**Prescribing Generics: Another Way to Help Your Patients**

Before you write “Dispense as Written” or “DAW” across the bottom of another prescription, please consider prescribing the generic equivalent. By doing so, you will play an instrumental role in saving your patients money on their health care costs.

According to a study conducted by Excellus BCBS, if every county in upstate New York increased its generic prescription drug fill rate to match that of the other upstate counties with the best rates (nearly 52 percent generic fill rate for some medicines), the estimated annual health care savings would exceed $880 million.

The report, titled “The Facts about Potential Savings from Generic Drugs in Upstate New York” is available on our Web site at www.excellusbcbs.com, under the “Public Policy and Research” section.

A good example of the cost savings in prescribing generic drugs is found with Prilosec. The average cost for a 30-day supply of brand name Prilosec is $138, the generic version of Prilosec costs $40, and the over-the-counter version in the same dosage (called Prilosec OTC) costs $24. Over a one year period, a patient’s medication costs could be reduced by $1,368 by switching from Prilosec to Prilosec OTC. (FLRx, the Excellus BCBS pharmacy benefit manager, covers Prilosec OTC as a generic medication if purchased with a physician prescription.)

The cost of prescription drugs has been widely cited as a major factor in the rising cost of health insurance premiums. About 17-19 percent of the benefit expenses for a typical upstate New York health plan is spent on pharmacy costs.
2006 Physician Booklets Mailed!
As you are probably aware, we recently mailed the 2006 physician booklets entitled “Rx Initiatives and Updates for 2006.” If you have not done so already, please take a moment to look through the booklets, as we’ve included important information and various provider tools. For example, you will find updated prior authorization forms, the 2006 3-tier guide, clinical information about Norvasc® and much more! For your convenience, we’ve also included a copy of the Norvasc tip sheet within this newsletter.

If you have not received a booklet and would like one, please contact the FLRx Pharmacy Help Desk at 1(800) 724-5033.

Mammograms: Physician Recommendation Makes a Difference
The rate of mammography screening in the United States has shown a slight decline in recent years. In 2004, 80 percent of Excellus BlueCross BlueShield’s female HMOBlue members between the age of 52 and 69 had a breast cancer screening within the previous two years.

However, studies have shown that physician recommendation has a powerful influence on patient response. When a woman’s doctor tells her to schedule a mammogram, she is three to four times more likely to get one.

As we reminded you in the September 2005 issue of this newsletter, the New York State Women’s Health Mandate requires coverage of an annual mammogram for women aged 40 and over without any physician recommendation for contracts that cover hospital, surgical or medical care.

There is clear evidence that early detection of breast cancer makes a difference in treatment options and survival rates. Please encourage your patients to start the New Year off right by scheduling a mammogram. Your suggestion can have a powerful impact.

New and Updated Guidelines Available on our Web Site
We’ve recently updated the following Clinical Guidelines:
- Hypertension
- Diabetes: Continuing Care for Diabetic Adults
- Congestive Heart Failure
- Attention Deficit/Hyperactivity Disorder (ADHD)

The updated guidelines are available on our Web site at www.excellusbcbs.com, along with many other clinical practice guidelines and materials.

We also have a new guideline for Acute Low Back Pain!
Click For Providers, then on Patient Care. Select Clinical Practice Guidelines from the menu on the left and scroll down to the guideline you need.

You Helped to Improve Our IVR
We’ve heard feedback from some of your offices regarding the user interface of our Interactive Voice Response (IVR) system for Provider Service calls. Some provider offices have felt that the menu options have been confusing or time consuming.

You will notice that we’ve recently taken steps to improve features of our menu options interface. The new options make it easier and faster to get to the information you’re seeking.

Special thanks to Connie Morton and Andrea Plain at Dr. Diego Cahn-Hidalgo’s office, for helping us identify opportunities to improve the system!

New Product: ViaHealth Employee Medical Benefit Plan
Please be advised that effective January 1, 2006, ViaHealth System will be offering a new Integrated Delivery Network (IDN) medical benefit program. The program, called The ViaHealth Employee Medical Plan, offers coverage through the BlueCard PPO network of providers. There is no coverage for services provided by out-of-network providers, with the exception of Urgent/Emergent care. The prefix for the new plan is ZFA. We’ve included a benefit description as an insert in this issue of Connection, that includes a sample of the ID card.
Hillside to Offer Employees New Plan Options

Beginning January 1, 2006, the Hillside Family of Agencies will offer to their employees three new health plan options to replace their previous HMO product offerings. The new plans will use the BluePPO provider network. The prefix for all three plans is ZFA.

The three plans are:

- BluePPO Gold, with $25 office visit copayment
- BluePPO Platinum, with $15 office visit copay
- BluePPO with HRA, a consumer-driven health plan, with annual deductible, coinsurance and copays. The deductible amounts vary depending on the type of coverage (i.e., single vs. family)

Please visit our Web site at www.excellusbcbs.com for more information.

Update Your Office Info on the Web

Beginning in January 2006, you will be able to make any changes to the demographic information about your practice by loading the information onto the Excellus BCBS Web site at www.excellusbcbs.com. In the past, we’ve made a form available for you to print out and fax back to us. The new capability will allow you to make your necessary changes faster and easier!

Expansion of Disease Management Program

Excellus BlueCross BlueShield is pleased to announce the availability of our standard disease management program for your Blue PPO, Blue Preferred PPO and BluePPO HSA patients. Population-based program services have been rolled out to our PPO members identified as having asthma, diabetes, and/or heart disease.

Your patients qualify for disease management enrollment through a number of ways: physician referral, self-referral, identification via medical and pharmacy claims or referral from one of our Excel for Life Programs. The level of intervention is based on the level of severity for the patient’s condition. The current standard disease management program is an opt-out program, which means that all identified members eligible for program enrollment are automatically enrolled but members may contact us and decline participation if they choose. The program is available at no additional cost to members and practitioners.

The standard disease management program provides educational information to patients and practitioners through activities such as educational newsletters, targeted reminder mailings regarding gaps in care and nationally accepted evidence-based clinical guidelines with supporting patient education tools. Patients who meet criteria placing them in a higher risk stratification level are also eligible to receive one-on-one telephonic educational counseling with a nurse through the Care Calls program as well as case management services for those high risk, medically complex members.

Visit our Web site at www.excellusbcbs.com to learn more about our disease management programs.

More About our New Look

We hope you like the new format for the Connection newsletter. During the coming year, you’ll notice that we will be presenting several topics as perforated inserts. An increasing number of these inserts will include headings that should make it easier for you to file the documents for future use, should you decide to do so.

The inserts will be organized under the following categories:

- Care Management
- Electronic Technology
- Quality Improvement
- Office Operations

Additionally, we will continue to provide you with in-depth information regarding our Pharmacy Management programs.

Here’s to 2006!
How to Identify BlueCard® (Out-of-Area) Plan Members

There’s an easy way to identify out-of-area members through BlueCard. When our members arrive at your office, be sure to ask them for their current membership identification card. The main identifier for all BCBS members is the alpha prefix.

BCBS Plan members have a three-character alpha prefix at the beginning of their ID numbers. The alpha prefix is key to facilitating prompt payments. The member ID is a combination of alpha and numeric characters.

Once you find the alpha prefix, call BlueCard Eligibility® at 1.800.676.BLUE (2583) to verify the patient’s membership and coverage. You may also check eligibility through our Web site. See the Provider Service Corner on Checking Member Eligibility in this newsletter for information on how to verify eligibility electronically. Whether you call to verify or use our Web site, you will need the information on the member’s ID card, so be sure to have it available.

In addition, the ID cards may have the following logos that appear on the front of Blue Plan member ID cards:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

When you see these logos, it means that the cardholder’s health plan participates in the BlueCard Program, which provides health care coverage for members outside their Blue Plan’s area. That is why it is important for you to ask for their ID card and then to verify their eligibility and coverage. If you have any questions, please contact Provider Service. Remember to submit all BlueCard claims to your local Excellus BCBS office.
Although there are several generic alternatives in the dihydropyridine calcium channel blocker (CCB) class, the market share of brand name Norvasc® grew to an all-time high of 47.2 percent in 2004. The question is, why? Is there a good reason Norvasc dominates the market? According to research, the answer is no. **There is no clear evidence that amlodipine (Norvasc) is superior to other medications in the setting of heart failure, hypertension and other indications.**

Currently, the dihydropyridine calcium channel blockers (CCB) felodipine (Plendil®), nicardipine (Cardene®), and nifedipine (Procardia®, Procardia XL®, Adalat®, Nifedical XL™) are available generically.

**For patients who require a CCB, consider prescribing a generic medication.**

<table>
<thead>
<tr>
<th>If the patient is currently on:</th>
<th>You may want to consider starting with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norvasc 2.5mg</td>
<td>felodipine ER 2.5mg QD</td>
</tr>
<tr>
<td></td>
<td>nifedipine ER 30mg QD</td>
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<tr>
<td></td>
<td>diltiazem ER or verapamil SR 180mg QD</td>
</tr>
<tr>
<td>Norvasc 5mg</td>
<td>felodipine ER 5mg QD</td>
</tr>
<tr>
<td></td>
<td>nifedipine ER 60mg QD</td>
</tr>
<tr>
<td></td>
<td>diltiazem ER or verapamil SR 240mg QD</td>
</tr>
<tr>
<td>Norvasc 10mg</td>
<td>felodipine ER 10mg QD</td>
</tr>
<tr>
<td></td>
<td>nifedipine ER 90mg QD</td>
</tr>
<tr>
<td></td>
<td>diltiazem ER or verapamil SR 360mg QD</td>
</tr>
</tbody>
</table>

**NOTE:** This table does not represent exact or equivalent dosing conversions. It is based on FDA approved dosing ranges and comparative doses from clinical trials for treating hypertension.

Nearly 30 percent of all Norvasc users use it as monotherapy, and the clinical evidence does not recommend this category as a first choice in any patient population. If a CCB is necessary, the generic equivalents are just as safe and effective, **and they are affordable.**

**Medical Evidence**

**Hypertension**
- According to the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), CCBs may be considered as initial therapy in patients with hypertension and one of the following “compelling indications:” high coronary disease risk and diabetes. **CCBs were not suggested as initial therapy for patients with hypertension and heart failure.**

- Additionally, the report (JNC 7) does not prefer any one long-acting dihydropyridine CCB over another, and the adverse affect profiles of the long-acting dihydropyridine CCBs are similar.
Chronic Stable Angina

- According to the July 2005 CCB report from the Oregon Health Resources Commission, there is consistent evidence which supports that amlodipine, nicardipine, and nifedipine can effectively treat chronic stable angina. According to the 2002 American College of Cardiology (ACC) and American Heart Association (AHA) guidelines, the long-acting CCBs, as a class, are noted as options for the management of chronic stable angina.

Heart Failure

- The 2005 American College of Cardiology (ACC) and American Heart Association (AHA) guidelines for chronic heart failure state that **most CCBs should be avoided in heart failure**, even when used to treat either hypertension or angina.

- According to the July 2005 CCB report from the Oregon Health Resources Commission, in the setting of CHF (defined as systolic dysfunction with a LVEF of less than 45 percent), there is evidence that amlodipine and felodipine do not decrease survival or cause harm in this patient population. However, neither do they improve survival nor decrease nonfatal cardiovascular events.

- Despite no head-to-head trials, the July 2005 CCB report also states that in patients with systolic dysfunction, the evidence does not demonstrate differences between amlodipine, felodipine, nifedipine, and nisoldipine on symptoms and exercise tolerance.

For Systolic Dysfunction in the clinical situation where hypertension, angina, or atrial fibrillation is comorbid: *

- There is consistent indirect evidence that showed both amlodipine and felodipine had neutral effects on all-cause mortality or combined fatal and nonfatal cardiovascular events.

- The evidence also showed no difference among amlodipine, felodipine, nifedipine and nisoldipine from effects on cardiac symptoms or exercise tolerance.


Medical Policy Update – January 2006

To ensure that the development of corporate medical policies occurs through an open, collaborative process, we encourage our participating practitioners to become actively involved in medical policy development. Each month, draft policies are posted in the Provider section of our Web site (www.excellusbcbs.com) for participating practitioners’ review and comment. Click on For Providers, then Medical Policies. Next, click on Preview & Comment on Draft Policies located at the bottom of the menu on the left side under Medical Policies. The following policies are tentatively scheduled to be available for comment in January 2006:

- Cochlear Implants
- Deep Brain Stimulation
- Living Skin Equivalents
- Lysis of Epidural Adhesions
- PET for Oncologic Applications

Corporate medical policies are used as a guide. Coverage decisions are made on a case-by-case basis and in accordance with the member's contract. While a technology or service may be medically necessary, payment of benefits is subject to the member's eligibility on the date the service is rendered and the benefit/exclusion provisions in the member's contract. Before rendering care, providers should verify the member's eligibility for the service by calling the Provider Service Department of your local plan.

The following new and updated medical policies have been reviewed and approved by the Corporate Medical Policy Committee, including practitioner representatives from Excellus BlueCross BlueShield, Central New York Region, Central New York Southern Tier Region, Utica Region, and Rochester Region.

Complete detailed policies are available on our Web site at www.excellusbcbs.com. Click on the For Providers menu option, then on View Our Medical Policies. Questions regarding medical policies may be directed to your Provider Relations Representative or to the Provider Service Department of your local health plan.

Medical policies are also located on the Web site for Excellus BlueCross Blue Shield members at www.excellusbcbs.com. To access our policies, members need to click on For Members, followed by Health and Wellness, then Research Health Conditions and lastly View our Medical Policies.

Medical policies and protocols apply to commercial and Medicaid products only when a contract benefit for the specific service exists. Excellus medical policies/protocols only apply to Medicare products when a contract benefit exists and where there are no National or Local Medicare coverage decisions for the specific service. A brief description of CMS coverage has also been provided for Excellus BlueCross Blue Shield medical policies at the end of each medical policy if a CMS coverage determination exists. Please refer to the Centers for Medicare & Medicaid Services (CMS) for medical policies pertaining to Medicare contracts. Web sites for review of CMS policies are:


Please note: Although medical policies are effective on the date they are approved by the Medical Policy Committee, updates to the claims processing systems may not occur for up to 90 days in order to allow you to update your billing systems accordingly.
NEW POLICIES recently approved by Corporate Medical Policy Committee

There were no new policies this reporting period.

CURRENT POLICIES recently updated by Corporate Medical Policy Committee

Allergy Immunotherapy which includes desensitization or hyposensitization, is medically appropriate in the following situations:
- for patients with demonstrated hypersensitivity that cannot be adequately managed by medications or avoidance;
- when there is a desire to avoid long-term pharmacotherapy; or
- for patients with coexisting allergic rhinitis and asthma where symptoms of asthma occur after natural exposure to aeroallergens and there is demonstrable evidence of clinically relevant specific IgE.

Injections of allergens should be individualized for each patient. Specific methods of immunotherapy (e.g., DNA immunization, Intranasal therapy, Provocative-neutralization therapy) which are considered investigational are outlined in the medical policy.

Allergy Testing, which includes percutaneous, intracutaneous/intradermal, patch, challenge, gamma globulin, and allergen specific IgE tests (e.g. RAST), is medically appropriate in particular clinical situations. Skin endpoint titration, mucous membrane and provocative testing are considered investigational as they are unproven means of diagnosing allergies.

CURRENT POLICIES recently updated with minimal changes

The following policies required only minimal changes (e.g., updating of references, changing language to meet legal needs). The coverage intent of the policies was not altered. These policies were recently approved for updating by the Health Plan Medical Directors and are available on our Web site.
- Autologous Chondrocyte Transplantation
- Celiac Disease Testing
- MRI Guided Ultrasonic Ablation of Uterine Fibroids
- Prenatal Genetic Testing and Counseling
- Ultraviolet Light Therapy for the Treatment of Psoriasis
- Vision Therapy

Medical Policies Converted to Medical Protocols

In some cases the Medical Directors have determined that certain medical policies should be considered medical protocols. Medical protocols do not deal with issues of technology assessment such as medical necessity of new technology, investigational/experimental procedures, vaccines, and/or new applications and indications for existing technology but rather they deal with clarifying coverage of services based on interpretation of member/subscriber contracts. In these cases, the former policies are now medical protocols and are the responsibility of the Corporate Medical Protocol Committee.

- Standing Devices

Policy Edits

Transendoscopic Therapies for GERD was edited to include information regarding the recent voluntary recall of all Enteryx Procedure Kits and injector products from commercial distribution. This action was initiated by Boston Scientific based upon growing data of serious adverse effects that have occurred related to the incorrect transmural injection of the product into vital organs that have gone unrecognized at the time of the procedure.
**Archived Medical Policies**

Policies are archived either because the technology has become standard of care or because there has been little utilization or few requests. Archiving a policy allows it to be used in decision-making but it will not be an active policy or be updated on an annual basis. Archived policies are available on the Internet Web site.

- **Acoustic Heart Sounds**

**Deleted Policies**

The following policies are scheduled to be deleted as it has been determined that the nationally recognized criteria currently utilized in determining medical appropriateness adequately address the Health Plan needs.

- **Prophylactic Mastectomy**
- **Prophylactic Oophorectomy**

**NEW PROTOCOLS recently approved by Corporate Protocol Committee**

There were none this reporting period.

**CURRENT PROTOCOLS recently updated by Corporate Protocol Committee**

There were none this reporting period.

**CURRENT PROTOCOLS recently updated with minimal changes**

The following protocols required only minimal changes (e.g., updating of references, changing language to meet legal needs). The **coverage intent of the protocols was not altered**. These protocols were recently approved for updating by the Health Plan Medical Directors and are available on our Web site.

There were none this reporting period.
QUALITY IMPROVEMENT

HEDIS and QARR Data Collection Beginning in March

The Quality Management Department will soon begin their annual Health Employer Data Information Set (HEDIS) and New York State Department of Health Quality Assurance Reporting Requirements (QARR) data collection.

HEDIS and QARR are sets of standardized performance measures designed to ensure that consumers and purchasers have the information they need to reliably compare managed health care plans. The performance measures in HEDIS and QARR are related to many significant public health issues such as cancer, heart disease, asthma, diabetes, recommended well care visits and age-appropriate immunizations and counseling. Managed care organizations are required to report our rates to the National Committee for Quality Assurance and the New York State Department of Health.

HEDIS/QARR are part of “health care operations” and HIPAA (Health Insurance Portability and Accountability Act) does not require authorization from individuals for health care operation activities. In February 2006, we will be sending a letter with a list to those providers who have members selected for these reviews. We will conduct most of the reviews in provider offices however, if there are only a small number of reviews we may request that you fax or mail the documentation in place of the on-site review.

We appreciate your ongoing support of these important quality activities. Thank you in advance for your patience and cooperation. If you have any questions or would like more information please call the Quality Management department at (585) 238-3665.

The following is a list of this year’s required reporting measures:

- Childhood Immunization
- Adolescent Immunization
- Lead testing
- Quality of Preventive Care for Adolescents
- Cervical Cancer Screening
- Colorectal Screening
- Comprehensive Diabetic Care
- Controlling High Blood Pressure
- Cholesterol Management for Patients with Cardiovascular Conditions
- Beta Blocker Treatment After and Acute MI
# Via Health Employee Medical Plan

## ViaHealth Employee Medical Plan Summary

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>VIAHEALTH NETWORK (Tier 1)</th>
<th>EXCELLUS BLUECROSS BLUESHIELD PPO NETWORK (Tier 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTIVE CARE</strong></td>
<td></td>
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</tr>
<tr>
<td>Annual Physical Exam</td>
<td>100% coverage after $30 Co-Pay</td>
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<tr>
<td>Well-Child Care</td>
<td>100% coverage</td>
<td></td>
</tr>
<tr>
<td>Annual Gynecologist Exam (Up to 2/year)</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Annual PSA Screening</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Immunizations (per visit) up to age 18</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
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<tr>
<td>Screening Colonoscopy</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
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<tr>
<td>Annual Mammogram</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Routine Eye Exams</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Children to age 18 – 1 every year</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Adults – 1 every 2 calendar years</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Allergy Shots (per visit)</td>
<td>100% coverage after $30 Co-Pay</td>
<td></td>
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<tr>
<td><strong>PHYSICIAN SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Visit and In-Office Services</td>
<td>100% coverage after $45 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Routine Lab</td>
<td>100% coverage after $45 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>• Minor Office Procedures</td>
<td>100% coverage after $45 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Specialist Physician Visit and In-Office Services</td>
<td>100% coverage after $60 Co-Pay</td>
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<tr>
<td>Including:</td>
<td></td>
<td></td>
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<tr>
<td>• Routine Lab and X-Rays</td>
<td>100% coverage after $60 Co-Pay</td>
<td></td>
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<tr>
<td>• Minor Office Procedures</td>
<td>100% coverage after $60 Co-Pay</td>
<td></td>
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<tr>
<td>• Second Surgical Opinion</td>
<td>100% coverage after $60 Co-Pay</td>
<td></td>
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<tr>
<td>Pediatric Services (For children up to and including age 18)</td>
<td>100% coverage after $15 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>• Primary Care Physician Visits</td>
<td>100% coverage after $15 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>• Specialist Physician Visits</td>
<td>100% coverage after $15 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Pre and Post Natal Maternity Care (Dependent Children Not Covered)</td>
<td>$45 Co-Pay for the first 10 Visits; remainder covered in full</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Office Visit and In-Office Services</td>
<td>100% Coverage after $45 Co-Pay</td>
<td></td>
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<tr>
<td><strong>IN-PATIENT SERVICES</strong></td>
<td></td>
<td>(MANDATORY PRIOR AUTHORIZATION IS REQUIRED FOR ALL ADMISSIONS)</td>
</tr>
<tr>
<td>Hospital Stay (non-Pediatric)</td>
<td>100% coverage</td>
<td>$500 Co-Pay per admission</td>
</tr>
<tr>
<td>Physician Expenses (non-Pediatric)</td>
<td>100% coverage</td>
<td></td>
</tr>
<tr>
<td>Pediatric Admissions (children up to and including age 18)</td>
<td>100% coverage</td>
<td></td>
</tr>
<tr>
<td><strong>OUT-PATIENT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery</td>
<td>100% coverage after $15 Co-Pay</td>
<td>$250 Co-Pay per surgery</td>
</tr>
<tr>
<td>Outpatient Services &amp; Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostic X-rays</td>
<td>100% coverage, $15 Co-Pay</td>
<td>$45 Co-Pay per procedure</td>
</tr>
<tr>
<td>• MRI, CT and PET Scans (Prior authorization is required)</td>
<td>100% coverage, $15 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>• Diagnostic lab and pathology</td>
<td>100% coverage</td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitative Therapy Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical</td>
<td>100% coverage, $15 Co-Pay/visit</td>
<td></td>
</tr>
<tr>
<td>• Occupational</td>
<td>(Combined total of 30 visits per calendar year)</td>
<td></td>
</tr>
<tr>
<td>• Speech</td>
<td>(Combined total of 30 visits per calendar year)</td>
<td></td>
</tr>
<tr>
<td>VIAHEALTH EMPLOYEE MEDICAL PLAN SUMMARY</td>
<td></td>
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<tr>
<td>----------------------------------------</td>
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<tr>
<td><strong>PSYCHIATRIC AND ALCOHOL/DRUG TREATMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Inpatient Psychiatric (Maximum 30 days / year)</td>
<td>100% coverage</td>
<td>$500 Co-Pay per admission</td>
</tr>
<tr>
<td>Inpatient Detoxification (Maximum 7 days / year; inpatient rehabilitation not covered)</td>
<td>100% coverage</td>
<td>$500 Co-Pay per admission</td>
</tr>
<tr>
<td>Outpatient Chemical Dependency (Maximum 60 visits / year)</td>
<td>100% coverage after $45 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Outpatient Acute Psychiatric (Maximum 20 visits / year)</td>
<td>50% coverage</td>
<td>50% coverage</td>
</tr>
<tr>
<td><strong>EMERGENCY ROOM CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room, Services and Supplies</td>
<td>100% coverage, after $75 Co-Pay (Waived if admitted within 24 hours)</td>
<td>100% coverage, after $150 Co-Pay (Waived if admitted within 24 hours)</td>
</tr>
<tr>
<td>Ambulance Services (Air and Ground)</td>
<td>$25 Co-Pay for Emergency Transportation</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>100% coverage, after $50 Co-Pay per visit</td>
<td>100% coverage, after $100 Co-Pay per visit</td>
</tr>
<tr>
<td><strong>ANCILLARY CARE &amp; SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (Prior authorization required if over $200)</td>
<td>80% coverage (Maximum annual limit of $5,000 per individual)</td>
<td>80% coverage (Maximum annual limit of $5,000 per individual)</td>
</tr>
<tr>
<td>External Prosthetics</td>
<td>80% coverage (Maximum annual limit of $15,000 per individual)</td>
<td>80% coverage (Maximum annual limit of $15,000 per individual)</td>
</tr>
<tr>
<td>Home Healthcare Visits and Services</td>
<td>Not Available</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Not Available</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Skilled Nursing Facility, Services and Supplies</td>
<td>100% coverage, up to 120 days; 360 days of lifetime</td>
<td>$500 Co-Pay, up to 120 days; 360 days of lifetime</td>
</tr>
<tr>
<td><strong>PHARMACY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs (Mandatory, if available)</td>
<td>ViaHealth Apothecary</td>
<td>$5 Co-Pay</td>
</tr>
<tr>
<td>Brand Preferred Drugs</td>
<td>$20 Co-Pay</td>
<td>$30 Co-Pay</td>
</tr>
<tr>
<td>Brand Non-Preferred Drugs</td>
<td>$30 Co-Pay</td>
<td>$40 Co-Pay</td>
</tr>
<tr>
<td><strong>VISION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Eyewear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Children to age 19 – 1 every calendar year</td>
<td>$60 Allowance</td>
<td></td>
</tr>
<tr>
<td>- Adults – 1 every 2 calendar years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I.D. Card Sample:</strong></td>
<td></td>
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</tr>
</tbody>
</table>
EVALUATING CLINICAL LITERATURE: Part three of a four part series on study design, statistics, interpreting results and bias.

Interpreting Confidence Intervals

• Confidence intervals can help you determine whether study results are weak or strong, definitive or not definitive. They are also more informative than a single value such as the p-value when assessing the strength of the evidence. To put it another way, confidence intervals are similar to a margin of error.

• Confidence intervals (CI) are an estimated range of values that attempt to quantify uncertainty. A narrow confidence interval implies high precision, whereas a wide interval implies poor precision, which is often an indication of an inadequate sample size. Most studies report CI as 95%, which means that if you conducted 100 identical studies, 95 of them would have results within the 95% CI. If the 95% CI includes zero (i.e., -1.2 to 2.4) then the outcome is NOT considered statistically significant because we cannot rule out the possibility that there is no effect. For example, a study of homeopathic treatment of pain and swelling after oral surgery (Lokken, 1995) examined swelling three days after an operation. The study showed that homeopathy led to a 1mm less swelling on average. The 95% confidence interval ranged from –5.5 to 7.5 mm, which appears to be a wide interval and implies that neither a large improvement due to homeopathy nor a large decrement could be ruled out.

• When reviewing a published medical report and interpreting confidence intervals, you should look for two things:
  • Does the interval contain a value that implies no change or no effect? Does the interval include zero?
  • Does the confidence interval lie partly or entirely within a range of clinical indifference?
    ▶ Clinical indifference represents values of such a trivial size that you would not want to change your current practice. For example, you would not prescribe a statin that lowered LDL by 1%.

• When looking at a negative trial, look to the upper end of the confidence interval, meaning the end that suggests the largest benefit from treatment. If even the smallest benefit of clinical importance lies above the upper limit of the confidence interval, the trial is definitively negative. In contrast, if clinically important benefits fall within the confidence interval, the trial has not ruled out the possibility that the treatment is worth while.

Reporting Results

Absolute Risk Reduction (ARR)- This is the absolute difference in outcome rates between the control and treatment groups. If 6% of the control group dies and 3% of the treatment group dies, the ARR is 3%.

Relative Risk Reduction (RRR)- Relative risk measures how much the risk is reduced in the experimental group compared to a control group. In our example above, the treatment would have a relative risk reduction of .05 or 50%. (The rate of death in the treated group is half of that in the control group.) RRR does not reflect the true magnitude of the treatment effect and its use can make treatment seem more effective (as in our example above), but it can also make adverse events appear more alarming. Be skeptical of any study or news release that reports the relative risk reduction without also reporting the absolute risk reduction.

Odds Ratio (OR)- Rather than looking at the risk of an event, the odds ratio looks at the odds of the event occurring. An odds ratio of 1 means that there is no difference in the odds of the event occurring between the groups. The further the OR is from 1, the greater the difference in odds between the two groups. The odds ratio is useful in retrospective studies such as case-control studies, where absolute risk and relative risk cannot be used (these measures can only be used in prospective studies). Odds ratios are comparable to relative risk when the outcomes being measured are rare, but the odds ratio can exaggerate risk when the disease or the outcome is common (>10%).

Number Needed to Treat (NNT)- The number needed to treat is a relatively new statistical concept that attempts to relay the “real world” meaning of absolute risk reduction. It represents the number of patients who would need to be treated in order to achieve benefit in one patient. NNT is calculated as 1/ ARR. In the example above, 33 patients would need to be treated in order to prevent one death (1/ 0.03).
New Warnings (www.fda.gov/cder/)

**Paxil®** *(paroxetine)* - On December 8, 2005, the FDA warned health care professionals that exposure to paroxetine in the first trimester of pregnancy may increase the risk for congenital malformations, particularly cardiac malformations. This warning was based on two unpublished studies, a Swedish national registry study and a U.S. insurance claims database study. These studies found that infants exposed to paroxetine in the first trimester had a 1.5-2% risk of cardiac defect compared to 1% risk in infants in the general population or infants exposed to other antidepressants. Most of the cardiac defects observed were atrial or ventricular septal defects. The study only examined the risk of exposure in the first trimester and there is currently no data addressing risk in the later stages of pregnancy. The FDA recommends that women taking paroxetine should consult with their doctor and states that paroxetine should generally not be initiated in women who are in their first trimester of pregnancy or in women who plan to become pregnant in the near future.

**Aranesp®, Epogen®, Procrit®** - On December 1, 2005, the FDA notified health care professionals that these package inserts have been updated to include safety information on reports of pure red cell aplasia and severe anemia (with or without other cytopenias) associated with neutralizing antibodies to erythropoietin in patients treated with these products. Most of these reports have occurred in patients being treated for chronic renal failure.

**NovoSeven®** *(recombinant coagulation factor VIIa)* - On December 1, 2005, the FDA notified health care professionals that the safety information for this product has been updated to include reports of thrombotic and thromboembolic adverse events in non-hemophilia patients. This warning is based on the results of a study in elderly, non-hemophiliac, intracerebral hemorrhage patients which demonstrated potential increased risk of arterial thromboembolic adverse events with the use of NovoSeven, including myocardial ischemia, myocardial infarction, cerebral ischemia and/or infarction.

**Long Acting Beta2- Adrenergic Agents (Advair®, Foradil®, Serevent®)** – On November 18, 2005, the FDA notified the manufacturers of these products to alert health care professionals and patients that these medications may increase the risk of severe asthma episodes, and death when these episodes occur. The FDA states that these medications should not be the first line treatment for asthma and should not be used unless other medicines, including medium or low-dose corticosteroids, are unable to control the patient’s asthma. A medication guide describing this increased risk is required to be provided to patients when any of these medications are dispensed.

**Ortho Evra®** - On November 14, 2005, the FDA notified health care professionals and patients of new warnings that the use of Ortho Evra birth control patches exposes women to higher estrogen levels than oral birth control pills containing 35 micrograms of estrogen (about 60 percent more estrogen). Estrogen use is linked to blood clots in the legs and lungs and other clotting problems such as strokes and heart attacks. It is not known whether the higher estrogen exposure from Ortho Evra actually increases the risk of these events.

**Amevive®** *(alefacept)* - On November 10, 2005, the FDA notified health care professionals to revisions in the contraindications for Amevive, used for moderate to severe chronic plaque psoriasis. Amevive should not be administered to patients infected with HIV. Amevive reduces CD4+ T lymphocyte counts, which may accelerate disease progression or increase complications of disease in these patients.
QUALITY IMPROVEMENT

NYS DOH Medical Record Documentation Requirements

During a recent review of medical records by the NYS Department of Health (DOH), two areas, Comprehensive History and Emergency Room/Inpatient follow-up, did not meet DOH standards.

When documenting in the patient's medical record, it is important to include a comprehensive patient history to comply with the DOH standards.

The DOH requires all of the following components be included in the medical record for all ages:

- Past medical history (including past illnesses, hospitalizations, surgeries, and/or serious accidents)
- Family history
- Personal and social history
- High risk behaviors: including use of tobacco, alcohol, drugs, other high risk behavior associated with the transmission of STDs and HIV disease
- Current problems and treatments
- Mental Health
- Reproductive history
- Domestic violence/abuse

For any emergency room visit or inpatient admission, the PCP is required to demonstrate acknowledgement of the ER visit and/or inpatient stay, and that appropriate follow-up occurred. This can be accomplished by:

- including a note or a discharge summary in the medical record
- including an emergency room visit sheet in the patient’s medical record that is either signed or initialed by the PCP
- a documented PCP follow-up visit, or by noting that the patient is seeing an appropriate provider.

The Excellus BCBS Medical Record Documentation Audit Tool can be found on our Web site at: https://www.excellusbcbs.com/providers/administration/forms_for_providers.shtml
A NEW TOBACCO CESSATION PROGRAM:  
Quit for Life™

Excellus BCBS supports members in their efforts to quit using tobacco. That’s why we’ve chosen Free & Clear and their award-winning program called Quit for Life™.

We wanted to make sure you knew about this valuable resource so that you can refer your patients who use tobacco. Quit for Life can help your patients quit tobacco for good, improve their health status and increase their life expectancy.

Quit for Life offers a scientifically-based and proven program based on 20 years of published research and clinical experience. It has helped thousands of people successfully quit tobacco.

Free & Clear, Inc. is a nationally recognized leader in delivering a proven, comprehensive approach to tobacco cessation that addresses all three aspects of tobacco dependence: physical, psychological, and behavioral.

When patients enroll in the Quit for Life Program they will receive:

- Phone-based sessions scheduled at the convenience of the participant
- Unlimited toll-free telephone access to quit coaches
- Recommendations on type, dose, and duration of medication if appropriate
- Fulfillment of nicotine replacement therapy (such as the patch or gum)
- A Quit Kit of materials designed to help participants quit tobacco through active self-management

Best of all, we are providing the Quit For Life program absolutely free to your patients who are commercial HMO and POS members and their adult dependents, age 18 and older. There is no charge for any aspects of the program.

As you use the five A’s to Ask, Assess, and Advise participants on their tobacco dependence, Quit for Life is there to help Assist and Arrange.

If you have patients who are using tobacco, refer them to the Quit for Life program for more information 800-442-8904 or to enroll in the program.