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Contact information:
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Independence Blue Cross
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27th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

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Partners in Health UpdateSM is a publication of Independence Blue Cross and its affiliates (Independence), created to provide valuable information to the Independence-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 Independence. This publication is the primary method for communicating such general changes. Suggestions are welcome.

For articles specific to your area of interest, look for the appropriate icon:
P Professional F Facility A Ancillary

Articles designated with a blue arrow include notice of changes or clarifications to administrative policies and procedures.

Keystone Health Plan East, Personal Choice®, Keystone 65 HMO, and Personal Choice 65SM PPO have an accreditation status of Commendable from NCQA.
Update your provider information with us

Have you made any changes to your key provider information? It is important that you notify us of any changes to the following:

- your mailing address
- your phone number
- name of your practice
- your office hours
- your acceptance of new patients
- your plan to dissolve your practice

We value your help in keeping our data files current. Accurate data files allow us to provide you with important information on billing, claims, changes or additions to policies, and announcements of administrative processes.

**Professional providers**

Please contact your Network Coordinator and notify them of any changes to your information.

**Facility and ancillary providers**

Per your contract, you are required to submit any changes to your information in writing. This request should be sent directly to the Senior Vice President of Contracting and the Legal Department at the addresses below:

- Independence Blue Cross
  Attn: Senior Vice President, Provider Networks and Value-Based Solutions
  1901 Market Street, 27th Floor
  Philadelphia, PA 19103

- Independence Blue Cross
  Attn: Legal Department
  1901 Market Street, 43rd Floor
  Philadelphia, PA 19103

Thirty days’ advance notice is required for processing.

*Note:* This information does not apply to providers contracted with Magellan Healthcare, Inc., an independent company. Please contact your Magellan Network Coordinator, if you have any questions. ☀
Reminder: Important billing information for modifiers 25 and –X{EPSU} and 59

This is a reminder that as of January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) edits are applicable to claims submitted on the CMS-1500 claim form or through the 837P transaction. Please refer to the following claim payment policies on NCCI edits:

- **Commercial:** #00.01.56a: National Correct Coding Initiative (NCCI) Code Pair Edits;
- **Medicare Advantage:** #MA00.041: National Correct Coding Initiative (NCCI) Code Pair Edits.

Access these policies on our Medical Policy Portal at www.ibx.com/medpolicy. Select Accept and Go to Medical Policy Online, and then select the Commercial or Medicare Advantage tab from the top of the page, depending on the version of the policy you’d like to view.

The CMS NCCI tables (Column 1/Column 2) are composed of code pair edits. These code pair edits identify services that are either a component of a more comprehensive code or two codes that should not be reported together. Procedure code pairs designated by CMS with an NCCI modifier indicator of 0 (zero) are not eligible to be reimbursed separately when reported on the same date of service for the same member when performed by the same provider. The NCCI edit identified in the CMS NCCI file for these procedure code pairs will be applied by Independence regardless of the presence of a modifier.

**Modifiers 25 and –X{EPSU} and 59**

Procedure code pairs designated by CMS with an NCCI modifier indicator of 1, when clinically appropriate, are eligible to be reported with an appropriate modifier for separate reimbursement. The most frequently used modifiers are 25 and –X{EPSU} and 59.

- **Modifier 25:** Modifier 25 is required when a significant, separately identifiable Evaluation and Management (E&M) service is performed by the same physician on the same day of a procedure or other service. For example, if an E&M service was also performed on the same day as an administration of an immunization, the E&M service should be billed with the modifier 25.
- **Modifiers –X{EPSU} and 59:** Modifiers –X{EPSU} and 59 are required to indicate that a procedure or service is separate, distinct, or independent from other non-E&M services performed on the same day by the same physician.

For more detailed information regarding the appropriate use of these modifiers, please visit our Medical Policy Portal at www.ibx.com/medpolicy. Select Accept and Go to Medical Policy Online, and then select the Commercial or Medicare Advantage tab from the top of the page, depending on the version of the policy you’d like to view:

- **Modifier 25:**
  - **Commercial:** #03.00.06l: Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure or Other Service;
  - **Medicare Advantage:** #MA03.003a: Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure or Other Service.
- **Modifiers –X{EPSU} and 59:**
  - **Commercial:** #03.00.08d: Modifiers XE, XS, XP, XU, 59;
  - **Medicare Advantage:** #MA03.005a: Modifiers XE, XS, XP, XU, 59.

Note: As communicated in the July 2015 edition of Partners in Health Update, providers should use the more specific –X{EPSU} modifiers to accurately represent the circumstances that render non-E&M services as separate, distinct, or independent. However, modifier 59 can still be reported if the service cannot be more accurately reported with one of the four specific modifiers. Providers cannot append more than one of these modifiers (i.e., XE, XP, XS, XU, or 59) to a single procedure code. Claims submitted with any of these modifiers may be subject to retrospective review and audit if it is determined that providers are not using them in accordance with the billing requirements in our claim payment policies.
Updated UB-04 guide and CMS-1500 toolkit now available

To accommodate the new ICD environment, we recently updated our UB-04 claims submission guide and the CMS-1500 claims submission toolkit to explain how providers should appropriately bill ICD-9 and ICD-10 codes.

The appropriate ICD diagnosis code indicator ("9" = ICD-9; "0" = ICD-10) and corresponding code set should be used in the following fields:

- UB-04: Fields 66 and 67
- CMS-1500 (02/12): Field 21

These updated resources are available on our website at www.ibx.com/providers/claims_and_billing/claims_resources_guides.html.

View up-to-date policy activity on our Medical Policy Portal

Changes to Independence medical and claim payment policies for our commercial and Medicare Advantage Benefits Programs occur frequently in response to industry, medical, and regulatory changes. We encourage you to view the Site Activity section of our Medical Policy Portal in order to keep up to date with changes to our policies.

The Site Activity section is updated in real time as changes are made to the medical and claim payment policies. Topics include:

- Notifications
- New Policies
- Updated Policies
- Reissued Policies
- Coding Updates
- Archived Policies

For your convenience, the information provided in Site Activity can be printed to keep a copy on hand as a reference.

To access the Site Activity section, go to our Medical Policy Portal at www.ibx.com/medpolicy and select Accept and Go to Medical Policy Online. From here you can select Commercial or Medicare Advantage under Site Activity to view the monthly changes. To search for active policies, select either the Commercial or Medicare Advantage tab from the top of the page. You can also get to our Medical Policy Portal through the NaviNet® web portal by selecting the Reference Tools transaction, then Medical Policy.

News & Announcements

In addition to the information posted in our Site Activity section, articles related to our website and medical and claim payment policies are periodically posted within the News & Announcements section. Simply select the appropriate link (Commercial, Medicare Advantage, or MAPPO Host) under the News & Announcements header on the Medical Policy Portal homepage to stay informed of the latest information.
Appropriate use of vitamin D testing

Vitamin D, also known as calciferol, is a fat-soluble vitamin that has a variety of physiologic effects, most prominently in calcium homeostasis and bone metabolism. Providers are reminded that there should be a direct medical need or indication for testing of vitamin D serum levels. Therefore, routine testing for vitamin D deficiency in healthy adults and children is not indicated according to evidence-based reviews or clinical practice guidelines from organizations that include, but are not limited to, the U.S. Preventive Services Task Force, the American College of Obstetrics and Gynecology, the American Society of Clinical Pathology, and the Endocrine Society.

Vitamin D testing should primarily be reserved for:

- individuals with signs and symptoms of vitamin D deficiency or toxicity;
- asymptomatic individuals at increased risk for vitamin D deficiency.

Individuals at increased risk for vitamin D deficiency may include those with osteoporosis, chronic kidney disease of at least stage 3, and parathyroid disorders.

When clinically appropriate, Independence’s participating laboratories are capable of performing vitamin D testing. If you have any questions about participating laboratories, please contact your Network Coordinator.

Reminder: Upcoming changes to drug precertification requirements for 2016

Effective January 1, 2016, new precertification requirements will apply to our commercial and Medicare Advantage HMO and PPO members for the seven medical benefit drugs listed below:

- Adagen® (pegademase bovine)
- Blincyto® (blinatumomab)
- Cyramza® (ramucirumab)
- Imlygic™ (talimogene laherparepvec)
- Kanuma™ (sebelipase alfa)*
- Lemtrada® (alemtuzumab)
- mepolizumab*

These changes will be reflected in an updated precertification requirement list, which will be posted to our website at www.ibx.com/preapproval in December, prior to these changes going into effect.

In addition, Notifications for new medical policies for Adagen (pegademase bovine) and Cyramza (ramucirumab) will be available in December.

Coverage for off-label use

The medical necessity criteria for these drugs are based on the U.S. Food and Drug Administration (FDA)-labeled indications. Coverage for off-label use of these drugs may be provided in accordance with the following policies:

- **Commercial**: #08.00.15c: Off-label Coverage for Prescription Drugs and Biologics
- **Medicare Advantage**: #MA08.012: Off-label Coverage for Prescription Drugs and/or Biologics

To view these policies, visit our Medical Policy Portal at www.ibx.com/medpolicy. Select Accept and Go to Medical Policy Online, and then select Commercial or Medicare Advantage depending on the version of the policy you’d like to view.

Look for more information about the availability of the new precertification requirement list in the December 2015 edition of Partners in Health Update. 

*Pending approval from the FDA
Providers required to use self-service options on NaviNet®

Over the past several years, Independence has instituted a number of provider self-service requirements under which providers must use the NaviNet web portal to obtain certain information. All participating providers, facilities, Magellan-contracted providers, and billing agencies that support provider organizations are required to use self-service options for the following:

- **Eligibility and claims status information.** All participating providers and facilities are required to use NaviNet to verify member eligibility and obtain Independence claims status information. The claim detail provided through NaviNet includes specific information, such as check date, check number, service codes, paid amount, and member responsibility.

- **Claim adjustments.** All participating providers and facilities must submit claim adjustment requests using the Claim Investigation Inquiry transaction on NaviNet. Providers must supply the necessary information to support an adjustment request. For example, if a provider is requesting a claim adjustment related to the payment amount, the provider must supply the member’s benefit product for the date of service at issue and the relevant terms in the provider’s contract in order for a review and adjustment consideration to occur.

- **Authorizations.** All participating providers and facilities must use NaviNet 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

Any provider who contacts Provider Services to obtain eligibility and claims status information, question a claim payment, submit a claim adjustment, or request an authorization will be directed to use the self-service options on NaviNet.

Resources available

Detailed user guides and webinars for many NaviNet transactions are available in the NaviNet Resources section of the Provider News Center at www.ibx.com/pnc/navinet.

All office locations are required to have NaviNet access. If you are not yet NaviNet-enabled, go to www.navinet.net to sign up. If your office is NaviNet-enabled but would like training on any of the self-service transactions, call the eBusiness Hotline at 215-640-7410.

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*This information does not apply to providers contracted with Magellan Healthcare, Inc. (Magellan). Magellan-contracted providers should contact their Magellan Network Coordinator at 1-800-866-4108 for authorizations.*

Magellan Healthcare, Inc., an independent company, manages mental health and substance abuse benefits for most Independence members.
Member benefit changes and clarifications for commercial members

Effective January 1, 2016, unless otherwise noted, the following member benefit changes and clarifications will be implemented for several commercial programs for Independence members:

<table>
<thead>
<tr>
<th>Type of benefit/service</th>
<th>Plans affected</th>
<th>Change/clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value-based programs reimbursement</td>
<td>PPO – All</td>
<td>Language is being updated to include value-based programs reimbursement disclosure language that explains the range of pricing arrangements for claims for services received outside a member’s plan service area.</td>
</tr>
<tr>
<td>disclosure language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric surgery* (weight loss surgery)</td>
<td>HMO – All</td>
<td>Language is being added to include a reference to bariatric surgery as a surgical treatment for obesity when certain requirements are met. Also being added is language to clarify that weight loss surgery to treat any medical condition (e.g., diabetes) is limited to one surgery per lifetime.</td>
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<tr>
<td></td>
<td>POS – All</td>
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<tr>
<td></td>
<td>DPOS – All</td>
<td></td>
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<tr>
<td></td>
<td>PPO – All</td>
<td></td>
</tr>
<tr>
<td>Specialty drug list</td>
<td>HMO – All</td>
<td>Language is being revised to indicate the changes made to the list of injectable/infusion therapy drugs for which members covered under a commercial plan (non-Medicare Advantage plan) are required to pay cost-sharing. The drugs on this list are covered under a member’s medical benefit and are typically administered by a health care provider. The cost-sharing amount will be collected at the provider’s office or facility each time the drug is administered. The actual cost-sharing amount is based on the terms of the member’s benefit contract. The updated drug list is available at <a href="http://www.ibx.com/preapproval">www.ibx.com/preapproval</a> or by calling 1-800-ASK-BLUE. Members should review the list at their earliest convenience and discuss any questions with their providers.</td>
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<tr>
<td></td>
<td>POS – All</td>
<td></td>
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<tr>
<td></td>
<td>DPOS – All</td>
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<tr>
<td></td>
<td>PPO – All</td>
<td></td>
</tr>
<tr>
<td>Preventive care*</td>
<td>HMO – All</td>
<td>Language is being added about Affordable Care Act (ACA) preventive care requirements. The new language directs members to visit <a href="http://www.ibx.com">www.ibx.com</a> to view the most up-to-date list of preventive services that the ACA requires Independence to cover, which will be available on January 1, 2016.</td>
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<tr>
<td></td>
<td>POS – All</td>
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<tr>
<td></td>
<td>DPOS – All</td>
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<tr>
<td></td>
<td>PPO – All</td>
<td></td>
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<tr>
<td>Medical foods*</td>
<td>HMO – All</td>
<td>Language is being updated regarding coverage of medical foods to clarify the items that are excluded from coverage.</td>
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<tr>
<td></td>
<td>POS – All</td>
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<tr>
<td></td>
<td>DPOS – All</td>
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<tr>
<td></td>
<td>PPO – All</td>
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<tr>
<td></td>
<td>Major Medical – All</td>
<td></td>
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<td></td>
<td>CMM – All</td>
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<tr>
<td>Diabetic supplies*</td>
<td>HMO – All</td>
<td>Language is being updated to clarify that diabetic supplies that are not available at a pharmacy may be purchased from a durable medical equipment (DME) provider and will be subject to the plan’s DME cost-sharing.</td>
</tr>
<tr>
<td>Exclusion for amounts payable by Medicare†</td>
<td>HMO – All</td>
<td>Language is being added to indicate that for purposes of this program exclusion, coverage is not available for a service, supply, or charge that is “payable under Medicare” when the member is eligible to enroll for Medicare benefits, regardless of whether the member actually enrolls for, pays applicable premium for, or maintains, claims, or receives Medicare benefits. The amount excluded for these claims will be either the amount “payable under Medicare” or the applicable plan fee schedule for the service, at the discretion of the plan.</td>
</tr>
<tr>
<td>(Applies only to Medicare-eligible individuals who do not enroll in Medicare)</td>
<td>POS – All</td>
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<td></td>
<td>DPOS – All</td>
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<tr>
<td></td>
<td>PPO – All</td>
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</tbody>
</table>

*Visit our Medical Policy Portal at www.ibx.com/medpolicy to review the medical and/or claim payment policies for these benefits/services.

†Change is effective January 1, 2017.

Please call Customer Service at 1-800-ASK-BLUE with any questions. ☑
Keystone 65 Focus now available for 2016

Independence has introduced Keystone 65 Focus Rx HMO (Keystone 65 Focus), a new Medicare Advantage benefit product for 2016. Keystone 65 Focus is a defined-network benefit product with more than 23,000 participating providers in southeastern Pennsylvania. Keystone 65 Focus members will enjoy similar benefits as with broader-network Medicare Advantage HMO benefit products, while taking advantage of lower premiums and out-of-pocket costs due to their more defined network of providers.

Participating providers

As a reminder, the following hospitals are participating in the Keystone 65 Focus network:

- Abington Health
  - Abington Memorial Hospital
  - Lansdale Hospital
- Aria Health
- Community Health Systems
  - Brandywine Hospital
  - Chestnut Hill Hospital
  - Jennersville Regional Hospital
  - Phoenixville Hospital
  - Pottstown Memorial Medical Center
- Doylestown Hospital
- Grand View Hospital
- Holy Redeemer Hospital and Medical Center
- Main Line Hospitals, Inc.
  - Bryn Mawr Hospital
  - Lankenau Medical Center
  - Paoli Hospital
  - Riddle Hospital
- St. Luke’s Health System
- Thomas Jefferson University Hospital, Inc.
  - Methodist Hospital
  - Thomas Jefferson University Hospital

Please note that if an Independence-participating hospital does not appear on this list, it means the hospital is not participating in the Keystone 65 Focus network. Members who choose Keystone 65 Focus for their health care coverage should only be referred to the hospitals listed above for their health care. Providers participating in the Keystone 65 Focus network can be found using the online provider directory at www.ibxmedicare.com/focusfinder.

Capitation arrangements for Keystone 65 Focus

The following capitation arrangements apply for the Keystone 65 Focus benefit product:

- Radiology and physical therapy services. Radiology and physical therapy services will not be capitated. Keystone 65 Focus members must be directed to a participating provider in the Keystone 65 Focus network. These services will be reimbursed on a fee-for-service basis for the Keystone 65 Focus benefit product. Referral requirements still apply.
- Laboratory services. Laboratory services will remain capitated, and Keystone 65 Focus members must be directed to their primary care physician’s capitated laboratory outpatient provider.

Look for more detailed information regarding capitation arrangements for the Keystone 65 Focus benefit product in the December 2015 edition of Partners in Health Update.

For more information

Refer to the article titled Keystone 65 Focus Rx HMO, our new Medicare Advantage benefit product in the October 2015 edition of Partners in Health Update for detailed information about Keystone 65 Focus. If you have Medicare patients who are interested in learning more about Keystone 65 Focus, please have them contact Customer Service toll-free at 1-800-645-3965 (TTY/TDD: 711), 8 a.m. to 8 p.m., seven days a week. Please keep in mind that providers must remain neutral when assisting patients with enrollment decisions. Any discussions with patients should be an objective assessment of the patient’s needs and potential options.

If you have any questions about Keystone 65 Focus, including the eligibility criteria for participation in the defined network, please refer to the frequently asked questions on our website at www.ibx.com/providers/focus.
Standards for medical record documentation: When there is a consultation

Coordination of care is a significant factor in today’s health care environment. With the increasing use of hospitals, urgent care centers, and retail health clinics, as well as multiple specialty services, it can be difficult to ensure that patients receive the best individual care. While electronic record systems may improve coordination of care, communication between specialists and primary care providers can still be challenging. Independence has established medical records standards to facilitate communication, coordination, and continuity of care and to promote efficient and effective treatment. One of these standards refers to coordination between providers of primary care and consultants.

Primary care
Primary care offices are generally the central point for care. Points to remember include:

- For HMO members, ask about referrals the patient requested or that your office provided. Referrals are part of the electronic record or patient chart and can be checked when the patient signs in at the front desk. If the patient was seen and no consultation is present, the staff can contact the office while the patient is still in the office.
- For radiology studies or testing ordered by a consulting practice that need to be coordinated by your office, check for a consultation note or call the requesting office for information. Document the request in the patient record, including the ordering consultant. Ask for a report to be sent to your office as part of the consultation note.
- Document all recommendations or referrals for consultation and rationale in the patient record. If a patient requested a referral, document the patient request.
- Don’t forget about behavioral health. Discuss behavioral health concerns with your patients or patient representatives and request permission to discuss care with the behavioral health provider. Some behavioral health concerns or treatments may affect or influence the patient’s response to medical care. Document all discussions in the medical records.
- Make sure to review all consultation notes and initial or sign the documents to indicate your review. Independence Medical Record Keeping Standards require the ordering practitioner to initial the review. Note: Review and signature by other professional staff in the office do not meet this requirement.

Specialty care
Specialists may coordinate care and/or act as a primary care provider. Points to remember include:

- For HMO members, send consultation notes/updates to the primary care provider after each patient encounter.
- Document all recommendations or referrals for consultation and rationale in the patient record. If a patient requested a referral, document the patient request.
- Don’t forget about behavioral health. Discuss behavioral health concerns with your patients or patient representatives and request permission to discuss care with the behavioral health provider. Some behavioral health concerns or treatments may affect or influence the patient’s response to medical care. Document all discussions in the medical records.
- Make sure to review all notes received by the primary care provider or other consultants. Initial or sign the documents to indicate your review. Note: Review and signature by other professional staff in the office do not meet this requirement.

Collaboration of care and medical record keeping standards are two requirements for accreditation by the National Committee for Quality Assurance (NCQA). NCQA views these standards as significant in providing quality and comprehensive care to patients.

Standards for maintaining appropriate medical records can be found in the Provider Manual for Participating Professional Providers (Provider Manual), available in the Current Publications section of Independence NaviNet® Plan Central. 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.
Our Quality Management Program promotes quality of care and service

Independence is dedicated to maintaining the highest standard of care and service for our members, providers, and the communities we serve. Information about our Quality Management Program is accessible on our website at www.ibx.com/providers/resources/standards. The website includes a description of our Quality Management Program, including program goals, objectives, and activities to improve clinical, network, and service quality.

- **Access and availability standards.** Independence 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.

- **Member rights and responsibilities.** All Independence members have defined rights and responsibilities.

- **Privacy and confidentiality.** Independence, 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.

- **Utilization review.** It is the policy of Independence that all utilization review decisions are based on the appropriateness of health care services and supplies, in accordance with Independence's definition of medical necessity and the benefits available under the member's coverage.

- **Medical record-keeping standards.** Well-maintained medical records are critical to facilitate communication, continuity, coordination, and an effective plan of care. Accordingly, Independence standards require that medical records are maintained in a manner that is current, detailed, and organized as required by applicable regulatory requirements.

Please review these above-listed standards with your staff to ensure that your office maintains the required access, documentation, and quality care expected of our network providers.

Information about our Quality Management Program and these standards can also be found in the Provider Manual for Participating Professional Providers (Provider Manual) and the Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers (Hospital Manual), which are available through the NaviNet® web portal. Paper copies of the Provider Manual and Hospital 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 more information about our Quality Management Program and our progress in meeting program goals, please visit our website or call Customer Service at 1-800-ASK-BLUE. Members can request the same information by calling Customer Service.
Policy reminder regarding utilization review decisions

In accordance with the benefits available under the member’s health plan and Independence’s definition of medical necessity, it is our policy that all utilization review decisions are based on the appropriateness of care, services, and supplies. Only physicians who conduct utilization reviews may make denials of coverage of health care services and supplies based on lack of medical necessity.

The nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services for us are not compensated or given incentives based on their coverage decisions. Medical directors and nurses are salaried employees. Contracted external physicians and other professional consultants are compensated on a per-case reviewed basis, regardless of the coverage determination. We do not reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals that would encourage utilization review decisions that result in denials or under-utilization.

Providers are required to enter all routine requests for authorization through the NaviNet® web portal. If there are any requests that require immediate review, involve members with coverage through the Federal Employee Program, or if NaviNet is not available, providers can call 1-800-ASK-BLUE. Facilities can also call 1-800-ASK-BLUE for ambulance and discharge planning needs.

More information about our utilization review policy and availability can be found on our website at www.ibx.com/providers/resources/standards/utilization_decisions.html.

Encourage pregnant Independence members to register for Baby BluePrints®

The Baby BluePrints program supports expectant mothers and promotes a healthy pregnancy throughout each trimester. We ask that you inform pregnant Independence members about the Baby BluePrints program at their first prenatal visit and encourage them to self-enroll by calling our toll-free number, 1-800-598-BABY. Upon calling, a Health Coach will explain the program to the member and ask her a series of questions to complete the enrollment process.

Once enrolled in the program, members will receive a welcome letter that includes information on how to access educational materials on our secure member website, www.ibxpress.com, and the 1-800-598-BABY phone number for questions and support during pregnancy. In addition, high-risk members eligible for condition management will be given the name and contact information for a Health Coach.

Resources available

A flyer is available upon request to place in the member’s chart and distribute at the first prenatal visit to encourage her to enroll in Baby BluePrints. To order flyers, please submit an online request at www.ibx.com/providersupplyline or call the Provider Supply Line at 1-800-858-4728. If you have any questions, please call Customer Service at 1-800-ASK-BLUE.
Help your patients stay healthy in mind, body, and spirit throughout the holiday season with SilverSneakers®

For many of your older patients, keeping active and making healthy choices becomes more of a struggle once the winter weather and holiday temptations begin to creep in. Some people even feel blue when the holidays come around. That’s why now is the perfect time to prepare your patients to take on the holidays with a healthy mindset and a solid fitness plan to help them bring in the new year with a new attitude, good habits, and a healthier lifestyle.

The Healthways SilverSneakers Fitness Program can help your patients stay healthy, physically and emotionally, throughout the holiday season and beyond! The nation’s leading exercise program for active older adults, SilverSneakers is a fitness benefit included with many Medicare plans. Your Independence Medicare Advantage patients may be eligible but not yet taking advantage of their SilverSneakers benefit.

The program offers Keystone 65 Select HMO, Keystone 65 Preferred HMO, and Personal Choice 65™ PPO members a fitness membership with access to more than 13,000 locations nationwide. So even if members are traveling over the holidays, they can still visit a fitness center. Members have access to exercise equipment, swimming pools, and fitness classes* like yoga, water-based strengthening, cardio, and more — all designed specifically for older adults. A Program Advisor® walks them through the process step by step, so it’s easy to get started. If the weather is bad, there are at-home options too.

SilverSneakers isn’t just a fitness program — it’s a social group. Social outings, walking groups, and workout buddies are some of the most popular aspects of the program. In addition to fitness center classes, SilverSneakers organizes classes and activities at parks, recreation centers, and other local venues where members can exercise, talk, and visit together, all while working toward a common goal — wellness! In fact, 37 percent of SilverSneakers members report they attend class to socialize, 68 percent of members participate in classes with a friend, and 34 percent participate with a spouse or significant other. What better way to fight the holiday blues?1

New Year’s Day (January 1) is the day most people decide to commit to big lifestyle changes, but forming good habits before the cookies, eggnog, and casseroles hit the table will set your patients up for a successful new year! Please encourage your patients to use their SilverSneakers benefit to keep active and even make some new friends over the holiday season.

Refer your Independence Medicare Advantage patients to www.silversneakers.com or 1-888-423-4632 (TTY: 711) for more information.

*Amenities vary by location.

1According to Healthways® 2014 SilverSneakers Annual Participation Survey.

SilverSneakers® is a registered trademark of Healthways, Inc., an independent company.
Suicide: A concern for all health care providers

We are pleased to present the final of a short series of articles in Partners in Health Update, “Suicide: A concern for all health care providers,” that is designed to provide you with information on suicide and the importance of your role in assessing your patients who may be at risk.

Part 4 – Suicide risk assessment: Important issues to remember

In the past few months, we have provided information regarding assessment and safety planning for your patients at risk of suicide. We have collaborated with Magellan Healthcare, Inc., an independent company, to help both primary care providers (PCP) and Behavioral Health providers (BHP) understand that suicide risk assessment is becoming an expectation of all health care professionals.

Suicide can be preventable but only if health care providers understand their role in recognizing and assessing for risk. A patient’s complaints of insomnia, anxiety, substance use, pain, or recent diagnosis of an illness can increase the risk of suicide. According to DSM (Diagnostic and Statistical Manual for Mental Health Disorders), although statistically a majority of people who commit suicide meet criteria for a behavioral health diagnosis, this information is only found after a review of the medical records because most of these people are not in mental health treatment. This reinforces the importance of the PCP’s role in assessing suicide risk.

The assessment of suicide risk has been a standard practice in mental health, and current literature has helped providers re-focus their efforts to assure that they are including the recommended questions.

Most importantly, collaboration between the PCP and BHP and building trusting relationships with the patient are the most effective activities in the prevention of suicide. Your patients can be embarrassed, ashamed, or so hopeless regarding their feelings of suicide that they can isolate themselves from others. But through your relationship with them, and in collaboration with their other health care provider(s), you can help patients to not act on suicidal impulses.

Assessing for suicide risk and developing a safety plan are necessary for all health care providers working toward the prevention of suicide. Below are several resources you can recommend to your patients who are at risk:

- National Suicide Prevention Lifeline: 1-800-273-8255
- Mental Health Association of Delaware: 302-654-6833 or 1-800-287-6423
- New Jersey Mental Health Cares Helpline: 1-866-202-HELP (4357)
- re:solve Crisis Network: 1-888-7-YOU CAN (1-888-796-8226) ◆

Magellan Healthcare, Inc., an independent company, manages mental health and substance abuse benefits for most Independence members.
## Important Resources

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<td>1-866-282-2707 or <a href="http://www.ibx.com/antifraud">www.ibx.com/antifraud</a></td>
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<td>Baby BluePrints®</td>
<td>215-241-2198 / 1-800-598-BABY (2229)*</td>
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<td>Prescription drug prior authorization</td>
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<td><a href="http://www.ibx.com/rx">www.ibx.com/rx</a></td>
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<td><a href="http://www.ibxmedicare.com">www.ibxmedicare.com</a></td>
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<td>Independence eBusiness Hotline</td>
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<td>Provider Supply Line</td>
<td>1-800-858-4728 or <a href="http://www.ibx.com/providersupplyline">www.ibx.com/providersupplyline</a></td>
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*Outside 215 area code*