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

Partners in Health Update® 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.

Contact information:
Provider Communications
Independence Blue Cross
1901 Market Street
27th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

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

The third-party websites mentioned in this publication are maintained by organizations over which Independence exercises no control, and accordingly, Independence disclaims any responsibility for the content, the accuracy of the information, and/or quality of products or services provided by or advertised in these third-party sites. URLs are presented for informational purposes only. Certain services/treatments referred to in third-party sites may not be covered by all benefits plans. Members should refer to their benefits contract for complete details of the terms, limitations, and exclusions of their coverage.

NaviNet is a registered trademark of NaviNet, Inc., an independent company.

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

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Keystone Health Plan East, Personal Choice®, Keystone 65 HMO, and Personal Choice 65® PPO have an accreditation status of Commendable from NCQA.
Out-of-pocket maximums for commercial HMO, POS, and PPO members beginning January 1, 2016

Under the Patient Protection and Affordable Care Act, also known as Health Care Reform, members should not be charged any cost-sharing (i.e., copayments, coinsurance, and deductibles) once their annual limit for essential health benefits has been met. Essential health benefits include medical benefits, prescriptions, pediatric dental services, and pediatric vision services for those members whose benefits include these services.

These limits are based on the member’s benefit plan. While some member benefit plan limits may be lower, they currently cannot exceed the following amounts:

- **Individual:** $6,600
- **Family:** $13,200

Beginning January 1, 2016, the annual limits will be changed to the following amounts:

- **Individual:** $6,850
- **Family:** $13,700

Once members have reached their out-of-pocket maximum, providers should not collect additional cost-sharing for essential health benefits.

**Out-of-pocket maximum calculations embedded for each individual**

In 2015, the total out-of-pocket maximum for some Independence plans accumulated on an aggregate basis — meaning that one individual within a family plan could have been required to pay out of pocket until the entire family’s out-of-pocket maximum was met.

In 2016, Health Care Reform regulations require an “embedded” in-network out-of-pocket maximum for each individual to limit the amount of out-of-pocket expenses that any one person will incur. This means that each member enrolled in an individual plan, or any person in a family plan, will only pay the in-network out-of-pocket maximum set for an individual and not be required to pay out of pocket to meet the family in-network out-of-pocket maximum for the plan. For a family plan, after one person meets the individual in-network out-of-pocket maximum for their plan, the other family members continue to pay out of pocket until the remaining in-network out-of-pocket maximum amount is met.

To verify if members have reached their out-of-pocket maximum, providers should use the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal. Once on the Eligibility and Benefits Details screen, the member’s current out-of-pocket expense (Accumulated Amount) and the maximum dollar limit (Threshold Amount) will be displayed at the bottom of the screen in the Benefit Accumulator section. ◆
New Independence Administrators office location

In January 2016, the Independence Administrators office located in Fort Washington, PA, will relocate to Philadelphia, PA. The new office will be located at:

1900 Market Street
Philadelphia, PA 19103

The move is strategically planned so that there is limited disruption to service. The first day of business in the new office space is scheduled for Monday, January 11, 2016.

Important contact information

The current mailing address, phone number, payer ID for Electronic Data Interchange services, and email address will remain the same.

<table>
<thead>
<tr>
<th>Mailing address</th>
<th>Email address and website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence Administrators c/o Processing Center P.O. Box 21974 Eagan, MN 55121</td>
<td>Email address: <a href="mailto:iacustomerservice@ibxtpa.com">iacustomerservice@ibxtpa.com</a> Website: <a href="http://www.ibxtpa.com">www.ibxtpa.com</a></td>
</tr>
</tbody>
</table>

Stay tuned for more updates from Independence Administrators.  

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

New Provider Automated System launch postponed

The launch of the new Provider Automated System, which was slated for December 1, 2015, has been postponed. We will post updates on the NaviNet® web portal and the Provider News Center once the new system is available.

What to expect

When you call 1-800-ASK-BLUE, be sure to say “Provider” or press 2 when prompted.

Once in the Provider Automated System, you will need to have your National Provider Identifier (NPI) or tax ID number, as well as the member’s information (member ID number and date of birth), ready in order to access the information below.

The Provider Automated System will enable providers to retrieve the following information by following a series of self-service voice prompts and questions specific to your inquiry:

- **Eligibility.** Check coverage status, effective dates, and group name information.
- **Benefits.** Verify copayment, coinsurance, and deductible information.
- **Claims.** Obtain paid status, claim denial reasons, paid amount, and member responsibility information.

*Note:* Within the eligibility, benefits, and claims inquiries, you will have the option to have information faxed to you, so be sure to have your fax number ready during the call.

For authorizations, you will be directed to a Customer Service representative for further assistance. This function is not available via self-service; however, you can enter and retrieve authorization information through NaviNet.

A user guide for the new Provider Automated System will be available on our website at www.ibx.com/providerautomatedsystem once the system has launched.
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
- your office hours
- name of your practice
- 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

Sixty 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.

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.
Common ICD coding errors identified on paper and electronic claims

Since the ICD-10 compliance date on October 1, 2015, Independence has noticed a number of common ICD coding errors that are affecting claims processing. Please follow the tips below to ensure that your claims are coded correctly:

- **Do not bill ICD-9 and ICD-10 codes on the same claim.** Per guidelines from the Centers for Medicare & Medicaid Services (CMS), you cannot bill with both ICD-9 and ICD-10 codes on a single claim unless otherwise specified.

- **Use the appropriate ICD code:**
  - **Outpatient claims.** For dates of service on or before September 30, 2015, you must bill with ICD-9 codes. For dates of service on or after October 1, 2015, you must bill with ICD-10 codes.
  - **Inpatient claims.** For dates of discharge on or before September 30, 2015, you must bill with ICD-9 codes. For dates of discharge on or after October 1, 2015, you must bill with ICD-10 codes.

- **DME and home infusion claims.** Durable medical equipment (DME) and home infusion claims should be coded based on the “From” date or initial date of service. If the “From” date is on or before September 30, 2015, you must bill with ICD-9 codes. If the “From” date is on or after October 1, 2015, you must bill with ICD-10 codes.

- **Use the appropriate diagnosis qualifier:**
  - **Paper claims.** When billing with ICD-9 codes, you must use the qualifier “9”. When billing with ICD-10 codes, you must use the qualifier “0” (CMS-1500, box 21; UB-04, field 66).
  - **Electronic claims.** Please refer to the most recent version of the HIPAA-mandated 5010 ASC X12 Implementation Guides for the 837I and 837P transactions.

- **Use valid codes.** Whether you are billing with ICD-9 or ICD-10 codes, please ensure that the codes you are using are valid and appropriate.

For more information, visit our dedicated ICD-10 web page at [www.ibx.com/icd10](http://www.ibx.com/icd10), which includes Frequently Asked Questions.◆

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**NAVINET®**

NaviNet® resources available on the Provider News Center

As previously communicated, Independence has instituted a number of provider self-service requirements under which providers must use the NaviNet web portal to obtain certain information. Therefore, all participating providers, facilities, Magellan-contracted providers, and billing agencies that support provider organizations are required to have NaviNet access.

Over the past several years, we have been making updates and enhancing Independence NaviNet Plan Central to provide the best tool possible for our provider network. Given the significant number of changes, we created a repository on our Provider News Center to house all NaviNet-related information we publish. The NaviNet Resources page is available at [www.ibx.com/pnc/navinet](http://www.ibx.com/pnc/navinet) and includes dozens of transaction-specific user guides and instructional webinars, as well as a communication archive of articles published in *Partners in Health Update* about NaviNet changes.

If you have any questions about NaviNet transactions or you would like training for your office, please call the eBusiness hotline at 215-640-7410. If you are not yet NaviNet-enabled, go to [www.navinet.net](http://www.navinet.net) to sign up.◆
Finally edition of *Inside IPP* and new BlueCard® resources now available

The Fall 2015 edition of *Inside IPP*, an inter-plan programs publication, is available on our website. This edition features the following articles:

- Final edition of *Inside IPP* and new BlueCard® resources now available
- Updated UB-04 guide and CMS-1500 toolkit now available
- Always use full member ID number when billing for service
- Reminder: Claim requirements for air ambulance service codes
- Providers financially responsible for preapproval of inpatient facility services for out-of-area members

Go to [www.ibx.com/insideipp](http://www.ibx.com/insideipp) to read this edition. You will also find a complete archive of past editions there.

Printed copies of *Inside IPP* are available by submitting an online request at [www.ibx.com/providersupplyline](http://www.ibx.com/providersupplyline) or by calling the Provider Supply Line at 1-800-858-4728.

**Final edition of *Inside IPP***

For many years, we have published *Inside IPP* to increase awareness of and satisfaction with the BlueCard Program.

Starting in 2016, we will communicate all BlueCard news and information in the BlueCard section of *Partners in Health Update*. Therefore, the Fall 2015 edition of *Inside IPP* is the final edition of this publication.

**BlueCard resources**

We have added a new BlueCard-specific page on our Provider News Center at [www.ibx.com/pnc/bluecard](http://www.ibx.com/pnc/bluecard). On this page, an archive of all articles published in the BlueCard section of *Partners in Health Update* will be available. Additionally, you will find other resources on this page, including the *Coordination of Benefits Questionnaire* for out-of-area members and the *Quick Guide to Blue Member ID Cards*. ◆
Professional Injectable and Vaccine Fee Schedule updates effective January 1, 2016

Effective January 1, 2016, we will implement a quarterly update to our Professional Injectable and Vaccine Fee Schedule for all contracted providers. These updates reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables.

Allowance Inquiry transaction
To look up the rate for a specific code, use the Allowance Inquiry transaction on the NaviNet® web portal. To do so, go to Independence NaviNet Plan Central, select Claim Inquiry and Maintenance from the Independence Workflows menu, and then select Allowance Inquiry. For step-by-step instructions on how to use this transaction, refer to the user guide available in the NaviNet Resources section of our Provider News Center at www.ibx.com/pnc/navinet.

Note: The Allowance Inquiry transaction returns current rates for professional providers only. The reimbursement rates that go into effect January 1, 2016, will be available through this transaction on or after this effective date. Provider payment allowances are for informational purposes only and are not a guarantee of payment.

If you have any questions about the updates, please contact your Network Coordinator.

Updated payer ID grids available soon
The payer ID grids contain valuable information to assist you in claims submission, including alpha prefixes, payer information, and claims mailing addresses by product.

We are in the process of updating the professional and facility payer ID grids to reflect new products for 2016. Please be sure to download the most current versions, which will be available later this month on our Electronic Data Interchange (EDI) web page at www.ibx.com/edi under EDI Resources.
Introducing telemedicine primary care for our commercial members

Effective January 1, 2016, Independence will cover telemedicine encounters for our commercial members seeking primary care services from primary care providers. Telemedicine allows members to interact with primary care providers using an audio/visual system that allows the member and provider to both see and hear one another. Telemedicine may be an accessible and convenient way to deliver primary care services for some members who cannot make it to the office.

To learn more about Independence’s telemedicine policy, please review the Notification for Claim Payment Policy #00.10.41: Telemedicine for Primary Care Services, which is available on our Medical Policy Portal at www.ibx.com/medpolicy. Select Accept and Go to Medical Policy Online, and then select Commercial under Active Notifications.

As telemedicine continues to evolve and expand and as the technology improves, Independence will keep you up to date with relevant changes to our policies. If you have any questions, please contact your Network Coordinator.

Update on coverage for digital breast tomosynthesis

Independence now covers digital breast tomosynthesis (DBT), also known as 3D mammography, as a preventive benefit for our commercial members.* DBT is now covered in the same manner as traditional two-dimensional mammography. This coverage is for dates of service on or after October 5, 2015. Our claims system has recently been updated to reflect this new coverage.

Policy updates

For more information about our coverage of DBT for our commercial members, refer to the Medical Policy #09.00.52d: Digital Breast Tomosynthesis, available on our Medical Policy Portal at www.ibx.com/medpolicy. Select Accept and Go to Medical Policy Online, then select the Commercial tab from the top of the page. You can then type the policy name or number in the Search field.

You can also view policy information through the NaviNet® web portal by selecting the Reference Tools transaction, then Medical Policy.

*Coverage depends on specific benefit plan terms, conditions, limitations, and exclusions. Individual benefits must be verified.

Reminder: Upcoming changes to medical benefit specialty drug cost-sharing for 2016

Effective January 1, 2016, as previously communicated, Independence will update our list of specialty drugs that require cost-sharing. Cost-sharing applies to select medical benefit specialty drugs for members who are enrolled in Commercial Flex products and select customized plans. The member’s cost-sharing amount is based on the terms of the member’s benefit contract. Individual benefits should be verified using the NaviNet® web portal.

The new cost-share list has been expanded to include more than 70 specialty drugs. The comprehensive 2016 cost-share drug list is now available at www.ibx.com/preapproval.
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. ◆

Independence medical record requests and ePASS® submissions now using EFT for payments

Payments issued on or after November 1, 2015, for medical record requests and SOAP Progress Note submissions through ePASS, will be processed and distributed through electronic funds transfer (EFT). We will continue to send paper checks for those providers who are not EFT-enabled; however, we encourage all providers to sign up for EFT.

If you are interested in receiving payment via EFT, please follow the instructions in our EFT Attestation and Registration Guide, which is available in the NaviNet® Resources section of the Provider News Center at www.ibx.com/pnc/navinet. If you have any questions on the EFT registration process, contact the eBusiness hotline at 215-640-7410. ◆
Upcoming changes to precertification requirements for 2016

As a reminder, in 2016 new precertification requirements will apply to our commercial and Medicare Advantage HMO and PPO members for the following service and drugs.

**Service**

Bronchial thermoplasty will require precertification approval from Independence in 2016 as follows:
- **Effective January 1, 2016**, precertification will be required for members enrolled in Medicare Advantage plans.
- **Effective March 1, 2016**, precertification will be required for members enrolled in commercial plans.

**Drugs**

As of January 1, 2016, the seven medical benefit drugs listed below will require precertification approval from Independence:

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

These changes will be reflected in an updated precertification requirement list, which will be posted later this month on our website at [www.ibx.com/preapproval](http://www.ibx.com/preapproval).

In addition, Notifications for the medical policies for Adagen (pegademase bovine) and Cyramza (ramucirumab) will be available this month:

- **Adagen (pegademase bovine):**
  - **Commercial:** #08.01.26: Pegademase bovine (Adagen®)
- **Cyramza (ramucirumab):**
  - **Commercial:** #08.01.25: Ramucirumab (Cyramza®)
  - **Medicare Advantage:** #MA08.075: Ramucirumab (Cyramza®)

To view the Notifications for these policies, visit our Medical Policy Portal at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy). Select Accept and Go to Medical Policy Online, and then select Commercial or Medicare Advantage under Notifications.

In January 2016, new policies for Imlygic™ (talimogene laherparepvec) and Nucala® (mepolizumab) will be made available. Medical necessity criteria for these drugs will be based on the U.S. Food and Drug Administration (FDA)-approved indications.

*Pending approval from the FDA*
Our prescription drug program and safe prescribing procedures

Independence has contracted with FutureScripts®, an independent company, to manage the administration and claims processing of our prescription drug programs. FutureScripts provides mail-order services and works with community pharmacies to provide medications to our members. Medication claims are generally processed directly with the pharmacy provider when the member obtains the prescription.

In order to oversee our pharmacy policies and procedures and to promote the selection of clinically safe, clinically effective, and economically advantageous medications for our members, Independence formed the Pharmacy and Therapeutics Committee. This Committee is a group of local physicians and pharmacists who meet quarterly to review, evaluate, and update the medications included in our formularies to ensure their continued effectiveness, safety, and value.

Select Drug Program®

The Select Drug Program is a formulary-based drug benefits program that is maintained by the Pharmacy and Therapeutics Committee and includes all generic drugs and a defined list of brand-name drugs that have been reviewed for medical effectiveness, safety, and value and approved by the U.S. Food and Drug Administration (FDA). This program is set up with a three-tiered cost-sharing structure:

- **Tier 1 – Generic formulary**: Includes most generic medications. Drugs are covered at the lowest formulary level of cost-sharing.
- **Tier 2 – Brand formulary**: Includes preferred brand medications. Drugs are covered at a higher formulary level of cost-sharing.
- **Tier 3 – Brand non-formulary**: Includes non-preferred medications. Drugs are covered at the highest non-formulary level of cost-sharing.

Coverage for drugs is based on the member’s prescription drug benefits. You can download the latest Select Drug Program formulary at [www.ibx.com/providers/pharmacy_information/select_drug](http://www.ibx.com/providers/pharmacy_information/select_drug) or call Provider Services at 1-800-ASK-BLUE for a printed copy.

Mail-order services

FutureScripts provides mail-order services as an option for Independence members to receive their medications. Most of the time, medication requests are processed upon receipt of a prescription from a physician; however, there may be times when the physician will need to contact FutureScripts for medication coverage, such as when formulary management limitations exist. See the “Prescribing safety” section on the next page for more details.

Generic medications

According to the FDA, generic drugs are equivalent to their brand-name alternatives in active ingredients, dosage, safety, strength, and performance and are held to the same strict standards as their brand-name counterparts. The only noticeable difference between a generic drug and its brand-name counterpart may be the shape and/or color of the drug. Generic drugs are just as effective as the corresponding brand-name drugs; however, they may cost up to 70 percent less, helping to reduce health care costs for members. The generic option is always the lowest cost for the member.

Please note that FutureScripts does not determine when a generic medication will be provided at the pharmacy. In accordance with state laws, generic medications may be provided by the pharmacist at the point of sale, if available, unless the physician indicates “dispense as written” or “brand necessary” on the prescription. However, if brand medications are prescribed in place of a generic medication, prior authorization may be needed before the drug is covered.

Exceptions

When necessary, consideration for an exception can be requested for a non-formulary medication to be covered at the formulary level of cost-sharing. Physicians may request coverage on behalf of a member when the following conditions are met:

- All formulary alternatives have been exhausted or there are contraindications to using them.
- A completed Formulary Exception Request form has been faxed to 1-888-671-5285 and contains the following information:
  - diagnosis for the drug requested
  - medication history
  - supporting medical information for the requested medication

The Formulary Exception Request form can be found at [www.futurescripts.com/FutureScripts/formulary_authorization/prior_auth_commercial.html](http://www.futurescripts.com/FutureScripts/formulary_authorization/prior_auth_commercial.html).
If the non-formulary exception request is approved, the physician will receive written notification and the drug will be processed at the appropriate formulary level of cost-sharing. If the request is denied, the physician and member will receive a denial letter.

Prescribing safety
As part of formulary management, Independence implements safe prescribing procedures that are designed to optimize the member’s prescription drug benefits by promoting appropriate utilization. These procedures are based on FDA guidelines, and the approval criteria were developed and endorsed by our Pharmacy and Therapeutics Committee. FutureScripts continuously monitors the effectiveness and safety of drugs and drug prescribing patterns. Several procedures support safe prescribing patterns for our prescription drug programs, such as prior authorization and age, gender, and quantity limits.

Prior authorization
Prior authorization is required for certain covered drugs to ensure that the drug is medically necessary, appropriate, and prescribed according to FDA guidelines. The approval criteria for these medications may include that the physician order a trial of a different drug, such as a generic or a therapeutic alternative. Clinical pharmacists evaluate the information submitted by the member’s prescribing physician, including available prescription drug therapy history. The clinical pharmacists determine whether there are any drug interactions or contraindications, that the dosing and length of therapy are appropriate, and that other drug therapies, if necessary, were utilized where appropriate.

The prior authorization process may take up to two business days (24 hours for urgent requests) once completed information from the prescribing physician has been received. Some drugs may have approval duration limits of 6 or 12 months. This means that after 6 or 12 months, the physician will need to request consideration for a new prior authorization. The prescriber is notified upon approval whether a limited approval duration exists. Physicians should fax the appropriate prior authorization form and all supporting medical information to FutureScripts at 1-888-671-5285. The prior authorization forms are available on the FutureScripts website at www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/prior_auth_commercial.html.

Age and gender limits
Upon approval of a drug, the FDA indicates specific safety limitations that govern prescribing practices. Age and gender limits are designed to prevent potential harm to members and to promote appropriate use. Pharmacists have access to up-to-date information regarding FDA guidelines. If a member’s prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. The prescribing physician may request consideration for prior authorization of these medications when medically necessary by completing the General Pharmacy form, available at www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/prior_auth_commercial.html. The member should contact the prescribing physician to request that he or she initiate the prior authorization process.

Quantity limits
Certain drugs have a limit on how many doses a member can receive per month. Quantity limits are based upon FDA-approved maximum daily doses and/or length of therapy of a particular drug. Quantity limits ensure that a drug is not taken in the wrong way and that the member does not take more than the FDA-approved maximum daily dose or length of therapy. If medically necessary, a physician can request consideration for a quantity limit exception by completing the General Pharmacy form, available at www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/prior_auth_commercial.html.

For additional information on pharmacy policies and programs, go to www.ibx.com/rx.
Contraceptive coverage changes for 2016

Beginning in December, some of your Independence patients may receive a letter from FutureScripts®, our pharmacy benefits manager and an independent company, explaining updated guidelines for contraceptive coverage. The letter explains that **beginning January 1, 2016**, upon group renewal, brand-name contraceptives that have a generic alternative will be covered with standard cost-sharing. The affected drugs are:

- Beyaz®
- Depo-subQ provera 104™
- Ella®
- Lo Loestrin®
- Minastrin®
- Ortho Tri-Cyclen® Lo
- Safyral®

Those brand-name contraceptives **without** a generic alternative or generic equivalent will continue to be covered at 100 percent. Likewise, generic contraceptives will continue to be covered at 100 percent. Brand-name contraceptives with generic equivalents will continue to be covered at standard cost-sharing.

Members are advised to contact their provider to find out if a generic alternative, generic equivalent, or any contraceptive drug that does not have cost-sharing is appropriate for them. When applicable, please issue a new prescription for the member.

For questions about pharmacy coverage, members can call the Pharmacy Benefit telephone number on the back of their ID card. ◆

Upcoming changes in coverage for intrauterine devices

An intrauterine device (IUD) is a small T-shaped contraceptive device that is inserted into the uterus by a practitioner in an office setting after a pelvic exam. The following four IUDs are currently approved by the U.S. Food and Drug Administration:

- Lilletta
- Mirena®
- ParaGard®
- Skyla®

These devices work through different mechanisms and have varying risks, durations of efficacy, and success rates. Providers should evaluate each member to determine which IUD is most appropriate, given her unique circumstances and medical history. Currently, IUDs are eligible for coverage under either the member’s medical or pharmacy benefit.

**Effective January 1, 2016**, IUDs will only be eligible for coverage under the member’s medical benefit, as these devices must be inserted by a physician in the office setting. These devices will no longer be eligible for coverage under the pharmacy benefit through FutureScripts®, our pharmacy benefits manager and an independent company. In addition, the removal of an existing IUD and insertion of a replacement IUD will also only be eligible for coverage under the member’s medical benefit.

If you have any questions about these changes, please contact Customer Service at 1-800-ASK-BLUE. ◆
Prescribing medications for your older adult patients

When you prescribe a new medication to adults ages 65 and older, please keep in mind that certain medications have a greater potential for side effects. Patients in this age group are twice as likely as those younger than 65 to experience adverse drug events — and almost seven times as likely to be hospitalized from them.

Keep in mind the following when potentially prescribing these medications:

- **High-risk medications.** The National Committee for Quality Assurance (NCQA) developed the High Risk Medication (HRM) list through its HEDIS® program. The Pharmacy Quality Alliance (PQA) has adapted and endorsed NCQA’s HRM measure. Working alongside the Centers for Medicare & Medicaid Services (CMS) to improve the quality of health care, PQA maintains a list of medications considered to be high-risk in older adults. This list is based on the “Beer’s Criteria” from the American Geriatrics Society standard list for potentially inappropriate medication use in older adults. CMS measures the number of Medicare Advantage HMO and PPO members ages 65 and older who are receiving HRMs from the list. Using this information, CMS grades each health plan’s quality of care through its Stars† program.

- **Adverse drug events.** Through the Beer’s Criteria, HRMs have been proven to put older patients at a higher risk for adverse drug events. For example, medications such as zolpidem, amitriptyline, estrogens, and glyburide place patients at a higher risk for drug-related toxicities and increased risk for falls and fractures. Looking at the criteria, we have an opportunity to minimize the use of these and other medications deemed high-risk.

There is an even greater risk when a patient is on more than one medication considered an HRM. Careful and appropriate use of drugs in the senior population is a critical quality-of-care issue. For these reasons we suggest that you use caution when prescribing one or more drugs on the list to patients ages 65 and older.


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Important message for providers who prescribe drugs for Medicare patients

**Beginning June 1, 2016,** the Centers for Medicare & Medicaid Services will enforce a requirement that Medicare Part D prescription drug benefit plans *may not cover drugs* prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances. Therefore, for providers not currently enrolled in Medicare, unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you are not able to prescribe covered Part D drugs. Please note that if you opt out, you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services).

If you need assistance with the process of enrolling in (or validly opting out of) Medicare, please contact the Medicare Administrative Contractor within your geographic area. ◆
Coverage of non-FDA-approved drugs

Before a new drug comes to market, it must go through a long process of approval by the U.S. Food and Drug Administration (FDA). Today, federal law requires prescription drugs to be shown to be both safe and effective under the Kefauver Harris Amendment to the Food, Drug, and Cosmetic Act, which was passed in 1962. During the approval process, the applicant (drug manufacturer) must demonstrate that its manufacturing process can reliably produce products with expected identity, strength, quality, and purity. Additionally, all labelling must provide necessary information for health care professionals to understand the product’s risks and uses. However, these requirements were not always in place.

The original Food and Drugs Act of 1906 prohibited the sale of misbranded or adulterated drugs but did not require FDA approval. In 1938, manufacturers were required to prove that the new drug was safe, but they were not required to prove efficacy. Then, in 1962, Congress amended the law and required manufacturers to show that their drugs were both safe and effective.

Conversely, there are some drugs (mostly older products) that, due to a variety of historical reasons, have been marketed and used without FDA approval. These may include:

- drugs available prior to the amended law requiring safety and efficacy;
- a manufacturer combining two approved products into a combination product without obtaining approval;
- a manufacturer marketing a currently approved product without obtaining FDA approval.

Verifying drug status

The Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book), available at www.accessdata.fda.gov/scripts/cder/ob/default.cfm, identifies FDA-approved drugs that have undergone the mandatory safety and efficacy requirements of the Federal Food, Drug, and Cosmetic Act. If a medication is not included in the Orange Book, it has not demonstrated the requirements in accordance with this Act. Those drugs that entered the market based solely on safety and/or drugs that were on the market prior to 1938 are not included in the Orange Book.

Many health care providers continue to unknowingly prescribe unapproved drugs, usually because they are unaware of the non-FDA-approved status of the drugs.

Effective January 1, 2016, Independence will no longer cover non-FDA-approved drugs. The table below lists examples of non-FDA-approved drugs, as well as some FDA-approved alternatives.

For more information

To learn more, read the following articles published by the FDA at www.fda.gov:

- Unapproved Prescription Drugs: Drugs Marketed in the United States That Do Not Have Required FDA Approval: www.fda.gov/drugs/guidancecomplianceregulatoryinformation/enforcementactivitiesbyfda/selectedenforcementactionsonunapproveddrugs/default.htm
- What are unapproved drugs and why are they on the market? www.fda.gov/AboutFDA/Transparency/Basics/ucm213030.htm

<table>
<thead>
<tr>
<th>Non-FDA-approved drug</th>
<th>Alternative medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sulfacetamide/sulfur (Avar®, Avar-E®, Avar® LS)</td>
<td>Clindamycin/benzoyl peroxide (Benzaclin®), benzoyl peroxide/erythromycin (Benzamycin®)</td>
</tr>
<tr>
<td>Lidoctaine/menthol patches (RelyyT Patch®, Silvera Pain Relief)</td>
<td>Lidoctaine patch (Lidoderm®)</td>
</tr>
<tr>
<td>Isomethetepine/dichloralphenazone/APAP (Migragesic IDA)</td>
<td>Sumatriptan (Imitrex®), butalbital/caffeine/APAP (Fioricet®)</td>
</tr>
<tr>
<td>Saliva substitute (NeutraSal®, Aquoral®, Caphosol®)</td>
<td>Over-the-counter (OTC) saliva products</td>
</tr>
<tr>
<td>Estrogen, Ester/Me-testosterone (Covaryx®)</td>
<td>Conjugated estrogens/medroxyprogesterone (Prempro®), estradiol-norethindrone (Activella®), bazedoxifene/conjugated estrogens (Duavee®)</td>
</tr>
<tr>
<td>Omega-3/DHA/EPA/Fish oil (Vascazen®), phyosterol/OM-3/DHA/EPA/FISH (Vayarol®)</td>
<td>Omega-3 acid Ethyl Esters (Lovaza®)</td>
</tr>
<tr>
<td>Choline Sal/Magnesium Salicylate (CHOLINE MAG TRISAL)</td>
<td>OTC aspirin, OTC acetaminophen, prescription and OTC ibuprofen</td>
</tr>
</tbody>
</table>

You can send inquiries regarding FDA-approved and non-approved drugs to druginfo@fda.gov.
Select Drug Program® Formulary updates

The Select Drug Program Formulary, which is available for commercial members, 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:

<table>
<thead>
<tr>
<th>Generic drug</th>
<th>Brand drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>alosetron hcl</td>
<td>Lotronex®</td>
<td>8. Stomach, Ulcer, &amp; Bowel Meds</td>
<td>June 1, 2015</td>
</tr>
<tr>
<td>bexarotene 75 mg</td>
<td>Targetin®</td>
<td>5. Skin Medications</td>
<td>July 13, 2015</td>
</tr>
<tr>
<td>bimatoprost</td>
<td>Not available</td>
<td>11. Eye Medications</td>
<td>May 4, 2015</td>
</tr>
<tr>
<td>clozapine odt 150 mg and 200 mg</td>
<td>Fazaclo® 150 mg and 200 mg</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>May 11, 2015</td>
</tr>
<tr>
<td>fenofibrate 120 mg</td>
<td>Fenoglise® 120 mg</td>
<td>4. Heart, Blood Pressure, &amp; Cholesterol</td>
<td>June 29, 2015</td>
</tr>
<tr>
<td>glatopa 20 mg/ml syringe</td>
<td>Copaxone® 20 mg/ml Syringe</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
<td>June 29, 2015</td>
</tr>
<tr>
<td>linezolid 600 mg*</td>
<td>Zyvox® 600 mg</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
<td>June 29, 2015</td>
</tr>
<tr>
<td>naftifine hcl cream 1%</td>
<td>Naftin® Cream 1%</td>
<td>5. Skin Medications</td>
<td>June 8, 2015</td>
</tr>
<tr>
<td>norethindrone ethinyl estradiol</td>
<td>FemHRT®</td>
<td>10. Female, Hormone Replacement, &amp; Birth Control</td>
<td>May 18, 2015</td>
</tr>
<tr>
<td>pyridostigmine bromide er</td>
<td>Mestinon® 180 mg</td>
<td>8. Stomach, Ulcer, &amp; Bowel Meds</td>
<td>July 6, 2015</td>
</tr>
<tr>
<td>risedronate sodium 5 mg, 30 mg, and 35 mg</td>
<td>Actonel® 5 mg, 30 mg, and 35 mg</td>
<td>9. Bone, Joint, &amp; Muscle</td>
<td>June 8, 2015</td>
</tr>
</tbody>
</table>

*Generic requires prior authorization.

continued on the next page
### Brand additions

These brand drugs were added to the formulary and covered at the appropriate brand formulary level of cost-sharing as of the date indicated below:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caverject®</td>
<td>Not available</td>
<td>13. Urinary &amp; Prostate Meds</td>
<td>September 1, 2015</td>
</tr>
<tr>
<td>Eliquis®</td>
<td>Not available</td>
<td>4. Heart, Blood Pressure, &amp; Cholesterol</td>
<td>September 1, 2015</td>
</tr>
<tr>
<td>Nutropin AQ®</td>
<td>Not available</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other</td>
<td>September 1, 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Miscellaneous Hormones</td>
<td></td>
</tr>
<tr>
<td>Restasis®</td>
<td>Not available</td>
<td>11. Eye Medications</td>
<td>December 1, 2015</td>
</tr>
</tbody>
</table>

### Brand deletions

**Effective January 1, 2016,** these brand drugs will be covered at the appropriate non-formulary level of cost-sharing:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify®</td>
<td>aripiprazole</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Actonel® 5 mg, 30 mg, and 35 mg</td>
<td>risedronate sodium 5 mg, 30 mg, and 35 mg</td>
<td>9. Bone, Joint, &amp; Muscle</td>
</tr>
<tr>
<td>Mestinon® 180 mg</td>
<td>pyridostigmine bromide er 180 mg</td>
<td>8. Stomach, Ulcer, &amp; Bowel Meds</td>
</tr>
<tr>
<td>Mirapex® ER 3 mg</td>
<td>pramipexole di-hcl 3 mg</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
<tr>
<td>Targretin®</td>
<td>bexarotene 75 mg</td>
<td>5. Skin Medications</td>
</tr>
</tbody>
</table>

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

**Effective January 1, 2016,** this brand drug will be covered at the appropriate non-formulary level of cost-sharing:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Formulary therapeutic alternative</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relpax®</td>
<td>sumatriptan, rizatriptan, zolmitriptan</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
</tbody>
</table>

There is no generic equivalent for the above brand drug; however, there are formulary therapeutic alternative drugs. These therapeutic alternative drugs are available at the appropriate formulary level of cost-sharing. We encourage you to discuss formulary alternatives with your patients. ◆
Prescription drug updates

For commercial members enrolled in an Independence prescription drug program, prior authorization and quantity limit requirements will be applied to certain drugs. The purpose of prior authorization is to ensure that drugs are medically necessary and are being used appropriately. Quantity limits are designed to allow a sufficient supply of medication based upon the maximum daily dose and length of therapy approved by the U.S. Food and Drug Administration for a particular drug. The most recent updates are reflected below.

Drugs requiring prior authorization

The prior authorization requirement for the following non-formulary drugs was effective at the time the drugs became available in the marketplace:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daklinza™</td>
<td>Not available</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
<td>August 3, 2015</td>
</tr>
<tr>
<td>Ixinity®</td>
<td>Not available</td>
<td>15. Diagnostics &amp; Miscellaneous Agents</td>
<td>June 1, 2015</td>
</tr>
<tr>
<td>Orkambi™</td>
<td>Not available</td>
<td>12. Allergy, Cough &amp; Cold, Lung Meds</td>
<td>July 13, 2015</td>
</tr>
<tr>
<td>Stiolto Respimat™</td>
<td>Not available</td>
<td>12. Allergy, Cough &amp; Cold, Lung Meds</td>
<td>June 1, 2015</td>
</tr>
<tr>
<td>Technivie™</td>
<td>Not available</td>
<td>1. Antibiotics &amp; Other Drugs Used for Infection</td>
<td>August 3, 2015</td>
</tr>
<tr>
<td>Zomacton™ 5 mg vial</td>
<td>Not available</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other Miscellaneous Hormones</td>
<td>May 11, 2015</td>
</tr>
</tbody>
</table>

Effective January 1, 2016, the following non-formulary drugs will be added to the list of drugs requiring prior authorization:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carac®</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Duxcis®</td>
<td>Not available</td>
<td>8. Stomach, Ulcer, &amp; Bowel Meds</td>
</tr>
<tr>
<td>Fortamet®</td>
<td>Not available</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other Miscellaneous Hormones</td>
</tr>
<tr>
<td>Janumet®</td>
<td>Not available</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other Miscellaneous Hormones</td>
</tr>
<tr>
<td>Janumet® XR</td>
<td>Not available</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other Miscellaneous Hormones</td>
</tr>
<tr>
<td>Januvia®</td>
<td>Not available</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other Miscellaneous Hormones</td>
</tr>
<tr>
<td>Onglyza®</td>
<td>Not available</td>
<td>7. Diabetes, Thyroid, Steroids, &amp; Other Miscellaneous Hormones</td>
</tr>
<tr>
<td>Proctocort® 30 mg supp</td>
<td>Not available</td>
<td>5. Skin Medications</td>
</tr>
<tr>
<td>Relpax®</td>
<td>Not available</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
</tr>
</tbody>
</table>

continued on the next page
Drugs with quantity limits

Quantity limits were/will be added or updated for the following drugs as of the date indicated below:

<table>
<thead>
<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Quantity limit</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aptensio XR™</td>
<td>Not available</td>
<td>30 capsules per 30 days</td>
<td>May 11, 2015</td>
</tr>
<tr>
<td>Axert® 6.25 mg</td>
<td>almotriptan maleate 6.25 mg</td>
<td>12 tablets per 30 days</td>
<td>January 1, 2016</td>
</tr>
<tr>
<td>Chantix®</td>
<td>Not available</td>
<td>180 days supply per 365 days</td>
<td>January 1, 2016</td>
</tr>
<tr>
<td>Evekeo™ 10 mg</td>
<td>Not available</td>
<td>120 tablets per 30 days</td>
<td>July 1, 2015</td>
</tr>
<tr>
<td>Ritalin® LA 60 mg</td>
<td>Not available</td>
<td>30 capsules per 30 days</td>
<td>July 6, 2015</td>
</tr>
<tr>
<td>Tuzistra™ XR</td>
<td>Not available</td>
<td>240 ml per 30 days</td>
<td>June 15, 2015</td>
</tr>
<tr>
<td>Various nicotine</td>
<td>nicotine gum, inhalers, lozenges</td>
<td>180 days supply per 365 days</td>
<td>January 1, 2016</td>
</tr>
<tr>
<td>Various nicotine</td>
<td>patches</td>
<td>180 days supply per 365 days</td>
<td>January 1, 2016</td>
</tr>
<tr>
<td>Zegerid®</td>
<td>omeprazole sodium bicarbonate</td>
<td>60 capsules per 30 days</td>
<td>January 1, 2016</td>
</tr>
<tr>
<td>Zyban® 150 mg</td>
<td>buproprion hcl sr 150 mg</td>
<td>180 days supply per 365 days</td>
<td>January 1, 2016</td>
</tr>
</tbody>
</table>

Drugs no longer requiring prior authorization

Effective December 1, 2015, the prior authorization requirement was removed for the following drug:

<table>
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<tr>
<th>Brand drug</th>
<th>Generic drug</th>
<th>Formulary chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vimpat®</td>
<td>Not available</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
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For additional information on pharmacy policies and programs, go to www.ibx.com/rx.  

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</thead>
<tbody>
<tr>
<td>Vimpat®</td>
<td>Not available</td>
<td>3. Pain, Nervous System, &amp; Psych</td>
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</table>

For additional information on pharmacy policies and programs, go to www.ibx.com/rx.  

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Capitation arrangements for Keystone 65 Focus

As previously communicated, 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 resulting from the defined network of providers.

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 (PCP) designated (capitated) laboratory outpatient provider.

*Note:* For all other Independence Medicare Advantage HMO benefit products, members should continue to be referred to their PCP's capitated sites for radiology, physical therapy, and laboratory services.

**Finding providers in the Keystone 65 Focus network**

Members who choose Keystone 65 Focus for their health care coverage should only be referred to providers who are participating in the Keystone 65 Focus defined network. You can find Keystone 65 Focus participating providers using the online provider directory at www.ibxmedicare.com/focusfinder.

The sample image shows how a PCP's capitated sites will appear when looking at the online provider directory for Keystone 65 Focus. Please be aware that you will see "N/A" for both Physical Therapy and Radiologist, as a result of capitation not applying to these services for this benefit product.

Providers will be able to use either the NaviNet® web portal or our online provider directory to identify Keystone 65 Focus-participating physical therapy and facility-based radiology providers. Later this month, we will also publish a list of freestanding radiology sites at www.ibx.com/providers/focus.

*continued on the next page*
Requesting referrals and authorizations for Keystone 65 Focus members

You may currently have Independence Medicare Advantage patients who choose to enroll in Keystone 65 Focus for 2016. Please be aware that, for these patients, their network of participating providers will be narrowing as of January 1, 2016. Therefore, if those patients have referrals or authorizations on file under their current Independence Medicare Advantage plan, you may need to issue a new referral or authorization on or after January 1, 2016, to a Keystone 65 Focus-participating provider.

In addition, if you need to request an authorization for a new Keystone 65 Focus member for services scheduled in early January, please note that you will not be able to do so via NaviNet until after January 1, 2016, when your patient’s coverage under Keystone 65 Focus goes into effect. If you must request an authorization prior to January 1, 2016, you will need to do so by calling 1-800-ASK-BLUE and following the prompts for authorizations.

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 benefits. 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. 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.

We encourage you to start having conversations with your Independence Medicare Advantage patients about their 2016 plan selection. If you have any questions about Keystone 65 Focus, refer to the frequently asked questions on our website at www.ibx.com/providers/focus. If you still have questions after reviewing this information, please contact your Network Coordinator. ◆

Clarification: New routine chiropractic and podiatry benefits for Medicare Advantage plans in 2016

For the 2016 Independence Medicare Advantage plans, additional benefits were added to cover up to six routine care visits for both chiropractic and podiatry services. A copayment will apply at each visit. Please note that this added coverage is in addition to the standard Medicare-covered chiropractic and podiatry services, which are detailed below:

- **Medicare-covered chiropractic**: Medicare Part B covers manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider.
- **Medicare-covered podiatry**: Medicare Part B covers podiatrist services for medically necessary treatment of foot injuries or diseases (like hammer toes, bunion deformities, and heel spurs). Part B generally doesn’t cover routine foot care (e.g., cutting or removal of corns and calluses; trimming, cutting, and clipping of nails; or hygienic or other preventive maintenance like cleaning and soaking the feet).

For Medicare Advantage HMO members, a referral is required for all chiropractic and podiatry services.

Copayments will apply at each visit for routine chiropractic and podiatry visits; however, the copayment amount does not count toward the member’s maximum out-of-pocket amount.

Prior to rendering these services, be sure to verify coverage using the Eligibility and Benefits Inquiry transaction on the NaviNet® web portal. ◆
Standards for medical record documentation: Medical record review

A medical record documents a member’s medical treatment, past and current health status, and treatment plans for future health care, while also being an integral component in the delivery of quality health care. Because of this, Independence established medical records standards to facilitate communication, aid in coordination and continuity of care, and promote efficient and effective treatment. Independence regularly assesses compliance with these standards and monitors the processes and procedures physician offices use to facilitate the delivery of continuous and coordinated medical care. Performance goals have been established to assess the quality of medical record keeping. Below is a summary of the standards.

Documentation
Each medical record must include the following:

- complete problem list;
- prominent documentation of medication allergies and adverse reactions (if the member has no known allergies or history of adverse reactions, this is appropriately documented in the record);
- food allergies, such as shellfish, which may affect medication management;
- past medical and surgical history; including prenatal, birth, and childhood illnesses for members ages 18 and younger;
- current medications;
- documentation of clinical findings and evaluation for each visit;
- diagnoses consistent with findings;
- treatment/action plans consistent with the diagnoses;
- preventive services/risk screening.

Confidentiality
Confidentiality of medical records must be maintained as follows:

- Records are stored securely.
- Only authorized personnel have access to records.
- Staff receive periodic training in member information confidentiality.

Organization
Medical records should be organized and kept as follows:

- Medical records are organized and stored in a manner that allows easy retrieval.
- Medical records are stored in a secure manner that allows access by authorized personnel only.

The complete set of standards for maintaining appropriate medical records is accessible on our website at www.ibx.com/providers/resources/standards/medical_record_standards.html. They can also be found in the Provider Manual for Participating Professional Providers (Provider Manual), which is 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.
Lead testing for CHIP members before their second birthday

Children enrolled in Pennsylvania’s Children’s Health Insurance Program (CHIP) should receive two lead blood tests for the detection of elevated blood lead levels (EBLL) before their second birthday. The first test should be done between ages 9 to 12 months; the second test prior to or no later than 24 months; and thereafter based on risk.

Recognizing your recommendation has tremendous influence on the parents/guardians of your pediatric patients and their decision to seek lead testing and screening information for their children, we are requesting your participation in ensuring all CHIP members receive lead testing before their second birthday. It is also important to note that all CHIP members, regardless of risk level, should be tested for EBLLs. Performing a risk-assessment questionnaire instead of a blood lead test does not meet this requirement.

The difference between lead testing and lead screening

A lead test is one or more capillary or venous blood test administered on or before a child’s second birthday and thereafter based on risk. Lead screening is described as an assessment or questionnaire regarding a child’s health or living environment. The Pennsylvania Insurance Department’s requirement for CHIP members is for a lead test and not just lead screening. Children should be screened by performing a risk assessment starting at 6 months, again at 9 and 18 months, and then annually from ages 3 to 6, with testing as appropriate.

Identifying CHIP members

Independence ID cards for CHIP members include the identifying words “PA Kids” written on the front, as shown in the sample CHIP ID card below.

Resources

The following resources provide additional information regarding lead testing recommendations:

- National Lead Poisoning Prevention: www.cdc.gov/nceh/lead/nlppw.htm
- Philadelphia Department of Public Health: 215-685-2788 (Philadelphia residents)
- National Lead Information Center: 1-800-424-LEAD (non-Philadelphia residents)
- Independence website: www.ibx.com/providers/resources
2015-2016 Clinical Practice Guideline Summary now available

We recently posted the 2015-2016 Clinical Practice Guideline Summary, which replaces the previous version. The revised summary includes a listing of all Clinical Practice Guidelines adopted by Independence that are considered the accepted minimum standard of care in the medical profession. Adherence to these guidelines may lead to improved patient outcomes.

Guidelines are available for the following medical and behavioral health conditions: asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, heart failure, obesity, renal disease, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, and substance abuse disorders.

Changes in the 2015-2016 Clinical Practice Guideline Summary include updates to the current guidelines, as well as the addition of the following guidelines:

- **Asthma.** Global Initiative for Asthma (GINA) Pediatric Pocket Guide
- **COPD.** Global Initiative for Chronic Obstructive Lung Disease (GOLD) Diagnosis of Diseases of Chronic Airflow Limitation: Asthma COPD and Asthma-COPD Overlap Syndrome (ACOS)
- **Coronary Heart Disease.** AHA/ACC Guideline for the Management of Patients with Non-ST-Elevation Acute Coronary Syndromes; and ACC/AHA/AACVPR/AAFP/ANA Concepts for Clinician-Patient Shared Accountability in Performance Measures
- **Diabetes.** Type 1 Diabetes Mellitus and Cardiovascular Disease A Scientific Statement from the American Heart Association and American Diabetes Association; and Cardiovascular Disease Risk Factors in Youth With Diabetes Mellitus
- **Heart Failure.** Transitions of Care in Heart Failure; and Decision Making in Advanced Heart Failure
- **Obesity.** Severe Obesity in Children and Adolescents: Identification, Associated Health Risks, and Treatment Approaches; and Clinical Practice Guidelines for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient — 2013 Update

In addition, guidelines for **Renal Disease** have been newly added.

Individual clinical decisions should be tailored to specific patient medical and psychosocial needs. As national guideline recommendations evolve, please update your practice accordingly. The summary provides the reference for each condition and links directly to the guidelines.

We update the guidelines annually based on changes made to nationally recognized sources. Changes are reviewed by internal and external consultants, as appropriate, and by the Independence Quality Committee, which is comprised of network physicians.

You can access the 2015-2016 Clinical Practice Guideline Summary at www.ibx.com/clinicalguidelines. Paper copies of the summary 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.
2015-2016 Member Wellness Guidelines now available

We recently posted the 2015-2016 Member Wellness Guidelines, which replaces the previous version. The goal of these guidelines is to provide members with a user-friendly version of evidenced-based wellness recommendations for the average-risk person. These recommendations are not a statement of benefits and some of these services may require cost-sharing.

The 2015-2016 Member Wellness Guidelines have been revised so the recommendations more appropriately meet the needs of the following individual age groups:
- Pediatric guidelines (ages birth to 17)
- Adult guidelines ages 18 – 64
- Adult guidelines ages 65 and older

We encourage you to review these recommendations with your Independence patients to determine which screenings would be appropriate based on specific patient medical and psychosocial needs.

The guidelines are updated annually based on changes made to nationally recognized sources. Changes are reviewed by internal and external consultants, as appropriate, and by the Independence Quality Committee, which is comprised of network physicians.

Access the 2015-2016 Member Wellness Guidelines on our website at www.ibx.com/clinicalguidelines. Paper copies 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.
## Important Resources

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<th><strong>Anti-Fraud and Corporate Compliance</strong></th>
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<tr>
<td>Hotline</td>
<td>1-866-282-2707 or <a href="http://www.ibx.com/antifraud">www.ibx.com/antifraud</a></td>
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<th><strong>Care Management and Coordination</strong></th>
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<tr>
<td>Baby BluePrints®</td>
<td>215-241-2198 / 1-800-598-BABY (2229)*</td>
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<tr>
<td>Case Management</td>
<td>1-800-313-8628</td>
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<td>Condition Management Program</td>
<td>1-800-313-8628</td>
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<th><strong>Credentialing</strong></th>
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<tr>
<td>Credentialing Violation Hotline</td>
<td>215-988-1413 or <a href="http://www.ibx.com/credentials">www.ibx.com/credentials</a></td>
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<th><strong>Customer Service</strong></th>
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<tr>
<td>Provider Services</td>
<td>1-800-ASK-BLUE (1-800-275-2583)</td>
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<th><strong>Electronic Data Interchange (EDI)</strong></th>
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<td>Highmark EDI Operations</td>
<td>1-800-992-0246</td>
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<th><strong>FutureScripts® (commercial pharmacy benefits)</strong></th>
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<tr>
<td>Prescription drug prior authorization</td>
<td>1-888-678-7012</td>
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<tr>
<td>Pharmacy website (formulary updates, prior authorization)</td>
<td><a href="http://www.ibx.com/rx">www.ibx.com/rx</a></td>
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<td>FutureScripts Secure Customer Service</td>
<td>1-888-678-7015</td>
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<td>Formulary updates</td>
<td><a href="http://www.ibxmedicare.com">www.ibxmedicare.com</a></td>
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<th><strong>NaviNet® web portal</strong></th>
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<tr>
<td>Independence eBusiness Hotline</td>
<td>215-640-7410</td>
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<tr>
<td>Registration</td>
<td><a href="http://www.navinet.net">www.navinet.net</a></td>
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<th><strong>Other frequently used phone numbers and websites</strong></th>
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<tr>
<td>Independence Direct Ship Drug Program (medical benefits)</td>
<td><a href="http://www.ibx.com/directship">www.ibx.com/directship</a></td>
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<td>Medical Policy</td>
<td><a href="http://www.ibx.com/medpolicy">www.ibx.com/medpolicy</a></td>
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<tr>
<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*