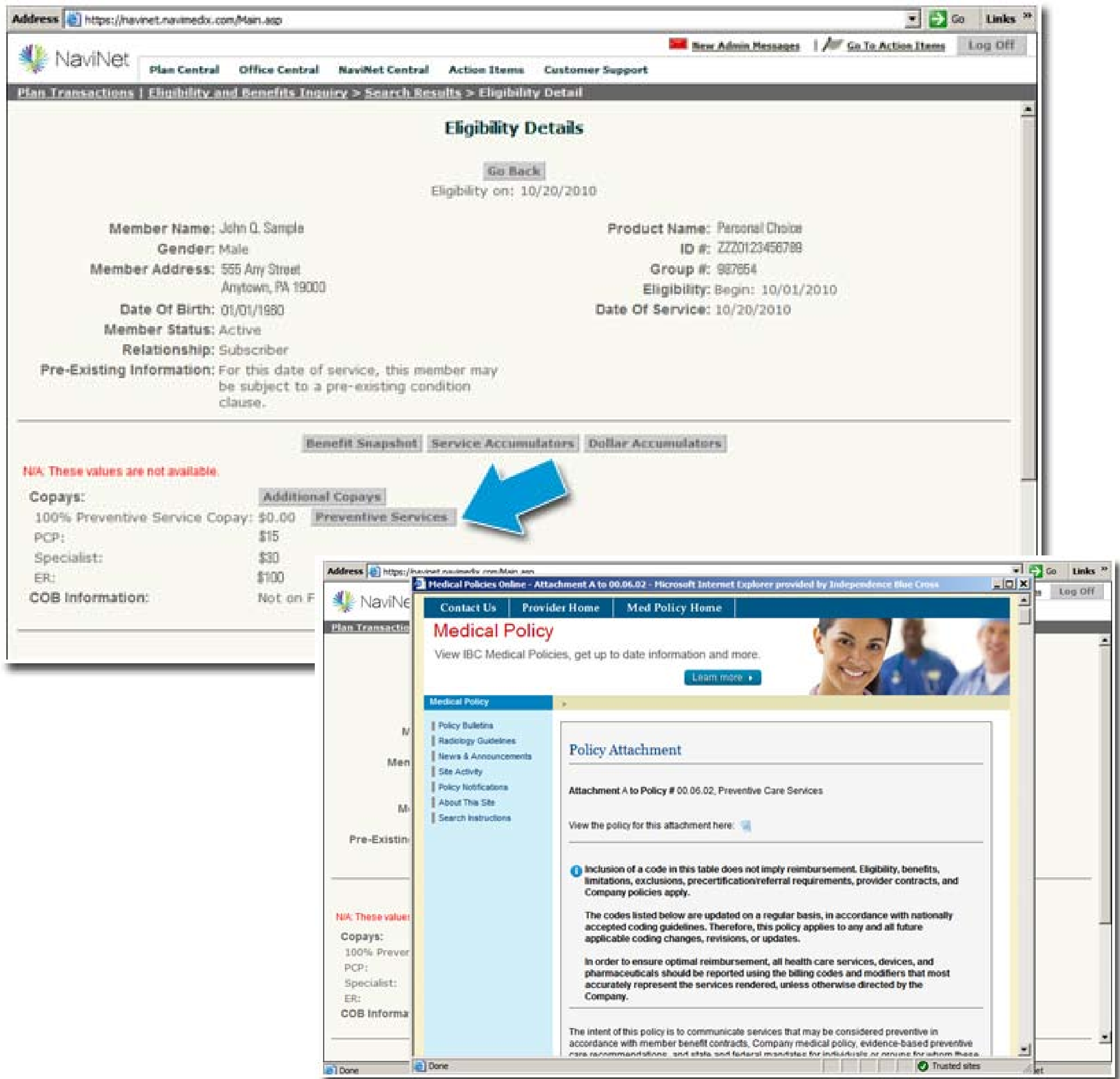
PFA

Enhancements made to the NaviNet web portal

In October, enhancements were made to the *Eligibility and Benefits Inquiry* and *BlueExchange® Out of Area* transactions. The following describes those changes and where they are located within the transactions.

Preventive services

You can now find additional information for eligible members regarding copayment amounts for preventive services. When you select *Eligibility and Benefits Inquiry* from the Plan Transactions menu and enter a member's information, you will notice a new option under the "Copays" section. By selecting *Preventive Services*, you will be taken to the IBC Medical Policy website where you can view Medical Policy #00.06.02: Preventive Care Services and a list of all services that have a $0 copay.



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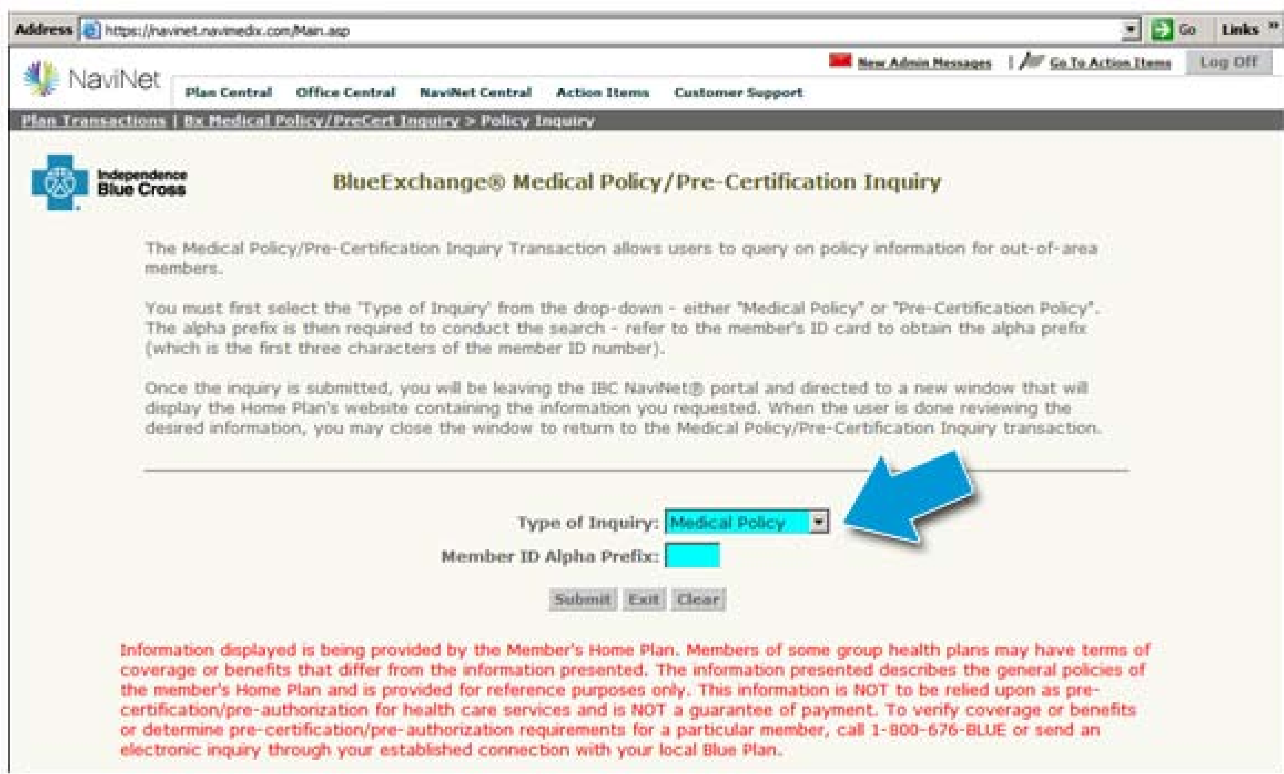
Enhancements made to the NaviNet web portal (continued)

Medical Policy/Precert Inquiry

The *BlueExchange Out of Area* transaction now offers a menu option that gives you access to information regarding a member's Home plan's medical policy and precertification requirements. To find this information, select *BlueExchange Out of Area* from the Plan Transactions menu and then *Medical Policy/PreCert Inquiry*.

To conduct a search, select *Medical Policy* or *Pre-Certification* from the drop-down menu under "Type of Inquiry." Simply enter the member ID alpha prefix noted on the insurance card and select *Submit*. The information displayed is provided by the member's Home plan. If you have any questions regarding the information, they should be directed to the member's Home plan.



If you have any questions regarding these enhancements, please contact NaviNet Customer Care at 1-888-482-8057 or our eBusiness Provider Hotline at 215-640-7410. If you are not NaviNet-enabled and would like to take advantage of these new enhancements, you can register for NaviNet access by going to *www.navinet.net* and selecting *Sign up* from the top right.

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 FutureScripts® Pharmacy and Therapeutics Committee reviews the formulary to ensure its continued effectiveness. The most recent changes are listed below.

Generic additions

The generic drugs below 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
diazepam rectal gel	Diastat®	3. Pain, Nervous System, & Psych	September 2, 2010
diazepam rectal gel	Diastat® AcuDial™	3. Pain, Nervous System, & Psych	September 10, 2010
hydrocodone-clorpheniramine suspension	Tussionex®	13. Allergy, Cough & Cold, Lung Meds	October 8, 2010
oxymorphone	Opana®	3. Pain, Nervous System, & Psych	October 1, 2010

Brand additions

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

Brand drug	Formulary chapter	Effective date
Clobex® Lotion, Shampoo, and Spray	5. Skin Medications	October 1, 2010
Epiduo®	5. Skin Medications	October 1, 2010
EpiPen®	13. Allergy, Cough & Cold, Lung Meds	October 15, 2010
Fragmin®	9. Biotechnology	October 1, 2010
Lunesta®	3. Pain, Nervous System, & Psych	October 1, 2010
Metrogel® Combo Pack	11. Female, Hormone Replacement, Birth Control	October 1, 2010
Oracea®	1. Antibiotics & Other Drugs Used for Infection	October 15, 2010
Qvar®	13. Allergy, Cough & Cold, Lung Meds	October 1, 2010
Rapaflo®	14. Urinary & Prostate Meds	October 1, 2010
Vectical®	5. Skin Medications	October 15, 2010
VESIcare®	14. Urinary & Prostate Meds	October 1, 2010

P

2011 performance incentive program revisions for PCPs

We have made changes to the Quality Incentive Payment System (QIPS) program for measurement year 2011 for participating primary care physicians (PCP) in Pennsylvania.

The QIPS Program Manual has been updated to reflect the following:

- **QPM feedback audit.** Provider office records may be audited based on feedback received from providers in response to the Quality Performance Measure (QPM) mailing sent in the first quarter following the end of the measurement period.
- **Medical cost exclusions.** Inpatient professional services were added to the list of exclusions.
- **Generic prescribing.** Changes have been made to the generic prescribing measure.
- **Medical Cost Management guidelines for combining practices.** Guidelines have been added for those providers requesting to combine their practice membership for purposes of meeting member thresholds as required by the Medical Cost Management Program.
- **Changes to practice composition.** Various scenarios have been outlined and describe how each would affect the provider's QIPS status.

QIPS Program Manual

The *QIPS Program Manual – Measurement year 2011* is now available on the NaviNet® web portal and provides additional information about these revisions. Printed copies of the QIPS Program 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.

For additional information regarding QIPS, please contact your Network Coordinator.

HEALTH AND WELLNESS

P

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

Call the Provider Support Line at 1-866-866-4694 to refer a member to a Health Coach if the member has any of the following conditions:

- asthma
- diabetes
- chronic obstructive pulmonary disease (COPD)
- coronary heart disease (CHD)
- migraine headache
- heart failure
- hypertension
- gastroesophageal reflux disease (GERD)
- peptic ulcer disease (PUD)

Health Coaches also provide decision support for numerous health-related issues, including back pain, fall prevention, depression, cardiometabolic risk, weight loss surgery, breast or prostate cancer, and chronic pain.

Information about our Connections Health Management Programs is available at *www.ibx.com/providerconnections*.

PFA

Clinical Practice Guidelines now available

The *2010-11 Clinical Practice Guideline Summary* is now available online and replaces the previous version. The new summary includes a listing of all IBC-adopted Clinical Practice Guidelines, which 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 includes the reference for each condition and links directly to the guideline.

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

Changes in the *2010-2011 Clinical Practice Guideline Summary* include:

- A1C can be used to screen and diagnose diabetes.
- A1C ≥ 6.5 percent meets criteria for diagnosing diabetes. A1C testing should be performed in a laboratory using a method that is certified by the National Glycohemoglobin Standardization Program (NGSP) and standardized to the Diabetes Control and Complications Trial (DCCT) assay.[1]
- Three out of five abnormal findings (increased blood pressure, raised triglycerides, lowered high-density lipoprotein cholesterol, raised fasting glucose, and central obesity) would qualify a person for metabolic syndrome. All components except waist circumference use a single set of cut points.[2]
- Men ages 45 to 79 and women ages 55 to 79 should use aspirin when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage.[3]

Practice tip

The National Committee for Quality Assurance (NCQA) Physician Practice Connections®-Patient Centered Medical Home™ (PPC-PCMH) Recognition Program includes ten "must-pass" elements in the standards including PPC-3A, the adoption and implementation of evidence-based guidelines for three chronic or important conditions. Clinical Practice Guidelines are a great resource for your practice to adopt and implement to meet this standard.

Take some time to review the Clinical Practice Guidelines, which are available at *www.ibx.com/clinicalguidelines*. If you do not have access to the Internet, call the Provider Supply Line at 1-800-858-4728 to obtain a printed copy.

[1] *From Standards of Medical Care of Diabetes-2010 from the American Diabetes Association.*

[2] *From Harmonizing the Metabolic Syndrome, A Joint Statement of the International Diabetes Federation Task Force on Epidemiology and Prevention; National Heart Lung and Blood Institute; American Heart Association; World Heart Federation; International Atherosclerosis Society; and International Association for the Study of Obesity, 2009.*

[3] *From the U.S. Preventive Services Task Force, 2009.*

PFA

Clinical Insights now available

The *2010-11 Clinical Insights: Effective Care for Patients with Chronic Conditions* is now available. Clinical Insights highlight topics that Health Coaches from the Connections℠ Health Management Program may discuss with members who have the following conditions:

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

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

You can view or download Clinical Insights on our website at *www.ibx.com/clinicalguidelines*. If you do not have access to the Internet, call the Provider Supply Line at 1-800-858-4728 to obtain a printed copy of the guideline summary or any of the individual guidelines.

PFA

SilverSneakers® Fitness Program helps Medicare Advantage HMO and PPO members stay healthy and independent — even with chronic conditions

As a physician, you want the best possible outcomes for your patients — both those who are healthy and others who may have chronic conditions such as diabetes, arthritis, hypertension, osteoporosis, congestive heart failure, depression, or dementia. Even though some of your Medicare Advantage HMO and PPO patients may view decline in physical and mental abilities as an inevitable part of the aging process, there is much that can be done to stay healthy, manage chronic conditions, and remain independent. One of the most important things older patients can do to avoid the "typical" decline in abilities is to engage in regular physical activity.

By taking advantage of the SilverSneakers Fitness Program, an innovative well-being solution, Medicare Advantage HMO and PPO members help to prove that fitness equals a healthier lifestyle. IBC offers SilverSneakers as a benefit to Medicare-eligible Keystone 65 Preferred HMO and Personal Choice 65℠ PPO members at no additional cost beyond their plan premium. To join the program, eligible members need only take their health plan ID card to any participating SilverSneakers location.

The program includes a basic fitness membership at a local participating SilverSneakers location, where members have access to cardio equipment, free weights, pools, group fitness classes, and other amenities. SilverSneakers classes are designed for an older-adult population and are taught by certified instructors trained specifically in older-adult fitness. Educational and social components round out the program. In addition, SilverSneakers members may use any of more than 10,000 participating locations in the nation (including Alaska, Hawaii, and Puerto Rico) if they move or travel.

Results from the program's *2009 Annual Member Survey* illustrate how our Medicare Advantage Keystone 65 Preferred HMO and Personal Choice 65 PPO members who participate in the SilverSneakers Fitness Program (respondents) fare compared to SilverSneakers members and non-SilverSneakers members nationally. Your patients who need to be convinced of the benefits of physical activity may be interested in the following results:

- When asked about their current health in general, 56 percent of respondents answered "Excellent" or "Very good" compared to 59 percent of SilverSneakers members nationally and 30 percent of non-SilverSneakers members nationally.
- When asked to compare their health in general now to one year ago, 48 percent of respondents answered "Much better" or "Somewhat better" compared to 42 percent of SilverSneakers members nationally and 15 percent of non-SilverSneakers members nationally.
- When asked how many days they were in poor physical health (out of 30), 62 percent of respondents checked "None (0 days)" compared to 63 percent of SilverSneakers nationally and only 56 percent of non-SilverSneakers members nationally.
- When asked how many days they were in poor mental health (in past four weeks), 78 percent of respondents checked "None (0 days)" compared to 72 percent of SilverSneakers members nationally and 56 percent of non-SilverSneakers members nationally. SilverSneakers members attest that participating in the program improves mood, influences positive relationships, provides a mentally stimulating experience, and helps with depression and dementia.

continued on next page

Proven maintenance of health

Research from the Medicare Health Outcomes survey indicates that physical health status typically declines each year due to aging alone, with greater decline expected when aging is combined with chronic disease. But data collected from SilverSneakers Fitness Program members with chronic conditions showed no statistically significant loss in health over one year, suggesting that participation in SilverSneakers improves quality of life for all involved.

SilverSneakers Fitness Program helps Medicare Advantage HMO and PPO members stay healthy and independent — even with chronic conditions (continued)

- Of members with health conditions, 88 percent of respondents indicated their conditions do not interfere with their daily activities, compared to 86 percent of SilverSneakers members nationally. This is likely due to the physical benefits gained by participating in SilverSneakers. As this IBC and SilverSneakers member acknowledges:

  I'm impressed with SilverSneakers! I feel 100 percent better after the exercises. I have asthma and arthritis in my back and hip. I would encourage anyone to join SilverSneakers. – D. Medunic, Limerick, Pa.

By participating in the SilverSneakers Fitness Program, our Medicare Advantage members (as well as members of other partnering Medicare plans across the nation) are able to enjoy a healthier, more active lifestyle. Refer your patients now to *www.silversneakers.com* for more information about the program or to help them find a local participating location.

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

Importance of dilated retinal eye exams in patients with diabetes

Diabetes, or more specifically diabetic eye disease, is the leading cause of new cases of blindness in adults between ages 20 and 74.[1] And yet a 2008 study by the Centers for Disease Control and Prevention reported that only 62 percent of adults older than 18 with a diagnosis of diabetes reported receiving a dilated eye exam within the last year.[2]

As part of our annual Clinical Practice Guidelines, IBC has adopted the American Diabetes Association's *Standards of Medical Care in Diabetes — 2010*.[3] These standards call for the following retinopathy screening schedules:

- Adults and children 10 and older with type 1 diabetes should have a dilated and comprehensive eye exam within five years of the onset of diabetes.
- People with type 2 diabetes should have a dilated and comprehensive eye exam shortly after the diagnosis of diabetes.
- Patients with type 1 and type 2 diabetes should receive subsequent dilated and comprehensive eye exams annually.

How IBC helps close the gap

We strive to improve the health of your patients, our members, by providing you with actionable clinical information and our members with timely reminders and health information.

We offer the SMART® Registry from the Connections℠ Health Management Program, Clinical Alerts on the NaviNet® web portal, and the annual Clinical Practice Guidelines. The SMART Registry includes the date of your eligible patients' most recent dilated retinal eye exam. If we have no claims data showing an exam, members are listed as having a gap. If members don't have a claim for a dilated retinal eye exam, you can refer them to a Health Coach who will reach out to offer support and information.

Clinical Alerts are notifications sent to primary care physicians, OB/GYNs, endocrinologists, and cardiologists. Clinical Alerts for eye exams are available for members with diabetes. Additional alerts are available for members with other conditions, such as cardiovascular conditions, and for routine screenings, such as cholesterol screening. You can view them through the *Eligibility and Benefits Inquiry* option in the Plan Transactions menu.

For more information about the Connections Program, visit *www.ibx.com/providerconnections*. If you have any questions about the program or wish to speak with a Connections Program Specialist about the SMART Registry, call 1-866-866-4694.

[1] *National Institute of Diabetes and Digestive and Kidney Diseases. National Diabetes Statistics, 2007 fact sheet. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, 2008.*

[2] *Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention. www.cdc.gov/diabetes/statistics/preventive/fAllPractices.htm.*

[3] *http://care.diabetesjournals.org/content/33/Supplement_1/S11.full.pdf+html.*

SMART® is a registered trademark of Health Dialog Services Corporation, an independent company.

PFA

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 maintain 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.

Important Resources

Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/antifraud
Care Management and Coordination Case Management	215-567-3570 1-800-313-8628*
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Connections℠ Health Management Programs Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ Complex Care Management Program	1-800-313-8628
Credentialing Credentialing Hotline	215-988-6534 www.ibx.com/credentials
Credentialing Violation Hotline	215-988-1413
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
Provider Services user guide	www.ibx.com/providerautomatedsystem
Direct Ship Injectable Program (Medical Benefit)	www.ibx.com/directship
eBusiness Help Desk	215-241-2305
FutureScripts® (Pharmacy Benefits) Prescription drug authorization Toll-free fax	 1-888-678-7012 1-888-671-5285
Direct Ship Specialty Pharmacy Program Fax	1-888-678-7012 215-761-9165
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
Medical Policy website	www.ibx.com/medpolicy
NaviNet® portal registration	www.navinet.net
Provider Supply Line	1-800-858-4728 www.ibx.com/providersupplyline

* Outside 215 area code

Visit our website:
www.ibx.com/providercommunications