Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.
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The Provider Manual for Participating Professional Providers (Provider Manual) is part of your Professional Provider Agreement, as applicable, with Independence Blue Cross’s managed care Affiliates (collectively referred to as “Independence” or “Plan” throughout this manual). This manual supplements the terms of your contract and is updated regularly to provide you with pertinent policies, procedures, and administrative functions relevant to the daily administration of your practice when providing Covered Services to Independence members.

The Provider Manual is one of several communication vehicles that enables us to offer timely, pertinent information to you. We will provide you with regular updates through the following resources:

- **Partners in Health Update℠**: Our online newsletter, available on our Provider News Center at [www.ibx.com/pnc](http://www.ibx.com/pnc), that includes real-time news and announcements on various topics such as administrative processes, medical policies, and other important information.

- **The NaviNet® web portal**: An online gateway that allows real-time transactions between Independence and its Providers.

- **Website**: [www.ibx.com/providers](http://www.ibx.com/providers)

### Who is the “Plan”?

As used herein, the term “Plan” refers to Independence Blue Cross and its managed care subsidiaries and Affiliates, including, but not limited to, Keystone Health Plan East and QCC Insurance Company.

### Navigating through the Provider Manual

This Provider Manual has been published in the Adobe® Acrobat Portable Document Format (PDF). The PDF offers time-saving, Web-like functionality that makes locating information quick and easy. For optimal performance, we suggest that you visit the Adobe® website at [www.adobe.com/downloads](http://www.adobe.com/downloads) and download the latest edition of Adobe® Reader at no cost.

A brief overview of some of the time-saving enhancements is listed below.

### Keyword search function

Every word in the Provider Manual can be found by conducting a keyword search. There are several simple ways to start a search. Each of the following methods will produce the same results:

- Choose **Edit** and then **Search** from the main menu drop-down.
- Press **CTRL + F**.
- Type directly into the “Find” field that may already appear on your toolbar.
- Right-click your mouse, and choose **Search**.

### Table of Contents

A hyperlinked Table of Contents is provided at the beginning of each section. Just click on a topic of interest, and you will be taken directly to that section.

### Reference links

For your ease of reading and navigation, many sections of the Provider Manual refer to a particular page or section within the manual where additional information is located. These reference links are displayed in green. Whenever you come across one of these reference links, simply click the green text to view the page or section indicated.

**Example:** Refer to the General Information section for additional contact information.
Hyperlinked websites

All websites mentioned in the *Provider Manual* are hyperlinked. If the *Provider Manual* refers to a website — either an Independence or third-party website — you can click the *italicized* web address, and the website will open in your Web browser. All links are current as of the date indicated at the bottom of each section.

*Note:* You must have an Internet connection to view these sites.

**Definitions**

All capitalized terms in this manual shall have the meaning set forth in either your Provider Agreement or the Member’s benefits plan, as applicable.

A Payor is an entity which, pursuant to a Benefit Program Agreement with Independence, funds, administers, offers, or arranges to provide Covered Services and which has agreed to act as Payor in accordance with Independence’s Agreement with its Participating Providers. Independence itself is a Payor in certain circumstances. With respect to a self-insured plan covering the employees of one or more employers, the Payor is the employer.

Independence is not a guarantor of payment for other Payors. In the event a Benefit Program Agreement with a self-insured plan Payor is terminated, for any reason, including, but not limited to, the failure of such Payor to fund its self-insured plan in accordance with the terms of the Benefit Program Agreement, Independence shall update its electronic member eligibility database as soon as reasonably possible, to reflect the non-Member status of such self-insured plan’s employees. In accordance with your agreement with Independence, the Hospital may directly bill individuals who are not or were not Members on the date of service. Notwithstanding anything to the contrary in your agreement with Independence, Hospital may also directly bill Members of such self-insured plans for services, which are denied by Independence, or for any amounts owed, when a self-insured Payor fails to fund its self-funded plan in accordance with the terms of the Benefit Agreement.
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## Contact Information

### Important Telephone Numbers

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<th>Outside Philadelphia area</th>
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<tr>
<td><strong>AIM Specialty Health® (AIM)</strong></td>
<td></td>
<td>1-800-ASK-BLUE</td>
</tr>
<tr>
<td>Precertification requests for CT/CTA, MRI/MRA, PET, nuclear cardiology, facility-based sleep studies, continuous positive airway pressure titration, sleep equipment (APAP, BPAP, CPAP), related supplies, Cardiology Utilization Management Program, and Musculoskeletal Utilization Management Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anti-Fraud and Corporate Compliance Hotline</strong></td>
<td></td>
<td>1-866-282-2707</td>
</tr>
<tr>
<td><strong>Baby BluePrints®</strong></td>
<td>215-241-2198</td>
<td>1-800-598-BABY [2229]</td>
</tr>
<tr>
<td>Perinatal case management</td>
<td></td>
<td></td>
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<tr>
<td><strong>CareCore National, LLC d/b/a eviCore healthcare (eviCore)</strong></td>
<td></td>
<td>1-866-686-2649</td>
</tr>
<tr>
<td>Precertification requests for nonemergent outpatient radiation therapy services</td>
<td></td>
<td></td>
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<tr>
<td>Precertification and/or prepayment reviews for genetic/genomic tests, certain molecular analyses, and cytogenetic tests</td>
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<td></td>
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<tr>
<td><strong>Clinical Services – Utilization Management</strong></td>
<td></td>
<td>1-800-ASK-BLUE</td>
</tr>
<tr>
<td>Requests for authorization of services should be entered through the NaviNet® web portal.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Credentialing</strong></td>
<td></td>
<td>215-988-1413</td>
</tr>
<tr>
<td>Credentialing violation hotline</td>
<td></td>
<td><a href="mailto:application_requests@ibx.com">application_requests@ibx.com</a></td>
</tr>
<tr>
<td>Credentialing and re-credentialing inquiries</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Customer Service</strong></td>
<td></td>
<td>1-800-ASK-BLUE</td>
</tr>
<tr>
<td><strong>Keystone Health Plan East HMO/POS</strong></td>
<td></td>
<td>1-800-ASK-BLUE</td>
</tr>
<tr>
<td>Hours: Mon. – Fri., 8 a.m. – 6 p.m.</td>
<td></td>
<td>1-800-ASK-BLUE</td>
</tr>
<tr>
<td><strong>Personal Choice® PPO</strong></td>
<td></td>
<td>215-241-4400</td>
</tr>
<tr>
<td>Hours: Mon. – Fri., 8 a.m. – 6 p.m.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Federal Employee Program (FEP)</strong></td>
<td></td>
<td>215-241-2365</td>
</tr>
<tr>
<td>Hours: Mon. – Fri., 8 a.m. – 6 p.m.</td>
<td></td>
<td>1-800-645-3965</td>
</tr>
<tr>
<td><strong>Keystone 65 HMO/POS</strong></td>
<td></td>
<td>215-561-4877</td>
</tr>
<tr>
<td>Hours: 8 a.m. – 8 p.m., 7 days a week (on weekends and holidays from February 15 through September 30, your call may be sent to voicemail)</td>
<td></td>
<td>1-888-718-3333</td>
</tr>
<tr>
<td><strong>Personal Choice 65SM PPO</strong></td>
<td></td>
<td>1-888-926-1212</td>
</tr>
<tr>
<td>Hours: 8 a.m. – 8 p.m., 7 days a week (on weekends and holidays from February 15 through September 30, your call may be sent to voicemail)</td>
<td></td>
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<tr>
<td><strong>MedigapSecurity and Security 65®</strong></td>
<td></td>
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<tr>
<td>Hours: 8 a.m. – 8 p.m., 7 days a week (on weekends and holidays from February 15 through September 30, your call may be sent to voicemail)</td>
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<tr>
<td><strong>TTY/TDD</strong></td>
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<td>711</td>
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Language assistance services are offered through the AT&T Language Line for Members who have difficulty communicating because of an inability to speak or understand English.
## General Information

### Provider Manual

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<th>Service</th>
<th>Within Philadelphia area</th>
<th>Outside Philadelphia area</th>
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<tr>
<td><strong>FutureScripts® (Pharmacy Benefits)</strong></td>
<td></td>
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<tr>
<td>Hours: Mon. – Fri., 8 a.m. – 6 p.m.</td>
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<tr>
<td><strong>FutureScripts® Secure (Medicare Part D)</strong></td>
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<tr>
<td>Hours: Mon. – Fri., 8 a.m. – 6 p.m.</td>
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<tr>
<td><strong>Blood Glucose Meter Hotline</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Health Coaching</strong></td>
<td></td>
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<tr>
<td>Case management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO/PPO (Medicare Advantage and Commercial)</td>
<td></td>
<td></td>
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<tr>
<td>Hours: Mon. – Fri., 8 a.m. – 5 p.m.</td>
<td></td>
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<tr>
<td>Condition management</td>
<td></td>
<td></td>
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<tr>
<td>Hours: 24 hours a day, 7 days a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Highmark EDI Operations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours: Mon. – Fri., 8 a.m. – 5 p.m.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Independence Administrators</strong></td>
<td></td>
<td>1-888-356-7899</td>
</tr>
<tr>
<td><strong>Independence Blue Cross and Highmark Blue Shield Caring Foundation</strong></td>
<td>1-800-464-5437</td>
<td></td>
</tr>
<tr>
<td><strong>Keystone First</strong></td>
<td></td>
<td>1-800-521-6007</td>
</tr>
<tr>
<td>Hours: Mon. – Fri., 8 a.m. – 5 p.m.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse on call 24 hours a day</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
<td>1-800-688-1911</td>
</tr>
<tr>
<td>Magellan Healthcare, Inc. Customer Service and Precertification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Keystone Health Plan East Members with Caring Foundation benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independence Administrators</td>
<td></td>
<td>1-800-634-5334</td>
</tr>
<tr>
<td>Hours: 24 hours a day, 7 days a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NaviNet®</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NaviNet customer care (technical issues)</td>
<td></td>
<td>1-888-482-8057</td>
</tr>
<tr>
<td>eBusiness Hotline (portal registration and questions)</td>
<td></td>
<td>215-640-7410</td>
</tr>
<tr>
<td><strong>Office Administration/Patient Education Resources Order Form</strong></td>
<td><a href="http://www.ibx.com/resourceorderform">www.ibx.com/resourceorderform</a></td>
<td></td>
</tr>
<tr>
<td><strong>Tandigm Health</strong></td>
<td></td>
<td>1-844-TANDIGM, option 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: 215-2382271</td>
</tr>
</tbody>
</table>

### Claims mailing addresses

For a complete list of claims submission addresses, refer to the professional payer ID grid at [www.ibx.com/edi](http://www.ibx.com/edi). There, claims submission information is broken out by prefix/product name.

In addition, the following address should be used for outer-county claims:

<table>
<thead>
<tr>
<th>Outer County Claims – Lehigh, Lancaster, Northampton, and Berks County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Receipt Center</td>
</tr>
<tr>
<td>P.O. Box 21184</td>
</tr>
<tr>
<td>Eagan, MN 55121</td>
</tr>
</tbody>
</table>
Network Coordinators

Network Coordinators play a critical role in educating our network Providers and their office staff on policies, procedures, and specific billing processes. Network Coordinators also serve as a liaison for the Provider’s office and may promote or suggest workflow solutions.

In an effort to build and sustain a strong working relationship with Participating Providers, Network Coordinators will:

▪ communicate with Primary Care Physician (PCP) offices and select specialists on a regular basis to help resolve issues, review medical and claims payment policies, discuss new policy implementation, review utilization reports, recommend sources for more efficient utilization, and explain new products and programs;
▪ investigate and assist in providing resolution to Provider inquiries;
▪ identify policy and procedural issues that your office experiences and recommend potential resolutions;
▪ conduct initial orientation with your staff about our managed care network;
▪ explain procedures for requesting claims adjustments or initiating appeals.

Note: Network Coordinators cannot revise claims submissions.

We encourage you to utilize the self-service tools available through the NaviNet web portal, including the verification of Member eligibility, claim status, and claim inquiry submission.

Network Coordinators serve multiple Provider offices in the network. All inquiries regarding your office are important to us. Your Network Coordinator will address your questions in as timely a manner as possible.

Network Coordinator Locator Tool

The Network Coordinator Locator Tool identifies your Network Coordinator, his or her direct telephone number, fax number, manager, and the Medical Director who supports your practice or facility. Inquiries can also be submitted directly to your Network Coordinator through this tool.

To use the Network Coordinator Locator Tool, go to www.ibx.com/providers and select Contact Us from the “Providers” drop-down menu. When you open the tool, you will be prompted to enter either your National Provider Identifier (NPI) or your tax ID number and State. Your Network Coordinator’s contact
information will be displayed. If you receive an error message, or if your Network Coordinator’s information is unavailable, contact Customer Service for assistance.

Provider Services

Provider Services serves as a valuable resource to you, in addition to your Network Coordinator. The role of Provider Services is to:

▪ service Provider telephone inquiries in an accurate and timely manner;
▪ educate Providers and facilitate effective communication between Providers and Independence by responding to telephone inquiries in a timely and accurate way;
▪ educate Providers about self-service utilization;
▪ assist Providers in the resolution of claim inquiries.

To reach Provider Services, call Customer Service at 1-800-ASK-BLUE and follow the voice prompts.

Physician-to-Physician email platform

Independence Network Medical Directors offer a Physician-to-Physician email platform that provides direct, clear, and succinct messaging to assist Physicians in providing quality care to our Members. Email topics may include policy and billing changes, important upcoming mailings (e.g., Quality Incentive Payment System [QIPS] program, Preventive and Quality Improvement Program [PQIP], and Primary Care Advancement Model [PCAM]) and notifications regarding future fee schedule updates. These emails also include useful resources, such as important Independence contact information, links to NaviNet, and articles posted in Partners in Health UpdateSM.

The Network Medical Directors will only send an email when there is information of significant value for Independence-Participating Physicians. Go to http://tinyurl.com/ibc-email to join the Network Medical Directors Physician-to-Physician email list.

Provider Communications

To access the most current and updated information regarding Independence and our policies, procedures, and processes, refer to our online newsletter, Partners in Health Update, which is available on our Provider News Center at www.ibx.com/pnc, NaviNet Plan Central, and this Provider Manual. These resources are designed to work in unison to provide your office with timely informational updates.

To receive email updates that provide you with the latest information, including Partners in Health Update and news alerts, simply complete our email address submission form at www.ibx.com/providers/email. Allow up to two weeks for us to process your request, and remember to add Independence (provider_communications@ibx.com) to your email address book. We respect your privacy and will not make your email address available to third parties. For more information about our privacy policy, go to www.ibx.com/privacy.

ibx.com/providers

Find important information and resources, such as forms and billing guidelines specific to our Provider network. Simply place your cursor over the “Providers” tab along the top, and choose from the drop-down menu that appears. Information in this menu is broken out as follows:

▪ Provider News Center
▪ Policies & Guidelines
▪ Claims and Billing
▪ Tools and Resources
Provider News Center

The Provider News Center is our Provider-dedicated website, located at www.ibx.com/pnc, which features up-to-date news and information of interest to Providers and the health care community. The site has a user-friendly interface that allows you to easily navigate the latest news and information of interest to you and your office:

- **Latest News.** All Provider news posted in *Partners in Health Update* within the previous month is listed on the home page.
- **Spotlight.** Promotional banners located along the top of the website highlight important news.
- **Dedicated News.** The home page features dedicated sections for important topics (e.g., Opioid Awareness) with significant impact to our Participating Providers.
- **Sortability & Searchability.** All news is grouped into convenient categories (such as Billing & Reimbursement, NaviNet Resources, and Products) and broken out by Provider type (Professional, Facility, or Ancillary) so you can quickly find news that's relevant to you and your office staff. You can also conduct keyword searches to pinpoint specific content.

Additionally, the Provider News Center includes a Quick Links section that gives easy access to our traditional Independence resources, such as Independence forms, the Independence Medical Policy Portal, NaviNet, and our Provider publication indices.

**NaviNet Plan Central**

In addition to fast, secure, and HIPAA-compliant access to Provider and Member information and real-time transactions, NaviNet-enabled Providers have access to a valuable source of information on our NaviNet Plan Central page. This page contains important tools and resources, including:

- the latest Provider news and announcements;
- the most current version of our publications and Provider manuals;
- links to fee schedule information and NaviNet Resources;
- information about Patient-Centered Medical Homes;
- helpful documents, including frequently asked questions, enrollment forms for our Medicare Advantage plans, and health and wellness tools;
- contact information.

**Office Administration/Patient Education Resources Order Form**

To replenish office supplies such as the *Provider Manual* and allergy stickers, use the online request form available at www.ibx.com/resourcesorderform. Have the following information ready so your order can be processed in an error-free, timely manner:

- NPI
- office name
- office address
- office telephone number

Orders are normally shipped within 48 hours and should arrive at your office within 5 – 7 business days.
Privacy and confidentiality

Provider obligations
Contracted Providers are required to maintain confidentiality of Member protected health information (PHI) and records, in accordance with applicable laws.

Access to PHI
The Health Insurance Portability and Accountability Act (HIPAA) and its implemented privacy regulations permit a HIPAA-Covered Entity, such as Independence, to request and obtain our Members’ individually identifiable health information from third parties. An example of a “third party” would be a HIPAA-Covered Entity such as a health care Provider. When such PHI is requested for purposes of treatment, payment, and/or health care operations, the Member’s authorization is not required. HIPAA specifically permits health care Providers to disclose PHI, including Members’ medical records to health plans for treatment, payment, or health care operations. Independence uses this information to promote Members’ ready access to treatment and the efficient payment of Members’ claims for health care services.

Other Independence activities that can be categorized as “treatment, payment, or health care operations” under HIPAA include, but are not limited to, the following:

- Treatment includes the provision, coordination, and management of the treatment. It also includes consultation and the Referral of a Member between and among health care Providers.
- Payment includes review of various activities of health care Providers for payment or reimbursement; to fulfill the health benefit plans’ coverage responsibilities and provide appropriate benefits; and to obtain or provide reimbursement for health care services delivered to its Members. Activities that fall into this category include, but are not limited to, determination of Member eligibility, reviewing health care services for Medical Necessity, and utilization review.
- Health care operations includes certain quality improvement activities, such as case management and care coordination, quality of care reviews in response to Member or State/federal queries, and prompt response to Member complaints/grievances; site visits as part of Provider credentialing and recredentialing; medical record reviews to conduct clinical and service studies to measure compliance; administrative and financial operations, such as conducting Healthcare Effectiveness Data and Information Set (HEDIS®) reviews and Customer Service activities; and legal activities, such as audit programs, including fraud and abuse detection, and to assess Providers’ conformance with compliance programs.

Privacy policies
Protecting the privacy of our Members’ information is very important to us. That is why we have taken numerous steps to see that our Members’ PHI, whether in oral, written, or electronic form, is kept confidential.

We have implemented policies and procedures regarding the collection, use, and disclosure of PHI by and within our organization and with our business associates. We continually review our policies and monitor our business processes to ensure that Member information is protected, while continuing to make the information available as needed for the provision of health care services. For example, our procedures include processes designed to verify the identity of someone calling to request PHI, procedures to limit who on our staff has access to PHI, and policies that require us to share only the minimum necessary amount of information when PHI must be disclosed. We also protect any PHI transmitted electronically outside our organization by using only secure networks or by using encryption technology when the information is sent by email.
We do not use or disclose PHI without the Member’s written authorization unless we are required or permitted to do so by law. If use or disclosure of a Member’s PHI is sought for purposes that are not specifically required or permitted by law, the Member’s written authorization is required. To be deemed valid, Member authorizations must include certain elements required by State and/or federal law. Members may print a copy of our Authorization to Release Information form from www.ibx.com/privacy or request a copy by calling Customer Service.

For more detailed information about our Members’ privacy rights and how we may use and disclose PHI, review our Notice of Privacy Practices, which is available on our website at www.ibx.com/privacy.

Email

New software that secures outbound email containing PHI encrypts the message so that it is unintelligible to unauthorized parties. Instead of receiving an email with Member PHI directly to your inbox, you will receive an email stating that there is a secure message waiting for you on a secure server. A link will take you, via a secured browser, to that server, where you will receive instructions for opening the email.

We have implemented this secured email system to meet the requirements of HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH). While this process requires some extra steps, we are making every effort to ensure that there is no significant disruption to your communications with us.

Providing PHI for Member appeals of enrollees in self-insured group health plans

Employers and health and welfare funds are called “Plan Sponsors” when they sponsor self-insured group health plans that have a large number of enrollees. When they make elections about claim fiduciary status, they also determine the entity ultimately responsible for final decisions on benefits and other issues in Member appeals for these plans. Sometimes their elections require special arrangements for processing Member appeals for their self-insured group health plans. Because self-insured group health plans are HIPAA-Covered Entities, we have summarized the following points that network Providers need to know about requests for PHI for Member appeals of enrollees in self-insured group health plans.

- Network Providers may receive requests for PHI for the Member appeals of enrollees in self-insured group health plans offered through Independence from (1) Independence, (2) employers or health and welfare funds that sponsor the self-insured group health plan, and/or (3) other entities.

- A response to these PHI requests satisfies HIPAA privacy requirements when the PHI is released to an authorized entity as part of the self-insured group plan’s treatment, payment, and/or health care operations (TPO).

- Independence’s requests for PHI of enrollees involved in these Member appeals will always qualify for release as TPO because Independence is a HIPAA-authorized entity for these self-insured group health plans. Plan Sponsors authorize the initial filing of all Member appeals for self-insured group plans that they offer through Independence to be submitted to Independence. Beyond that, the Plan Sponsor’s claims fiduciary election determines whether Independence acts in these Member appeals in (a) its full, standard role as processor and decision-maker for all internal levels of review or (b) a more limited role that facilitates review by other designated entities.

- Employers, health and welfare funds, and other designated entities may only obtain PHI for enrollees involved in Member appeals of self-insured group health plans if they have proper authorization. The Plan Sponsor may authorize them to obtain PHI for these Member appeals by designating them to handle processing and/or decision-making at certain levels of the self-insured group plan’s Member appeals process. When this occurs, PHI may be released to them as TPO consistent with the Plan Sponsor’s authorization.
Network Providers should rely on their own internal resources and established protocols for handling PHI requests. Provider Services and other Independence departments will only be able to give you limited information about Independence’s role in processing Member appeals for self-insured group health plans that are offered through Independence.

**Third-party payment policy**

**Our position**

Independence has a policy to not accept premium payments or Copayments, Deductibles, or other cost-sharing payments (collectively, Cost-Sharing Payments) made by certain third parties, including, without limitation, payments made directly or indirectly by a health care Provider or supplier.

Please carefully review Independence’s policy below to ensure that you are not in violation of the policy. It should be noted that reimbursement to health care Providers or suppliers for services provided to such Members may be subject to retroactive adjustments by Independence to the extent such premium funding is or was in violation of this policy.

**Our policy**

The following policy applies to all Independence-Participating Providers.

*Direct and/or Indirect Third-Party Payments of Member Premiums and Cost-Sharing*

Independence will not accept premium payments or Cost-Sharing Payments made by third parties on behalf of its Commercial and Medicare Members except as noted below.

*Accepted Third-Party Payments*

In accordance with applicable laws, regulations, and regulatory guidance, this policy does not apply to premium payments or Cost-Sharing Payments made by:

1. the Ryan White HIV/AIDS Program under title XXVI of the PHS Act;
2. an Indian tribe, tribal organization, or urban Indian organization; or
3. a local, state, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

In addition, Independence will accept third-party payments:

1. from family members.
2. made by bona fide religious institutions and other bona fide not-for-profit organizations only when each of the following criteria is met:
   a. the assistance is provided on the basis of the insured’s financial need,
   b. the institution or organization is not a health care Provider or supplier,
   c. the premium payments and any Cost-Sharing Payments cover an entire policy year, and
   d. the institution or organization does not have any direct or indirect financial interests. For illustrative purposes only:
      i. a direct financial interest may exist if the third-party itself has a financial interest in the payment of health insurance claims;
      ii. an indirect financial interest may exist, for example, if the third-party receives funding from other individuals or entities that have a financial interest in the payments of the health insurance claims; and
      iii. in the case of a nonprofit foundation or other charitable entity (including without limitation a religious organization), a financial interest may exist if the entity receives a financial contribution from a health care Provider or supplier.
In addition, Providers are required to comply with applicable rules and regulations.

**Violation of Policy**

Independence will monitor third-party payments to assure compliance with this policy and long-standing anti-fraud regulations. Any premium payments or Cost-Sharing Payments received in violation of this policy will not be applied to the Member’s benefit plan. If premium payments or Cost-Sharing Payments have been made by third parties in violation of this policy, the Member will be provided with an opportunity to secure alternative funding through qualified sources. Reimbursement to health care Providers or suppliers for services provided to such Members may be subject to retroactive adjustment by Independence to the extent such premium funding is or was in violation of this policy or the earlier version of this policy.

Independence maintains sole discretion with respect to its acceptance of third-party payments that are permitted under this policy and may make changes to its administration of this policy at any time to the extent needed to support compliance with the law and/or applicable regulatory guidance. This policy may be updated from time to time.

**The IBX App**

We encourage our Members and Providers to download our free smartphone app, which is available for both iPhone and Android phones. With frequently updated and improved features, the IBX App gives Members easy 24/7 access to health care coverage.

The Doctor’s Visit Assistant allows the user to:

- fax or email a copy of their ID card;
- check the status of Referrals and claims;
- view their health history and prescribed medications;
- record notes and upload photos of symptoms.

The IBX App also offers expanded Provider search capabilities and other ways for users to manage their health on the go. Users of the IBX App can easily find doctors, hospitals, pharmacies, urgent care centers, and Patient-Centered Medical Homes; access benefit information; and track Deductibles and spending account balances.

**IBX Wire**

IBX Wire is a private, HIPAA-compliant, digital tool that leverages the accessibility of text messaging and the security of the Web to deliver practical and usable plan- and service-based information. Independence commercial Members are invited to sign up for IBX Wire, a free communication service, when they receive their health plan ID card.

IBX Wire focuses on preventive health screening reminders, such as flu shots and cervical and colorectal cancer screenings, as well as important news related to Health Care Reform.

In addition, content includes HEDIS® gaps in care for the following:

- asthma control
- breast cancer screening
- cardiovascular disease management
- chlamydia screening
- diabetes management
Note: IBX Wire is not currently available for Medicare Advantage, Medicare Supplement, Blue Extra, Medicaid, or Children’s Health Insurance Program (CHIP) Members.

Cost and quality transparency tools

Our Member portal at ibxpress.com has been optimized across various browsers and is accessible through a Member’s desktop, mobile phone, and tablet. We have redesigned the entire user interface to drive more Member engagement and have introduced new, innovative capabilities while continuing to provide access to the same existing features Members use most.

We enhanced our Find a Doctor tool focusing our design on how Members actually use the tool. The platform has been developed through ongoing usability testing, where Members are asked what they want, how the tools are working for them, and whether their needs are met. As a result, the tools within the platform are intuitive and simple to use. Being able to easily research Providers, treatments, and crucial decision-making information allows Members to feel confident in their health care choices. Some of the most notable features of the tool include:

- A single search bar helps Members find doctors, facilities, treatments, and services with common, everyday language.
- All-in-one search results provide the essential information a Member needs to make an informed decision from nearby doctors to cost estimates, quality ratings and patient reviews, network designations, and more.
- Quick-glance comparisons point to cost-effective options for Providers, treatments, and facilities.
- Patient review and ratings offer insights into fellow Members’ actual experiences with Providers.
- Informative Provider profiles and nationally recognized quality measurements help Members find the right fit for care.
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Rendering services

Be sure to verify Member eligibility and cost-sharing amounts (i.e., Copayments, Coinsurance, and Deductibles) each time a Member is seen.

How to verify Member eligibility

Member ID cards carry important information, such as name, ID number, prefix, and coverage type. If you use a Member’s ID card to verify information, please keep in mind that the information displayed on the card may vary based on the Member’s plan. Eligibility is not a guarantee of payment. In some instances, the Member’s coverage may have been terminated.

- Always check the Member’s ID card before providing service. If a Member is unable to produce his or her ID card and/or is not listed on the Primary Care Physician’s (PCP) capitation roster, ask the Member for a copy of his or her Enrollment/Change Form or temporary insurance information printed from www.ibxpress.com, our secure Member website. This form is issued to Members as temporary identification until the actual ID card is received and may be accepted as proof of coverage. The temporary ID card is valid for a maximum of ten calendar days from the print date.

- Participating Providers are required to use the NaviNet® web portal for all Member eligibility inquiries. There are occasions when a Member’s health insurance may be effective before his or her ID card is received in the mail. In this situation, you can still verify the Member’s eligibility by using the Eligibility and Benefits Inquiry transaction on NaviNet and selecting the “Patient Name/Patient Date of Birth” search type.

- A webinar and guide that offer guidance on where to obtain Member eligibility and claims status information through NaviNet are available in the NaviNet Resources section of our Provider News Center at www.ibx.com/pnc/navinet.

Note: For HMO and POS Members, PCPs should refer to their monthly capitation roster. Members are listed in alphabetical order, with family members listed together. In the event that there is a question about the Member’s eligibility or panel assignment, check NaviNet.

If we are unable to verify eligibility, we will not be responsible for payment of any Emergency or nonemergency services.

Copayments

Members are responsible for making all applicable Copayments. The Copayment amounts vary according to the Member’s type of coverage and benefits plan. In addition, please note the following:

- Copayment verification:
  - Copayments can be found by selecting the various links at the bottom of the Eligibility and Benefits Details screen when using the Eligibility and Benefits Inquiry transaction in NaviNet.
  - For HMO and POS Members, the PCP Copayment is also noted on the monthly capitation roster.
  - For Members with coverage through Keystone HMO Proactive, our tiered Provider network plan, the Eligibility and Benefits Inquiry transaction on NaviNet should be used to verify patients’ Copayment amount for their office visit. This transaction will display the appropriate cost-sharing amounts for all three benefit tiers. Therefore, you will need to know your benefit tier placement to determine the appropriate amount to collect from the Keystone HMO Proactive Member.
  - For Members in a PPO tiered network plan, acute care facilities and ambulatory surgical centers (ASC) are grouped into one of two in-network tiers, based on cost and quality measures. With these options, Members pay lower out-of-pocket costs when they receive care from tier 1 Providers.
Radiology, physical therapy, and occupational therapy services may be subject to Copayment amounts that differ from the specialist Copayment amount identified on the Member’s ID card. Copayments for these services should be verified using the Eligibility and Benefits Inquiry on NaviNet.

**Collecting Copayments:**

- Copayments may not be waived and should be collected at the time services are rendered. If a Member is unable to pay the Copayment at the time services are rendered and has been provided with prior notice of this requirement, Providers may bill the Member for the Copayment. Providers may also bill the Member a nominal administration fee for billing costs in addition to the Copayment; however, such billing fees must reflect the actual cost of the billing and must not be unreasonable or in excess of the Copayment amount.

- A Provider must notify a Member if the office provides services where the Member may be billed by more than one Provider. For example, the office must inform the Member when he or she will be charged a Copayment for a Physician service and a Copayment for an ancillary service, such as radiology. If two services are billed on the same date of service, two Copayments may be required.

- PCPs may not charge a Member for a Copayment unless the Member is seen by a Provider. No Copayment is to be charged or collected by the PCP if a Member is only picking up a copy of a Referral or prescription from the office.

- If the Member’s specified Copayment is greater than the allowable amount for the service, only the allowable amount should be collected from the Member. However, if the allowable amount for the service is greater than the Copayment, the specified Copayment should be collected in full from the Member. In the event that a Copayment is collected and the practice subsequently determines that the allowable amount is less than the Copayment, the difference between the Copayment and the allowable amount must be refunded to the Member within a reasonable period of time (i.e., 45 days) at no charge/cost to the Member.

- Small group and individual commercial Members can utilize their Preventive Plus benefit to receive a colon cancer preventive screening colonoscopy with no Member cost-sharing ($0) when the service is performed at a Freestanding ASC. Providers must refer Members to a Freestanding ASC and associated gastroenterologist and colon and rectal surgeon in order for the Members to take advantage of the $0 cost-sharing. Providers can use the Find a Doctor tool to identify Preventive Plus locations. Note: When the service is performed at a hospital outpatient facility or hospital-based ASC, the Member will incur cost-sharing of up to $750.

- Large (51+) commercial fully insured and self-funded groups are offered a site-of-service benefit differential that helps Members save on out-of-pocket costs – based on where they receive care – for the following services:
  - preventive colonoscopy
  - outpatient lab*
  - outpatient surgery
  - physical/occupational therapy*
  - routine/complex radiology*

- Independence coordinates benefits for commercial Members who are Medicare-eligible, have not enrolled in Medicare Parts A or B, and for whom Medicare would be the primary payer. If a Member is eligible to enroll in Medicare Parts A or B but has not done so, Independence will pay as the secondary payer for services covered under an Independence commercial group Benefits Program (e.g., Personal Choice®, Keystone Health Plan East), even if the Member does not enroll.
for, pay applicable premiums for, maintain, claim, or receive Medicare Part A or B benefits. This affects any Member who is Medicare-eligible and for whom Medicare would be the primary payer.

It is important that you routinely ask your Medicare-eligible Members to show their Medicare ID cards. If you have identified a Member who is eligible to enroll in Medicare Parts A and B, but has not done so, you may collect the amount under “Member Responsibility” on the Provider Explanation of Benefits (EOB), which includes any cost-sharing plus the amount Medicare would have paid as the primary payer.

For Members enrolled in a Qualified Medicare Beneficiary program, Federal law prohibits Medicare Providers from collecting Medicare Part A and Medicare Part B cost-sharing (i.e., Deductibles, Coinsurance, or Copayments) for these Members. Therefore, when billing Independence for services rendered for these Members, you must accept our reimbursement, according to your Agreement with Independence, as payment in full. For enrollees who are eligible for both Medicare and Medicaid, you may bill the State for applicable Medicare cost-sharing.

For Members enrolled in the Vital Care Program, our value-based insurance design model, the specialist Copayment will vary. Therefore, the Eligibility and Benefits Inquiry transaction on NaviNet should be used to verify your patients’ Copayment amount for their office visit.

**Health Care Reform requirements.** The following Copayment rules are required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform):

- There is no Member cost-sharing (i.e., $0 Copayment) for certain preventive services provided to Members. Our policy on preventive care services includes the list of applicable preventive codes and is available at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

  *Note:* The $0 Copayment does not apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a Copayment. However, if the Member is experiencing a significant problem that requires a problem-focused service that cannot be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring adjustment of medications, or follow-up at a shorter interval than would be normally anticipated, it would allow for cost-sharing.

- Independence is required to pay the cost of certain contraceptive services for eligible Members within non-profit religious organizations and closely held corporations. These Members will receive a separate ID card that indicates “Contraceptive Coverage.” Using this ID card, contraceptive methods approved by the U.S. Food and Drug Administration will be covered at an in-network level with no cost-sharing under the medical benefit and covered with no cost-sharing for generic products and for those brand products for which we do not have a generic alternative or generic equivalent under the pharmacy benefit at retail and mail-order pharmacies. Please note these contraceptive services are covered under the pharmacy benefit only if the Member has an Independence prescription drug plan.

- Members should not be charged any cost-sharing (i.e., Copayments, Coinsurance, and Deductibles) for essential health benefits once their annual limit has been met. These limits are based on the Member's benefit plan but may not exceed $7,150.00 for an individual, and $14,300.00 for a family. To verify if Members have reached their out-of-pocket maximum for essential health benefits, Providers should use the Eligibility and Benefits Inquiry transaction on NaviNet.

  *Note:* 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.

Independence routinely audits the claims we adjudicate to ensure they are paid accurately and in accordance with the Member’s benefit plan. Audits include, but are not limited to, ensuring appropriate application of cost-sharing.

*Available under PPO options only.

**Concierge medicine**

Concierge medicine, also referred to as retainer medicine, is a relationship between a patient and a Physician in which the patient pays an annual fee or retainer. Please note that charging Independence Members a mandatory annual payment violates the terms of your Independence Professional Provider Agreement (“Agreement”). Participating Providers who elect to open a concierge practice are in violation of their Agreement and are subject to termination from the Independence network.

**Missed appointments**

According to the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage plans, and their contracted Providers, may charge Members administrative fees for missed appointments under certain circumstances. However, if a Provider charges for missed appointments, he or she must charge the same amount for all patients (i.e., Medicare or non-Medicare).

According to the Professional Provider Agreement for Independence-participating Providers, although the Provider may charge for a missed appointment, he or she may not charge a “surcharge,” such as an added fee – above and beyond their Member liability – for services rendered. Such a practice creates a barrier to access to care and violates CMS anti-discrimination regulations.

**Telemedicine**

Independence covers telemedicine encounters for our commercial Members seeking primary care services from PCPs (family medicine, internal medicine, general medicine, and pediatric medicine) who offer telemedicine services as an additional method of delivery. These encounters allow our Members to interact with PCPs using a Health Insurance Portability and Accountability Act (HIPAA)-secure audio/visual system that allows Members and Providers to see and hear one another in real time.

Benefits include:

- Gives PCPs the ability to communicate with their patients in the event that an in-person encounter is not possible.
- Provides a more cost-effective option than visiting an ER, retail health clinic, or urgent care center for non-emergency medical conditions.
- Offers care after normal business hours, including nights, weekends, and even holidays (availability may vary).

For specific coverage information, please review our Telemedicine for Primary Care Services policy, which is available on our Medical Policy Portal at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).
Referrals

One of the most important functions a PCP performs is coordinating the care a Member receives from a specialist. By coordinating Referrals, PCPs help to make the process of patient care appropriate and continuous.

Participating specialists and facilities must receive PCP Referrals through NaviNet. Referrals can be accessed from 5 a.m. until 10 p.m., Monday through Saturday and from 9 a.m. until 9 p.m. on Sunday. Submitting Referrals in a timely manner helps to prevent claim denials for “no Referral.”

*Note:* Specialists should ensure a Referral is on file before rendering services. Services obtained without a Referral, when one is required, will not be covered by Independence.

Because Referrals submitted through NaviNet are electronic, you are not required to mail hard copies of these Referrals to Independence.

Issuing encounters/Referrals

To find a Provider who participates in our network, use the Find a Doctor tool at [www.ibx.com](http://www.ibx.com). A link to the Provider Directory is also available through NaviNet by selecting Reference Tools from the Workflows menu.

Medicare Advantage HMO plans

Medicare Advantage HMO Members no longer require a Referral from their PCP when they need to see an in-network, participating specialist. PCPs are still required to direct Medicare Advantage HMO Members to their capitated site for certain services (i.e., laboratory, radiology, occupational therapy, and physical therapy).† In addition, Providers are still required to obtain Precertification/Preapproval for certain services prior to rendering services for all Medicare Advantage Members.

†Radiology and physical therapy services are not capitated for Keystone 65 Focus Rx HMO (Keystone 65 Focus) Members. These Members must be directed to a Participating Provider in the Keystone 65 Focus network.

Commercial HMO and POS plans

Physicians must issue a Referral for managed care patients covered under our HMO or POS plans when referring them for specialty care, including nonemergency specialty and hospital care. HMO Members are required to have a Referral from their PCP to access specialty care. Referrals are valid for 90 days and do not guarantee active eligibility on the date of service.

Members who are not eligible on the date of service are responsible for payment. Nonemergency services (other than Direct Access services) that have not been referred by the PCP are not covered.

Note the following:

- It is important to be as specific as possible when issuing a Referral. All visits must occur within the 90-day period following the date the Referral is issued.
- For HMO and POS Members, all radiology, short-term physical and occupational therapy, and outpatient laboratory Referrals must be referred to the PCP’s capitated site. Refer to the Specialty Programs section of this manual for additional information.
- Providers in Berks, Lancaster, Lehigh, and Northampton Counties in Pennsylvania are not required to choose capitated radiology or short-term rehabilitation sites.
- Keystone Health Plan East (KHPE) Members must be referred to Participating Providers only. If a Participating Provider cannot provide care, and a Referral to a nonparticipating Provider is contemplated, such a Referral will require Preapproval.
If a Participating Provider is not available for Referral or direction of the Member, the ordering Provider must obtain Preapproval from Independence before referring/directing the Member to a non-Participating Provider. When a Provider refers a Member to a non-Participating Provider or provides/requests non-covered services to or for a Member, the Provider must inform the Member in advance, in writing, of the following:

- a list of the services to be provided;
- Independence will not pay for or be liable for the listed non-covered services;
- the Member will be financially responsible for such services.

Referrals are not required for the following services:

- vision screenings
- routine, preventive, or symptomatic OB/GYN care
- screening or diagnostic mammography
- behavioral health
- out-of-network care (for POS Members only)
- radiology services preapproved by AIM Specialty Health® (AIM), an independent company
- dialysis

POS Members may need Preapproval for some specialty services. Be sure to check the Member’s chart for a Referral, or verify that an electronic Referral is “on file” through NaviNet by selecting Encounters and Referrals from the Workflows menu, and then Referrals.

**Direct POS plans**

Keystone Direct POS Members are allowed to see most Providers without a Referral; however, these Members are required to obtain a Referral from their PCP for routine radiology, physical/occupational therapy, and spinal manipulations. For laboratory services, Members must obtain a laboratory requisition from their PCP or specialist and then be directed to their designated (capitated) laboratory site for services. For all other services, Members may visit any KHPE HMO network Provider without a Referral.

For Direct POS Members to receive the highest level of benefits, PCPs should refer them to their capitated site for capitated services (i.e., radiology, physical/occupational therapy, and laboratory) unless Preapproval has been obtained for an alternate site.

*Note:* Mammography services are not capitated, and Direct POS Members may go anywhere in-network for mammography.

How the plan works:

- A Direct POS Member selects a participating PCP from the KHPE HMO network.
- No Referrals are required for Members to see participating specialists.
- Referrals are required for routine radiology (except mammograms), spinal manipulation, and physical/occupational therapy services.
- A requisition form is required for laboratory services.
- The Member is responsible for applicable cost-sharing.
- The Member does not need to file claim forms for services provided by participating specialists.

*Note:* For services requiring precertification through AIM (CT/CT scans, MRI/MRA, echocardiography services, nuclear cardiology services, and PET scans), a separate Referral is not required. Additionally, Referrals are never required for mammography.
**PPO plans**

PPO plans do not require Referrals. Personal Choice® and Personal Choice 65℠ PPO Members may use a nonparticipating Provider, but they may be responsible for a higher cost-sharing.

**OB/GYN Referrals**

Under our Direct Access OB/GYN℠ Program, HMO and POS Members may see any network OB/GYN specialist or subspecialist without a Referral for Preventive Care visits, routine OB/GYN care, or problem-focused OB/GYN conditions.

Specialties and subspecialties not requiring Referrals include, but are not limited to, the following:

- OB
- GYN (including urogynecologist)
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist
- midwife

Services not requiring Referrals from PCPs or OB/GYN Providers include, but are not limited to, the following:

- all antenatal screening and testing
- fetal or maternal imaging
- hysterosalpingogram/sonohysterogram

You must continue to use the **OB/GYN Referral Request Form** for the following services:

- pelvic ultrasounds, abdominal X-rays, intravenous pyelograms (IVP), and DXA scans (these tests should be performed at the Member’s capitated radiology site);
- initial consultations for HMO Members for endocrinology, general surgery, genetics, gastrointestinal, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP Referral).

*Note:* Certain products have specialized Referral and Preapproval requirements and/or benefits exceptions.

**Mammography Referrals**

All commercial HMO and POS Members may obtain screening and diagnostic mammography, provided by an accredited in-network radiology Provider, without obtaining a Referral or prescription.

Medicare Advantage HMO and PPO Members have access to screening and diagnostic mammography without the need for a Referral or written prescription.

Note the following:

- Certain radiology facilities may still require a Physician’s written prescription. This may need to be communicated to your HMO and POS Members asking about mammography. Continue to provide a prescription for the mammography study if required by the radiology site.
- Proper certification, credentialing, and accreditation are required in order for network Providers to provide mammography services to our Members.
Hospital Referrals

Commercial Members: When referring Members for a surgical procedure or hospital admission, the PCP needs to issue only one Referral to the specialist or attending/admitting Physician. This Referral will cover all facility-based (i.e., hospital, ASC) services provided by the specialist or attending/admitting Physician for the treatment of the Member’s condition. The Referral is valid for 90 days from the date it was issued. The admitting Physician should obtain the required Preapproval. Any pre-admission testing and hospital-based Physician services (e.g., anesthesia) will be covered under the hospital or surgical Preapproval.

Medicare Advantage Members: Referrals are no longer required for Medicare Advantage HMO Members. However, the admitting Physician still must obtain the required Preapproval. Any pre-admission testing and hospital-based Physician services (e.g., anesthesia) will be covered under the hospital or surgical Preapproval.

Note: Certain products have specialized Referral and Preapproval requirements and/or benefits exemptions.

Referrals for Members residing in long-term care/custodial setting

PCPs with a long-term care (LTC) panel must issue a Referral to an in-network Provider for any professional service or consultation for an LTC-panel Member. This requirement includes:

- podiatry, physical therapy, and radiology services
- consultation or follow-up with a specialist
- ancillary services

Note: LTC-panel Members do not have capitation requirements for laboratory, physical therapy, or radiology services. However, Members who remain on the PCP office panel will be held to the capitation requirements of their benefits plan. Also, the services listed above do not require Preapproval. For a list of services that require Preapproval, please visit our website at www.ibx.com/preapproval.

PCPs should submit Referrals for LTC-panel Members in advance of the service being provided. Referrals can be submitted by using NaviNet, and they should be submitted in a timely manner to allow for appropriate claims processing. Claims will not be authorized for payment without a Referral on file.

In addition, consultants and ancillary Providers are encouraged to provide the Referral information with the claim to assist in processing.

Member must be on PCP’s LTC panel

Please note the following requirements related to PCPs and their LTC panel:

- PCPs who provide services to Members in an LTC/custodial setting must have a separate LTC Provider number established in our system. This separate Provider number must be used when submitting claims for services rendered to Members residing in an LTC facility (custodial Members).
- If you do not have a separate LTC Provider number and you are seeing Independence Members residing in an LTC/custodial setting, please contact your Network Coordinator to establish an LTC Provider number.
- The Members you provide care to in the LTC setting must be on your LTC panel or the claim may be denied. This could also affect normally capitated services that the Member may receive while residing in the LTC/custodial setting.
- Remind your Independence LTC patients who are not included on your LTC panel that they, or their legal representatives, need to contact Customer Service to select your LTC location. You may also
want to consult with the administrative staff of the LTC facility to assist with educating Members and/or their legal representatives of the need to be on their PCP's LTC panel. Please note that LTC locations are **not** listed in the online Find a Doctor tool.

**Setting up a PCP LTC panel**

To set up an LTC panel, PCPs should contact their Network Coordinator.

A PCP's LTC panel uses the same NPI and address as the PCP's office. However, he or she is assigned the Continuing Care Retirement Center taxonomy code of 311Z00000X to distinguish the LTC setting from the office setting.

Following the creation of this new Provider record, PCPs will need to register it on NaviNet and set up electronic funds transfer (EFT) — *even if they already use these tools at their current practice location.*

**Member consent for financial responsibility**

The **Member Consent for Financial Responsibility** form is used when a Member does not have a required Referral for nonemergency services or elects to have services performed that are not covered under his or her benefits plan. By signing this form, the Member agrees to pay for noncovered services specified on the form. The form must be completed and signed before services are provided.

The form is available on our website at [www.ibx.com/providerforms](http://www.ibx.com/providerforms). This form does not supersede the terms of your Agreement, and you may not bill Members for services for which you are contractually prohibited.

*Note:* If an HMO or POS Member presents without a Referral, the Provider should request that the Member completes a financial responsibility form.

**Medicare Advantage HMO and PPO Members**

Providers must give Keystone 65 HMO and Personal Choice 65 PPO Members written notice that noncovered/excluded services are not covered and that the Member will be responsible for payment before services are provided. The notice must contain the specific services that are not covered. A generalized waiver form is not acceptable. Should a Member file an appeal, CMS requires that we include confirmation that the Member was informed in advance that the services are not covered.

If the Provider does not give written notice of noncovered/excluded services to the Member, then he or she is required to hold the Member harmless.

**90-day grace period for APTC Members**

The Patient Protection and Affordable Care Act (PPACA) requires a three-month grace period for Members who receive the Advanced Premium Tax Credit (APTC) and are delinquent in paying their portion of their health insurance premiums before the Member’s health insurance can be terminated. Please note that Members must first pay their initial premium payment to be eligible for the grace period.

To identify when an APTC Member is in a delinquent payment status on his or her monthly insurance premiums, a yellow banner with an alert icon and message indicating “Pending Investigation” will display on the Eligibility and Benefits Details screen in NaviNet. You will need to select the benefit category labeled Health Benefit Plan Coverage (i.e., the system default benefit category) on the left side of the display and scroll to the bottom of the screen to view additional details.

One of the below messages will display depending upon the period of delinquency:

- Hix grace period 1st month of delinquency — eligible claims will be paid;
- Hix grace period 2nd month of delinquency — all claims will be suspended;
- Hix grace period delinquent greater than 3 months — all claims will be denied.

For more information on using this transaction, please refer to the Eligibility and Benefits Inquiry Guide at www.ibx.com/pnc/navinet.

**Product offerings**

For a complete list of products offered through Independence and the prefixes that correspond to these products, refer to our payer ID grids at www.ibx.com/edi.

Some Members have varying cost-sharing and Deductibles based on their plan (e.g., Flex). Providers are required to use NaviNet to verify eligibility and benefits information.

**Preapproval guidelines**

Preapproval is required to evaluate the Medical Necessity of proposed services for coverage under applicable Benefits Programs. When referring Members to a hospital, the PCP only needs to refer to the admitting/performing Physician, who is then responsible for obtaining Preapproval.

**Responsibilities**

**Responsibilities of the admitting/performing Physician for hospital admissions**

- Make hospital admission arrangements.
- Acquire the following required information:
  - Member name and date of birth
  - Member ID number
  - admission date
  - place of admission
  - diagnosis
  - planned procedure
  - medical information to support the Preapproval review request
- For HMO and POS Members, notify the Member’s PCP of the diagnosis, planned procedure, and hospital arrangements and request one Referral.
- Contact the hospital with the Preapproval code.

**Responsibility of the PCP**

Submit one Referral for the admitting/performing Physician through NaviNet.

**Responsibility of the HMO/POS Member**

- Request a Referral from the PCP.
- POS Members are responsible for obtaining Preapproval, when required, when seeking services without a Referral.

**Responsibility of the PPO Member for out-of-network care**

Obtain Preapproval review for all services requiring Preapproval.
Responsibility of the hospital, skilled nursing facility, freestanding ASC, or rehabilitation facility

- To initiate Preapproval, Providers should use NaviNet. Providers can check the status of an authorization using NaviNet by selecting Authorizations from the Workflows menu, then Authorization Status Inquiry.
- NaviNet-enabled Providers may submit electronic Preapproval requests to Independence for services to be rendered at an acute care facility or ASC. Discharge planning questions are presented during the submission process and are optional.

Refer to the Clinical Services section of this manual for more information on Preapproval requirements. Preapproval requirements are also available on our website at www.ibx.com/preapproval.

Note: Certain products have specialized Referral and Preapproval requirements and/or benefits exemptions.

NaviNet® web portal

NaviNet, a HIPAA-compliant, Web-based connectivity solution offered by NaviNet, Inc., an independent company, is a fast and efficient way to interact with us to streamline various administrative tasks associated with your Independence patients’ health care. By providing a gateway to Independence’s back-end systems, NaviNet enables you to submit and receive information electronically with increased speed, efficiency, and accuracy. The portal also supports HIPAA-compliant transactions.

Self-service requirements

All Participating Providers, facilities, Magellan-contracted Providers, and billing agencies that support Provider organizations are required to have NaviNet access and must complete the tasks listed below using NaviNet.

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

- **Referrals and encounters.** All Participating Providers are required to use NaviNet to submit Referrals. In addition, Providers can submit encounters either using NaviNet or via Electronic Data Interchange. Members may view and print Referrals by logging on to our secure Member website at www.ibxpress.com or through our IBX App for mobile devices.

- **Authorizations.** All Participating Providers and facilities must use NaviNet to initiate the following authorization types: medical/surgical procedures, chemotherapy/infusion therapy, durable medical equipment (DME), Emergency hospital admission notification, home health (dietitian, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy), and home infusion.

Requests for medical/surgical procedures can be made up to six months in advance on NaviNet. In most cases, requests for Medically Necessary care are authorized immediately; however, in some cases authorization requests may result in a pended status (e.g., when additional clinical information is needed or when requests may result in a duplication of services). NaviNet submissions that result in a pended status can vary in the time it takes for completion. If an urgent request (i.e., procedure or admission for the same or next day) results in a pended status, please call 1-800-ASK-BLUE for assistance.
Note: If the authorization is in a pended status, it is not yet approved. Providers should not submit any claims or claim inquiry requests that relate to the pended authorization until it has an approved status of “certified.” If claims are submitted prior to the authorization being approved, they may be rejected.

- **Claim adjustment request or inquiry.** Providers who call Customer Service to question a claim payment or to request a claim adjustment will be directed to submit the request via NaviNet using the Claim Investigation Inquiry transaction. Please refer to the Billing section for further instruction. Requests can be submitted for dates of service up to 18 months prior to the current date of service.

### Out-of-area Members

Through the BlueExchange® Out of Area option in the Workflows menu, Providers can review claims status, view eligibility and benefits information, and make Referral/authorization submissions for out-of-area Members. The following are other transactions available through the BlueExchange Out of Area menu option:

- **BlueCard® COB Questionnaire.** This questionnaire should be completed by all out-of-area Members prior to rendering service to streamline claims processing and expedite payment to Providers.
- **Medical Policy/Precept Inquiry.** This transaction allows Providers to obtain information regarding the Home Plans’ medical policy and Preapproval requirements just by entering the prefix of the out-of-area Member.
- **Pre-Service Review for Out-of-Area Members.** Through this transaction, Providers can access the Provider portal of an out-of-area Member’s Home Plan and conduct electronic pre-service reviews. Users may still need to call the Member’s Home Plan to request Preapproval if the Home Plan does not offer the pre-service review electronically.

### Capitation rosters

PCPs and specialty capitated Providers can view, print, and download electronic copies of their capitation rosters through NaviNet.

### NaviNet Security Officer

The NaviNet Security Officer is your office’s primary contact with NaviNet regarding security issues with the portal. NaviNet-enabled offices must have at least one NaviNet Security Officer designated. The Security Officer also interacts with NaviNet users in your office and with NaviNet Customer Support to ensure that users are getting the most out of NaviNet.

HIPAA mandates that each Provider office designate a Security Officer to be aware of the electronic storage and transmission of patient information within and from your office. This person can also take the role of the NaviNet Security Officer.

### Roles and responsibilities

A NaviNet Security Officer is responsible for making sure that NaviNet is used in a HIPAA-compliant way. He or she is also responsible for configuring Providers, users, and permissions so the office can use NaviNet effectively as well as efficiently.

To fulfill these responsibilities, the Security Officer undertakes several special tasks, including:

- ensuring that every staff member who accesses NaviNet has his or her own unique user name and password;
- ensuring that user names and passwords are not shared with anyone else in the office;
- adding, reactivating, deactivating, and terminating NaviNet users in the office, when appropriate;
- resetting user passwords;
changing the amount of time before NaviNet automatically logs off from an inactive session;
notifying NaviNet if someone else takes on the role of Security Officer;
setting transaction permissions for individual users;
making sure the office is registered to all applicable health plans;
making sure the office has the right tax ID numbers, groups, and Providers available for NaviNet transactions.

For more detailed information on common Security Officer tasks, as well as best practices, please select Help at the top of NaviNet Plan Central and then the Security Officers tab.

**NaviNet Resources**
Detailed guides and webinars are available for many transactions in the NaviNet Resources section of our Provider News Center at [www.ibx.com/pnc/navinet](http://www.ibx.com/pnc/navinet). Interactive training demos are also available to all users on NaviNet. Simply select Help from the top of the screen, and then select Independence Blue Cross from the Select a Health Plan drop-down menu.

If you are a current NaviNet user and need technical assistance, contact NaviNet at 1-888-482-8057 or our 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.

*This information does not apply to Providers contracted with Magellan Healthcare, Inc. (Magellan). Magellan-contracted Providers should contact Magellan at 1-800-688-1911 to request an authorization.*

**iEXCHANGE®**
Independence Administrators, which offers third-party administration services to self-funded health plans based in the Philadelphia region and has plan Members throughout the U.S., provides you with an additional online service called iEXCHANGE, a MEDecision product. iEXCHANGE supports the direct submission and processing of health care transactions, including inpatient and outpatient authorizations, treatment updates, concurrent reviews, and extensions. This online service is offered through AmeriHealth Administrators, an independent company that provides medical management services for Independence Administrators. Certain services require precertification to ensure that your patients receive the benefits available to them through their health benefits plan. With just a click of the mouse, you can log into iEXCHANGE, complete the precertification process, and review treatment updates.

Available transactions include:
- inpatient requests and extensions
- other requests and extensions (outpatient and ASC)
- treatment searches
- treatment updates
- Member searches

After registering, you can also access iEXCHANGE through NaviNet for Independence Administrators plan Members. For more information or to get iEXCHANGE for your office, visit [www.ibxtpa.com/providers](http://www.ibxtpa.com/providers) or contact the iEXCHANGE help desk at Independence Administrators by calling 1-888-444-4617.
Provider Automated System

The Provider Automated System enables 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:* For authorizations, Providers should enter and retrieve information through NaviNet.

To access the Provider Automated System, call **1-800-ASK-BLUE** and say “Provider” or press 1 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 requested information.

A user guide for the Provider Automated System is available at **www.ibx.com/providerautomatedsystem.**

Change of network status

**Updating your Provider information**

When submitting claims, reporting changes in your practice, or completing recredentialing applications, it is essential that the information you transmit is timely and accurate. You are contractually required to notify us in writing in a timely manner when changing key Provider demographic information.

It is critical that you regularly review your demographic information in the Provider directory to ensure that all of the information is accurate. We may periodically send you a **Provider Demographic Profile** for review. If you receive a profile, we ask that you complete and sign it by the due date stated. If no updates are required, you must return the signed profile as confirmation that your information remains accurate. Please note that if we do not receive your signed profile by the due date stated, your information will be suppressed from the Provider directory. Once your signed profile is received, your information will be updated to display in the directory.

The **Provider Change Form** can be used to notify us of most changes to your basic practice information. See the **Completing the Provider Change Form** section for more information. You may also contact your Network Coordinator or call Customer Service.

Lead time requirements:

- **30-day notice.** Independence requires 30 days advanced notice for the following changes/updates to your practice information:
  - updates to address, office hours, total hours, phone number or fax number;
  - changes in selection of capitated Providers (HMO PCP only);
  - addition of new Providers to your group (either newly credentialed or participating);
  - changes to hospital affiliation;
  - changes that affect availability to patients (e.g., opening your panel to new patients).

- **60-day notice.** Independence requires 60 days advanced written notice for closure of a PCP practice or panel to additional patients.

- **90-day notice.** Independence requires 90 days advanced written notice for resignation and/or termination from our network.
Note: Independence will not be responsible for changes not processed due to lack of proper notice from the Provider. Failure to provide proper advance written notice to Independence may delay or otherwise affect Provider payment.

The recredentialing process is another way we keep your Provider information current. Return your recredentialing application packet promptly or update your CAQH application at least quarterly.

If you have accepted any payments during the year, Independence must report that income on the annual 1099 Form. All Providers are reminded that practice demographics should be kept current to receive accurate 1099 Forms. Payments will be processed more efficiently if Provider information is current.

Completing the Provider Change Form*

Professional Providers can quickly and easily submit most changes to their basic practice information by downloading a copy of the Provider Change Form at www.ibx.com/providerforms. Please be sure to print clearly, provide complete information, and attach additional documentation as necessary.

Mail your completed Provider Change Form to:
Independence Blue Cross
P.O. Box 41431
Philadelphia, PA 19101-1431

You can also fax the completed form to Network Administration at 215-238-2275. Please be sure to keep a confirmation of your fax.

Note: The Provider Change Form cannot be used if you are closing your practice or terminating from the network. Refer to the Resignation/termination from the Independence network section regarding policies and procedures for resigning or terminating from the network.

Authorizing signature and W-9 Forms

Updates resulting in a change on your W-9 form (e.g., changes to a Provider’s name, tax ID number, billing vendor or “pay to” address, or ownership) require the following signatures:

- **Group practices**: A signature from a legally authorized representative (e.g., Physician or other person who signed the Agreement or one who is legally authorized to bind the group practice) of the practice is required.
- **Solo practitioners**: A signature from the individual practitioner is required.

An updated copy of your W-9 Form reflecting these changes must also be included to ensure that we provide you with a correct 1099 Form for your tax purposes. If you do not submit a copy of your new W-9 Form, your change will not be processed.

Closing a PCP practice to additional patients

A participating PCP must notify his or her Network Coordinator at least 60 days in advance of any intent to close the practice to additional patients. There are three status levels for offices:

- **Open**: Practice is accepting new patients.
- **Current**: Practice is accepting existing patients currently in the practice but covered by other insurance.
- **Frozen/Closed**: Practice is not accepting additions to the HMO or POS panel. Providers in this category do not appear in the Provider Directory.
Offices with practices designated as “current” will be listed in the Provider Directory as such. Should existing patients of one of our Plans switch to another of our Plans through their employer group, they will be able to select a closed office.

*Note:* Close-of-practice notification should be in writing and addressed to your Network Coordinator.

### Age limitations on a PCP practice

If your practice subscribes to minimum and/or maximum age limits for Members, notify your Network Coordinator of this policy in writing. Members have expressed dissatisfaction over choosing a practice and subsequently discovering that the practice limits patients based on age.

PCPs should check their capitation statement to identify Members who fall outside their practice’s age limitations. Contact Customer Service to arrange to have Members who fall outside of your practice’s age limitations notified to choose a new PCP.

### Patient transition from a pediatrician to an adult PCP

Pediatricians should systematically alert adolescents who are approaching the maximum age for patients treated in their practice to allow them to transition smoothly to a new PCP who has experience in treating adults.

If Members require further assistance on how to switch from a pediatrician to a new PCP, ask them to call Customer Service at the telephone number on their ID card.

### Changing PCPs

A Member can change his or her PCP by logging on to our secure Member website, [www.ibxpress.com](http://www.ibxpress.com), using the mobile IBX App, or by calling Customer Service.

The PCP change process for both commercial and Medicare Advantage HMO and PPO Members is as follows:

- When Members request a PCP change, they will need to provide a reason for the change. The change will take effect 14 calendar days later or the 1st of the following month, whichever comes first.
- *Note:* The two exceptions to this timing are if (1) the change is due to No Initial PCP Selection or (2) Current PCP no Longer in Network, in which case the change takes effect the 1st of the current month.

*Note:* Providers cannot make a change to a Member’s PCP on the Member’s behalf.

### Resignation/termination from the Independence network*

Providers who choose to resign from the network should first contact their Network Coordinator to discuss the reason for the resignation. In addition to the telephone call, the Provider must give the network at least 90 days advance written notice in order to terminate network participation.

Written notice can be sent to:

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

In accordance with your contractual obligation to comply with our policies and procedures and professional licensing standards, a specialist or specialty group must notify affected Members if a specialist leaves the group or otherwise becomes unavailable to Independence Members or if the group terminates its agreement with Independence.
To help ensure continuity and coordination of care, we notify Members affected by the resignation/termination of a PCP or PCP practice site at least 30 days prior to the effective date of termination and assist them in selecting a different Provider or practice site. Independence’s notification of PCP resignation/termination does not relieve the PCP from his or her professional obligation to also notify his or her patients of the resignation/termination. Call Customer Service with any questions.

**Continuity of care**

When a Provider’s contract is terminated without cause, we allow Members to have continued access to that Provider at the current contracted rate under the following circumstances:

- Members undergoing active treatment for a chronic or acute medical condition have access to the terminated Provider through the current period of active treatment, or for up to 90 calendar days following termination, whichever is shorter.
- Members in their second or third trimester of pregnancy have access to their discontinued Provider through the postpartum period.

*This information does not apply to Providers contracted with Magellan. Magellan-contracted Providers should contact their Magellan Network Coordinator at 1-800-866-4108.*

**Terminating a Member from a practice**

If a situation arises when a PCP or other treating Physician initiates termination of its Physician-patient relationship and needs to release an Independence Member from his or her practice, there are some important things to remember. The PCP or treating Physician must notify both the Member and Independence in writing if terminating a Member from his or her practice. To notify Independence, the Physician must contact his or her Network Coordinator, contact Customer Service, or address correspondence to:

Independence Blue Cross  
Attn: Network Services  
1901 Market Street, 28th Floor  
Philadelphia, PA 19103

The Physician must also continue treating the Member for current medical conditions for 30 days after ending the Physician-patient relationship to allow time for the Member to select a different treating Physician. During this time, we will assist the Member in selecting a different PCP or other treating Physician. If the Member asks the Physician or office staff for assistance in selecting a new PCP or other treating Physician, he or she should be referred to Customer Service at 1-800-ASK-BLUE.

In the event the Member is threatening or violent towards the Physician or office staff, the Member’s access to the office may be terminated immediately.

**Non-discrimination**

Physicians cannot discriminate against any Member on the basis of the Member’s coverage under a benefit program, age, sex, race, color, religion, ancestry, national origin, disability, handicap, health status, source or amount of payment, or utilization of medical or mental health services or supplies. Other unlawful reasons for discharging a Member, without limitation, include the filing by such Member of any complaint, grievance, or legal action against the Provider or Independence. Participating Physicians are also prohibited from excluding or closing a practice to certain Members as a result of the reimbursement (e.g., closing a practice to capitated HMO patients only). Physicians are also not permitted to terminate their relationship with a Member who has complicated or expensive medical needs unless the Provider has received written approval from Independence that there is good cause for such termination and that such termination is in the Member’s best interest.
Medical record requests

When a Provider initiates termination of the Physician-patient relationship with the Member, the Physician cannot charge Members for requests for copies of medical records. The Physician must facilitate the sharing of such records among health care Providers directly involved with the Member’s care.

Compliance training for Medicare programs

CMS requires all first-tier, downstream, and related entities (FDR) complete the following courses, which are available through the Medicare Learning Network (MLN):

- Medicare Parts C and D General Compliance Training
- Combating Medicare Parts C and D Fraud, Waste, and Abuse

An FDR is defined by CMS as a party that enters into a written agreement to provide administrative services or health care services to a Medicare enrollee on behalf of a Medicare Advantage or Part D plan. FDRs include, but are not limited to, contracted health care Providers, pharmacies, suppliers, and vendors.

As a Provider of health care services for Independence Medicare Advantage and Medicare Part D Prescription Drug Program (Medicare Part D) Members, you and your staff are expected to comply with CMS requirements by completing this training. Please visit the Medicare Learning Network at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf to access and complete your Medicare compliance training at the time of hire and annually thereafter.

We suggest that you and your staff maintain records of completion.

Hospital comparison tool

Our Hospital Advisor tool provides hospital quality and safety information to both Providers and Members so they can research and compare hospitals based on procedure/diagnosis and location and can review details on process and outcomes results. The search results can also be customized according to which measures (e.g., volume, mortality, complications, and length-of-stay) are most important to the user.

Providers can access the Hospital Advisor tool through NaviNet by selecting Reference Tools from the Workflows menu, and then selecting Provider Directory. Once on the Provider Search screen, select the Hospital Quality Search Tool link at the bottom of the page to access the tool. Members can access the tool by using the Find a Doctor tool at www.ibxpress.com.
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Corporate and Financial Investigations Department

The Corporate and Financial Investigations Department (CFID) is responsible for the prevention, detection, and investigation of all potential areas of fraud, waste, and abuse against Independence. The CFID is also responsible for conducting audits of Providers and pharmaceutical-related services. It identifies, selects, and audits Providers for inaccurately paid claims. In addition, the CFID seeks financial recoveries of overpaid claims and submits these claims for correct adjudication. The CFID is comprised of the following:

- CFID Support
- Financial Investigations
- Professional and Ancillary Provider Audits
- Facility Provider Audits
- Pharmacy Audits

CFID Support

CFID Support uses data-mining software to proactively identify aberrant claims, billing patterns, and trends across all Independence lines of business. CFID Support gathers and evaluates information from a variety of sources to support CFID:

- STARS and STAR Sentinel — sophisticated software data-mining tools that analyze all categories of claims received, Provider demographics, and Member benefits — are primary sources of audit and investigation identification and selection.
- Members and Providers can confidentially report concerns through the toll-free hotline, 1-866-282-2707, and our website, www.ibx.com/antifraud.
- Leads are received from internal business areas, as well as external law enforcement agencies, regulatory authorities, and industry specialists.

Financial Investigations

Financial Investigations evaluates all allegations of fraud, waste, and abuse involving Providers, Members, vendors, associates, and others. They use a wide array of investigative tools to:

- identify and investigate fraudulent and abusive activities;
- make referrals to federal, State, and local law enforcement for criminal and/or civil prosecution;
- make referrals to regulatory authorities for violations of professional licensure;
- recover losses related to fraud and abuse;
- employ prevention techniques to decrease and eliminate future losses;
- make recommendations to terminate Providers for cause from the Independence network.

Professional and Ancillary Provider Audits

The Provider Audits area reviews claims, medical records, and billing records of professional and ancillary Providers to determine the presence of unsupported charges and incorrect payments. It also ensures that all Provider categories and specialties are subject to audits and that claim adjustments are made to accurately reflect the services performed. Communication is maintained between auditors and Provider representatives throughout the audit process.
This process typically includes the following:
- advance notification to the Provider of an intent to audit;
- notification to the Provider about the anticipated purpose and scope of the audit (subject to change);
- possible onsite and/or desk audits;
- contact with the Provider to obtain copies of billing and/or medical records (original records may be inspected onsite);
- an initial findings report, which is submitted to the Provider;
- a two-level internal review process for any Provider who has concerns about the audit findings*;
- final audit findings, communicated to the Provider in writing.

Note the following:
- Providers must request any review process in writing and furnish documents not previously submitted.
- Both pre- and post-pay claims are subject to audit selection.
- Peer claim submission comparisons may be utilized.
- Repayment for overpaid claims will be required.

For questions or concerns regarding audit communications, Providers should contact the specific CFID auditor listed on the communication. If you are unsure of the appropriate audit contact, please send a detailed inquiry to ProviderAuditInquiries@ibx.com.

*This two-level review process is limited to reviews of Independence’s initial audit findings and is separate from the Provider claim appeal or Member appeal process.

**Production of records and examination under oath**

When requested by Independence or designated representatives of federal, State, or local law enforcement and/or regulatory agencies, Providers shall produce copies of all medical/financial records requested within 30 days. Providers will permit access to the original medical/financial records for comparison purposes within the requested time frames and, if requested, shall submit to examination under oath regarding the same.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records within 30 days as requested, in addition to other remedies, Independence reserves the right to require Selective Medical Review before claims are processed for payment to verify that claim submissions are eligible for coverage under the applicable benefits plan.

**Documentation requirements for durable medical equipment services**

Independence’s durable medical equipment (DME) documentation requirements are consistent with the Centers for Medicare & Medicaid Services documentation requirements, which underscore the importance of securing and retaining documentation. If required documentation is not available on file to support a claim at the time of an audit or record request, Independence may seek repayment from the DME supplier for claims not properly documented.

Documentation requirements for DME include the following:
- Before submitting a claim to Independence, the DME supplier must have on file a timely, appropriate, and complete order for each billed prescription order item that is signed and dated by the Member’s servicing Provider.
Proof of delivery is required in the medical record and must include a contemporaneously prepared delivery confirmation or Member's receipt of supplies and equipment. If delivered by a commercial carrier, the medical record documentation must include a copy of delivery confirmation. If delivered by the DME supplier/Provider, the medical record documentation must include a copy of delivery confirmation that is signed by the Member or caregiver. All documentation must be prepared at the same time as delivery and be available to Independence upon request.

- The DME supplier must monitor the quantity of accessories and consumable supplies that a Member is actually using and contact the Member regarding replenishment of supplies no sooner than approximately seven days prior to the delivery/shipping date. Dated documentation of this Member contact is required in his or her medical record. Delivery of the supplies should be done no sooner than approximately five days before the Member would exhaust his or her on-hand supply.

Report fraud, waste, and abuse

If you suspect health care fraud, waste, or abuse against Independence, we urge you to report it. All reports are confidential. You are not required to provide your name, address, or other identifying information.

You have three options for submitting your report:

1. Submit the *Online Fraud & Abuse Tip Referral Form* electronically at [www.ibx.com/antifraud](http://www.ibx.com/antifraud).
2. Call the confidential anti-fraud and corporate compliance toll-free hotline at 1-866-282-2707.
3. Write a description of your complaint, enclose copies of supporting documentation, and mail it to:
   Independence Blue Cross
   Corporate and Financial Investigations Department
   1901 Market Street
   Philadelphia, PA 19103
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Claim Payment Policy Department

The goal of the Claim Payment Policy Department (CPPD) is to facilitate Member access to health care that is clinically appropriate, effective, and of high quality as determined by a critical analysis of scientific literature, current community practice, and the involvement of practitioners in policy development.

CPPD’s role within Independence

CPPD works with various areas in the company to determine, verify, and publish coverage decisions for services through policy development, maintenance, and revision. Coordination of policy implementation and ensuring accurate claims processing are also part of this process. Specific functions of the CPPD include the following:

- determine coverage positions for medical products or services through technology evaluation, new policy development, and revisions to existing policies;
- develop claim payment policy to communicate:
  - Independence’s coverage and reimbursement position on a specific topic or service;
  - the requirements for coverage and reimbursement;
  - the instructions for reporting specific services.
- monitor and evaluate medical and claim payment policies for clinical/administrative accuracy in accordance with National Committee for Quality Assurance (NCQA) guidelines, or more frequently when changes in technology have occurred;
- support medical code activities as well as establish and maintain the development and documentation of coverage positions for Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) medical codes;
- facilitate clinical review of Quality Management initiatives/programs through the medical policy committee;
- meet regulatory requirements related to technology assessment and medical policy to achieve accreditation (by NCQA, among others);
- comply with governmental policies (e.g., Medicare), legislative mandates, etc.;
- communicate medical and claim payment policy determinations to Participating Providers through newsletters, direct mail, and our website;
- research and communicate responses to inquiries regarding policies, Medical Necessity issues, new and emerging technologies, reimbursement issues, and coding;
- make medical and claim payment policies available on our website;
- coordinate the consistent application of medical and claim payment policies;
- provide routine review and revision activity to update policy information as new data is received;
- educate Independence associates regarding policy and supporting documents;
- serve as content owner of procedure code-to-procedure code edits and edit rationale disclosure;
- offer support of procedure code-to-procedure code editing software for accuracy of claims processing;
- develop ongoing review to ensure utilization in the most appropriate and cost-effective setting for the delivery of injectables.
Access to policies

Providers can view our medical and claim payment policies on our Medical Policy Portal at www.ibx.com/medpolicy. The policies are available to assist Providers in administering and understanding the provisions of benefits and are separated into the following benefit programs:

- Commercial
- Medicare Advantage
- MAPPO Host

To search for active policies, select the appropriate tab from the top of the page and enter the policy name or policy number in the Search field.

Notifications

Notifications for our commercial and Medicare Advantage business are posted online prior to the effective dates of the policies. Notifications are listed by the intended effective dates, so you can become familiar with them in advance. To read policy notifications, follow these instructions:

2. Select Accept and Go to Medical Policy Online.
3. Select Commercial or Medicare Advantage from the Active Notifications section, depending on the benefit program you wish to view.

Site Activity

The Site Activity section is updated in real time as changes are made to the Medical Policy Portal and includes a snapshot of all activity that occurred within a given month, including:

- notifications
- new policies
- updated policies
- reissued policies
- coding updates
- archived policies

To access the Site Activity section, go to our Medical Policy Portal 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.

You can also get to the Medical Policy Portal through the NaviNet® web portal by selecting the Reference Tools transaction, and then Medical Policy. Policies are updated frequently, so it’s important to check the site often.
Blue Exchange® Out of Area

The BlueExchange Out of Area transaction on NaviNet offers a menu option that gives you access to information regarding the medical policy of a Member’s Home plan. To find this information:

1. Select BlueExchange Out of Area from the Workflows menu.
2. Select Medical Policy/PreCert Inquiry.

Follow these steps to conduct a search:

1. Select Medical Policy from the drop-down menu under “Type of Inquiry.”
2. Enter the prefix noted on the Member ID card.
3. Select Submit.

The information displayed is provided by the Member’s Home plan. Questions pertaining to the information displayed should be directed to the Member’s Home plan.
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Overview

The Billing section is designed to keep you and your office staff up to date on how to do business with us. Included are topics such as submitting Clean Claims, submitting proper codes used for accurate disbursement, and information and requirements pertaining to your National Provider Identifier (NPI). In addition, this section contains important information about electronic transaction channels, including clearinghouse options for electronic claims submission and the NaviNet® web portal, our secure Provider portal that expedites processing and payment.

NaviNet® web portal

NaviNet, a Health Insurance Portability and Accountability Act (HIPAA)-compliant, Web-based connectivity solution offered by NaviNet, Inc., an independent company, is a fast and efficient way to interact with us to streamline various administrative tasks associated with our Members' health care. By providing a gateway to the systems used by Independence, NaviNet enables you to submit and receive information electronically with increased speed, efficiency, and accuracy.

For detailed information on NaviNet, see the Administrative Procedures section of this manual.

Clinical Relationship Logic

Clinical Relationship Logic pertains to the edits used to appropriately adjudicate claims in a claims processing system. Clinical Relationship Logic, or Code-to-Code Edits (e.g., Incidental, Integral, Component, Mutually Exclusive, etc.), is applied to claims submitted on the CMS-1500 claim form or through the 837P transaction. Medicare’s National Correct Coding Initiative (NCCI) Edits are also applied.

Visit www.ibx.com/providers/claims_and_billing/clinical_relationship_logic.html to access the code-to-code edit list and NCCI Edits.

Billing/reimbursement requirements

Providers are required by the HIPAA Transactions and Code Sets Rules to use only codes that are valid at the time a service is provided from the following coding systems:

- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases – Tenth Revision (ICD-10)

National entities, including the American Medical Association, CMS, and the U.S. Department of Health and Human Services (HHS), release scheduled updates to CPT, HCPCS, and ICD-10 procedure/diagnosis codes, respectively. We monitor those schedules and react according to the following timeline:

- **CPT**: Biannual release of codes with effective dates of January 1 and July 1.
- **HCPCS**: Quarterly release of codes with effective dates of January 1, April 1, July 1, and October 1.
- **ICD-10-CM**: Biannual release of codes with effective dates of April 1 and October 1.

*Note*: Timeline reflects schedule of the dictating entity and, therefore, may be subject to change.

Providers are required to bill Usual, Customary, and Reasonable charges for codes that are valid at the time of service.
CPT and HCPCS billing codes

Procedures must be billed using the five-digit numeric CPT codes from the Physician’s CPT manual. Attachments or written descriptions of the services being performed will not be considered a proper billing procedure. Documentation in the Member’s medical report must clearly support the procedures, services, and supplies coded on the health insurance form.

Note: Some CPT codes may be included in global fees to facilities and therefore are not eligible for separate reimbursement. You may bill the facility in those instances.

Some services or procedures performed by health care professionals are not found in the CPT coding system. If a specific CPT code cannot be located, check for a reportable HCPCS code. Unlisted procedure codes should not be used unless a more specific code is not available.

Unlisted procedure codes

Each section of the CPT coding system includes codes for reporting unlisted procedures. They may be new procedures that have not yet been assigned a CPT code, or they may simply be a variation of a procedure that precludes using the existing CPT code. Because unlisted procedure codes are subject to manual medical review, processing may take longer than usual.

All unlisted/not otherwise classified (NOC) codes must be submitted with the appropriate narrative description of the actual services rendered on the CMS-1500 claim form in order to be processed. For claims that are electronically submitted, refer to the HIPAA Transaction Standard Companion Guide available at www.ibx.com/edi.

- **Paper.** For paper-submitted claims, additional information regarding the narrative description of the specific services provided should be submitted on the CMS-1500 claim form in the shaded area extending from field 24A through 24G, directly above the NOC/unlisted procedure code. If a description is not provided, the entire claim will be rejected with a message to resubmit with a narrative description.

- **Electronic.** For electronically-submitted 837P claims, the NOC descriptions should be filled into the Loop 2400 data element SV101-1 – Description.

Pricing procedure for unlisted or NOC services

This pricing and processing procedure for unlisted or NOC Covered Services is used for all products covered under your Provider Agreement.

- We maintain a database of historical pricing decisions for similar services previously reviewed and priced by Independence. If available, an appropriate fee in this database may be used to price the current claim.

- If the database does not have pricing for the current claim, then the claim is reviewed by us for a pricing decision. We may request that the Provider submits additional information to facilitate pricing the claim. The additional information requested may include, but is not limited to, an operative report, a letter of Medical Necessity, an office note, and/or an actual manufacturer’s invoice. Providers should submit additional information only if specifically requested to do so by Independence. Upon being recommended for payment and processing, claims are priced using our standard pricing methodology, which is designed to consider new procedures, and are processed in accordance with applicable claim payment policies and exclusions and limitations in benefit contracts.

- Providers who disagree with a specific unlisted/NOC service pricing determination should follow the normal appeals process described in the Appeals section of this manual.
Providers are reminded to always use the most appropriate codes when submitting claims. Claims submitted with NOC codes when a valid CPT or HCPCS code exists may be denied.

**National Drug Code submissions**

Pharmacy and medical claims for all unlisted and nonspecific drug codes (without a corollary CPT or HCPCS code) require submission of a National Drug Code (NDC) in the correct format and location to properly adjudicate these claims consistent with our group benefits plans. If the NDC is not submitted in an 11-digit format or is missing, the claim will not be processed and will be returned to you for correction. The 11-digit format is 5-4-2 and is found on most drug packaging. This format serves a functional purpose: The first segment of the NDC identifies the labeler/manufacturer; the second segment identifies the product, strength, dosage form, and formulation; and the third segment identifies the package size of the drug.

A complete list of unlisted and nonspecific codes that require the submission of an NDC to properly process the claim is available at www.ibx.com/providers/claims_and_billing/claims_resources_guides.html.

Note: Compound drugs should be reported with (1) an unlisted and/or nonspecific (CPT or HCPCS) code and (2) the NDC with the most expensive ingredient.

**Report diagnosis codes to the highest degree of specificity**

We require that all Providers report diagnosis codes to the highest degree of specificity according to the most current *ICD-10 Coding Manual*. This requirement applies to all claims and encounters. It reflects:

- the need for better diagnostic information for quality and medical management;
- the decision to make our coding policy more consistent with other major carriers and with CMS ICD-10 coding guidelines;
- the decision by CMS to determine Medicare Advantage premiums based on the severity of illness of enrolled Members. Supporting documentation in the Member’s medical record must clearly support the procedures, services, and supplies coded on the claim form.

Always report with the highest level of specificity possible for an individual patient.

**HIPAA 5010 and ICD-10**

- **HIPAA 5010.** HHS stipulates that any health care entity that submits electronic health care transactions, such as claims submissions, eligibility, and remittance advice, must comply with the X12 Version 5010 standards. The *HIPAA Transaction Standard Companion Guide* is available at www.ibx.com/edi to assist you in submitting HIPAA 5010-compliant transactions.

- **ICD-10.** HHS requires the use of International Classification of Diseases, 10th Revision (ICD-10) on all claims. Visit www.cms.gov/icd10 for more information.

**Billing guidelines**

Included in this section is billing information specific to certain types of services, including diagnostic ultrasounds, interrupted maternity care, observation services, office-based services, radiologic guidance, routine gynecological exams, and surgery claims.
Diagnostic ultrasounds
Certain participating specialist types are eligible to provide specific diagnostic ultrasounds to HMO and PPO Members. HMO Members do not require a Referral from their Primary Care Physician (PCP) for diagnostic ultrasound services provided by the OB/GYN specialists.

Note: Although certain participating specialist types are eligible to provide specific diagnostic ultrasounds, in some Service Areas, we have an arrangement in which we pay the hospital a global payment when the service is provided in the outpatient hospital. In these instances, the Physician’s Provider Explanation of Benefits (EOB) will indicate that the Physician must seek reimbursement from the hospital.

Outpatient hospital
Additionally for HMO Members, hospitals that are not the Member’s capitated radiology site may perform and be reimbursed for specific diagnostic ultrasounds. If the hospital is the capitated radiology site for the Member, these Covered Services are included in the capitation payment and no additional payment will be made.

For more detailed information, including the eligible procedure and diagnosis codes, please refer to our policies on obstetrical ultrasounds at www.ibx.com/medpolicy.

Interrupted maternity care
If you provide prenatal visits alone to any Independence Member, bill those services with the appropriate CPT code as follows:

- **Fewer than four visits.** If you provided fewer than four visits total, bill in the following way:
  - **First visit:** Bill 99205 (new patient) or 99215 (established patient).
  - **Second and third visits:** Most second and third visits typically require only a level-three office visit. Exclusively billing these visits at higher levels than Medically Necessary is not an appropriate billing practice and is subject to post-payment review.

- **Four to six visits.** If you provided a total of four to six visits, bill only 59425.

- **Seven or more visits.** If you provided a total of seven or more visits, bill only 59426.

Long-term care facility services
Services for Members in a long-term care (LTC) facility are to be billed with Place of Service code 32. Taxonomy code 311Z00000X should be used by Providers to identify that they are billing for their LTC panel. PCP LTC panels are reimbursed on a fee-for-service basis.

*Failure to submit claims for services performed in the office or LTC facility with the applicable NPI and correct correlating taxonomy code may result in incorrect claims processing.*

Observation services
When a Physician provides service to a Member at an observation level of care, the Physician should use the following Evaluation and Management (E&M) codes when billing for these services to ensure accurate processing of the claim:

- 99217
- 99218
- 99219
- 99220
- 99234
- 99235
- 99236
We recognize the appropriate use of observation services (i.e., observation status and observation level) to monitor patients and treat medical conditions on an outpatient basis and to evaluate a patient’s need for acute inpatient admission. Observation services are outpatient services that include diagnosis, treatment, and stabilization of patients from a minimum of six to a maximum of 24 hours, per InterQual® guidelines.

Independence uses guidelines for decision-making from InterQual, a product of McKesson, an independent company, to determine which patients have severity of illness and intensity of service requirements that are appropriate for observation. Observation services can be provided in any location within a facility.

**Office-based services**

If an office-based service (e.g., an office visit or outpatient consultation) is performed by a professional Provider in an office-based setting within a facility or on a facility campus, the facility is not eligible for reimbursement and should not bill for the service. Only the professional Provider is eligible for reimbursement for the service provided to the Member.

The facility is not eligible to receive reimbursement for a room charge even though a professional Provider office may be located within the facility.

**Radiologic guidance of a procedure**

The following reimbursement methodologies apply to claims processing of radiologic guidance and/or supervision and interpretation of a procedure:

- Radiologic guidance and/or supervision and interpretation of a procedure are performed by either the same professional Provider who performs the surgical procedure or a different professional Provider.
- Radiologic guidance and/or supervision and interpretation of a procedure are performed in conjunction with a Covered procedure and are eligible for separate reimbursement consideration by Independence.

When the same Provider performs and reports both the radiologic and the diagnostic or therapeutic procedures, both procedures are eligible for reimbursement consideration to the Provider. However, both of the following requirements must be met:

- Both the radiologic guidance and/or supervision and interpretation service — as well as the procedure for which it is performed — must be covered for the radiologic guidance and/or supervision and interpretation to be eligible for separate reimbursement consideration.
- Documentation in the medical record must reflect the radiologic guidance and/or supervision and interpretation procedure performed by the Physician. The medical record must be available to us upon request. Providers should not submit medical records to us unless otherwise requested.

Visit [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy) for more information about our claim payment policy for radiologic guidance of a procedure.

**Routine gynecological exams**

Visit [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy) for more information about our policy on female preventive care services, including routine gynecological exams.

For additional information, refer to the *OB/GYN* section of this manual.

**Surgery claims**

Providers are required to follow the appropriate billing procedures as they relate to multiple surgeries, assistant surgery, and co-surgery.
Multiple surgeries

- **Performed on the same date of service.** Surgeons must bill multiple surgical procedures for the same date of service on a single claim.
- **Performed on different dates of service.** To avoid claim underpayments, surgeons must bill multiple surgical procedures for different dates of service as separate claims.

Assistant and co-surgery

For surgical procedures performed by both a primary surgeon and an assistant surgeon or co-surgeon, separate claim submissions are required. The primary surgeon and assistant surgeon or co-surgeon must report separate claims.

- **Performed on same date of service.** Multiple surgical procedures performed on the same date of service must be reported on a single claim (i.e., one claim for each surgeon).
- **Performed on different dates of service.** To the extent that a surgeon, assistant surgeon, or co-surgeon performs multiple surgical procedures on different dates of service, each date of service must be reported on its own claim.

Inappropriate billing may result in erroneous claim payments. For more information regarding assistant surgery, co-surgery, and multiple surgery guidelines, review the respective claim payment policies, which are available at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

Clean Claims

A Clean Claim is one that does not require further information for processing, in accordance with applicable law. Incomplete and inaccurate claims will be returned as non-clean claims. Returned claims are not necessarily a denial of benefits but arise from our need for accurate and complete information. Additionally, claims that do not have adequate information to identify the billing Provider can be neither processed nor returned.

Clean Claims (both electronic and paper-submitted) must meet the following conditions:

- The service is a Covered Service by the Independence Member’s benefits plan.
- The claim is submitted with all required information on a claim form or in other instructions distributed to the Provider.
- The person to whom the service was provided was an Independence Member on the date of service.
- We do not reasonably believe the claim was submitted fraudulently.
- The claim does not require special treatment. Special treatment means unusual claim processing is required to determine whether the service is covered.

**Clean Claims requirements**

The following information must appear correctly for a claim to be considered clean:

- Group Provider NPI*
- performing Provider NPI
- tax ID number
- billing address
- Member’s ID number (including applicable prefix and suffix) of the patient on the claim
- Member’s date of birth
- Member’s name of the patient on the claim
*Be sure the Group Provider NPI is associated with the Group Tax ID number on file at Independence.

**Provider NPI requirement**

For purposes of processing a claim, you must submit a valid NPI as the primary identifier on the claim. In addition, the performing Provider NPI must be recorded on all claims. This is a required data element in conjunction with HIPAA compliance and other requirements. HMO, POS, and PPO claims submitted without the NPI of the Physician or other professional Provider performing the procedure or service will be rejected and returned as non-clean claims, which must be resubmitted with the necessary information.

For proper claims processing, please ensure that your billing NPI is affiliated with the entity that submits your electronic claims (e.g., your clearinghouse vendor). If your billing NPI is not affiliated with the submitter, claims will not be accepted for processing and will reject.

*Note:* Taxonomy codes are used to distinguish Provider specialties and are required on all claims.

Further information about NPIs and how to bill using NPIs is available on our website at [www.ibx.com/npi](http://www.ibx.com/npi).

**Member ID numbers on ID cards**

To better protect Member identity and privacy, we use a unique Member ID number for external communications to Members, including on all Member ID cards. Use this Member ID number when processing Member information. Please note the following:

- Members have a 3-character prefix and a 12-digit Member ID number, called a “unique Member ID” (UMI).
- The subscriber and all Members covered under the subscriber’s policy share the same ID number.
- Members with our Medicare Supplement plan – MedigapSecurity – have a 13-digit ID number, with the last digit being an alpha character.

For all local and out-of-area claims, always include both the prefix and complete Member ID number as it appears on the Member’s ID card to facilitate claims processing. Independence rejects claims not billed with the complete Member ID number and date of birth. For timely and accurate claim payment, the full Member ID must be billed as it appears on the Member ID card.

*Note:* For HMO and POS Members, the laboratory indicator (e.g., A, H, L, M, N, or T) located on the front of HMO and POS Member ID cards should not be included in the Member’s ID number.

**Place-of-service codes**

Participating Providers are required to use the most current place-of-service codes on professional claims to specify the entity where service(s) was rendered. The most frequently submitted place-of-service codes are listed in the following table. Always consult with your vendor or practice management system contact to discuss payer-specific changes to your system.

<table>
<thead>
<tr>
<th>Place-of-service code</th>
<th>Place-of-service name</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient</td>
</tr>
<tr>
<td>23</td>
<td>Emergency department/room — hospital</td>
</tr>
</tbody>
</table>
### Submitting claims

Visit our website at [www.ibx.com/edi](http://www.ibx.com/edi) for information on claims submission, billing, and tools related to these activities. This site makes it easy to find important claims-related information and provides access to electronic billing guidelines, the HIPAA Transaction Standard Companion Guide, payer ID grids, claim form requirements, and the Trading Partner Business Center.

#### Claims submission for Independence Members

If you are a Participating Provider with Independence submitting claims for Independence commercial HMO, POS, and PPO and Medicare Advantage HMO and PPO Members, you must submit the claim directly to Independence. This requirement applies both to Providers in the Independence five-county service area (i.e., Bucks, Chester, Delaware, Montgomery, and Philadelphia counties) and Providers located in contiguous counties (i.e., counties that surround the Independence five-county service area).

Claims for Independence Members may not be submitted to a local plan if the Provider is contracted with Independence. For example, an Independence-Participating Provider located in Camden County, New Jersey (i.e., a contiguous county) should not submit a claim to Horizon Blue Cross Blue Shield of New Jersey for an Independence Member. Rather, he or she should submit the claim directly to Independence.

If an Independence-Participating Provider attempts to submit a claim to his or her local plan for an Independence Member, the claim will be denied. No payment will be issued by Independence until the claim is correctly submitted to Independence.

#### CMS-1500 claim submitters

All paper claims must be submitted on a CMS-1500 claim form. A sample CMS-1500 claim form is included in the CMS-1500 claims submission toolkit, available at [www.ibx.com/providers/claims_and_billing/claims_resources_guides.html](http://www.ibx.com/providers/claims_and_billing/claims_resources_guides.html).

Providers who submit CMS-1500 claim forms can also submit these claims by using the 1500 Claim Submission transaction on NaviNet. Providers are then able to review the status of these submitted claims through the Claim Log transaction. Please keep in mind the following when using the 1500 Claim Submission transaction:

- Claims submitted using this transaction must have a date of service on or after October 1, 2015.
- Providers are able to use the 1500 Claim Submission transaction to submit Independence commercial and Medicare Advantage claims, as well as out-of-area Medicare Advantage PPO claims.
- Providers are not able to use the 1500 Claim Submission transaction to submit claims with secondary and tertiary payers.

### Place-of-service codes and names

<table>
<thead>
<tr>
<th>Place-of-service code</th>
<th>Place-of-service name</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Ambulatory surgical center</td>
</tr>
<tr>
<td>31</td>
<td>Skilled nursing facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing facility</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance — land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance — air or water</td>
</tr>
<tr>
<td>65</td>
<td>End-stage renal disease treatment facility</td>
</tr>
<tr>
<td>81</td>
<td>Independent lab</td>
</tr>
</tbody>
</table>

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1/1/2018
This transaction is available to Providers seven days a week: Monday through Saturday from 5 a.m. to 10 p.m. and Sunday from 9 a.m. to 9 p.m.

A user guide that explains how to use this transaction is available in the NaviNet Resources section of our Provider News Center at www.ibx.com/pnc/navinet.

Note: If you submit claims using the HCFA-1500 claim form, you will continue to receive the Rejected Claim Report for notification of rejected claims. The error description on the Rejected Claim Report will aid you in correcting and resending claims to ensure an expedited remittance.

Electronic claim submitters
To process EDI transactions, Independence uses the Highmark Gateway, which is managed and operated by Highmark, Inc.

If you submit claims electronically, you will receive a 277CA for notification of both rejected and accepted claims. The error description on the 277CA will aid you in correcting and resending files to ensure an expedited remittance.

For more information about claims resolution, refer to the professional Claims Resolution Matrix, available on the Independence Trading Partner Business Center at www.highmark.com/edi-ibc under Resources.

For questions related to conducting EDI business with Independence via the Highmark Gateway, please call Highmark EDI Operations at 1-800-992-0246. Highmark EDI Operations is available Monday through Friday, 8 a.m. to 5 p.m., ET.

Clearinghouse options for electronic claims submission
Your software vendor may be contractually obligated to use a specific third-party clearinghouse vendor for electronic submissions. That clearinghouse can assist you with testing to ensure that your electronic claims submissions are seamless. Many clearinghouse options are available.

Clearinghouses may update their submission rules from time to time. Always contact your clearinghouse for confirmation of up-to-date, specific submission requirements.

If you are interested in submitting electronic claims and have existing practice management software, contact your vendor as they will more than likely have an existing clearinghouse vendor that connects to the Highmark Gateway.

Submitting Coordination of Benefits information electronically
Providers may submit Coordination of Benefits (COB) information electronically for professional services using the 837P format. For instructions on how to bill electronically, visit www.ibx.com/edi.

Submitting COB information electronically eliminates the need for paper claims submission. Claims submitted electronically are processed faster and have a significantly higher “first-pass” adjudication rate. This means faster payment to you.

Medicare crossover process
Per the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross® and Blue Shield® plans, Providers should submit all Medicare crossover adjustment requests and all 100 percent Medicare-denied claims (where there is additional Beneficiary liability) electronically through Group Health Incorporated.
Through the BCBSA’s national Medicare Advantage PPO Network Sharing Program, we accept Medicare Advantage PPO enrollees from other Blue plans who travel or reside in our five-county Philadelphia service area as our local Members. Claims for these Members should be submitted to Independence for processing.

**Claims preprocessing**

Claims preprocessing validates claims data that is critical for claims processing and payment, prior to Independence receiving the claim. We incorporated the HIPAA-compliant 837P transactions into the existing Claim Preprocessing System (CPPS) for Keystone Health Plan East (KHPE) HMO, KHPE POS, Keystone 65 HMO, Personal Choice®, and Personal Choice 65SM PPO claims.

The benefits of claims preprocessing:

- increased accuracy of claims processing and payment;
- avoidance of payment delays due to missing or inaccurate data;
- error reports that, when appropriate, provide data needed for error correction.

Types of claims preprocessed:

- all electronically submitted KHPE HMO, KHPE POS, Keystone 65 HMO, Personal Choice and Personal Choice 65 PPO claims in the ANSI X-12 HIPAA-compliant 5010A1 format with a 95056, 54704, or SA704 NAIC code;
- all KHPE HMO, KHPE POS, Keystone 65 HMO, Personal Choice, and Personal Choice 65 PPO claims billed via the CMS-1500 claim form.

If you are having problems with rejected claims, refer to the *Electronic claim submitters* section in this manual. This information will help you to submit claims successfully.

**Claims resolution**

We have published claims resolution documents that highlight rules that are applied to claims and advise on how to remedy rejected claims for resubmission of a Clean Claim. These documents are available on the Trading Partner Business Center at [www.highmark.com/edi-ibc](http://www.highmark.com/edi-ibc) under Resources.

Please note that Providers should continue to submit claims according to our guidelines. Provider claims will continue to be validated against the existing business rules.

**Submission of claims adjustments**

When submitting adjustment requests electronically to your Network Coordinator or our Adjustment Department using Microsoft® files (e.g., Excel® or Access®), please submit the following fields:

- Independence claim ID number
- Member ID number
- date of service from/to
- procedure/service code
- Member first and last name
- Subscriber ID number
- vendor (billing) Provider name and number
- performing Provider name and number
- modifier
- Member ID number
- date of service from/to
- procedure/service code
- Member first and last name
- Subscriber ID number
- vendor (billing) Provider name and number
- performing Provider name and number
- modifier
- revenue code
- units billed
- charged (billed) amount
- allowed amount
- payment amount
- expected amount
By submitting your adjustment requests with the fields listed, we will be able to improve the turnaround time and maintain a higher level of service while processing the claim.

**Claim Investigation**

Participating Providers are required to use the Claim Investigation transaction on NaviNet to submit claim inquires including requests for claim review for claims that have been finalized by the health plan. Providers can then view responses to their questions using the Claim Investigation Inquiry transaction. **Note:** Providers can continue to submit corrected claims electronically or manually through paper.

Please note the following:

- Ensure that you have access to the portal and understand how to utilize the transaction.
- We will continue to redirect those Providers who submit paper claim review requests to the portal to initiate the claim review.
- Please be specific when describing the reason for the claim review. **Note:** A number of Providers are submitting claim review requests for lack of Referral or authorization. If a claim denied for lack of Referral or authorization and one was required, you must submit a valid Referral or authorization number in order for the claim to be reconsidered. The submission of medical records as a replacement for a required authorization or Referral is not valid.
- For claims processed on our legacy system (pre-migration), you can edit the claim and submit late charges.
- For claims processed on our new system (post-migration), you **cannot** edit the claim or submit late charges.

If you have a large volume of claim review requests to submit for the same issue, please contact your Network Coordinator to discuss before submitting multiple claim review requests through the portal.

For more information about this transaction, please refer to the Claim Investigation Submission Guide, available in the NaviNet Resources section of our Provider News Center at [www.ibx.com/pnc/navinet](http://www.ibx.com/pnc/navinet).

**Provider Explanation of Benefits (EOB)**

The Provider EOB contains detailed claims information for the payment of claims, claims adjustments, and claims interest payments to Providers. Provider EOBs include A/R detail, when appropriate, and may contain multiple PDF documents. The various payment types include spending account payment, remittance payment, and facility remittance.

Participating Providers can use the EOB and Remittance transaction on NaviNet to get claim payment information for finalized claims. Through this transaction, Providers can download and/or print their Provider EOB. Providers can also search for statements in two-week increments. Up to four months of historical remittance data will be stored at a time, so it is important to download and save reports on a regular basis.

To access the EOB and Remittance transaction, select **ePayment** from the Workflows menu, and then **EOB and Remittance**. To help you interpret your Provider EOB, we have published a guide that is available in the NaviNet Resources section of our Provider News Center at [www.ibx.com/pnc/navinet](http://www.ibx.com/pnc/navinet). **Note:** Your designated Security Officer has access to the transaction, and he or she will manage access for applicable staff.
Overpayments

If your office receives an overpayment from Independence and you need to submit an adjustment to correct the overpayment, you can do so in one of the following ways:

- **NaviNet.** Participating Providers with access to NaviNet should initiate an adjustment to correct an overpayment by selecting the Claim Inquiry and Maintenance transaction and then Claim Status Inquiry. From there you can enter one of the two appropriate search criteria options:
  - Billing Provider/Member ID/Date of Birth
  - Billing Provider/Member Last Name/First Name/Date of Birth

  Once the search is complete, you can find a link to Claim Investigation through the Claims Search Results and Claim Details screens. Through the Claim Investigation link you can submit the credit and/or retraction request, which will appear on a future Provider EOB.

- **Overpayment/Refund Form.** Offices that are not yet NaviNet-enabled can submit their adjustment request using the Overpayment/Refund Form, which is located at [www.ibx.com/providerforms](http://www.ibx.com/providerforms). Once the form has been completed, please mail it, along with a copy of the Provider EOB, to:

  Independence Claims Overpayment
  1901 Market Street, 39th Floor
  Treasury Services – Misc. Cash Receipts
  Philadelphia, PA 19103-1480

Explanation of Payment

Independence Members who have a spending account will have a new payment option called Direct Pay to Provider (DPTP). DPTP allows Members to pay Providers directly from their Health Savings Account (HSA), Health Reimbursement Account (HRA), or Flexible Spending Account (FSA). For HRA and FSA participants, DPTP is an employer-configuration option only; HSA participants can set up their preferences by logging on to our secure Member website, ibxpress.com.

Providers will be able to view HRA details through the Eligibility and Benefits Inquiry transaction on NaviNet, including the Deductible amount and who is responsible for payment first (the employer or the Member), and how much they would pay. Unless informed by the Member, Providers are unable to determine whether a Member has an FSA or HSA.

For medical claims that require processing to determine the Member liability, the claim is processed and then automatically sent to the spending account system to determine if the claim is covered and if funds are available under one or more spending accounts. If the account is an FSA or HRA and the employer offers DPTP, the payment is either automatically sent to the Provider or sent after the Member has approved it. In this case, the Provider will receive a spending account Explanation of Payment (EOP). Providers will be able to view EOPs through the EOB and Remittance Inquiry transaction on NaviNet. A spending account payment related to a medical claim will generally arrive a week after the claim has been completely processed.

EOPs will differ depending upon the method of payment (check vs. electronic funds transfer [EFT]). A guide explaining how to read your EOP is available on our Provider News Center at [www.ibx.com/pnc](http://www.ibx.com/pnc).
Provider claims inquiry

The Provider claims review process will consider HMO, POS, and PPO claims payment issues concerning the application and correction of coding, claims logic, and other general issues related to claims processing norms. Claims data is available for up to 18 months prior to the current date.

You can initiate the Provider claims review process using NaviNet for claims that are in the paid or denied status. Select Claims Investigation Inquiry from the Claim Inquiry and Maintenance option in the Workflows menu. Be sure to clearly identify the claims issue and be prepared to provide any supporting documentation to help explain your position.
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Overview

The Clinical Services – Utilization Management (UM) department is comprised of health care professionals whose objective is to support and facilitate the delivery of quality health care services to our Members. This is accomplished through several activities, including Preapproval/Precertification of elective health care services, medical review, facilitation of discharge plans, and case management. *All capitalized terms in this section shall have the meaning set forth in either your Provider Agreement or the Member’s benefits plan, as applicable.*

Utilization review process and criteria

**Utilization review overview**

Utilization review is the process of determining whether a given service is eligible for coverage or payment under the terms of a Member’s benefits plan and/or a network Provider’s contract.

In order for a service to be covered or payable, it must be listed as included in the benefits plan, it must not be specifically excluded from coverage, and it must be Medically Necessary. The vast majority of Independence benefits plans exclude coverage for services considered experimental/investigational and those considered primarily cosmetic in nature.

To assist us in making coverage determinations for certain requested health care services, we apply established Independence medical policies and medical guidelines based on clinical evidence to determine the Medical Necessity for the requested services. We also evaluate the appropriateness of the setting (e.g., office, inpatient, outpatient) for Covered Services requested by a Member’s health care Provider that may be provided in alternate settings or sites. When a Covered Service can be administered in various settings, Providers should request Preapproval/Precertification, as required by the applicable benefits program, to provide the Covered Services in the most appropriate and cost-effective setting for the Member’s current medical needs and condition, including any required monitoring. Independence’s review for Preapproval/Precertification will be based on the clinical documentation from the requesting health care Provider supporting the requested setting.

It is not practical to verify Medical Necessity on all procedures for all occasions. Therefore, certain procedures may be determined by Independence to be Medically Necessary and automatically approved, based on the following:

- the generally accepted Medical Necessity of the procedure itself
- the diagnosis reported
- the agreement with the Provider performing the procedure

For example, inpatient surgical procedures directly related to cancer diagnoses are approved without a requirement for detailed review.

Utilization reviews generally include several processes depending on the timing of the review and the service for which a determination is requested.

- **Preapproval/Precertification.** When a review is required *before* a service is performed, it is a Preapproval/Precertification review.

- **Admission Review.** Initial review of the Medical Necessity of an emergency admission.

- **Concurrent review.** Reviews occurring *during* a hospital stay or when services are already being provided are concurrent reviews.

- **Retrospective/Post-service review.** Those reviews occurring *after* services have been performed are either retrospective or post-service reviews. Independence follows applicable State and federal
standards for the time frames in which such reviews are to be performed and for when coverage or payment determinations are issued and communicated.

Pennsylvania law requires that initial prospective, concurrent, and retrospective utilization review decisions of managed care plans be communicated verbally, as well as confirmed in writing, to the Member and the requesting health care Provider within specific time frames. We ask that our Participating Providers inform Members of our initial utilization review decisions upon their receipt of the communication from Independence. Providers should document that they gave this verbal notification. Independence provides written notification of determinations to both Providers and Members within the required time frames.

Note: For retrospective determinations, in situations where the Member is held harmless from financial responsibility for the service, Providers are not required to notify the Member in this way.

Generally, when a requested service requires utilization review to determine Medical Necessity, nurses perform the initial case review and evaluation for coverage approval. Only an Independence Medical Director may deny coverage for a service based on Medical Necessity.

The nurses review applicable policies and procedures in the benefits plan, taking into consideration the Member’s condition and applying sound professional judgment. Evidence-based clinical protocols are applied to specific procedures. When the clinical criteria are not met, the service request is referred to an Independence Medical Director for further review and coverage or payment determination. Independent medical consultants, who are board certified in the relevant medical specialty as required by the particular case under review, may also be engaged to conduct a clinical review. If coverage for a service is denied based on lack of Medical Necessity, written notification is sent to the requesting Provider and Member notifying them of the denial and their due process appeal rights in accordance with applicable law.

Independence’s utilization review program encourages peer-to-peer discussion regarding coverage decisions based on Medical Necessity by giving Physicians direct access to Independence Medical Directors to discuss coverage determinations. The nurses, Independence Medical Directors, other professional Providers, and independent medical consultants who perform utilization review services are not compensated or given incentives based on their coverage review decisions. It is our policy that all utilization review decisions are based on the appropriateness of health care services and supplies, in accordance with the benefits available under the Member’s coverage, our definition of Medical Necessity, and applicable medical policies.

Independence Medical Directors and nurses are salaried; contracted external Physicians and other professional consultants are compensated on the basis of the number of cases reviewed, regardless of the coverage determination. Independence does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives that would encourage utilization review decisions that result in under-utilization.

Selective medical review

In addition to the foregoing requirement, Independence reserves the right, under our Utilization and Quality Management Programs, to perform a medical review prior to, during, or following the performance of certain Covered Services (selective medical review) that are otherwise not subject to reviews as previously described. In addition, we reserve the right to waive medical review for certain Covered Services for certain Providers, if we determine that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services.

Providers are notified in advance when we are planning on performing selective medical review, Members may not be penalized when required selective medical review results in a determination that a service is not medically necessary is not obtained by the Provider.
Delegation of utilization review activities and criteria

In certain instances, Independence has delegated utilization review activities to entities with expertise in medical management of a certain membership population or type of benefits (such as mental health/substance abuse, diagnostic imaging, and outpatient radiation therapy). A formal delegation and oversight process is established in accordance with applicable law and with nationally recognized utilization review and quality assurance accreditation body standards. In such cases, the delegate’s utilization review criteria are generally adopted by Independence for use by the delegated entity.

Utilization review and criteria for mental health/substance abuse services

Utilization review activities for mental health/substance abuse services have been delegated by Independence to a contracted behavioral health management company, Magellan Healthcare, Inc., an independent company. This company administers the mental health and substance abuse benefits for the majority of our Members.

Clinical criteria, guidelines, and other resources

The following clinical criteria, guidelines, and other resources are used to help make Medical Necessity and appropriateness coverage decisions:

- **InterQual®.** A product of McKesson, an independent company, the InterQual clinical decision-support criteria model is based on the evaluation of intensity of service and severity of illness. Covered Services for which InterQual criteria may be applied include, but are not limited to, the following:
  - home health care
  - inpatient rehabilitation
  - long-term, acute care facility
  - observation
  - skilled nursing facility (SNF)
  - some elective-surgery settings for inpatient and outpatient procedures
  - inpatient hospitalizations

In addition, we apply acute-care guidelines for Emergency admissions. Admissions that do not meet acute intensity of services and severity of illness are reviewed by an Independence Medical Director, and coverage or payment is denied if guidelines are not met. Observation services do not require Preapproval/Precertification but are subject, at Independence’s discretion, to InterQual criteria for Medical Necessity, which requires that the treatment and/or procedures include at least six hours of observation.

Note that medical records may be required to complete a review to determine coverage or payment in many situations including, but not limited to, a Medical Necessity review or cosmetic review.

When submitting a written request for utilization review, be sure to attach the request letter to the medical records and submit records electronically or as instructed. Medical records that arrive attached to a request letter require less research and are rapidly forwarded to the appropriate team for review.

We may conduct focused evaluation of the Medical Necessity for the use of an inpatient setting for certain elective surgical procedures. Examples include, but are not limited to: cardiac catheterizations, laparoscopic cholecystectomies, tonsillectomies, adenoidectomies, hernia repairs, and battery and generator changes. Providers must submit clinical documentation for instances where it is believed that the outpatient setting would not be appropriate and inpatient admission is necessary.
Clinical Services – Utilization Management

In addition, Emergency admissions where these procedures are performed must also meet guidelines from InterQual regarding acute admission.

- **Centers for Medicare & Medicaid Services (CMS) guidelines.** CMS adopts and publishes a set of guidelines for coverage of services by Medicare (for Medicare Advantage HMO and PPO Members).

- **Independence medical policies.** Independence internally develops a set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services that are considered Medically Necessary. Independence medical policies may be applied for Covered Services including, but not limited to, the following:
  - durable medical equipment (DME)
  - infusion therapy
  - nonemergency ambulance transports
  - review of potential cosmetic procedures and obesity surgery
  - review of potential experimental or investigational services

- **Non-certification decisions.** The criteria used to make non-certification decisions are stated in the letters to the Members and Providers, along with instructions on how to request specific guidelines. Providers may request the specific guidelines or criteria used to make specific utilization management determinations by faxing a request to 215-761-9529 or submitting a request to:
  - Request for InterQual Criteria
  - Clinical Services – Utilization Management Department
  - 1901 Market Street, 30th Floor
  - Philadelphia, PA 19103

### Important definitions

**“Medically Necessary” or “Medical Necessity”**

“Medically Necessary” or “Medical Necessity” shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease of its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factor.

**Experimental/investigational**

**Experimental/investigational services:** A drug, biological product, device, medical treatment, or procedure that meets any of the following criteria:

- is the subject of ongoing phase I or phase II clinical trials;
- is the research, experimental study, or investigational arm of ongoing phase III clinical trials, or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with a standard means of treatment or diagnosis;
• is not of proven benefit for the particular diagnosis or treatment of the covered person’s particular condition;
• is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence*, as effective and appropriate for the particular diagnosis or treatment of a covered person’s particular condition;
• is generally recognized by either the Reliable Evidence* or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of a covered person’s particular condition is recommended.

A drug is not considered experimental/investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process (e.g., an investigational new drug exemption — as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia recognize the usage as appropriate medical treatment:

• American Hospital Formulary Service (AHFS) Drug Information
• U.S. Pharmacopeia (USP) – National Formulary

Any drug that the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered experimental/investigational.

A biological product, device, medical and/or behavioral health treatment, or procedure is not considered experimental/investigational if it meets all of the Reliable Evidence* criteria listed below:

• Reliable Evidence exists that the biological product, device, medical and/or behavioral health treatment, or procedure has a definite positive effect on health outcomes.
• Reliable Evidence exists that over time the biological product, device, medical and/or behavioral health treatment, or procedure leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
• Reliable Evidence clearly demonstrates that the biological product, device, medical and/or behavioral health treatment, or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
• Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigative settings.
• Reliable Evidence shows that the prevailing opinion among experts, regarding the biological product, device, medical and/or behavioral health treatment or procedure, is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment for a particular diagnosis.

*Reliable Evidence is defined as any of the following: Reports and articles in the authoritative medical and scientific literature; the written protocol used by the treating facility or the protocols of another facility studying substantially the same drug, biological product, device, medical and/or behavioral health treatment, or procedure; or the written, informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical and/or behavioral health treatment, or procedure.

Preapproval/Precertification review

For non-urgent services requiring Preapproval/Precertification, Providers are encouraged to contact Independence at least five business days prior to the scheduled date of the procedure to ensure documentation of timely Preapproval/Precertification. Preapproval/Precertification can be requested
through the NaviNet® web portal. Providers may also obtain the status of an authorization through NaviNet. NaviNet is also used to verify individual Member benefits. Providers may submit authorization requests for services rendered by an infusion therapy Provider, a prosthetics Provider, or a DME Provider. Providers must submit authorization requests for services rendered by a home health Provider, including skilled nursing, physical therapy, speech therapy, occupational therapy, home health aide, social work, and dietitian.

The UM department will evaluate your request and will notify your office once a decision has been reached for those cases that require clinical review. You will be provided with a Preapproval/Precertification reference number based on the determination of your request. Failure to obtain Preapproval/Precertification may result in Provider penalties or denials of payment regardless of Medical Necessity.

Requests for Medicare Advantage Members (e.g., Keystone 65 HMO) must include all required information within ten days of the initial request to assure completion within the CMS-specified time frame of 14 days.

At the time of Preapproval/Precertification review, the following information will be requested:

- name, address, and phone number of the Subscriber
- relationship to the Subscriber
- Member ID number
- group number
- Physician name and phone number
- facility name
- diagnosis and planned procedure codes
- indications for admission: signs, symptoms, and results of diagnostic tests
- past treatment
- date of admission or service
- estimated length of stay (SNF and rehabilitation only)
- current functional level (SNF and rehabilitation only)
- short- and long-term goals (SNF and rehabilitation only)
- discharge plan (SNF and rehabilitation only)

Note: For potentially cosmetic procedures, photos and test results may be required

Certain products have specialized Referral and Preapproval/Precertification requirements. Visit www.ibx.com/preapproval to view a list of current services and drugs, including without limitation infusion drugs that require Preapproval/Precertification. Please note that these requirements vary by benefits plan and are subject to change.

For your reference, we have published a list of medical codes that require precertification, which can be found at www.ibx.com/medpolicy under Services Requiring Precertification.
Certain surgical procedures

The following procedures are generally performed on an outpatient basis when elective, and not urgent or emergent:

- thyroidectomy — partial or total
- parathyroidectomy
- recurrent hernia
- temporomandibular joint (TMJ) arthroplasty and discectomy
- arthroscopy (shoulder, elbow, wrist)
- open reduction internal fixation of uncomplicated wrist or finger fractures
- cardiac catheterization

We ask that Providers perform these procedures as outpatient; however, if you feel there are medical reasons that would justify an inpatient stay, Independence will review these upon request and approve the inpatient setting if medically appropriate. If we approve these procedures as inpatient and the patient goes home the same day, we will reimburse these procedures as outpatient. You may direct your review requests to the Precertification Department by calling 1-800-ASK-BLUE and saying Authorizations.

Note: None of the procedures listed above require Preapproval/Precertification if performed in the outpatient setting.

Medications

For all drugs covered under the medical benefit that require Preapproval/Precertification, Providers will be required to report Member demographics, such as height and weight.

Certain drugs that require adherence to Dosing and Frequency Guidelines will be reviewed during Preapproval/Precertification. Dosing and Frequency Guidelines are included in the medical policies for such drugs, which are available at www.ibx.com/medpolicy.

Dosing and Frequency Guidelines help Independence verify that our Members’ drug regimens are in accordance with national prescribing standards. These guidelines are based on current FDA approval, drug compendia (e.g., American Hospital Formulary Service Drug Information®, Micromedex®), industry-standard dosing templates, drug manufacturers’ guidelines, published peer-reviewed literature, and pharmacy and medical consultant review. Requests for coverage outside these guidelines require documentation (i.e., published peer-reviewed literature) to support the request.

Note: Infusion drugs that are newly approved by the FDA during the term of a Provider contract are considered new technology and will be subject to Preapproval/Precertification requirements, pending notification by Independence.

Nonemergency ambulance transport

Nonemergency medical ambulance transport services require Preapproval/Precertification when such a transport meets all of the following criteria:

- It is a benefit as outlined in the Member contract.
- It is a means to obtain Covered Services or treatment.
- It meets requirements associated with transport origin, destination, and Medical Necessity.

Visit www.ibx.com/medpolicy to view our Nonemergency Ambulance Transport Services policy.
Obstetrical admissions
Preapproval/Precertification and prenotification for a maternity admission for a routine delivery are not required.

Out-of-network requests
HMO: In the rare event a given service is not available from Providers in the Independence network, and a Primary Care Physician (PCP) wishes to refer an HMO Member to an out-of-network Provider, the Referral must be Preapproved/Precertified; otherwise, the service may not be covered. All HMO out-of-network requests are referred to a Medical Director. The Member must meet the following guidelines:

- The Member must have first sought and received care from either a Participating Provider in the same American Board of Medical Specialties or an American Osteopathic Association-recognized specialty as the nonparticipating Provider that the Member has requested (a Referral from the Member’s PCP is required).
- The Member must have been advised by the Participating Provider that there are no Participating Providers who can offer the requested Covered Services. Independence reserves the right to make the final determination of whether there is a Participating Provider who can provide the Covered Services. Applicable program terms including Medical Necessity, Referrals, and Preapproval/Precertification review by Independence, when required, will apply.

POS (Point of Service): PCP-referred requests are the same as for HMO Members. However, POS Members have the option to seek care from any Provider without a Referral, even when one is required, subject to our Deductible, Coinsurance, and Preapproval/Precertification review requirements.

PPO: PPO Preapproval/Precertification review requests for service performed by out-of-network Providers are the responsibility of the Member. Members with PPO coverage may obtain out-of-network Covered Services; however, these will be reimbursed at the out-of-network level of benefits. Members may be balance-billed for the difference between reimbursement and the out-of-network Provider’s charge.

Preapproval/Precertification through AIM
Independence has contracted with AIM Specialty Health® (AIM), an independent company, to manage Preapproval/Precertification requests for the following services:

- outpatient nonemergent diagnostic imaging services and certain high-technology radiology services for our managed care Members;
- non-emergent cardiovascular tests/diagnostic procedures and nonsurgical treatments for obstructive coronary artery disease that are part of the Cardiology Utilization Management Program for all commercial and Medicare Advantage Members;
- non-emergent musculoskeletal spine and joint procedures that are part of the Musculoskeletal Utilization Management Program for all commercial and Medicare Advantage Members;
- sleep studies and continuous positive airway pressure (CPAP) titration studies in the facility setting for all commercial and Medicare Advantage Members.

For more detailed information on the Preapproval/Precertification requirements for these services, refer to the Specialty Programs section of this manual.
Preapproval/Precertification through eviCore

Independence has contracted with CareCore National, LLC dba eviCore healthcare (eviCore), an independent specialty benefit management company, to manage Preapproval/Precertification requests for the following services:

- nonemergent outpatient radiation therapy services for all commercial and Medicare Advantage Members;
- certain genetic/genomic tests for all commercial Members.

*Note:* Preapproval/Precertification is not required when radiation therapy is rendered in the inpatient hospital setting.

Independence’s Radiation Treatment of Breast Carcinoma guideline indicates that a hypofractionated regimen is the preferred treatment for patients with early stage (T1-2N0) breast carcinoma who meet certain criteria. For these patients, a request for Preapproval/Precertification of conventional fractionation will require a peer-to-peer call with an eviCore Radiation Oncologist.

In addition, eviCore manages prepayment review for all genetic/genomic tests, along with certain molecular analyses and cytogenetic tests, for all commercial Members.

For more detailed information on eviCore and radiation therapy and genetic/genomic tests, refer to the *Specialty Programs* section of this manual.

Preapproval/Precertification through Tandigm

Independence has contracted with Tandigm Health (Tandigm), a population health services organization serving many primary care practices in the Philadelphia area, to manage Preapproval/Precertification requests for certain services.

The following services are delegated to Tandigm for precertification and/or concurrent review for Members who have a Tandigm Primary Care Physician:

- inpatient elective admissions;
- long-term acute care (LTAC) and acute rehabilitation;
- skilled nursing facility (SNF) admissions;
- select outpatient procedures (bariatric, Carticel®, cochlear implant, and uvulopalatopharyngoplasty);
- reconstructive and potentially cosmetic procedures;
- elective (nonemergency) ground, air, and sea ambulance transport;
- all home health services, excluding infusion therapy;
- prosthetics/orthotics and durable medical equipment, except continuous positive airway pressure;
- medical foods;
- out-of-capitation laboratory, radiology, and occupational and physical therapy;
- continuity of care;
- day rehabilitation;
- hyperbaric oxygen therapy.

Requests for skilled nursing placement, acute rehabilitation, and LTAC admissions for Tandigm Members are managed by Tandigm. Impacted facilities (hospitals, SNFs, LTACs) can contact Tandigm directly by calling 1-844-TANDIGM, option 5, or by sending a fax to 215-238-2271. Independence discharge planning staff can also direct facilities to Tandigm when requesting placement for Tandigm Members. Continued stay/concurrent review for these admissions is managed by Tandigm.
Penalties for lack of Preapproval/Precertification
It is the network Provider’s responsibility to obtain Preapproval/Precertification for the services listed at www.ibx.com/preapproval. If Preapproval/Precertification is not obtained where required under the Member’s benefits, neither the Member nor Independence will be responsible for payment. Members are held harmless and may not be billed for the service that was not Preapproved/Precertified where required.

Standing Referrals and specialist used as a PCP
HMO Members with life-threatening, degenerative, or disabling diseases/conditions are permitted to receive a standing Referral to a specialist with clinical expertise in treating the disease or condition. This will be granted upon approval of the treatment plan by the UM department, the Member’s PCP, and the specialist.

Members with life-threatening, degenerative, or disabling diseases/conditions are also permitted to have a specialist designated as their PCP to provide and coordinate their primary and specialty care. This will occur only after the specialist has agreed to meet our requirements to function as a PCP and after the UM department has approved the treatment plan.

Customer Service can provide direction on how to initiate a request for these circumstances. A standardized form must be completed by the Member, the PCP, and the specialist, as appropriate, and must include the diagnosis and clinical plan. The form is sent to the UM department and reviewed by an Independence Medical Director. If the request is denied, the Member, PCP, and specialist will be notified verbally and in writing of the denial and the clinical rationale for the denial. The Member will be directed on how to initiate an appeal.

All Members who request standing Referrals shall be evaluated for ongoing case management support and continued follow-up of their disease or condition.

Admission Review
Admission review is the initial review of the circumstances surrounding an Emergency admission to determine whether coverage for inpatient services will be granted. The review examines the severity of the Member’s condition based on patient presentation and diagnostic study results, as well as the treatment provided, and whether the patient’s condition is such that it symptoms are unlikely to resolve within 24 hours. Admissions for rule out of seriously acute conditions should be considered for observation level of care.

Concurrent review
Concurrent review is the review of continued stay in the hospital or skilled nursing facility after an admission is determined to be Medically Necessary. Our concurrent review program consists of both onsite and telephone reviews, based on the Agreement with the individual hospital.

Keep the following in mind:
- Concurrent review is performed when the reimbursement is per-diem.
- If concurrent review is not obtained by the first uncovered day where required, neither the Member nor Independence will be responsible for payment. Members are held harmless and may not be billed for the days not reviewed, regardless of Medical Necessity.
- When payment is based on a per-case or diagnosis related group (DRG)-based arrangement, a determination is made whether the admission meets criteria guidelines, both in elective and Emergency scenarios, and no further concurrent review is performed.
For elective admissions (surgical) that were Preapproved/Precertified, confirmation of the procedure performed will be expected.

Retrospective/post-service review

Retrospective/post-service review is a review of a case after services have been provided in order to determine coverage or eligibility for payment. This may occur when:

- charts were unavailable at the time of initial review;
- Preapproval/Precertification was not performed as required or was unavoidably delayed.

Requests for retrospective review can be initiated by calling 1-800-ASK-BLUE. Services requiring Preapproval/Precertification that were not Preapproved/Precertified may be denied on an administrative basis.

Discharge planning coordination

Discharge planning is the process by which Independence care coordinators, after consultation with the Member, his or her family, the treating Physician, and the hospital care manager, do the following:

- assess the Member’s anticipated post-discharge problems and needs;
- assist with creating a plan to address those needs;
- coordinate the delivery of Member care.

Discharge planning may occur by telephone or onsite at the hospital. All requests for placement in an alternative level-of-care setting/facility (such as acute or sub-acute rehab or SNF) will be reviewed for Medical Necessity. Providers must supply the requested information to the UM department to determine whether placement is appropriate according to InterQual guidelines.

When appropriate, alternative services (such as home health care and outpatient physical therapy) will be discussed with the Member, his or her family, the attending Physician, and the hospital discharge planner or social worker.

Once alternative placement is authorized, the approval letter is sent to the Member, the hospital, and the attending Physician. If the request does not meet the criteria, the case is referred to an Independence Medical Director for review and determination.

Denial procedures

All cases that do not appear to satisfy the relevant Medical Necessity criteria are referred to and reviewed by an Independence Medical Director for a determination. If the service is determined to be covered, Independence staff will inform the Provider who submitted the request.

If we determine that the information provided by the hospital is insufficient to determine Medical Necessity, the case will be pended. If clinical information is requested and not provided within 48 hours of the request, the request will be denied due to lack of information. Any information provided after the denial for lack of clinical information has been processed will be reviewed and the case will be reconsidered for approval. It is not necessary to appeal a denial for lack of clinical information.

For non-urgent (elective) care, the information must be submitted within 10 calendar days of the initial request or prior to the date of service, whichever comes first. If the information is not submitted in the applicable time frame, the request may be denied and the information regarding an appeal process will be included in the denial letter.
All determinations are communicated verbally, and written confirmation is sent to the attending Physician, hospital, PCP, and Member, as applicable. The clinical review criteria applied in rendering an adverse coverage or payment determination are available free of charge and will be furnished upon request. All adverse determination (denial) notifications include the contractual basis and the clinical rationale for the denial, as well as instructions for how to initiate an appeal.

For detailed information about the appeals process, refer to the *Appeals* section of this manual.

**Observation status**

Observation status is an outpatient service that does not require authorization. It should be considered if a patient does not meet InterQual acute inpatient criteria and one or more of the following apply:

- Diagnosis, treatment, stabilization, and discharge can be reasonably expected within 24 hours.
- Treatment and/or procedures will require more than six hours of observation.
- The clinical condition is changing, and a discharge decision is expected within 24 hours.
- It is unsafe for the patient to return home, or a caregiver is unavailable (arrangements need to be made for a safe and appropriate discharge setting, such as sub-acute care/SNF or home care).
- Symptoms are unresponsive to at least four hours of ER treatment.
- There is a psychiatric crisis intervention or stabilization with observation every 15 minutes.

Observation status does not require a physical “stay” in an observation unit and does not apply to ER observation of less than six hours.

Independence uses InterQual level-of-care guidelines to determine Medical Necessity and reserves the right to retrospectively audit claims where there has been billing for observation status to assure that appropriate guidelines have been met.

If a Member has received observation services and is subsequently admitted, the date of the admission becomes the date that observation began. Observation services that result in an admission are subject to utilization management review for Medical Necessity.

**Reconsideration and review processes**

**Peer-to-Peer Reconsideration process**

In the event that an adverse determination (denial) is issued without direct discussion between an attending/ordering Physician and an Independence Medical Director, the requesting Provider (including attending/ordering Physician or hospital medical director) may request a Peer-to-Peer Reconsideration with an Independence Medical Director. Peer-to-Peer Reconsideration is an optional, informal process designed to encourage dialogue between the requesting Provider and Independence’s Medical Directors and may be requested by a Physician for a Preapproval/Precertification, concurrent, or post-service review denial based on Medical Necessity.

Medicare refers to any determination issued by a health plan where a Medicare beneficiary may be financially liable for receiving a service in the event the health plan denies the claim as an organization determination. This is typically applicable only for Preapproval/Precertification determinations. For Medicare Advantage plans, once Independence issues an adverse organization determination denying coverage, any change to that organization determination is considered a reconsideration and must be handled as an appeal. Independence Medical Directors are available to discuss cases and explain the clinical rationale for utilization management determinations. In the event an adverse organization determination has already been issued, the Independence Medical Director will be able to explain the
basis for her or his determination. Should new information become available that would change the
determination, the Medical Director will assist the treating Physician in accessing the appeal process and
make this new information available in the appeal process.

Please note the following:

▪ For concurrent review denials, the Peer-to-Peer Reconsideration process should be initiated while the
Member is in the hospital; however, hospitals have up to two business days from the date the Member
is discharged to initiate the process. For Preapproval/Preauthorization denials, the process should be
initiated after the Provider has received notification of the denial but before the service is actually
rendered.

▪ To initiate the process, the attending Physician, ordering Physician, hospital Utilization Management
department Physicians, or their designated Physician representative (e.g., hospital medical director) may contact an Independence Medical Director by:
  – filling out the Peer-to-peer request form found at www.ibx.com/providerforms;
  – calling the Physician Referral Line at 1-888-814-2244, or at 215-241-0494 within Philadelphia.
    The Physician Referral Line is available Monday through Friday from 8:30 a.m. to 5 p.m.

▪ A Medical Director will initiate a call to the Provider within five business days from the time the
request for a peer-to-peer reconsideration has been received. If the Provider cannot be reached, the
Medical Director documents the attempt and renders a final determination. Whenever possible, the
Medical Director Support Unit staff facilitates “warm call transfers” between Providers and Medical
Directors and schedules telephone appointments between Medical Directors and Providers.

▪ A decision to overturn all or a portion of the initial adverse determination will be communicated in
writing to the Provider.

Continuity of care

If a Provider’s contract is discontinued, the Member has access to the primary or specialty care
practitioner or practitioner group as applicable, for up to ninety (90) calendar days from which the
Member is currently receiving an active course of treatment provided that the practitioner agrees to
continue to provide services to the Member under the terms and conditions of the Plan. A Member is
undergoing an active course of treatment if the Member has regular visits with the practitioner to
monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other
treatment, or modify a treatment protocol. Active treatment does not include routine monitoring for a
chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

Pregnant women enrolled in an HMO, POS, or PPO plan may continue to receive treatment by a Physician
who has terminated from the network, unless the termination was due to unsafe health care practices that
jeopardize the health, welfare, or safety of the Members, through the completion of postpartum care.

The continuity-of-care period may be extended by Independence when clinically appropriate. Coverage of
Covered Services provided during the continuity-of-care period is contingent upon the Provider’s
Agreement to comply with the terms and conditions applicable to Independence Participating Providers,
prior to providing services for this time period.

If Independence initiates termination of a Provider with cause, Independence is not responsible for
coverage of health care services provided by the terminated Provider to the Member following the date of
termination. Notification will be provided to our Members, and arrangements will be made to facilitate
transfer to another Participating Provider.
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Emergency care

Emergency services are eligible for payment in accordance with the following definition of an Emergency:

The sudden onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- placing the Member’s health, or in the case of a pregnant Member, the health of the Member and/or unborn child, in jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part.

Emergency transportation and related Emergency services provided by a licensed ambulance Provider constitute an Emergency service.

PCP responsibilities when sending commercial HMO/POS Members to the ER

- Primary Care Physicians (PCP) must provide coverage 24 hours a day, 7 days a week, for their practice.
- HMO/POS Members should not be referred to the emergency room/department (ER) for capitated services.
- All ER Referrals should be documented in the Member’s medical record.
- Follow-up care, blood work, and repeated X-rays must be managed and appropriately referred by the PCP.

Member responsibilities when using the ER

- In an Emergency, the Member should proceed to the nearest ER for care, regardless of the Member’s physical location.
- There is no requirement for the Member to contact his or her primary Physician or PCP before visiting an ER. However, we encourage Members to contact their primary Physician or PCP before visiting an ER for guidance if the Member is unsure about whether an Emergency condition exists.
- The Member is responsible for any applicable ER Copayment or Coinsurance associated with his or her coverage, unless the ER visit results in immediate Emergency inpatient hospitalization. The Copayment/Coinsurance is not waived in the case of emergent outpatient surgery.
- When the Member is admitted to the hospital from the ER, the Copayment may be waived. The Member’s schedule of benefits provides specific information on ER Copayments and Copayment waivers.

Follow-up care

Generally, follow-up care after an ER visit is considered routine care. For commercial Members, routine (nonemergent) follow-up care provided in the ER setting by a Participating Provider is not a Covered Service. Members should not be referred back to the ER for follow-up care services if they can be referred to their primary or specialty care Physician without medically harmful consequences.

Examples of routine follow-up care in the ER include the following:
- patient returns to have a prescription extended that was written in the ER;
- patient returns to the ER for reapplication of bandages, splints, or wraps;
• patient who had a laceration repaired with sutures returns to the ER to have the sutures removed.

When follow-up care provided in the ER setting is denied as a noncovered service, commercial Members may be billed for such noncovered services subject to the terms of your Participating Provider Agreement. This requires, in relevant part, that you give the Member written notice prior to providing the noncovered services indicating that follow-up care in the ER setting is not covered and that the Member will be financially responsible for such noncovered services.

Routine (nonemergent) follow-up care provided in the ER setting by a Participating Provider is not eligible for a separate ER visit payment.

Nonemergency care

HMO/POS Members: HMO/POS plans cover other nonemergent care rendered in the ER when Preapproved by the PCP or obstetrical care Provider. If the Member’s condition is nonemergent in nature and care cannot be provided in a timely fashion by the PCP or PCP-referred specialist, the Member may be referred to the appropriate ER of a participating hospital. The PCP must use his or her medical judgment to determine what “timely” care is based on the Member’s presenting symptoms.

PPO Members: The Member is responsible for seeking necessary medical care from the appropriate setting and Providers.

For more information on Preapproval requirements, elective admissions, urgent admissions from the Physician’s office, or transfers, see the Care Management and Coordination section of this manual.

Urgent care

Independence offers Members an urgent care benefit, designed to give them a lower cost alternative to the ER, when medically appropriate. This benefit allows Members to receive care for urgent medical issues at approved urgent care centers and retail health clinics when they do not have access to their Physician’s office but do not require the advanced medical services of an ER.

- Urgent care centers. Urgent care centers are staffed by board-certified Physicians who can provide medically necessary treatment for a sudden illness or injury that is not life-threatening.

- Retail health clinics. Retail health clinics are staffed by certified family nurse practitioners trained to diagnose, treat, and write prescriptions for (when clinically appropriate) common illnesses and medical conditions. Local supervising Physicians are on call during clinic hours of operation to provide guidance and direction when necessary.

Urgent care needs are for urgent medical issues that do not require the advanced medical services of the ER when the Physician is unavailable. Generally, urgent care is categorized as medically necessary treatment for a sudden illness or accidental injury that requires prompt medical attention, but is not life-threatening and is not an emergency medical condition, when a Member's PCP (or primary Physician for PPO) is unavailable.

Examples of urgent care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, and X-rays that are not Preventive Care or follow-up care. Eligible Members do not need a Referral or Preapproval to be eligible for urgent care services.

Children’s Health Insurance Program (CHIP) Members: All CHIP Members are enrolled in the Keystone Health Plan East (KHP) HMO program with coverage for urgent care and retail clinic visits. CHIP Members are issued an Independence Member ID card with the words “PA KIDS” written on the front of the card.
Approved urgent care centers and retail health clinics

Approved urgent care Providers can be identified using the Find a Doctor tool at www.ibx.com. Once on the Provider Search screen, select the Find an Urgent Care Center button to conduct a search.

Providers may want to print out a list of the approved urgent care centers and retail health clinics in their area to keep on hand and share with the staff who handle after-hours calls. This list may be instrumental in cases when a Member requires urgent medical attention, but a Provider’s office is closed and ER care is not required.

Member responsibilities when using urgent care

Our Eligibility and Benefits Inquiry transaction on the NaviNet® web portal includes Copayment information for urgent care services. To view the urgent care Copayment for eligible Members, select Eligibility and Benefits Inquiry from the Workflows menu, enter the search criteria for the Member, and choose Select next to the appropriate Member.

Note: Not all Members are eligible for the urgent care benefit. As always, check Member eligibility and benefits on NaviNet prior to rendering service.

Ambulatory care

Preapproval may be required for select outpatient procedures. Preapproval for those select procedures must be obtained at least five business days prior to the scheduled date of the procedure. For Flex HMO and POS products, Providers are responsible for obtaining Preapproval as needed. For self-referred services covered under POS, it is the Member’s responsibility to obtain Preapproval at least five business days before the scheduled date of the procedure.

Go to www.ibx.com/preapproval for the list of services that require Preapproval. Note: This list is subject to change upon notice to the Provider.

Billing multiple services

Independence requires that professional claims be billed on one CMS-1500 claim form or electronic 837P transaction when two or more procedures or services were performed for the same patient, by the same performing Provider, and on the same date of service. When services rendered on the same date, by the same Provider are billed on two claims, it is defined as “split-billing.”

The only instances when split-billing is acceptable to Independence are when we specifically require services to be billed on separate claims based on an Independence policy (i.e., assistant or co-surgery claims). Some examples of split-billing, which is not allowed by Independence, include:

- two or more procedures or services performed by the same Provider, on the same date of service, on the same patient, and submitted on more than one claim form;
- services considered included in the primary services and procedures as part of the expected services for the codes are billed on separate claim forms.

Providers must bill on one claim form for all services performed on the same day, for the same patient, unless there is an Independence policy that supports split-billing for the services or procedures performed.

Failure to do so prohibits the application of all necessary edits and/or adjudication logic when processing the claim. As a result, claims may be under- or over-paid and Member liability may be under- or over-stated.

If a service for which there is no policy to support split-billing is inadvertently omitted from a previously submitted claim, the original claim should be corrected.
**Note:** Do not submit a separate claim for the omitted services, as that will create a split-billed claim and all individually submitted claims will be adjusted to deny.

### Radiation therapy

Preapproval through CareCore National, LLC d/b/a eviCore healthcare (eviCore), an independent company, is required for nonemergent outpatient radiation therapy services for all commercial and Medicare Advantage HMO, POS, and PPO Members.

**HMO/POS Members:** For commercial HMO/POS members, the PCP must issue a Referral for “evaluate or follow-up.” All Referrals are valid for 90 days. The PCP may estimate the total number of visits expected based on the initial consult report from the specialist or may indicate “unlimited/as needed.”

**Note:** Referrals are no longer required for Medicare Advantage HMO/POS members.

**PPO Members:** Members can seek out-of-network services for radiation therapy prescribed by a Physician. Services obtained within the Independence network are paid according to the contracted fee schedule. When Members elect to receive out-of-network radiation therapy, claims are processed according to the out-of-network benefits level.

### Blood and blood products

Subject to the terms and conditions of the applicable benefits contract, the administration of blood and blood products is covered for managed care plans under the basic medical benefits when Medical Necessity criteria are met. Note the following:

- Individual Member benefits must be verified for blood products, autologous blood drawing, storage, and transfusion services.
- Not all groups have coverage for blood and blood products.
- Some contracts require Member payment for up to three pints of blood prior to benefit eligibility.
- Coverage may be subject to Preapproval.

### Determining whether procedures are cosmetic

In general, all plans require Preapproval for potentially cosmetic procedures. A list of procedures that are, or may be considered to be, cosmetic and thus may not be covered under the Member’s plan is available at [www.ibx.com/preapproval](http://www.ibx.com/preapproval). Some procedures, depending on specific medical criteria, may be approved for coverage. For coverage consideration, the Provider must complete the Preapproval process.

Participating Providers should submit their requests through NaviNet prior to services being performed. Failure to obtain Preapproval where required may lead to a denial of payment. Review the medical policy for each potentially cosmetic procedure at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy). The medical policies contain a definition of and our coverage position for each procedure.

### Skilled nursing facilities

Skilled nursing facility (SNF) services are covered for HMO, POS, and PPO Members who need skilled or sub-acute care. SNF services are subject to Preapproval and may be subject to certain benefits limits.

All SNF admissions are either arranged by care coordinators or Preapproved through the Preapproval process. SNF admissions are reviewed weekly or more often, if necessary, to facilitate appropriate use of benefits and to promote optimal benefits coverage. SNF reviews may be onsite or by telephone or fax, depending on the arrangement with the individual SNF.
Note: Medicare Advantage HMO and PPO Members may be admitted to a SNF from home without admission to an acute-care facility first. Admissions must follow the Preapproval process.

Inpatient hospital

Inpatient hospital benefits are available to HMO, POS, and PPO Members and are subject to Preapproval. In the case of an urgent or emergent admission for an HMO, POS, or PPO Member, the hospital shall notify Independence within 48 hours or on the next business day.

HMO/POS Members: The attending Physician is required to obtain Preapproval for all non-urgent or nonemergent admissions.

PPO Members: The hospital or attending Physician should Preapprove all non-urgent or nonemergent admissions.
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Capitated services

Within the HMO/POS products, there are a number of outpatient services included in the following designated (capitated) programs. These services are:

- diagnostic radiology*
- short-term rehabilitation*
- laboratory

Generally, Primary Care Physicians (PCP) must refer Members only to their capitated site for these services, as noted under the Radiology services and Laboratory services headers in this section. Each capitated Provider is contracted to provide a full range of services, including treatment of pediatric Members.

Note: Radiology and physical therapy services are not capitated for Keystone 65 Focus Rx HMO (Keystone 65 Focus) Members. These Members must be directed to a Participating Provider in the Keystone 65 Focus network. Referral requirements still apply.

If you are a Provider who is contracted for specialty capitation for one of the above services, you are required to either provide that service on-site or arrange for the service through a subcontractor arrangement. Therefore, it is important that you arrange for provision of the service with a subcontractor and maintain that arrangement in order to serve your patients. If you do not already have subcontractors in place, take steps to establish an arrangement.

When using a subcontractor, a Referral should still be completed using the capitated Provider’s information.

If, for some reason, circumstances require a Referral to a site other than your office’s capitated site, contact Customer Service at 1-800-ASK-BLUE for assistance and direction for Preapproval review.

Note: PCPs in Berks, Lancaster, Lehigh, and Northampton counties in Pennsylvania are not required to choose capitated radiology or short-term rehabilitation sites. However, these Providers are required to choose capitated laboratories.

Radiology services

HMO/POS Members*

- Outpatient nonemergent radiology services are provided through a network of contracted Providers.
- Each PCP is required to select one site as his or her capitated radiology site. PCPs should refer their Independence Members to this site for outpatient radiology services. POS Members may self-refer to a site other than the PCP’s capitated radiology site but will be subject to Deductibles and Coinsurance.
- HMO specialists should refer Members back to their PCP for a Referral for any needed radiology services with the exception of CT or CTA scans, PET scans, MRIs, MRAs, or nuclear cardiology services, which should be precertified. See the precertification for diagnostic imaging services section for details. The exceptions also include fracture care and X-rays performed to rule out a fracture by a specialist Physician who is contracted to perform these services.
- Members may receive mammography and breast ultrasound services by a participating radiologist or outpatient department of a hospital. This service is not part of the Diagnostic Radiology Program; therefore, there are no capitated site or Referral requirements.
General ultrasounds for a normal pregnancy must be referred to the capitated site selected by the Member’s PCP. PCP-capitated radiology sites can be found on the NaviNet® web portal through the Eligibility and Benefits Inquiry transaction.

OB/GYNs must use NaviNet to submit OB/GYN Referrals to refer patients to their PCP’s capitated radiology Provider for general and diagnostic ultrasounds for pregnancy.

Ultrasounds and testing for identified high-risk patients may be referred to a Participating Perinatal Provider, antenatal testing unit, or any participating hospital when certain conditions are met based on diagnosis and servicing Provider.

Pediatric Members (newborn through age 12) may obtain a Referral to any radiology facility in the HMO network. These Members are not required to use capitated radiology sites.

For a complete listing of services, review the medical policy for diagnostic radiology services included in capitation at www.ibx.com/medpolicy.

*Radiology and physical therapy services are not capitated for Keystone 65 Focus Members. These Members must be directed to a Participating Provider in the Keystone 65 Focus network. Referral requirements still apply.

**PPO Members**

There are instances when specialists may perform radiology services. If a specialty practice is not permitted to perform radiology services in their office, Members should be directed to a participating radiology site to receive benefits with the lowest out-of-pocket costs.

A Member must receive all nonemergency diagnostic radiology and imaging studies from a network radiology Provider in order for Members to receive in-network benefits.

**Precertification for diagnostic imaging services**

We are contracted with AIM Specialty Health® (AIM), an independent company, to perform precertification for outpatient nonemergent diagnostic imaging services and certain high-technology radiology services for our managed care Members.

Ordering Physicians — PCPs or specialists — are required to obtain precertification for the following outpatient nonemergent diagnostic services:

- CT/CTA scans
- CCTA/FFR
- echocardiography
- MRA
- MRI
- nuclear cardiology services
- PET scans
- PET/CT fusion

You can initiate precertification for these services in one of the following ways:

- NaviNet. Select AIM from the Authorizations option in the Independence Workflows menu.

Reviews for the above services will be performed by AIM, as the Independence designee, according to Medical Necessity criteria.

For more information and a complete list of our high-technology radiology services, please review our policies at www.ibx.com/medpolicy.
Note: If the above-listed services are being ordered as mapping and planning for surgery or are ordered as part of a guided procedure (such as a needle biopsy), the ordering Provider should call the Preapproval telephone number listed on the Member’s ID card. Ordering Providers should not call AIM under these circumstances.

For HMO/POS Members, precertification replaces the need for a PCP Referral. Therefore, a PCP Referral for these services is not needed. The precertification is valid for 60 days from the date the services were requested. For radiology services not included in the previous listing, a Referral is required or claims will be denied for lack of precertification.

Review authorized procedure codes and descriptions
Providers should review the procedure codes and descriptions that have been authorized before performing the service. If the procedures billed are not those that have been authorized, or within the same procedure code grouping of the codes that have been authorized, the service will be denied appropriately for “no authorization on file.”

Both ordering and performing Providers can access AIM’s ProviderPortal through NaviNet by selecting the Authorizations transaction and then choosing AIM or by visiting www.aimspecialtyhealth.com/goweb.

The AIM ProviderPortal is available 7 days a week and offers Providers the following:

- an easy-to-use interface for efficient precertification requests;
- printable precertification summary information sheets for completed requests;
- online tracking of previous precertification requests and status of open requests.

If there is a discrepancy between the procedure to be performed and the procedure that received prior authorization/approval, the performing Provider should work with both the ordering Physician and AIM to address the discrepancy and request any necessary changes to the authorization before rendering service.

Short-term rehabilitation therapy services
For conditions subject to significant improvement within the benefits period, HMO Members are generally eligible for a maximum of 60 consecutive days of short-term outpatient rehabilitation therapy. Therapy beyond the benefits period is not covered. Chronic conditions that are not likely to significantly improve within the benefits period are not eligible for coverage.

Members in Flex Programs are eligible for a maximum of 30 visits (combined) per year for physical and occupational therapy and 20 visits per year for speech therapy.

For PPO Members, certain chiropractic services may be applied to the short-term rehabilitation services benefits limit.

Keystone 65 HMO Members are covered for physical therapy benefits beyond 60 consecutive days when performed with the expectation of improving, restoring, and/or compensating for loss of the Member’s level of function, which has been lost or reduced by injury or illness. Therapy performed repetitively to maintain the same level of function is not covered. Physical therapy Providers must consult the Keystone 65 HMO Member’s PCP before discharging the Member from treatment.

For physical medicine and rehabilitation services, a prescription/order must be received from a Physician prior to a Member receiving therapy services. Independence requires a prescription from a Physician for our Member’s coverage, even though there are Providers (referred to as Direct Access by the American Physical Therapy Association [APTA]) who have been issued certificates by their State regulatory agency that permit them to treat a patient for 30 calendar days without a prescription/order from a Physician. In addition to other criteria, only physical therapy services ordered by a Physician are eligible.
for reimbursement. Independence may also request documentation for therapy services rendered and conduct audits that investigate proper documentation.

>Note: Benefits may vary by employer group. Individual benefits must be verified.

†Be advised that the APTA’s Direct Access has no relation to Independence’s Direct AccessSM OB/GYN benefit for HMO and POS Members.

**HMO/POS Members‡**

- Outpatient physical therapy and occupational therapy (PT/OT) services are provided through a network of contracted Providers.
- Each PCP is required to select one site as his or her capitated PT/OT site. PCPs should refer their Independence Members to this site for all PT/OT services. POS Members may self-refer to a site other than the PCP’s capitated PT/OT site, but will be subject to Deductibles and Coinsurance. For a complete listing of services included in the capitated PT/OT program, refer to our policy on physical medicine and rehabilitation services eligible for reimbursement above capitation to PT/OT Providers for Members enrolled in HMO/POS products at www.ibx.com/medpolicy.

‡Radiology and physical therapy services are not capitated for Keystone 65 Focus Members. These Members must be directed to a Participating Provider in the Keystone 65 Focus network. Referral requirements still apply.

**Services excluded from capitation**

The following services are excluded from the capitation requirement:

- diagnosis-specific hand therapy
- speech therapy
- lymphedema therapy
- vestibular rehabilitation
- orthoptic/pleoptic therapy, when provided by a licensed ophthalmologist or optometrist

The provision of splints, braces, prostheses, and other orthotic devices is not included in the monthly capitation. Such devices are provided by HMO-Participating durable medical equipment (DME)/prosthetic Providers. Certain DME and prosthetic devices require Preapproval by our Care Management and Coordination (CMC) department.

**Referral and Preapproval requirements**

A Referral (through NaviNet) from the Member’s PCP is required whenever a Member is referred for treatment or evaluation.

- Under most circumstances, one Referral per Member per condition is sufficient.
- All HMO Referrals are valid for 90 days from the date they are issued.
- No Preapproval is required for Referrals made to the capitated Provider. CMC must Preapprove services provided by any Provider other than the PCP’s capitated Provider based only on Medical Necessity and not on convenience factors.
- Speech therapy services do not require Preapproval.

**Evaluation and treatment**

When an HMO Member is first referred to a capitated Provider for evaluation, an initial comprehensive physical therapy evaluation will be given. A specific course of treatment will be coordinated among the PCP, specialist, and therapist. The therapist will then institute the course of treatment determined to be most appropriate.
Treatment required

When a physical therapist evaluates a patient, a course of treatment is recommended at that visit. The following are examples of possible outcomes of this initial evaluation:

- The therapist may evaluate and recommend implementation of a therapy program at the therapy center. In this case, the therapy benefit begins with the first visit after the evaluation.
- The therapist may evaluate the Member and determine that the condition does not require therapy at a physical therapy center. In this case, a self-administered home therapy program or other exercises may be prescribed. The therapist may then recommend one or more of the follow-up visits to properly assess the Member’s progress.

Interrupted therapy

Occasionally, due to a change in the treated condition or a concurrent illness, rehabilitation therapy may be interrupted. For example, a Member receives short-term rehabilitation therapy for an acute condition, during which time he or she has surgery for this condition. The surgery is considered an interruption of therapy, and the Member is eligible to use any of the remaining benefit days postoperatively. The PCP must electronically submit a new Referral for any therapy that occurs more than 90 days after the date of the original Referral.

Autism coverage

The diagnosis and treatment of autism spectrum disorders (ASD) are covered for Independence Members enrolled in a 51+ fully insured commercial group product or the Children's Health Insurance Program (CHIP). Before you provide care related to ASD, be sure to verify Member eligibility through NaviNet.

Coverage is provided for enrolled individuals under age 21 and requires coverage for the following:

- evaluations and tests needed to diagnose an autism disorder;
- Medically Necessary prescribed treatments such as applied behavioral analysis and rehabilitative care, blood level tests, psychiatric and psychological services, speech/language therapy, occupational therapy, physical therapy, and prescription drugs.

Services not covered under the Commonwealth of Pennsylvania autism mandate include benefits that are normally excluded from coverage under the Member's medical plan, including services that are not Medically Necessary.

Services for ASD, including those rendered in a school setting, must be Medically Necessary and must have a primary diagnosis of ASD. Depending on the service that is being requested, the Member, or a health care Provider on a Member's behalf, may be required to submit a treatment plan to Independence once every six months for review and approval. Services for ASD will not be subject to any limits on the number of visits. However, services are subject to applicable Member cost-sharing, policy limits, maximums, exclusions, and precertification and Referral requirements under the Member's benefits program.

Refer to our policy on the evaluation and management of ASD, which is available at www.ibx.com/medpolicy, for specific coverage information regarding the diagnosis and treatment of ASD. Note that our Medical Policy is consistent with applicable State mandates.
Laboratory services

General guidelines

If you are a Participating Physician, you may bill only for Covered Services that you or your staff perform. Participating Physician offices are not permitted to submit claims for services that they have ordered but that have not been rendered. Billing of laboratory services performed by a contracted or noncontracted laboratory is not reimbursable.

Independence requires you to direct Members and/or their lab specimens to a participating outpatient laboratory Provider, with the following exceptions:

- in an emergency;
- as otherwise described in the applicable Benefit Program Requirements;
- as otherwise required by law.

The following participating contracted laboratories for outpatient services are available for capitation:

<table>
<thead>
<tr>
<th>Laboratory name</th>
<th>Laboratory indicator on ID card</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abington Memorial Hospital Laboratory</td>
<td>A</td>
<td>215-481-5406</td>
</tr>
<tr>
<td>Atlantic Diagnostic Laboratories, Inc.</td>
<td>D</td>
<td>267-525-2470</td>
</tr>
<tr>
<td>Health Network Laboratories</td>
<td>N</td>
<td>1-877-402-4221</td>
</tr>
<tr>
<td>Hospital of the University of Pennsylvania (and Penn Medicine at Radnor)</td>
<td>H</td>
<td>1-800-789-7366</td>
</tr>
<tr>
<td>Laboratory Corporation of America® Holdings (LabCorp)</td>
<td>L</td>
<td>1-800-631-5250</td>
</tr>
<tr>
<td>Mercy Health Laboratory</td>
<td>M</td>
<td>610-237-4175</td>
</tr>
<tr>
<td>Pottstown Memorial Hospital</td>
<td>P</td>
<td>610-327-7522</td>
</tr>
<tr>
<td>SMA Medical Laboratories</td>
<td>F</td>
<td>215-322-6590</td>
</tr>
<tr>
<td>Thomas Jefferson University Laboratory§</td>
<td>T</td>
<td>215-955-6545</td>
</tr>
</tbody>
</table>

$Available to specific practices only.

You can find laboratory indicators on the front of the Member ID card or through NaviNet.
Specialized pathology testing for HMO, POS, and PPO Members is offered by the capitated laboratories as well as by the following specialized laboratory Providers:

<table>
<thead>
<tr>
<th>Laboratory name</th>
<th>Specialty</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accupath Diagnostic Laboratories, Inc.</td>
<td>Hematopathology, complex solid tumors, molecular oncology and genetics</td>
<td>1-800-447-8881</td>
</tr>
<tr>
<td>Assurex Health, Inc.</td>
<td>GeneSight® psychotropic assay for refractory depression</td>
<td>1-866-757-9204</td>
</tr>
<tr>
<td>CardioDx, Inc.</td>
<td>Corus® CAD blood test for obstructive coronary artery disease</td>
<td>1-866-941-4996</td>
</tr>
<tr>
<td>CBL Path, Inc.</td>
<td>Pathology, oncology, genetic testing</td>
<td>1-877-225-7284</td>
</tr>
<tr>
<td>DIANON Pathology</td>
<td>Surgical pathology, including uropathology, gastrointestinal pathology, dermatopathology, and breast pathology</td>
<td>1-800-328-2666</td>
</tr>
<tr>
<td>Exact Sciences Laboratories, LLC</td>
<td>Colorectal cancer screening and Cologuard</td>
<td>1-844-870-8870</td>
</tr>
<tr>
<td>Genomic Health, Inc.</td>
<td>Oncotype DX® breast cancer assay</td>
<td>1-866-662-6897</td>
</tr>
<tr>
<td>Institute of Dermatopathology, PC/ AmeriPath® New York, Inc.</td>
<td>Dermatopathology</td>
<td>1-800-553-6621</td>
</tr>
<tr>
<td>Integrated Genetics</td>
<td>Reproductive genetic testing: prenatal &amp; postnatal testing, prenatal diagnostics, genetic testing</td>
<td>1-800-848-4436</td>
</tr>
<tr>
<td>Integrated Oncology</td>
<td>Hematopathology, complex solid tumors, molecular oncology and genetics</td>
<td>1-800-447-8881</td>
</tr>
<tr>
<td>LabCorp</td>
<td>Specialty testing includes genetic testing, molecular oncology, HLA testing, esoteric coagulation, infectious disease, immunoassays, and microbiology</td>
<td>1-800-631-5250</td>
</tr>
<tr>
<td>Litholink (LabCorp subsidiary)</td>
<td>Testing and clinical decision support for kidney stone prevention</td>
<td>1-800-338-4333</td>
</tr>
<tr>
<td>MDxHealth, Inc.</td>
<td>ConfirmMDx® for prostate cancer, molecular, and epigenetic diagnostics for urologic cancers</td>
<td>1-866-259-5644</td>
</tr>
<tr>
<td>MedTox Laboratories (LabCorp subsidiary)</td>
<td>Specialized toxicology and medical drug monitoring</td>
<td>1-800-832-3244</td>
</tr>
<tr>
<td>Monogram BioSciences (LabCorp subsidiary)</td>
<td>HIV and HCV drug resistance assays and molecular oncology</td>
<td>650-635-1100</td>
</tr>
<tr>
<td>Myriad Genetics Laboratories, Inc.</td>
<td>BRCA Analysis, COLARIS®, and COLARIS AP®</td>
<td>201-791-3600</td>
</tr>
<tr>
<td>Nant Health, LLC</td>
<td>GPS Cancer™ for molecular oncology profiling</td>
<td>1-844-696-6427</td>
</tr>
<tr>
<td>NeoGenomic Laboratories</td>
<td>Oncology genetic testing</td>
<td>1-866-776-5907</td>
</tr>
<tr>
<td>Penn Cutaneous Laboratory</td>
<td>Dermatopathology</td>
<td>1-866-337-6522</td>
</tr>
<tr>
<td>Penn Cytogenetic Laboratory</td>
<td>Cytopathology</td>
<td>1-800-789-7366</td>
</tr>
</tbody>
</table>
HMO/POS Members

All routine laboratory services for HMO/POS Members must be directed to and processed by the PCP’s capitated laboratory site.

We encourage Providers to set up accounts with their capitated laboratory sites to accommodate testing needs, improve recordkeeping, promote communication between the laboratory and the Physician, and facilitate timely receipt of laboratory supplies. In accordance with your contractual requirements, it is necessary to use a Participating Laboratory Provider. Specialists who draw or collect specimens should establish accounts with all laboratories since they are required to send HMO Members’ laboratory specimens to their PCP’s capitated laboratory.

In the unusual circumstance that you require a specific test for which you believe no participating laboratory can perform, contact Customer Service, as Preapproval is required to issue a Referral to a nonparticipating laboratory.

PPO Members

Routine laboratory services for PPO Members must be sent to one of the in-network laboratories. For PPO Members, laboratory class code I and II services may be performed in the Physician’s office in accordance with Independence’s claim payment policy. For a complete listing of laboratory class code I and II services, refer to www.ibx.com/medpolicy. If a laboratory test is not listed as level I or level II, it is considered a level III test. Level III outpatient laboratory tests must be referred to a commercial laboratory or one of the network hospitals that has contracted with the Personal Choice® network to perform outpatient laboratory services.

Note: Members who have out-of-network benefits (e.g., PPO) may choose to use a nonparticipating laboratory for a medically necessary service, but they may have greater out-of-pocket costs associated with that service. In addition, the Member will be financially responsible for the entire cost of any service that is noncovered (e.g., experimental/investigational).

Traditional Members

Members with Traditional (Indemnity) coverage may receive laboratory services from any Independence-participating hospital. All services for Traditional Blue Cross Members are reimbursed at the hospital’s negotiated outpatient rate.

Requesting laboratory services

When requesting laboratory services, fill out the laboratory requisition form completely, including the Member’s insurance information (Member ID number, address, type of coverage, etc.), the tests you are ordering, his or her diagnosis, and the location where the reports are to be sent. This helps ensure that the laboratory claim will process properly and reduces Member billing issues.

To locate drawing stations for capitated laboratories, use the Find a Doctor tool at www.ibx.com. Once on the Provider Search screen, type Independent Laboratory in the search field at the top of the page and the ZIP code or city/state you desire. Then select the blue magnifying glass to begin your search.
Keep in mind the following:

- All routine laboratory services for HMO/POS Members must be directed to and processed by the PCP’s capitated laboratory site.
- To obtain current capitation information, use the Eligibility and Benefits Inquiry transaction on NaviNet.
- PCPs may obtain a specimen in the office or send an HMO Member to a drawing station.
- Specialists (including OB/GYNs) must send HMO Member specimens to the laboratory capitated by that Member’s PCP. Whether specialists obtain the specimen in their office or direct the Member to a draw site operated by one of the capitated laboratories for testing, the study must be performed by the laboratory capitated by the Member’s PCP.
- All Members sent to a drawing station must be sent with the appropriate laboratory requisition form. The requesting office should complete the appropriate laboratory requisition form (not an HMO Referral). These requisition forms permit multiple Physicians to receive results; the initiator must provide full names and addresses of the Physicians who should receive a duplicate copy. Note: If the Member does not present the requisition form when his or her blood is drawn, the Member will be billed by the drawing station.

**Capitated laboratory change requests.** Capitated laboratory change requests should be submitted in writing to your Network Coordinator, on office letterhead, with the name and signature of the appropriate PCP clearly noted. If a capitated laboratory change request is received on or before the 15th day of the current month, it will be effective the first day of the following month. Capitated laboratory change requests received on the 16th or later will not be effective until the following month. For example: A change request received January 15 becomes effective February 1. A change request received January 16 does not become effective until March 1.

**STAT laboratory services.** For HMO, POS, and PPO Members, STAT laboratory services that are specifically listed on the STAT laboratory listing may be performed at one of the participating hospital facilities. Routine laboratory services and those not listed on the approved STAT listing must be sent to the PCP’s capitated laboratory for HMO Members. Refer to the current STAT laboratory listing, which is located at www.ibx.com/medpolicy. If routine laboratory services are provided by a hospital, those services will not be reimbursed and the Member may be billed if he or she has been informed that routine laboratory services provided in a hospital are not Covered Services and if he or she agrees, in writing, to be financially responsible for those services.

**Home phlebotomy.** Home phlebotomy is available when Members are homebound. Services may be arranged by contacting one of the contracted home phlebotomy Providers listed in the following table. These Providers perform home phlebotomy services for all Members. These Providers will perform the home draw only and deliver the sample to the participating capitated laboratory (HMO) or participating laboratory/hospital (PPO). Some capitated laboratories also offer home phlebotomy for patients who reside in assisted living or nonskilled nursing homes. This service is covered only as defined by Medicare guidelines, which are applied for all Members regardless of coverage.

<table>
<thead>
<tr>
<th>Laboratory name</th>
<th>Service</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aculabs, Inc.</td>
<td>Performs mobile draws in long-term care facilities</td>
<td>732-777-2588</td>
</tr>
<tr>
<td>Brookside Clinical Laboratories</td>
<td>Performs mobile draws in long-term care facilities</td>
<td>610-872-6466</td>
</tr>
<tr>
<td>Professional Technicians, Inc.</td>
<td>Performs mobile home draws</td>
<td>215-364-4911</td>
</tr>
</tbody>
</table>
**Requesting genetic testing**

Genetic testing can identify alterations in an individual’s genetic makeup that may indicate the possibility of risk or the presence of disease (i.e., inherited or acquired) or carrier status. Genetics is an extensive and expansive field, and due to its continuously evolving nature, a large number of genetic tests are in the research phase of development at this time.

Keep in mind the following:

- Independence’s laboratory network has extensive genetic testing capabilities; therefore, Providers should refer Members only to participating laboratories for Covered Services.
- In the unusual circumstance that a specific test and related services are not available through a participating laboratory, Providers must contact Independence to obtain Preapproval. Preapproval is required for use of a nonparticipating laboratory.
- When applicable under the terms of your Independence Agreement, if a Provider uses a nonparticipating laboratory for HMO Members and does not obtain Preapproval from Independence, the Provider is required to hold the Member harmless. The Provider will be responsible for any and all costs to the Member and shall reimburse the Member for such costs or be subject to claims offset by Independence for such costs.

GPS Cancer™ testing by NantHealth®, an independent company, is available for eligible Independence commercial Members. Please review our policy, which is available at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy), for the terms, conditions, and limitations of coverage.

¶An affiliate of Independence has a financial interest in Nant Health, LLC.

**Contractual obligation to use Participating Providers**

When applicable under the terms of your Independence Provider Agreement, if a Provider continues to direct Members and/or their lab specimens to a nonparticipating laboratory and does not obtain Preapproval from Independence, the ordering Provider is required to hold the Member harmless.

The ordering Provider will be responsible for any and all costs to the Member and shall reimburse the Member for such costs or be subject to claims offset by Independence for such costs. In addition, further noncompliance may result in immediate termination of your Independence Provider Agreement.

If a Provider 1) refers a Member to a nonparticipating laboratory for nonemergent services without obtaining Preapproval from Independence to do so; 2) sends a Member’s lab specimen to a nonparticipating laboratory without Preapproval; or 3) provides or orders noncovered services for a Member, the Provider must inform the Member in advance, in writing, of the following:

- a list of the services to be provided;
- that Independence will not pay for or be liable for the listed services;
- that the Member will be financially responsible for such services.

To access the **Member Consent for Financial Responsibility for Unreferred/Non-Covered Services Form**, go to [www.ibx.com/providerforms](http://www.ibx.com/providerforms).

Providers should also be aware of the coverage status of the tests they order and should notify the Member in advance if a service is considered experimental/investigational or is otherwise noncovered by Independence.
**Cardiology Utilization Management Program**

Precertification for the following non-emergent tests and procedures is required through AIM for all commercial and Medicare Advantage Members for the evaluation of medical necessity:

- **Cardiovascular tests/diagnostic procedures:**
  - Coronary angiography
  - Peripheral arterial ultrasound

- **Nonsurgical treatments for obstructive coronary artery disease:**
  - Percutaneous coronary intervention (PCI), including:
    - Balloon angioplasty
    - Stents
    - Atherectomy

You can initiate precertification for these services in one of the following ways:

- **AIM’s ProviderPortal.** Go to [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb).
- **NaviNet.** Select AIM from the Authorizations option in the Independence Workflows menu.

For additional information on this utilization management program, please refer to our medical policy at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

**Genetic/genomic tests, certain molecular analyses, and cytogenetic tests**

Precertification for certain genetic/genomic tests is required through CareCore National, LLC d/b/a eviCore healthcare (eviCore), an independent specialty benefit management company, for all commercial Members.

Please note that the ordering Provider is responsible for submitting precertification requests for the applicable tests. **Failure to adhere to the precertification process may result in your Independence patients receiving a bill for the testing.**

You can initiate precertification for genetic/genomic tests in one of the following ways:

- **NaviNet.** Select CareCore from the Authorizations option in the Independence Workflows menu.
- **Telephone.** Call eviCore directly at 1-866-686-2649.

**For laboratory Providers:** When a request for genetic/genomic testing is received, laboratories must ensure a precertification is on file before rendering services. If precertification is not on file for the Member, it is the laboratory’s responsibility to submit a request to eviCore.

In addition, eviCore manages prepayment review for all genetic/genomic tests, along with certain molecular analyses and cytogenetic tests, for all commercial Members.

For additional information on this utilization management program, please refer to our medical policy at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).
Musculoskeletal Utilization Management Program

Precertification for the following non-emergency modalities is required through AIM for all commercial and Medicare Advantage Members:

- **Spinal surgical procedures.** Cervical, thoracic, lumbar, and sacral (including all concurrent spinal procedures and all associated revision surgeries):
  - Cervical Decompression With or Without Fusion
  - Cervical Disc Arthroplasty
  - Lumbar Disc Arthroplasty
  - Lumbar Discectomy, Foraminotomy, and Laminotomy
  - Lumbar Fusion and Treatment of Spinal Deformity (including Scoliosis and Kyphosis)
  - Lumbar Laminectomy
  - Noninvasive Electrical Bone Growth Stimulation
  - Vertebroplasty/Kyphoplasty
  - Bone Graft Substitutes and Bone Morphogenetic Proteins

- **Surgical procedures of the joint.** Including all associated revision surgeries:
  - Shoulder Arthroplasty
  - Shoulder Arthroscopy and Open Procedures
  - Hip Arthroplasty
  - Hip Arthroscopy and Open Procedures
  - Knee Arthroplasty
  - Knee Arthroscopy and Open Procedures
  - Meniscal Allograft Transplantation of the Knee
  - Treatment of Osteochondral Defects

AIM will also review the setting and level of care (i.e., inpatient vs. outpatient – for spine and select joint services only) requested to ensure it's appropriate for the patient's procedure based on his or her specific clinical circumstances.

You can initiate precertification for these services in one of the following ways:

- **AIM’s ProviderPortal.** Go to [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb).
- **NaviNet.** Select AIM from the Authorizations option in the Independence Workflows menu.

For additional information on this utilization management program, please refer to our medical policy at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

**Radiation therapy**

Precertification for nonemergent outpatient radiation therapy services is required through eviCore for all commercial and Medicare Advantage Members. Precertification is not required when radiation therapy is rendered in the inpatient hospital setting.

Independence’s Radiation Treatment of Breast Carcinoma guideline indicates that a hypofractionated regimen is the preferred treatment for patients with early stage (T1-2N0) breast carcinoma who meet certain criteria. For these patients, a request for precertification of conventional fractionation will require a peer-to-peer call with an eviCore Radiation Oncologist.
You can initiate precertification for nonemergent outpatient radiation therapy in one of the following ways:

- **NaviNet.** Select *CareCore* from the Authorizations option in the Independence Workflows menu.
- **Telephone.** Call eviCore directly at 1-866-686-2649.

For additional information on nonemergent outpatient radiation therapy services, please refer to our medical policies at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

### Routine eye care/vision screening

**HMO and POS Members:** Routine eye exams are covered through HMO and POS medical plans and administered by Davis Vision®, an independent company.

- Members may contact Customer Service to verify eligibility and to locate a Participating Provider for routine services.
- Member Copayments for routine eye care differ depending on the Member’s specific benefits. Specialist Copayments are indicated on the Member’s ID card. Our small group (2-50 employees) plans cover routine eye care 100 percent.
- For medical conditions, a Referral from the Member’s PCP to a participating optometrist or ophthalmologist is required.

**PPO Members:** Routine eye care is not covered under our small group (2-50 employees) plans. Nonroutine care related to the treatment of a medical condition related to the eye is covered, subject to applicable specialist Copayment.

### Sleep studies

Precertification for sleep studies and continuous positive airway pressure (CPAP) titration studies in the facility setting is required through AIM for all commercial and Medicare Advantage Members.

DME Providers are required to obtain precertification for APAP, BPAP, and CPAP (PAP) machines and their replacement supplies (e.g., tubing, water chambers, face masks).

AIM also incorporates a compliance element to the precertification process. Usage data will be collected for all Members using PAP therapy. This data will be analyzed by AIM to determine if the Member has been compliant in using their PAP machine and if a request for precertification of continued rental and/or supplies will be approved or denied.

You can initiate precertification for these services in one of the following ways:

- **AIM’s ProviderPortal.** Go to [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb).
- **NaviNet.** Select *AIM* from the Authorizations option in the Independence Workflows menu.

For additional information on sleep testing services, please refer to our medical policy at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

### Specialty medical drugs

Specialty medical drugs are typically injectable and infusion therapy drugs that must be given by a health care Provider, usually in a Physician’s office, outpatient facility, infusion suite, or in the Member’s home through a home infusion Provider. These drugs are typically eligible for coverage under the Member's medical benefit.
Specialty medical drugs meet certain criteria including, but not limited to, the following:

- The drug is used in the treatment of a rare, complex, or chronic disease.
- A high level of involvement is required by a health care Provider to administer the drug.
- Complex storage and/or shipping requirements are necessary to maintain the drug's stability.
- The drug requires comprehensive patient monitoring and education by a health care Provider regarding safety, side effects, and compliance.
- Access to the drug may be limited.

For more information about specialty medical drugs, go to www.ibx.com/specialty_medical_drug. This site provides information about how Independence manages medical specialty drugs. To use the site, simply enter in the name of a specialty medical drug, and information will be populated, including Preapproval requirements, relevant medical policies, and direct ship ordering information. This site also contains other resources, including a list of all Independence-designated specialty drugs, grouped by their most common therapeutic class.

**Direct Ship Drug Program**

Independence offers the Direct Ship Drug Program, through which in-network Physicians can order certain specialty medical drugs that are administered in the office and are eligible for coverage under the Member’s medical benefit when Medical Necessity criteria are met. Independence contracts with specific specialty drug vendors who provide these medications at no cost to our network Physicians.

This program is available to all Independence in-network Physicians. Direct Ship to out-of-area Physicians is subject to BlueCard® rules for ancillary Providers.

The advantages of using the Independence Direct Ship Drug Program include:

- Independence places the order with the vendor based on the Physician’s request and handles all payments for the drugs.
- Physicians do not have to submit reimbursement forms for the cost of the drugs.
- Physicians do not have to dedicate office space to long-term drug storage.

A complete list of specialty medical drugs that are available through the Direct Ship Drug Program is available on our website at www.ibx.com/directship. There Providers will also find drug request forms and instructions for ordering.

**Most Cost-Effective Setting Program**

Independence wants to ensure that our Members receive injectable/infusion therapy drugs in a setting that is both safe and cost-effective for their clinical condition. Independence reviews the most appropriate setting for commercial Members to receive certain injectable and infusion therapy drugs as part of the precertification review process.

The hospital outpatient facility is typically the most costly setting in which to administer drugs. The settings that Independence considers to be cost-effective are:

- a Physician’s office;
- the Member’s home, where the drug is administered by an in-network home infusion Provider;
- an ambulatory (freestanding) infusion suite, not owned by a hospital or health system in our network.
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Overview
Magellan Healthcare, Inc. (Magellan) is an independent managed care behavioral health care company contracted by Independence to manage the mental health and substance abuse benefits for the majority of our Members with HMO, POS, PPO, EPO, Federal Employee Program (FEP), and Traditional (Indemnity) coverage. Magellan develops and contracts with its own network of behavioral health Providers.

Members are not capitated to a specific behavioral health site. However, for a Member to receive the highest level of benefits, behavioral health services must be provided by Magellan behavioral health Providers.

Note: Magellan is available 24 hours a day, 7 days a week, at 1-800-809-9954.

Emergency admissions
Preapproval for Emergency admissions is not required. When a Member is admitted as an inpatient through the emergency room/department, the hospital is required to notify Magellan within 48 hours or on the next business day.

Obtaining behavioral health services
Providers should instruct Members to call the mental health/substance abuse services telephone number on their Member ID card to access behavioral health services. Magellan will provide information for three to four Participating Providers for Members to contact for services. Members can also search for a behavioral health Provider by logging on to www.ibxpress.com.

Preapproval and continuing authorizations are not required for routine and medication management outpatient mental health services under most Independence benefits plans. However, Preapproval is required for substance and alcohol abuse services, mental health inpatient services, Partial Hospitalization Programs, Intensive Outpatient Programs and repetitive transcranial magnetic stimulation (rTMS). Members must call Magellan once an appointment has been made to ensure that the Preapproval process is properly initiated.

Benefits vary based on plan type and employer group. Not all employer groups use Magellan for behavioral health benefits. Providers should verify benefits and eligibility by contacting Magellan.

Note: When HMO, POS, PPO, and EPO Members receive services from a Magellan Provider, the Provider is responsible for obtaining any required Preapproval.

HMO/referred (in-network) POS Members
In order for HMO/referred (in-network) POS Members to receive in-network mental health and substance abuse benefits, they must use a Magellan HMO/referred (in-network) POS Provider. Members can select any participating Magellan HMO/referred (in-network) POS network Provider.

All HMO/referred (in-network) POS inpatient, nonemergency admissions, Partial Hospitalization Programs/Intensive Outpatient Programs/rTMS, and mental health and substance abuse services must be Preapproved. To Preapprove an admission or Partial Hospitalization Program/Intensive Outpatient Program/rTMS, contact Magellan.

PCP and behavioral health Provider communication
Our Clinician Collaboration Form gives Providers the opportunity to communicate vital information to behavioral health Providers. The form can be downloaded from our website at...
www.ibx.com/providerforms or from the NaviNet® web portal under Health and Wellness in the Administrative Tools & Resources section of Independence Plan Central. The form can also be filled out electronically for medical record keeping and electronic transmission purposes.

The form can aid Providers in discussions with patients about behavioral health treatments and promote collaboration in care between primary care Providers and behavioral health Providers.

The form also enables Primary Care Physicians (PCP) to communicate relevant health information to the behavioral health Provider. Relevant health information includes medication use (to avoid contraindications), past and present medical conditions, allergies, relevant laboratory results, and contact information for the referring Physician.

Physicians must secure patient consent to forward personal information.

**Claims submission**

Independence is responsible for receiving and paying all claims from behavioral health Providers for Independence Members, including the claims for Members enrolled in HMO/POS and CHIP benefit plans. Refer to the payer ID grids located at www.ibx.com/edi for the appropriate claims submission information.

**PPO/EPO Members**

In order for the majority of Members with PPO or EPO coverage to receive in-network mental health and substance abuse benefits, they must use the Magellan PPO Provider network.

All PPO inpatient and Partial Hospitalization Programs/Intensive Outpatient Programs/rTMS for mental health and substance abuse services must be Preapproved by calling Magellan.

**Claims submission**

Refer to the payer ID grids located at www.ibx.com/edi for the appropriate claims submission information for PPO and EPO Members.

**FEP PPO Members**

In order for Members with FEP PPO coverage to receive in-network mental health and substance abuse benefits, they must obtain Preapproval for inpatient services.

**Professional mental health and substance abuse services**

- FEP Members must use the Highmark Blue Shield Premier Blue Mental Health and Substance Abuse professional Provider network.
- Benefits and eligibility must be obtained from Highmark Blue Shield’s Behavioral Health Services unit at 1-800-258-9808. FEP Member eligibility can also be verified by contacting FEP Customer Service at 215-241-4400.

**Facility mental health and substance abuse services**

- FEP Members must use the Magellan PPO facility Provider network to receive in-network mental health and substance abuse benefits. Benefits vary based on FEP plan type. All inpatient services must be Preapproved by calling Magellan.
- Benefits and eligibility can be verified by contacting FEP Customer Service at 215-241-4400.
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Claims submission
Refer to the payer ID grids located at www.ibx.com/edi for the appropriate claims submission information for FEP PPO Members.

Traditional (Indemnity) Members
Magellan also manages the mental health and substance abuse benefits for Traditional Members. Almost all inpatient and Partial Hospitalization Programs/Intensive Outpatient Programs/rTMS for mental health and substance abuse services must be Preapproved. To Preapprove an admission or Partial Hospitalization Program/Intensive Outpatient Program service/rTMS, call Magellan.

Claims submission
Refer to the payer ID grids located at www.ibx.com/edi for the appropriate claims submission information for Traditional Members.

Autism coverage
The diagnosis and treatment of autism spectrum disorders (ASD) are covered for Independence Members enrolled in a 51+ fully insured commercial group product or the Children's Health Insurance Program (CHIP). Before you provide care related to ASD, be sure to verify Member eligibility through NaviNet. Coverage is provided for enrolled individuals under age 21 and requires coverage for the following:

- evaluations and tests needed to diagnose an autism disorder;
- Medically Necessary prescribed treatments such as applied behavioral analysis and rehabilitative care, blood level tests, psychiatric and psychological services, speech/language therapy, occupational therapy, physical therapy, and prescription drugs.

Services not covered under the Commonwealth of Pennsylvania autism mandate include benefits that are normally excluded from coverage under the Member's medical plan, including services that are not Medically Necessary.

Services for ASD, including those rendered in a school setting, must be Medically Necessary and must have a primary diagnosis of ASD. Depending on the service that is being requested, the Member, or a health care Provider on a Member's behalf, may be required to submit a treatment plan to Independence once every six months for review and approval. Services for ASD will not be subject to any limits on the number of visits. However, services are subject to applicable Member cost-sharing, policy limits, maximums, exclusions, and Precertification and Referral requirements under the Member's benefits program.

Applied Behavioral Analysis
Methodologies to promote learning are believed to enhance verbal and non-verbal communication, improve developmentally appropriate self-care, teach social skills, and reduce maladaptive behaviors (e.g., harm to self or others). These methodologies are based on several model programs, including behavioral, structured teaching, and/or developmental programs.

As set forth in the medical policy for evaluation and management of ASD, coverage of Applied Behavioral Analysis (ABA) services is contingent on the following:

- A current (within 24 months), documented diagnosis of ASD consistent with the DSM-5 criteria, using validated assessment tools, has been made by a qualified licensed treating professional Provider including a Physician, Physician assistant, psychologist, or certified registered nurse practitioner as is consistent with state licensing requirements.
The qualified licensed treating professional Provider is other than the behavior analyst practitioner performing services related to ABA services.

- An individualized, documented treatment plan has been developed by a licensed professional Provider (e.g., MD/DO, licensed psychologist).

- ABA services must be provided by or under the supervision of the following professionals: a Board Certified Behavior Analyst-Doctoral (BCBA-D) or Board Certified Behavior Analyst (BCBA)-graduate-level certification in behavior analysis.

- Must be approved by Magellan.

For specific coverage information regarding the diagnosis and treatment of ASD, review our medical policy at www.ibx.com/medpolicy. Note that our policy is consistent with applicable State mandates.
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Overview
This section provides information on benefits, policies, and procedures specific to obstetrical/gynecological (OB/GYN) care, women’s preventive health services, Baby BluePrints® perinatal case management, and postpartum programs, including the Mother’s Option® program. Not all groups have access to all services; therefore, Providers should verify Member eligibility and benefits using the NaviNet® web portal.

OB/GYN specialists cannot be designated as the HMO/POS Member’s Primary Care Physician (PCP).

Note: Benefits may vary by employer group. Individual benefits must be verified.

OB/GYN Emergency coverage
- In emergent situations, Members should proceed directly to a hospital for treatment. HMO/POS Members are instructed to call their PCP (or OB/GYN Provider if pregnant) for instructions in nonemergent situations. The OB/GYN Provider may act as the referring Physician during pregnancy for pregnancy-related conditions.
- Be aware that Member Copayments for emergency room/department (ER) visits (emergent or nonemergent) are generally higher than office visit Copayments.

Direct Access OB/GYNSM for HMO/POS Members
Direct Access OB/GYN allows HMO/POS Members to receive services from any network OB/GYN specialist or subspecialist without a Referral for Preventive Care visits, routine OB/GYN care, or problem-focused OB/GYN conditions.

Specialties and subspecialties not requiring Referrals include, but are not limited to, the following:
- OB
- GYN (including urogynecologist)
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist
- midwife
- reproductive health centers
- abortion centers
- mammography centers (screening and diagnostic mammograms and follow-up ultrasounds only)

Although no PCP or OB/GYN Referrals are required when services are provided by network OB/GYN Providers, OB subspecialists, or certified nurse midwives (CNM), Plan and specific group restrictions may apply. Check the Member’s benefits before providing the following services:
- abortion
- assisted infertility services
- Depo-Provera®
- diaphragm fitting
- intrauterine device (IUD) insertion and removal for contraception
contraceptive implant insertion and removal
- tubal ligation

**OB/GYN electronic Referrals**

**HMO/POS Members**
- OB/GYN Providers, CNMs, and OB/GYN specialists may send HMO/POS Members for additional services.
- Referrals must be sent and retrieved using NaviNet.
- The *Referral Request Form*, available on NaviNet, must be used for the following services:
  - pelvic ultrasounds, abdominal X-rays, intravenous pyelograms (IVP), and DXA scans (these tests must be performed at the Member’s capitated radiology site); see “OB/GYN capitation requirements for HMO/POS Members” below for more information;
  - initial consultations for HMO Members for endocrinology, general surgery, genetics, gastrointestinal, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP Referral).
- OB/GYN Referrals are valid for 90 days from the date of issue.
- Referrals are valid for eligible HMO Members. Members are responsible for payment if they are not eligible HMO Members on the date services are rendered.

**Direct POS Members**
- Direct POS Members never need a Referral to receive care from participating specialists. Preapproval requirements can be found at [www.ibx.com/preapproval](http://www.ibx.com/preapproval). *Note:* Direct POS Members should be referred to their PCP’s capitated site for laboratory and radiology services.

**PPO Members**
- PPO Members do not need Referrals. However, their benefits can be different from those of HMO Members. Benefits should be verified through NaviNet before rendering care. Preapproval requirements can be found at [www.ibx.com/preapproval](http://www.ibx.com/preapproval).

**OB/GYN capitation requirements for HMO/POS Members**
- Laboratory:
  - All routine laboratory work must be sent to the PCP’s capitated laboratory site. The Member’s capitated laboratory site is indicated on her Member ID card. Further information is also available on NaviNet. *Note:* Direct POS Members should be referred to their PCP’s capitated site for laboratory and radiology services for in-network benefits.
  - For HMO and POS referred benefits, Referrals are required.
- Ultrasounds:
  - General ultrasounds for normal pregnancy and gynecology must be referred to the PCP’s capitated radiology site. Nuchal translucency screening ultrasounds (first trimester screening) must be performed by ultrasound units certified for the study. Verify certification before issuing a Referral. Visit the Nuchal Translucency Quality Review Program website at [www.ntqr.org](http://www.ntqr.org). Participating laboratories provide the accompanying blood tests; therefore, there is no need to send Members to an out-of-network Provider for these tests.
For high-risk or follow-up ultrasounds, testing, and consultations for high-risk OB patients, Members can be sent directly to a network HMO maternal fetal medicine Provider without Preapproval.

- Radiology:
  - Diagnostic or screening mammograms and follow-up ultrasounds may be performed at any participating site.
  - Sonohysterograms and hysterosalpingograms are not included in capitation and may be scheduled at any participating radiology facility.
  - All other radiologic procedures, including DXA scans, must be performed at the PCP’s capitated site.

Preapproval requirements

Prenotification of maternity care and Preapproval of the hospital length of stay is not required.

All requests for services from a nonparticipating Provider must be Preapproved for HMO Members. Referrals to a nonparticipating facility or Provider are not accepted electronically.

- If you determine that a nonparticipating Provider is needed for your patient, submit the request through NaviNet or call Customer Service.
- POS and PPO Members have the option to receive care from an out-of-network Provider but will incur a higher out-of-pocket cost.
- To request an exception for services to be covered at the Member’s in-network level, Preapproval is required.

Certain services may require Preapproval, depending on benefits coverage. For a list of services that require Preapproval, go to www.ibx.com/preapproval.

Please note the following:

- Hospital admissions, other than maternity/surgical procedures, require Preapproval. Also note the following:
  - Except for deliveries, the admitting Physician is responsible for obtaining Preapproval at least five days prior to the scheduled admission and notifying the facility of the Preapproval number.
  - A separate Referral to a participating hospital is not required for hospital admissions for participating OB/GYN Providers. The hospital must contact us prior to the admission to verify Member eligibility and the Preapproval number.
- Pre-admission testing and hospital-based Physician services (e.g., anesthesia) are covered under the hospital Preapproval.

Women’s preventive health services

Annual gynecological exam

The following services are components of a routine, preventive OB/GYN visit:

- breast examination;
- limited screening history and examination;
- physical exam (breast, abdomen, pelvic, and rectal);
- counseling regarding contraception, human sexuality and dysfunction, menopause, and sexually transmitted diseases;
- Pap and human papillomavirus (HPV) testing as appropriate per guidelines;
- pelvic examination;
- specimen collection and wet mount (including those for sexually transmitted infection [STI] testing).

**Copayments for routine and nonroutine services**

When a Member visits your office for GYN services, you should collect the appropriate Copayment. To verify the correct Copayment, refer to the Member’s ID card and NaviNet.

As required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform), there is no Member cost-sharing (i.e., $0 Copayment) for certain preventive services provided to Members. Review the preventive care services policy, which includes the list of applicable preventive codes, at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).

Therefore, in most circumstances for routine annual GYN visits, a Copayment should not be collected. However, in cases where both a routine annual screening and specific problem-focused Evaluation and Management (E&M) services are delivered during the same visit, both routine and nonroutine Copayments may apply. Bill separately for the problem-focused E&M visit only if the services you rendered beyond the preventive visit separately meet Current Procedural Terminology (CPT®) criteria for the E&M code.

*Note:* Documentation in the medical record must support the services billed.

**Contraceptive services**

Under Health Care Reform, Independence is required to pay the cost of certain contraceptive services for eligible Members within non-profit religious organizations and closely held corporations. These Members will receive a separate ID card that indicates “Contraceptive Coverage.” Using this ID card, contraceptive methods approved by the U.S. Food and Drug Administration will be covered at an in-network level with no cost-sharing under the medical benefit and covered with no cost-sharing for generic products and for those brand products for which we do not have a generic alternative or generic equivalent under the pharmacy benefit at retail and mail-order pharmacies. Please note these contraceptive services are covered under the pharmacy benefit only if the Member has an Independence prescription drug plan.

**Requirements/restrictions by product line**

**HMO and POS Members (Non-Flex)**

- PCP capitated sites must be used, except for Emergencies and for mammograms.
- Members have coverage for all required routine and nonroutine visits.
- All initial services related to GYN care can be ordered directly by the OB/GYN Provider without a Referral from the PCP.

**HMO and POS Members (Flex Series)**

- PCP capitated sites must be used, except for Emergencies and for mammograms.
- Members have coverage for an annual routine GYN exam with Pap test.
- Nonroutine GYN visits are covered.
PPO Personal Choice® Members (Flex and Non-Flex)

- Members may visit any specialist in the Personal Choice network without a Referral.
- The highest benefits level is available when in-network radiology and laboratory sites are used.
- Members have coverage for an annual routine GYN exam with Pap test. Some groups’ coverage runs on a calendar-year basis and some on a contract-year basis. Contact Customer Service for further information on your patient's coverage.
- Nonroutine GYN visits are covered.

Medicare Advantage HMO and PPO Members

Members have coverage for one routine GYN exam and Pap test annually.

Reimbursement above examination fees

The following procedures are eligible for separate reimbursement (if they are a covered benefit for the Member) when performed during a routine GYN exam:

- administration of Depo Provera®
- endometrial biopsy
- office ultrasound ONLY with diagnosis of “rule out ectopic pregnancy” (for HMO Members only)
- contraceptive implant insertion and removal*
- diaphragm fitting*
- IUD insertion and removal*

For more information on ultrasounds, refer to the Billing section of this manual.

*This is not a standard PPO benefit. In addition, some HMO groups do not cover these procedures. Verify eligibility through NaviNet.

Breast cancer screening

Mammography screening reminder program

We provide annual reminders to schedule a yearly mammogram for female managed care Members ages 42 – 64 with a gap in care (i.e., no record of having a mammography screening during a certain time frame). Outreach strategies include direct mailings, telephone calls, text message reminders, or any combination thereof.

Mammography Referral requirements

Referrals are not required for screening and/or diagnostic mammography from an accredited radiology Provider.

HMO Members must go to an in-network radiology site, but they are not restricted to their capitated site for diagnostic or screening mammograms or for ultrasound follow-up if needed. However, follow-up MRI and other radiologic imaging must be done at their capitated site, unless an out-of-capitation exception is requested and approved by Independence.

Breast ultrasounds also do not require a Referral and may be performed at an in-network radiology site or outpatient department of a hospital.
Note the following:

- Certain radiology facilities may require a Physician’s written prescription. You may need to communicate this to your HMO Members asking about mammography. Be sure to provide a written prescription for the mammography study if this is a requirement of the radiology site.
- Proper certification, credentialing, and accreditation are required for in-network Providers to render mammography services to our Members.
- All MRIs require precertification through AIM Specialty Health® (AIM). Refer to the Specialty Programs section of this manual for additional information about AIM.

**Breast Cancer Risk Assessment Tool**

Based on the Gail Model, the Breast Cancer Risk Assessment Tool is a computer program developed by the National Cancer Institute that estimates a woman’s five-year and lifetime risk of developing breast cancer. The tool is available on [www.ibx.com/providers](http://www.ibx.com/providers) by selecting Resources for Patient Management from the Providers drop-down menu, then Internet Resources. Women are advised to discuss their individual risk factors and options for prevention and treatment with their health care Providers. Women who are identified as high-risk may be offered chemoprophylaxis against breast cancer.

**Cervical cancer screening**

We provide coverage for standard Pap test and liquid-based Pap test technologies, such as ThinPrep® and SurePath®, and for other appropriate studies and procedures, including HPV viral typing. The Member may be responsible for office visit Copayments, and the Member’s health plan benefits may be based on specific time frames. For coverage questions, Members should contact Customer Service at the telephone number on their ID card.

**Cervical cancer screening reminder program**

We provide annual reminders to encourage female Members to discuss revised recommendations for cervical cancer screening, as well as their individual risk factors, with their health care Providers, as appropriate.

- Female Members ages 21 – 29 with a gap in care (i.e., no plan evidence of a Pap test during a certain time frame) are encouraged to schedule and receive regular Pap tests.
- Female Members ages 30 – 64 with a gap in care (i.e., no plan evidence of a Pap test with an HPV co-test during a certain time frame) are encouraged to schedule and receive regular Pap tests with an HPV co-test.

Outreach strategies include direct mailings, telephone calls, text message reminders, or any combination thereof.

**Osteoporosis screening**

According to our medical policy, bone mineral density testing is covered, but no more frequently than every two years, except for specific situations. Visit [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy) to view this medical policy in its entirety.

To learn about FRAX® (World Health Organization Fracture Risk Assessment Tool), go to [www.shef.ac.uk/FRAX](http://www.shef.ac.uk/FRAX).
Assisted reproductive technologies coverage

HMO/POS Members
- No Referral is necessary for assisted reproductive technologies (ART) services. Members may be sent by either their PCP or OB/GYN Provider, or they may schedule a visit with the specialist themselves.
- Most HMO/POS Member benefits contracts exclude in vitro fertilization (IVF) and related services.
- Verify coverage of specific procedures and pharmacy benefits through NaviNet.

PPO Members
- Not all Member benefits contracts include coverage for ART services. Verify coverage of specific procedures and of pharmacy benefits through NaviNet.
- Infertility drug coverage:
  - Office injectables are covered under PPO medical benefits when group coverage includes an ART coverage rider.
  - If a rider exists, Preapproval may be required.
  - Providers should call Customer Service for specific information about benefits coverage for infertility treatments.

Maternity care
First trimester prenatal care correlates well with good maternity outcomes. We urge you to schedule first visits with your pregnant Independence Members within the first trimester so that folic acid and appropriate counseling can be provided. In addition, we ask you to encourage your pregnant Independence Members to self-enroll in our Baby BluePrints® maternity program by calling 1-800-598-BABY.

Notifications
Independence does not require prenotification of maternity care. In the event of an interrupted pregnancy (miscarriage or termination) for a Member who is enrolled in Baby BluePrints, please notify us as soon as possible by calling 1-800-598-BABY so we can discontinue maternity-related calls and educational mailings.

Performing antepartum ultrasounds

HMO Members
- Maternal fetal medicine specialists may perform ultrasounds in the office for patients with high-risk pregnancies.
- OB/GYN Providers may perform limited abdominal and transvaginal ultrasounds to rule out ectopic pregnancies. No Preapproval is required if the ultrasound is billed with the appropriate diagnosis code. For more information see the Billing section of this manual.
- All other ultrasounds should be performed at the capitated site of the Member’s PCP.

PPO Members
- OB and maternal fetal medicine specialists may perform ultrasounds in their offices as medically appropriate.
- Preapproval is not required.
OB services paid above the global fee

OB Providers may perform the following OB services in their offices and be paid above the global fee (or refer to in-network Providers with OB/GYN Referrals):

- glucose tolerance test
- non-stress test
- amniocentesis
- RhoGAM®
- tubal ligation
- 17-alpha hydroxyprogesterone caproate with Preapproval through www.ibx.com/directship
- external cephalic version
- CNMs*

*CNMs performing home births are eligible for a site-of-service differential.

Note: The home birth global fee includes postpartum home visits.

Postpartum office visits

Postpartum visits should be scheduled 21 to 56 days after delivery. Adhering to this time frame provides the best opportunity to assess the physical healing of new mothers and to safely prescribe contraception, if necessary. It also meets NCQA (National Committee for Quality Assurance) guidelines for postpartum care. Visits should be clearly labeled “postpartum care.” Members should schedule postpartum visits prior to discharge from the hospital.

Delivery out of the service area

- **HMO Members.** If Members do not deliver in the service area, they must call the Customer Service number on their Member ID card. Some services may not be fully covered if performed out-of-network.
- **POS Members.** Members have the option to deliver out-of-network and/or out of the service area, but they will be subject to Deductibles and Coinsurance.
- **PPO Members.** Members may access care outside of the service area from Providers who participate in the BlueCard® PPO Program. Out-of-network services are subject to out-of-network cost-sharing (i.e., Deductible/Coinsurance).

Baby BluePrints® maternity program

Our maternity program is designed to educate all pregnant Independence Members about pregnancy and preparing for parenthood throughout each trimester. The program also helps to identify expectant mothers who may be at risk for complications during their pregnancy and to assist in improving the quality of care to pregnant women and newborns. If any risk factors are detected, our OB nurse Health Coaches provide telephone support to our Members and their Physician or midwife to help coordinate their benefits and provide information they need for the healthiest delivery possible.

Encourage your Independence patients to self-enroll

Ensuring that maternity Members are enrolled in our Baby BluePrints high-risk perinatal program is imperative for early outreach. We ask that you inform Independence Members about the Baby BluePrints program and encourage them to call our toll-free number, 1-800-598-BABY, to self-enroll. Upon calling, a Health Coach will explain the program to the Member and ask her a series of questions to complete the enrollment process.
Our Health Coaches use the information as a means for identifying, tracking, and risk-stratifying all pregnant Members for care management and coordination.

If in subsequent prenatal visits you discover that a maternity Member has not yet self-enrolled in Baby BluePrints, or you feel that she may benefit from case management due to a high-risk pregnancy, you can refer the Member to the program by completing an online physician referral form at www.ibx.com/providerforms. When you submit this form, we will make certain that Members who need additional support are encouraged to enroll in case management. You can also call 1-800-313-8628 or 1-800-598-BABY to refer a high-risk maternity Member for case management.

**Educational materials**

Baby BluePrints materials focus on education. Once registered, mothers-to-be will receive a welcome letter and information on how to access educational materials on our secure Member website, ibxpress.com. Once on the site, Members can find information about good self-care during pregnancy and its impact on mother and baby and about potential problems during pregnancy. Benefits information is also provided.

Additionally, Members can receive exclusive discounts on the Saving Baby’s Cord Blood® storage program from CorCell®.

Members may also participate in the Mother’s Option® program (see *Postpartum programs*).

**Risk assessment**

Members are screened for risk by our Health Coaches when they call to enroll into Baby BluePrints and then are screened again at 28 weeks into their pregnancy by telephone if they are enrolled in case management. An OB nurse Health Coach is available to talk to Members, answer questions, and assist with their care throughout their pregnancy.

If complications are detected, Members can expect:
- personalized OB nurse case management;
- individualized education on how to reduce risk factors;
- periodic assessments throughout their pregnancy;
- coordination of home care services as Medically Necessary and ordered by a Physician or midwife.

**Pregnancy depression screening**

Targeted questions screen pregnant women at enrollment and, if enrolled in case management, around their 28th week for risk factors associated with depression. Your office may receive calls regarding those Members who screen positive on the 28th week questionnaire or who are judged to be at risk during any other intervention. OB nurse Health Coaches will assist you with triage and Referrals to the Member’s behavioral health Provider or to Emergency services as required.

**Antenatal/antepartum care**

Antenatal case management programs are available for, but not limited to, the following:
- chronic or gestational hypertension
- hyperemesis gravidarum
- gestational diabetes
- preterm labor
In addition, the following antepartum services are available:

- skilled nursing visits, which may include:
  - 17-alpha hydroxyprogesterone caproate injections for women who are at complete bed rest and have a history of preterm delivery;
  - self-injection techniques for insulin, heparin, and others;
  - home blood glucose, blood pressure, and urine monitoring;
  - betamethasone injections (initial set only, repeat injections require Medical Director approval);
- nutrition consults/evaluations;
- social service evaluations;
- durable medical equipment (DME).

**Preapproval of antepartum home care services**

Call the appropriate perinatal home health agency for them to obtain Preapproval review of all antepartum home care programs/services, such as, but not limited to:

- chronic or gestational hypertension
- hyperemesis gravidarum
- gestational diabetes
- preterm labor

The perinatal agency will then obtain orders for all care to be rendered from the attending Physician/CNM.

Members can obtain additional support from Health Coaches by calling 1-800-ASK-BLUE.

**Postpartum programs**

**Mother’s Option® program**

Through this program, all Members who have an uncomplicated pregnancy and delivery have the option of choosing a shorter stay in the hospital. In order to support a smooth and safe transition home, home care visits are available according to the following guidelines:

**Shortened length of stay (managed care Members)**

**Uncomplicated vaginal delivery**

- If discharged within the first 24 hours following delivery. Two home health visits are available if desired by the Member. These visits do not require Preapproval, but they should be arranged by a hospital discharge planner with one of the Mother’s Option home care Providers. The first visit should occur within 48 hours of discharge. The second visit should occur within five days of discharge.

- If discharged within the first 48 hours following delivery. One home health visit is available if desired by the Member. This visit does not require Preapproval, but it should be arranged by a hospital discharge planner with one of the Mother’s Option home care Providers. This visit should occur within 48 hours of discharge.

**Uncomplicated cesarean delivery**

- If discharged within the first 96 hours following delivery. One home health visit is available if desired by the Member. This visit does not require Preapproval, but it should be arranged by a
hospital discharge planner with one of the Mother’s Option home care Providers and should occur within 48 hours of discharge.

**Standard length of stay (managed care Members)**

When the standard length of stay is 48 hours (vaginal) or 96 hours (cesarean), one home health visit is available if desired by the Member/Provider. This visit does not require Preapproval, but it should be arranged by a hospital discharge planner with one of the Mother’s Option home care Providers. These visits must occur within five days of discharge.

If additional home health visits are Medically Necessary beyond the described Mother’s Option visits, these must be Preapproved by calling the maternity department at 1-800-598-BABY.

**CMM Members.** Members who opt for less than 48-hour discharge for vaginal delivery and less than 96 hours for cesarean section are eligible for one home care visit. Prenotification for this visit must be done by calling the maternity department as previously noted.

**Baby BluePrints postpartum services**

**Postpartum care**

Postpartum home skilled nursing visits beyond those provided through Mother’s Option are approved when Medically Necessary. These visits must be Preapproved and include:

- wound/incision checks and wound care as needed
- bilirubin checks and home phototherapy
- infant assessments
- blood pressure checks
- IV antibiotics
- home physical therapy

**Lactation support coverage**

- Lactation support services include information about valuable community resources, educational websites, or certified lactation consultants.
- Health Coaches are available for initial breast feeding support by telephone. Additionally, they will be able to evaluate the need for further assistance (e.g., community resources, lactation consultant, or OB Provider).

Under Health Care Reform, lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum periods, is currently covered during an inpatient maternity stay as part of an inpatient admission, the postpartum Mother’s Option visit, and through the OB postpartum visit and/or pediatrician well-baby visit.

**Breast pump coverage**

Hospital-grade pumps are covered under the following circumstances and when supplied by an in-network Provider:

- detained premature newborn;
- infants with feeding problems that interfere with breast feeding (e.g., cleft palate/cleft lip).

Under Health Care Reform, Members can purchase one portable manual or electric breast pump, plus supplies, per pregnancy from a participating, in-network DME Provider with no Member cost-sharing.
Note: The rental of hospital-grade breast pumps requires approval for Medical Necessity. Rentals are available at no cost-sharing only for those Members who require the use of a hospital-grade pump. If approval is obtained for Medical Necessity, Member cost-sharing will not be applied when the Member rents the breast pump from an in-network DME Provider.

**Preapproval for home phototherapy**
Preapproval is required when ordering home phototherapy to treat jaundiced newborns. Skilled nursing visits must also be Preapproved.
# Health and Wellness Provider Manual

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Overview

Our Clinical Programs Support department plans and implements programs that support Members and help Providers achieve the best management of their patients’ health. Our preventive health and wellness programs support your efforts to identify and protect your patients against health problems before they develop.

Our preventive health initiatives promote:
- regular wellness visits;
- preventive health screenings;
- immunization programs for children, adolescents, and adults.

Clinical Services – Care Management

The Clinical Services – Care Management Department includes condition and case management programs. Registered Nurse Health Coaches are available to enhance your ability to provide coordinated care for your patients and promote integration of care among Members and their families, Physicians, and community resources.

Condition management

To help keep our Members healthy, we offer condition management on a voluntary basis at no charge to the Member. Our condition management program is designed to support your relationships with your patients and to enhance your ability to provide evidence-based care. Recognizing that the Physician-patient relationship is at the heart of patient care, this program has been designed to:
- enhance your ability to provide integrated care for your patients;
- provide Members with evidence-based information so they can understand their diagnoses and their health care options, while actively participating in health care decision-making with you;
- promote integration of care among Members and their families, Physicians, Health Coach, social workers, and community resources;
- provide you with opportunities to improve the effectiveness of testing and treatment compared to national benchmarks.

Condition management helps to identify and support Members who have certain chronic conditions, including the following:

- asthma
- chronic kidney disease
- chronic obstructive pulmonary disease (COPD)
- coronary artery disease (CAD)
- diabetes
- gastro-esophageal reflux disease (GERD)
- heart failure
- high-risk pregnancy
- HIV
- hyperlipidemia
- hypertension
- inflammatory bowel disease
- maternity
- metabolic syndrome
- migraine
- musculoskeletal pain
- obesity
- osteoporosis
- upper gastrointestinal (GI) disease (includes GERD and peptic ulcer)

Management of these conditions, through education and support, may be associated with improved health care outcomes. Our condition management program offers Members educational materials and personal health coaching from registered nurses to help them learn self-care skills and adhere to the treatment plans.
they develop with their Physicians. The program also places special emphasis on the importance of
managing the comorbidities that exist in many patients who have a chronic condition.

Independence Health Coaches actively reach out to Members with identified clinical needs who may
benefit from personal health education and support. Eligible Members have access to the program
24 hours a day, 7 days a week, by calling 1-800-ASK-BLUE (1-800-275-2583; TTY/ TDD: 711).
Physicians can also call Health Coaches at 1-800-313-8628 to communicate any feedback or concerns,
request individual Member information, or refer a Member. Messages are returned within two business
days.

*Note:* Member benefits may vary based on State requirements, benefits plan (HMO, PPO, etc.), and/or
employer group. All Members covered through fully insured employer groups are automatically
considered eligible for condition management. Members covered through self-insured employer groups
may not be eligible for the program. Providers and Members can call Customer Service at
1-800-ASK-BLUE (1-800-275-2583; TTY/ TDD: 711) to verify program eligibility.

Visit [www.ibx.com/providerconnections](http://www.ibx.com/providerconnections) to view Provider rights and responsibilities.

### Case management

Case management is a collaborative process that provides a Member with health management support
through coordinated programs for Members who are experiencing complex health issues or challenges in
meeting their health care goals.

Through telephone outreach, Registered Nurse Health Coaches, provide education about a Member’s
disease, condition, or medications and offer resources and information to help the Member better
understand how to manage his or her health. Our Health Coaches work with Independence social workers
to help the Member navigate the health care and social service system to optimize his or her ability to use
those resources effectively. Health Coaches may also refer Members to other Independence programs and
to available community resources for additional assistance and support.

When a Member is referred to case management, his or her Health Coach will contact your office to offer
support, with the goal of helping the Member reach the medical treatment goals you have established. The
Member’s Health Coach will ask questions about the treatment plan and offer information on what
services are available through the Member’s benefits plan. He or she will incorporate any information you
provide into the case management plan of care and support your treatment plan by maintaining contact
with the Member in between office visits.

Examples of cases to refer for case management and health coaching include, but are not limited to, the
following:

- autoimmune disorders
- bone marrow/primary stem cell transplant
- cancer (breast, cerebral, colorectal, lung, ovarian, prostate, rare cancers)
- comprehensive complex case management
- cerebrovascular accident
- complex pediatric medical conditions
- frequent admissions for same or similar conditions
- frequent falls/safety issues
- hepatitis C
- joint replacement
- mechanical ventilator
- medication issues, including non-adherence
- Member requiring multiple services in the home
- multiple sclerosis
- neuromuscular disease
- nutritional deficits
- post-neonatal intensive care
- sickle cell disease
- wound/skin
To refer a Member to case management, complete the online Physician Referral form, which is available at [www.ibx.com/providerforms](http://www.ibx.com/providerforms). You may also refer a Member by calling us at 1-800-313-8628.

A Health Coach will call your office to discuss the Referral with you — it’s that simple. A Referral to case management provides both you and your patient with additional support when it is needed most. When your patient has met all of the case management goals that you helped to establish, case management will end. The Health Coach will notify you when this has been achieved.

**Health Information Line**

Members have round-the-clock access to a Health Coach for all of their health-related questions and concerns by calling 1-800-ASK-BLUE (1-800-275-2583; TTY/TDD: 711).

**Preventive health initiatives**

The Clinical Programs Support department offers population-based initiatives with the objective of improving patient health outcomes through adherence to nationally recommended preventive health guidelines. These initiatives use various Member and Provider reminders and tools to improve compliance for preventive health services. Some of the preventive initiatives and tools are described within this section.

Our website includes direct links to screening tools and resources as well as worksheets and tracking forms for Providers. These tools can help track current and future health screening needs of our Members. Visit [www.ibx.com/providers](http://www.ibx.com/providers) and select Resources for Patient Management from the “Provider” drop-down menu.

**Preventive health outreach**

We promote recommended preventive services and tests to targeted Member populations. The objective of these population-based initiatives is to improve adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations. We may vary the topics and timing as new evidence-based recommendations are issued for preventive screenings, immunizations, and gap-in-care needs of our managed care population. Our outreach programs include breast, cervical, and colorectal cancer screening; pediatric, adolescent, and adult immunization; and influenza and pneumococcal immunizations.

**Vaccine information statements (VIS)**

A VIS is an information sheet produced by the Centers for Disease Control and Prevention (CDC), in compliance with the National Childhood Vaccine Injury Act of 1986, which requires that a VIS be used to inform vaccine recipients, or their parents, about the benefits and risks of vaccines. A VIS must be provided, prior to administration, for any vaccine that is covered under the Vaccine Injury Compensation Program. The following VIS forms must be used: DTaP, Td, MMR, polio, hepatitis B, Hib, varicella, and pneumococcal conjugate. Practitioners must also record which VIS was given, the date the VIS was given, and the VIS publication date.

For copies of VIS forms, visit the CDC website at [www.cdc.gov/vaccines/pubs/VIS](http://www.cdc.gov/vaccines/pubs/VIS).

**KIDS immunization registry**

Kids Immunization Database/Tracking System (KIDS), the city of Philadelphia’s immunization registry, encourages Physicians treating children residing in Philadelphia County to record their practice’s immunization information with the registry service. The Department is continuing its efforts to increase the number of immunizations captured as well as the Physicians using the system.
Participation in KIDS was implemented through a city health regulation that requires all Physicians with practices in Philadelphia County to report immunizations given to children, from birth to age 6, who reside in Philadelphia County.

For more information on KIDS or the city health regulation, contact the KIDS registry coordinator at 215-685-6468. Information is also available online at https://kids.phila.gov. If you need information on our immunization policies or coverage, call Customer Service. Providers can also request a consolidated immunization history by calling the KIDS hotline at 215-685-6784.

**Lead screening and prevention**

The CDC is focused on the prevention of lead exposure in children in order to eliminate dangerous lead sources in children’s environments before they are exposed. They maintain that the effects of lead exposure in children cannot be corrected. Even low levels of lead in blood have been shown to affect learning disabilities and behavioral problems.

Through yearly outreach, Providers are advised to try to prevent the occurrence of blood lead levels of 5μg/dL and above in children by:

- testing children between ages 9 and 12 months; again prior to age 24 months, and thereafter based on risk, if children have not yet been tested;
- screening children and their family members who have been exposed to high levels of lead or whose homes were built before 1978;
- screening children who should be tested under their state and local health screening plan.

**Updated blood lead levels**

Children identified as having an elevated level of 5μg/dL or greater in the blood is the new level of concern. The level of concern has now been lowered from 10μg/dL or greater to 5μg/dL to identify children with blood levels that are much higher than most children’s levels.

The new blood lead level value means that more children will likely be identified as having lead exposure — allowing parents, health care Providers, public health officials, and communities to take action earlier to reduce the children’s future exposure to lead. The revised recommendation does not change the guidance that chelation therapy be considered when a child has a blood lead level greater than or equal to 45 μg/dL.

For more information about lead testing, lead screening, safety, and prevention, Providers can visit the Independence website at www.ibx.com/providers/resources; or contact the Philadelphia Department of Public Health at 215-685-2788 (Philadelphia residents) or National Lead Information Center at 1-800-424-LEAD (non-Philadelphia residents).

**Healthy LifestylesSM Solutions***

Through Healthy Lifestyles Solutions, Members can take advantage of a variety of innovative wellness programs that provide them with incentives to help keep them and their families in good health. Members should contact Customer Service at the number on the back of their ID card to learn more about the programs that are available to them. They can also visit the Member portal at www.ibxpress.com.

*Healthy Lifestyles Solutions is available to most Members. Members can call Customer Service at 1-800-ASK-BLUE to determine eligibility.*
Reimbursements
Eligible Members can take advantage of a variety of innovative Healthy Lifestyles Solutions wellness programs that provide them with incentives to help keep them in good health, including the following:

▪ **Fitness:** Independence commercial Members can receive a reimbursement of up to $150 for the cost of fitness center fees.

▪ **Weight management:** Independence reimburses Members for a portion of fees for approved weight management programs.

▪ **Tobacco cessation:** Independence Members receive a reimbursement for the cost of an approved program used to help them quit smoking.

Discounts

*Blue365®*

Eligible Independence Members have access to Blue365, a discount program that is part of our Healthy Lifestyles Solutions program. With exclusive value-added discounts and offers from leading national companies, Blue365 gives Members exactly what they need — an easy-to-use, valuable resource to help them access health and wellness products and services while saving money. Discounts are available for fitness center memberships and equipment; nutrition and weight management programs; laser vision correction; parent and senior care; hearing aids; and healthy travel. Participants include Reebok®, LasikPlus®, and Jenny Craig®.

The Blue365 discounts complement our Healthy Lifestyles Solutions program. For example, Members can receive discounts on fitness-related products and fitness center memberships through Blue365 and also participate in our Fitness Program, which offers a reimbursement to qualifying Members.

*Note:* Blue365 offers access to savings on items that Members may purchase directly from independent vendors. Blue365 does not include items covered under Member policies with Independence or any applicable federal health care program. Members can find out what is covered under their policy by calling Independence at 1-800-ASK-BLUE or by visiting the Member portal at www.ibxpress.com. The Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield plans, may receive payments from Blue365 vendors. Neither BCBSA nor Independence recommends, endorses, warrants, or guarantees any specific Blue365 vendor or item.

†Most discounts are free; some require an annual fee to access discounts. Members can visit www.ibxpress.com for more details on Blue365.

Women’s health

*Baby BluePrints®*

Our maternity program is designed to educate all pregnant Members about pregnancy and preparing for parenthood throughout each trimester.

*Saving Baby’s Cord Blood®*

*Saving Baby’s Cord Blood*, through CorCell®, an independent company, provides Members with the opportunity to preserve blood from their newborn baby’s umbilical cord. CorCell offers Members exclusive discounts and convenient payment plans on the collection and storage of cord blood.

For more information on these programs, refer to the *OB/GYN* section of this manual.
Family health

Healthy Families and Kids

Our Healthy Families and Kids website, available at www.ibx.com/individuals/member_resources/family_health/index.html, contains important health-related information for families about the physical, emotional, and social issues that can affect their children. The site includes information on the following:

- asthma;
- BMI and weight categories, exercise, nutrition, eating disorders, and substance abuse;
- bullying, peer pressure, stress, and depression;
- childhood, adolescent, and adult immunizations and the crucial role they play in protecting the health of their children and their entire family;
- drugs, alcohol, and tobacco;
- tips and articles for parents on a wide range of health topics.

Children can learn how to gain the confidence they need to make smart choices for their health and parents can learn about preteen and adolescent health issues by visiting the site frequently.

Health Resources for Adoptive Parents and Guardians

For parents who have recently adopted a child or for those considering adoption, health and safety are important issues. Our Health Resources for Adoptive Parents and Guardians booklet provides important information about health, development, immunizations, home and child safety tips, nutrition, bonding and attachment, choosing a daycare or preschool, and adding children to your health insurance plan. Members can download the booklet from our secure Member website, www.ibxpress.com.

Wellness Profile

The interactive online Wellness Profile can help Members identify and learn about possible health risks; discover opportunities for improving overall well-being; and connect to other health resources. Once a Member completes the Wellness Profile, he or she will receive a customized summary report that contains an overall health score of 0 to 100. The report includes health risks and suggests ways the Member can improve his or her health. The Wellness Profile is available on our secure Member website at www.ibxpress.com.

Nutrition counseling

For commercial Members

Most commercial managed care Members are eligible for up to six fully covered one-on-one nutrition counseling sessions with a participating registered dietitian or primary care Provider per benefit contract year. The purpose of the six nutrition counseling visits is to support our Members in establishing good eating habits that will contribute to a healthier lifestyle. Primary Care Physicians (PCP) may bill for nutrition counseling services above capitation.

A nutrition counseling visit could include:

- an assessment of dietary habits;
- the use of measurement tools, such as the BMI, to assess risks;
- development of strategy and goals to achieve dietary changes;
- ongoing support to maintain dietary changes and re-evaluate goals;
- guidance toward an appropriate exercise program.
HMO Members must use an in-network Provider to take advantage of these benefits and do not need a Referral for these services. PPO and POS Members may use an out-of-network Provider subject to applicable Deductibles and Coinsurance. For all Members, Copayments do not apply when using an in-network Provider for these nutritional counseling services.

Nutrition counseling in a group setting is not eligible for payment. Providers should not bill for medical nutrition therapy with the following codes: 97804, G0271. Only diabetic education services rendered by Providers who are certified by the American Diabetes Association® are eligible for payment with these codes.

Members can learn about the nutrition counseling program by visiting the Member portal at www.ibxpress.com.

*Note:* Only certain Providers (i.e., PCPs or registered dietitians) are eligible to provide nutrition counseling services. Appointments with nutritionists are not a covered benefit.

**For Medicare Advantage Members**

Medical Nutrition Therapy benefits are available to Keystone 65 HMO and Personal Choice 65 SM PPO Members with a Medicare medical benefit Part B who meet at least one of the following conditions:

- diabetes
- renal (kidney) disease (but not on dialysis)
- have had a kidney transplant in the last 36 months (when therapy is ordered by a doctor)

Medical Nutrition Therapy services must be performed by a participating registered dietician or nutrition professional who meets certain requirements. Services may include nutritional assessment, one-on-one counseling, and therapy services.

Please note that eligible Medicare Advantage HMO and PPO Members are limited to the following benefits for Medical Nutrition Therapy per calendar year:

- three hours of one-on-one counseling during the first year of Medical Nutrition Therapy under their Medicare Advantage coverage;
- two hours of one-on-one counseling each year after the first year.

There is no Copayment, Coinsurance, or Deductible for eligible Members receiving Medical Nutrition Therapy within the limitations listed. Providers may prescribe additional hours of treatment if the Member’s condition changes; however, a claim may be denied if a Provider recommends services for Members who do not meet the eligibility requirements, recommends services that Medicare does not cover, or requests services more often than Medicare covers.

Be sure to renew services yearly for Members if treatment continues into the next calendar year.

**SilverSneakers®**

Independence offers a fitness benefit – the SilverSneakers® fitness program – to eligible Medicare Advantage HMO and PPO Members. SilverSneakers delivers innovative physical activity and social interventions to attract Members and keep them engaged in improving their health. The program provides a basic fitness membership that allows participants to:

- access more than 14,000 fitness locations nationwide, including women-only sites;
- use cardio equipment, free weights, pools, walking tracks, and other amenities;
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- take signature SilverSneakers group fitness classes designed specifically for active older adults and led by certified instructors, plus SilverSneakers FLEX® classes for options outside the traditional gym setting*;
- learn about relevant health topics;
- participate in fun social activities and events;
- receive guidance and assistance from a SilverSneakers Program Advisor*, a dedicated staff member at the fitness location.

Each eligible Medicare Advantage HMO and PPO Member receives a mailing from SilverSneakers that includes the Member’s personal Member ID card and a list of the four fitness locations closest to his or her home. Members can simply take the ID card to the location of their choice and present it at the front desk. Members who have either not received an ID card or may have misplaced it can call 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET or visit the Member portal at www.ibxpress.com, to request a new ID card be mailed and to obtain their SilverSneakers ID number, which can be used at the location until the new ID card arrives in the mail. Members do not have to have the actual card to visit a fitness location or take SilverSneakers FLEX classes; all they need is their unique SilverSneakers Member ID number.

Note: SilverSneakers is a benefit offered to Keystone 65 Select HMO, Keystone 65 Preferred HMO, and Personal Choice 65 PPO Members at no additional cost. Medicare Advantage HMO and PPO Members who are eligible for the SilverSneakers Fitness Program may not participate in the Healthy Lifestyles Solutions fitness reimbursement program.

*Classes and amenities vary by location. Not all locations offer classes.

Independence health rewards

Independence health rewards is a program being offered to eligible Medicare Advantage Members, including Keystone 65 Select HMO, Keystone 65 Preferred HMO, Keystone 65 Focus Rx HMO, and Personal Choice 65 PPO Members, to incent them to receive certain health care services. The rewards program offers gift cards to eligible Members who complete the services designated in the program for that calendar year. For example, in 2017, eligible Members could earn $25 gift cards for receiving breast cancer screening, diabetes eye exam, and colon cancer screening.

Eligible Medicare Advantage Members can register online at www.ibxmedicare.com/rewards or call 1-888-286-1253 to start earning rewards. Once registered, Members will receive information that explains how the program works. When Members complete applicable recommended health care activities, they can document them either online, by mail, or by phone. Members will receive their reward in the mail approximately four to six weeks after submission for activities reported by mail or phone, or they can redeem an instant e-gift card for activities reported online.

Healthy LifestylesSM Solutions Rewards

Healthy Lifestyles Solutions is an incentive-based program that encourages Members to engage in healthy activities, ranging from physical fitness and education to age-appropriate preventive screenings and services. Employer groups with 100 or more employees have the option of adding this incentive program to their employee’s Personal Choice® or Keystone Health Plan East coverage.

With Healthy Lifestyles Solutions, HealthPoints are awarded when milestones are reached. One HealthPoint equals $1. Employers may provide rewards to their enrolled Members through gift cards or health account deposits. There are many ways that participating employees can earn their HealthPoints.
Some examples include completing a Wellness Profile, visiting their health care Provider, and receiving an annual flu vaccine.

Members are encouraged to visit the Member portal at www.ibxpress.com to learn more about our Healthy Lifestyles Solutions Rewards program.

**Clinical Practice Guidelines**

The *Clinical Practice Guidelines* are evidence-based guidelines adopted from nationally recognized sources or adapted following a development process that includes input from board-certified practitioners of appropriate specialties. *Clinical Practice Guidelines* are based on sound medical evidence and the sources are included in the guideline information disseminated to practitioners. Adherence to these guidelines may lead to improved patient outcomes. Individual clinical decisions should be tailored to specific patient medical and psychosocial needs. As national guideline recommendations evolve, we suggest that you update your practice accordingly.

*Clinical Practice Guidelines* are divided into the following categories:

- **Clinical Practice Guidelines.** Guidelines for clinical practice that are considered the accepted minimum standard of care in the medical profession. Guidelines are available for the following medical and behavioral health conditions: asthma, chronic obstructive pulmonary disease (COPD), heart disease, diabetes, obesity, autism spectrum disorders, depression, and substance use disorders.

- **Member Wellness (Preventive Health) Guidelines.** Guidelines that provide Members with a user-friendly version of evidenced-based wellness recommendations for the average-risk person and are divided into Children (ages birth to 17), Adult (ages 18 – 64), and Adult (ages 65 and older) recommendations.

- **Perinatal Guidelines.** Guidelines for clinical practice that are considered the accepted minimum standard of care for Perinatal Care.

The *Clinical Practice Guidelines* are available on our website at www.ibx.com/clinicalguidelines. To obtain a printed copy of the guidelines grid, use the online request form at www.ibx.com/resourceorderform.

*Note:* The guidelines are not a statement of benefits. Benefits may vary based on State requirements, benefits plan (HMO, PPO, etc.), and/or employer group. Member coverage can be verified through the NaviNet® web portal or by calling Customer Service.
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Overview

Our independent pharmacy benefits managers, FutureScripts® and FutureScripts® Secure, handle the administration and claims processing of Independence prescription drug programs. As part of our commitment to comprehensive coverage, we offer a wide range of plans covering prescription drugs approved by the U.S. Food and Drug Administration (FDA).

The Pharmacy and Therapeutics Committee oversees our pharmacy policies and procedures and to promote the selection of clinically safe, clinically effective, and economically advantageous medications for our Members. The Committee is comprised of internal and external clinical pharmacists and physicians in a variety of specialties.

The Pharmacy and Therapeutics Committee periodically reviews and evaluates our drug formularies to ensure their continued effectiveness, safety, and value. The Committee meets on no less than a quarterly basis to review and update the formularies. Physicians are notified of these changes through Partners in Health UpdateSM.

Before you prescribe drugs to Members, we recommend that you become familiar with this section. In it you will find information about our prescription drug programs, formularies, and prior authorization process.

Prescription drug programs

Members with an Independence prescription drug benefit may have coverage through one of the programs listed in this section. Coverage for drugs is based on the Member’s benefits program. Commercial formularies are reviewed over the course of the year for value, quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the marketplace. As a result, they are updated throughout the year. Some drugs may be subject to utilization management programs to ensure appropriate clinical use and cost efficiency.

Select Drug Program®

The Select Drug Program formulary provides the broadest access to cost-effective covered prescription drugs on multiple tiers including generics, brands, and specialty drugs. Generally, all FDA-approved medications are covered, except for routinely excluded categories (e.g., drugs used for cosmetic purposes) and other specific drug exclusions.

Value Formulary Drug Program

The Value Formulary is a restricted formulary. It provides a comprehensive list of medications that include generics, brands, and specialty drugs. Drugs are included based on medical effectiveness, positive results, and value. Drugs may not be included on the formulary when there are covered alternative medications used to treat the same condition in a more cost-effective manner.

The Value Formulary includes at least two agents to treat each covered disease state when available. New drugs are not included on the Value Formulary until reviewed by the Pharmacy and Therapeutics Committee. Drugs not covered on the Value Formulary are considered non-formulary. Formulary alternatives are available on the plan’s website.

Premium Formulary

The Premium Formulary is a restricted formulary. It provides a comprehensive list of medications that include generics, brands, and specialty drugs. Drugs are included based on medical effectiveness, positive results, and value. Drugs may not be covered when there are covered alternative medications used to treat the same condition in a more cost-effective manner.
The Premium Formulary excludes new medications at their market launch for six months to allow for appropriate review of evidence and overall clinical value when compared to other formulary alternatives. This minimizes Member disruption if the medication is permanently excluded.

**Standard Drug Program**
The Standard Drug Program is similar to the Select Drug Program, except that it consists of a two-tier cost-share structure with the generic cost-share being lower than the brand cost-share.

<table>
<thead>
<tr>
<th>Commercial formulary</th>
<th>Online search tool link</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-Tier Value Formulary</td>
<td></td>
</tr>
<tr>
<td>Premium Formulary</td>
<td><a href="https://ctrx.benefits.catamaranrx.com/rxpublic/portal/memberMain?customer=IBCPREMIUM">https://ctrx.benefits.catamaranrx.com/rxpublic/portal/memberMain?customer=IBCPREMIUM</a></td>
</tr>
</tbody>
</table>

**Medicare Part D**
Medicare Part D, a Medicare prescription drug benefit, is designed to provide quality pharmaceutical coverage at an affordable cost for Medicare Beneficiaries. It also provides Medicare Beneficiaries who have limited income with extra help paying for prescription drugs. All Keystone 65 HMO and Personal Choice 65℠ PPO Members who qualify for a low-income subsidy have access to comprehensive coverage with low cost-sharing, which allows them to pay only a small amount for their prescriptions.

With the Medicare Part D Drug Formulary, Members pay a Copayment or Coinsurance at retail pharmacies for up to a 90-day supply of drugs listed on the formulary after Members satisfy a deductible. Since non-preferred drugs may result in a higher level of cost-sharing for Members, we suggest you review the Medicare Part D Drug Formulary for preferred formulary alternatives, which have a lower level of cost-sharing.

<table>
<thead>
<tr>
<th>Medicare Advantage Plan</th>
<th>Online Search Tool Link</th>
</tr>
</thead>
</table>
Prescribing requirements
Supported by the Affordable Care Act (ACA) and as required by the Centers for Medicare & Medicaid Services (CMS), prescribing Providers must include their individual (Type 1) National Provider Identifier (NPI) on all prescriptions for Medicare Advantage HMO and PPO Members who are covered under Medicare Part D.

Prescriber identifiers are valuable Part D program safeguards. These identifiers are the only data on Part D drug claims to indicate that legitimate practitioners have prescribed drugs for Medicare enrollees. Without valid prescriber identifiers, efforts made by CMS to determine the validity, medical necessity, or appropriateness of Part D prescriptions and drug claims may be limited.

Medicare Part D vaccine administration (e.g., Zostavax®, Shingrix™)
CMS requires that Medicare Part D vaccine administration for Medicare Advantage HMO and PPO Members be covered under their Medicare Part D benefits. Part D Members have four options for receiving a vaccination. The available options and how you can collect payment from the Member are as follows:

<table>
<thead>
<tr>
<th>Where the Member receives vaccine</th>
<th>Who administers the vaccine</th>
<th>Member payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>Pharmacist</td>
<td>Member pays his or her pharmacy. Copayment/Coinsurance to the pharmacy.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Physician</td>
<td>Member pays his or her pharmacy Copayment/Coinsurance to the pharmacy for the vaccine. Physician may request the standard fee for the administration up front.</td>
</tr>
<tr>
<td>Physician's office</td>
<td>Physician</td>
<td>Physician may request the standard fee for the vaccine and its administration up front.</td>
</tr>
<tr>
<td>FutureScripts Secure Specialty Pharmacy</td>
<td>Physician</td>
<td>Member pays his or her pharmacy Copayment/Coinsurance to the Specialty Pharmacy for the vaccine. Physician may request the standard fee for the administration up front.</td>
</tr>
</tbody>
</table>

It is important that you routinely ask your Medicare Advantage HMO and PPO Members to show their Medicare ID cards. This will ensure appropriate collection of the Member’s responsibility.

When you collect payment directly from the Member for either a Part D vaccine or administration, be sure to provide the Member with a receipt. The Member should then submit the receipt, along with a Direct Member Reimbursement Form, to Independence for reimbursement consideration and to ensure that all out-of-pocket expenses are accurately accumulated toward his or her other pharmacy benefits. Members can request this form by contacting Customer Service.

Note: These procedures do not apply to Medicare Part B immunizations, which include hepatitis B (for intermediate and high-risk individuals), influenza, or pneumococcal vaccines, which are covered through the Member’s Part B (medical) benefits. Members must receive Part B vaccines from a Provider who can bill it as a medical claim, which may also include clinics inside certain pharmacies that are contracted with Independence as Participating Providers, such as CVS, Rite Aid, and Walgreens. These three vaccines may continue to be administered and billed as usual. All other vaccines, including childhood vaccines, are covered under Part D and must be billed through the Member’s Part D benefits.
Part D vaccine ordering instructions

If a Part D vaccine is needed, there are two ways the Member can get it:

1. **Office administration.** The Physician should write a prescription for the Part D vaccine that a Member can take to a retail pharmacy. The Member will be charged the appropriate Part D Copayment/Coinsurance, and the vaccine will count toward his or her true out-of-pocket (TrOOP) expense. The Member should then bring the vaccine back to the Physician’s office for administration. He or she should pay the Physician the full fee for the administration of the vaccine. If the Physician also charges for the office visit, the Member is responsible for the applicable office visit Copayment. The Physician should provide the Member with a receipt for payment of the vaccine administration, and the Member can submit that receipt to his or her Part D carrier for reimbursement consideration.

2. **Administration at the pharmacy.** The Member may obtain a covered Part D vaccine and have it administered at a local retail pharmacy where he or she will be charged the applicable cost-share.

**Participating pharmacy networks**

Members should take their Member ID card to a pharmacy that participates in the FutureScripts or FutureScripts Secure network. Many retail pharmacies in the U.S. are part of this network, including large chains and independently owned pharmacies. When Members are traveling in the U.S., participating pharmacies will accept Member ID cards and dispense medications based on the Member’s pharmacy benefits.

**FutureScripts Preferred Pharmacy Network (commercial Members)**

The FutureScripts Preferred Pharmacy Network is a smaller version of our full FutureScripts pharmacy network for commercial Members. With this preferred network, Members who have this benefit continue to have access to more than 50,000 pharmacies, such as CVS, Wal-Mart, and Target, in addition to independent pharmacies; however, the FutureScripts Preferred Pharmacy Network specifically excludes Walgreens and Rite Aid.

Pharmacies that are not part of the FutureScripts Preferred Pharmacy Network (i.e., Walgreens and Rite Aid) are considered non-participating or out-of-network for Members who are covered under these products. If a Member elects to get a prescription filled at Walgreens or Rite Aid, it will be considered an out-of-network claim and the Member will be responsible for the total cost of their prescription drug(s) at the time of purchase.

**FutureScripts Secure Pharmacy Network (Medicare Advantage Members)**

We contract with FutureScripts Secure to provide Medicare Part D prescription benefit management services for Medicare Advantage Members.

The network includes:
- national chain and independent retail pharmacies
- long-term care and home-infusion pharmacies
- Indian Health Service/Tribal/Urban Indian Health (I/T/U) Program pharmacies
- a network mail order pharmacy service

In order to receive benefits through the plan, prescriptions generally must be filled at a network pharmacy.
**Standard and Preferred Pharmacies**

Some pharmacies contract with our plan to offer lower cost-sharing to plan Members. This is known as preferred pharmacy cost-sharing. Members may fill prescriptions at either a preferred or standard pharmacy. They can save money on certain prescriptions by using a preferred pharmacy. For Medicare Advantage Members with a 5-tier formulary:

- Tier 1 and 2 prescriptions (which include most generic drugs) will have lower copayments when filled at preferred pharmacies.
- Tier 3, 4, and 5 prescriptions (which include brand-name, specialty and high-cost generic drugs) will have the same copayments at both preferred and standard pharmacy locations.

For a complete list of pharmacies, visit [www.ibxmedicare.com/health_plans/pharmacy.html](http://www.ibxmedicare.com/health_plans/pharmacy.html).

**Mail order program**

Most of our prescription drug programs include a mail order option that offers a convenient, cost-effective way for Members to receive their medications. FutureScripts and FutureScripts Secure process mail order prescriptions for our Members.

For a Member to use this benefit, the Physician should write two separate prescriptions for the Member: (1) a prescription for the initial supply, which the Member may fill immediately at a retail pharmacy, and (2) a prescription for the mail order program, which should be written for a 90-day supply of medication. Members receive information on how to fill mail order prescriptions upon enrollment. Shipments through the mail order program are available to all areas in the U.S.

**Drug formulary information**

The prescription drug programs mentioned earlier in this section use formularies to give Members cost-effective access to covered medications. When prescribing medications, Providers should be sure to consider what formulary through which Members have prescription drug coverage.

Before prescribing a medication for Members, keep in mind the following:

- Most Generic medications are covered at the lowest formulary level of cost-sharing.
- Preferred brand formulary medications are covered at a higher formulary level of cost-sharing.
- **Select Drug Program:** Members typically pay a fixed Copayment for up to a 30-day supply of drugs listed on the formulary and non-preferred medications are covered at the highest level of cost-sharing.
- **Value and Premium Formulary:** Non-formulary medications are not covered.
- **Medicare Part D:** Non-preferred prescription medications may result in a higher level of cost-sharing for Members. Be sure to review the Medicare Part D Drug Formulary for preferred formulary alternatives, which have a lower level of cost-sharing.

To help commercial Members understand their specific drug program and formulary, they have access to educational materials, including searchable look-up tools and formulary guides. To view the searchable drug tools or formulary guides, go to [www.ibx.com/rx](http://www.ibx.com/rx) and select the appropriate option under *Drug Formularies*. 
Requesting an exception (commercial Members)

Tier exceptions
When necessary, consideration for a tier exception can be requested for a non-preferred medication to be covered at a preferred level of cost-sharing. Physicians may request a less costly level of cost-sharing on behalf of a Member at any time.

The General Prior Authorization Request Form can be found on the FutureScripts website at www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/prior_auth_commercial/index.html by selecting the appropriate formulary.

If the tier 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.

Non-formulary exceptions for Value Formulary Members
Physicians may request formulary coverage of a non-formulary medication when there has been a trial of at least three formulary alternatives or there are contraindications to using the formulary alternatives. To do so, complete a Formulary Exception Prior Authorization Request Form, providing details to support use of the non-formulary medication, and fax it to 1-888-671-5285. If the non-formulary request is approved, the drug will be paid at the highest applicable level of cost-sharing. Safety edits like quantity limits will still apply. If the request is denied, both the requesting Provider and Member will receive a denial letter with the appropriate appeals language.

Prescription drug guidelines
Independence 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, age limits, and quantity limits.

Prior authorization requirements
We require prior authorization of certain covered, FDA-approved drugs for specific medical conditions. The approval criteria were developed and approved by the Pharmacy and Therapeutics Committee and are based on information from the FDA, manufacturers, medical literature, actively practicing consultant Physicians and pharmacists, Using criteria approved by the Pharmacy and Therapeutics Committee, FutureScripts and FutureScripts Secure evaluate requests for these drugs based on clinical data and information submitted by the prescribing Physician and available prescription drug history. Clinical pharmacist reviews will include contraindications, dosing and length of therapy appropriateness, and evaluation of other clinical options previously used.

If the request cannot be approved by applying established review criteria, a FutureScripts medical director reviews the request. If the request is not approved, the drug will not be a covered pharmacy benefit for your patient, and he or she will be responsible for the entire cost of the drug. If the request is approved, your patient will be charged the appropriate level of cost-sharing according to their benefit. For detailed information on the drugs that are subject to prior authorization and for specific approval criteria, go to www.ibx.com/rx and select Pharmacy Policy (for commercial or non-Medicare Part D Members).

When submitting requests, it is important to thoroughly complete all prior authorization forms and to promptly respond to outreach efforts when there is missing information.
Note: The list of drugs requiring prior authorization is subject to change. As the list changes, notification is given through Partners in Health Update.

Commercial Members
For pharmacy-related services, Participating Providers are required to use the appropriate form to request prior authorization for commercial Members. If a drug-specific form is not available, you may submit a general pharmacy form. These forms can be found by searching for the drug using our drug look-up tools at www.ibx.com/providers/pharmacy_information/formularies.html. Providers can also find a link to the forms at www.ibx.com/providers/pharmacy_information/prior_authorization.

To access the forms through our drug look-up tool:
1. Type in the drug that requires a prior authorization.
2. Click on the “PA” icon to view the policy details and form link.

Providers can also call FutureScripts at 1-888-678-7012 to have prior authorization forms faxed directly to their office.

The prior authorization process may take up to two business days once information is received from the prescribing Physician.

Medicare Advantage HMO and PPO Members
Participating Providers are required to use the appropriate form at www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/prior_auth_medicare.html to request prior authorization for Medicare Advantage Members. Providers may also submit a Coverage Determination Request form electronically at www.ibxmedicare.com/htdocs/contact_us/forms/coverage_determination.html. Please include all clinically relevant information. Many drugs have specific criteria.

Per CMS requirements, a standard Coverage Determination Request form must be completed within 72 hours for Medicare Advantage HMO and PPO Members. All expedited/urgent reviews must be completed within 24 hours.

Expiration of prior authorization
Some drugs are approved for a limited time, such as narcotics and growth hormones. Prior authorizations will include an expiration date at the time of the approval when applicable. If your patient needs to continue the drug therapy after the expiration date, you will need to submit a new request.

Age limits
Age limits are designed to prevent potential harm to Members and promote appropriate use. The approval criteria are based on information from the FDA, medical literature, actively practicing consultant Physicians and pharmacists, and appropriate external organizations. Approval criteria are reviewed by the Pharmacy and Therapeutics Committee.

If the Member’s prescription does not meet the FDA age guidelines, it will not be covered until prior authorization is obtained. To request an age limit exception, complete a general pharmacy form and fax it to 1-888-671-5285 for review. The form can be found at www.ibx.com/providers/pharmacy_information/prior_authorization.
Quantity limits

Quantity limits are designed to allow a sufficient supply of medication based on FDA-approved maximum daily doses and length of therapy of a particular drug. The various types are described below:

- **Quantity Over Time.** This quantity limit is based on dosing guidelines over a rolling time period. For example, sumatriptan 50mg tablets are limited to a quantity of 18 tablets per 30 days.

- **Maximum daily dose.** This quantity limit is based on maximum number of units of the drug allowed per day. For example, zolpidem is limited to 1 tablet per day.

- **Refill too soon.** With this quantity limit, if a Member used less than 75 percent of the total day supply dispensed, the claim will be rejected at the pharmacy. This will ensure that the medication is being taken in accordance with the prescribed dose and frequency of administration.

- **Day Supply Limit (for commercial only):** This limit is based on the day supply and not the quantity. However, quantity limits may apply as well. Day Supply Limits apply to some classes of drugs, such as narcotics. Low dose narcotic such as Percocet® and its generic are limited to two 5-day supplies within 60 days.

To determine if a covered drug for a patient has a quantity limit, call FutureScripts at 1-888-678-7012. For more detailed examples of quantity limits and procedures that support safe prescribing, visit www.ibx.com/safeprescribing.

To request a quantity limit exception, complete a general pharmacy form, which can be found at www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/prior_auth_commercial/prior_comm_selectForm.html, and fax it to 1-888-671-5285 for review.

96-Hour Temporary Supply Program (commercial Members)

We are aware that there may be times when an urgent supply is necessary for a medication requiring prior authorization. A one-time, 96-hour supply may be obtained for these medications. **Obtaining a 96-hour temporary supply does not guarantee that the prior authorization request will be approved.**

The 96-Hour Temporary Supply Program applies to certain drugs that require prior authorization. Under the 96-Hour Temporary Supply Program, if you write a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity limit for a medication and prior authorization has not been obtained, the following steps will occur:

- The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to the Member.
- By the next business day, FutureScripts will contact you to request that you submit the necessary documentation of Medical Necessity for review.
- Once the completed clinical information is received by FutureScripts or FutureScripts Secure, the review will be completed and the medication will be approved or denied.
  - **If approved:** The remainder of the prescription order will be filled, and the appropriate level of cost-sharing will be applied.
  - **If denied:** Notification will be sent to you and the Member.

*Note:* Some medications are not eligible for the 96-Hour Temporary Supply Program due to packaging or other limitations. Examples of ineligible medications are Retin-A® (tube), Enbrel® (2-week injection kit), medroxyprogesterone acetate (monthly injectable), and erectile dysfunction drugs.
30-day transition supply (Medicare Part D only)

A new Member who is currently taking medications that are not on the formulary or require a prior authorization can receive a one-time, 30-day supply during the first 90 days of enrollment into the Plan. These medications may require prior authorization or another exception listed in this section.

The retail pharmacy will receive an online message to process the claim, and the Member will be charged the applicable level of cost-sharing for this supply. The Member will receive a letter notifying him or her to contact the prescribing Physician, and the Physician will need to complete a prior authorization or exception request. The prescribing Physician will receive a copy of the letter. Processing of a transition supply request is not a guarantee of approval of the prior authorization or exception request.

Appealing a decision

If a request for prior authorization or exception results in a denial, the Member, or the Physician on the Member’s behalf (with the Member’s consent), may file an appeal. Both the Member and his or her Physician will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. To assist in the appeals process, it is recommended that the Physician be involved to provide any additional information on the basis of the appeal.

High-risk medications

When prescribing medication to adults ages 65 and older, please keep in mind that certain medications have a greater potential for side effects. These high-risk medications (HRM) are based on the “Beer’s Criteria” from the American Geriatrics Society standard list for potentially inappropriate medication use in older adults. The full list of HRMs can be viewed at https://pqaalliance.org/images/uploads/files/2017%20HRM_1v2.pdf.

Prior authorization requirements

Due to the risks of some HRMs, you may need to obtain prior authorization. Review the Medicare Formularies at www.ibxmedicare.com to determine which HRMs require prior authorization. If the medication requires prior authorization, you can obtain the proper form by scrolling to the Coverage Determination for Part D Drugs section at www.ibxmedicare.com/for_members/prescription_drugs.html#coverage.

Note: The Drug Pre-Authorization and Formulary transaction on the NaviNet® web portal should not be used to submit prior authorization requests for oral medications that are shipped directly to our Members. This transaction should be used only for injectable and infusible drugs covered under the medical benefit sent via the Independence Direct Ship Drug Program.

Preventive drugs covered at $0 Copayment (commercial Members)

As described in the ACA, certain preventive medications, including generic products and those brand products that do not have a generic alternative, are covered without cost-sharing with a Physician’s prescription when provided by a participating retail or mail-order pharmacy. Drugs that are considered preventive for certain ages and genders are covered at a $0 Copayment as listed in the following table:

<table>
<thead>
<tr>
<th>Drug class</th>
<th>Drug criteria</th>
<th>Age criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Folic acid</td>
<td>Applies to prescriptions for 0.4 – 0.8 mg.</td>
<td>Younger than 51</td>
</tr>
<tr>
<td></td>
<td>Note: Generic prenatal vitamins, such as folic acid, are included.</td>
<td></td>
</tr>
<tr>
<td>Iron supplements</td>
<td>N/A</td>
<td>Children ages 6 months through 1 year</td>
</tr>
</tbody>
</table>
Oral fluoride | N/A | Children ages 6 months to 5 years (60 months)
Aspirin to prevent cardiovascular disease | Applies to prescriptions for 81 mg. | Adults ages 50 through 59; women after 12 weeks’ gestation who are at high risk for preeclampsia
Breast cancer chemotherapy prevention | Applies to prescriptions for Tamoxifen 20 mg only. | Ages 35 and older
Tobacco interventions and nicotine replacements | Tobacco interventions include Chantix®, bupropion HCL (generic Zyban). Nicotine replacements include nicotine gums, nicotine inhalers, and nicotine patches. | Adults who use tobacco products
Vitamin D supplements | Limited to strengths less than 800 IU. | Ages 65 and older
Statin | Applies to prescriptions for Lovastatin 40 mg or less. | Ages 40 through 75 years with no history of cardiovascular disease

Mandated by the Women’s Prevention Services provision of the ACA, contraceptives are covered at 100 percent when provided by a Participating Provider for generic products and for those brand products that do not have a generic alternative. Brand contraceptive products with a generic alternative or generic equivalent are covered at the brand-name level of cost-sharing for the Member’s plan.

Note: The $0 Copayment does not apply to Special Care™, Children’s Health Insurance Program (CHIP), or Medicare Advantage HMO and PPO Members.

FutureScripts® Specialty Pharmacy

We coordinate with FutureScripts to offer Specialty Pharmacy to Members who have pharmacy coverage through Independence. Through this program, specialty injectables and specialty oral medications that are covered under the pharmacy benefit can be shipped directly to your patients.

When using FutureScripts Specialty Pharmacy, keep in mind the following:

▪ Quantities for specialty injectables and specialty oral medications will be evaluated to promote appropriate prescribing. In addition, medications obtained through this program may be subject to the Member’s benefits exclusions and review of Medical Necessity.
▪ Refills will be coordinated without additional paperwork.

Independence offers two preferred options for Participating Providers to request fulfillment of specialty pharmacy drugs for patients with an Independence prescription drug benefit: BriovaRx™ and PerformSpecialty®. BriovaRx and PerformSpecialty supply specialty drugs eligible under the Independence Member’s prescription drug benefit administered by FutureScripts.

Providers who are considering beginning an Independence Member on a new specialty drug therapy covered under the pharmacy benefit can use the following information:

▪ **BriovaRx.** Providers can call BriovaRx at 1-855-4BRIOVA (1-855-427-4682) to enroll the Member. Members can reach BriovaRx to have a prescription filled by calling 1-855-4BRIOVA (1-855-427-4682) or by visiting the BriovaRx website at www.briovarx.com.

▪ **PerformSpecialty.** Providers can call the PerformSpecialty Patient Care Line at 1-855-287-7888 to enroll the Member. Members can reach PerformSpecialty to have a prescription filled by calling their Patient Care Line at 1-855-287-7888 or by visiting the PerformSpecialty website at www.performspecialty.com.
Benefits of using one of these preferred specialty pharmacy Providers include refill reminders, ongoing patient education and support, consultation with pharmacists for Providers and Members, and confidential and convenient ordering and delivery.

**Mandatory specialty pharmacy benefit (commercial Members)**

Some Independence Members have a mandatory specialty pharmacy benefit where they must obtain their specialty drugs from BriovaRx or PerformSpecialty. For those Members with this benefit, the first prescription fill must be obtained through BriovaRx or PerformSpecialty. The Member may call the number on their identification card to find out the details of their plan.

**Self-injectable drugs**

Most self-injectable drugs are covered under the pharmacy benefit. However, injectables that cannot be administered without medical supervision, that are mandated by law, or that are required for Emergency treatment will continue to be covered under the medical benefit at the appropriate level of cost-sharing. The Independence Direct Ship Drug Program facilitates the shipment and Preapproval (as required) of injectable and infusible drugs that are covered under the medical benefit and are not commonly stocked in a Physician’s office.

For more information about drugs covered under the medical benefit and the Independence Direct Ship Drug Program, go to the *Specialty Programs* section of this manual.

**Blood Glucose Meter Program**

**For Commercial Members**

Abbott Laboratories and Ascensia Diabetes Care (formerly Bayer Health Care LLC), both independent companies, are the preferred brands of test strips for our prescription drug programs for commercial Members. In addition, they are the only test strips on the Select Drug Program Formulary.

- **Abbott monitors.** Preferred test strips include FreeStyle®, FreeStyle Lite®, and Precision Xtra®.
- **Ascensia monitors.** Preferred test strips include CONTOUR® NEXT test strips. All CONTOUR® NEXT portfolio of meters use the CONTOUR® NEXT test strips.

**Prior authorization requirements for test strips**

Independence requires prior authorization for any test strips that we consider non-preferred. In other words, if a Member chooses to use a test strip that is not listed above, you will need to complete a prior authorization form on your patient’s behalf. If the prior authorization is not approved, the non-preferred test strips will not be a covered pharmacy benefit for your patient, and he or she will be responsible for the entire cost of the test strips. If the request for the non-preferred test strips is approved, your patient will be charged the highest level of cost-sharing.

You can access a *prior authorization form* for diabetic test strips online at [www.ibx.com/providers/pharmacy_information/prior_authorization/index.html](http://www.ibx.com/providers/pharmacy_information/prior_authorization/index.html). Be sure to include supporting documentation for Medical Necessity. If your request contains insufficient information, it may be returned to you or the request may be denied.
Free meters for preferred test strips
Both Abbott and Ascensia glucose meters are available at no cost to Independence Members who are using the preferred test strips. Free meters can be obtained directly from either manufacturer, as detailed in the following information:

- **Abbott Diabetes Care products.** The Abbott Diabetes Care products include the following blood glucose meters:
  - FreeStyle Lite® Blood Glucose Monitoring System
  - FreeStyle Freedom® Lite Blood Glucose Monitoring System
  - Precision Xtra® Blood Glucose and Ketone Monitoring System
More information about these products is available at [www.diabetescare.abbott/products.html](http://www.diabetescare.abbott/products.html). To obtain an Abbott meter at no cost, you or your patient should call Abbott Diabetes Care at 1-866-224-8892 or visit their website at [www.diabetescare.abbott/products.html](http://www.diabetescare.abbott/products.html).

- **Ascensia Diabetes Care products.** Ascensia Diabetes Care offers the following blood glucose meters: NEXT EZ, CONTOUR® NEXT and CONTOUR® NEXT ONE.
Learn more about these products at [www.contournext.com/products/product-overview](http://www.contournext.com/products/product-overview). To obtain an Ascensia meter at no cost, you or your patient should call Ascensia Diabetes Care at 1-800-401-8440.

If you have questions about the preferred test strips or the Blood Glucose Meter Program, contact FutureScripts at 1-888-678-7012.

For Medicare Advantage Members
Independence Medicare Advantage Members must use diabetic test strips and a glucose monitor from the preferred manufacturer brands Accu-Chek® and OneTouch® in order to have their test strips and glucose meters covered at $0 Copayment.

All other manufacturers’ brand of test strips and glucose meters will not be covered by Keystone 65 HMO plans. For Personal Choice 65 PPO, an out-of-network coinsurance will apply to all other manufacturers’ brand of test strips and glucose meters.

If their current glucose monitor does not work with either of these preferred brands of test strips, Medicare Advantage Members can obtain a new glucose monitor at no cost with a prescription from a Provider.

Test strips can be obtained from either a network pharmacy or durable medical equipment supplier.

Medication Therapy Management program
We offer a Medication Therapy Management (MTM) program to Members enrolled in a commercial or Medicare Advantage plan.

MTM includes services that seek to facilitate communication between health care professionals and Members to help improve health outcomes. Pharmacists who are part of the MTM program review medications to identify potential adverse interactions, while also educating Members on medication side effects and interactions. They can even identify ways to save money on out-of-pocket medication costs.

Independence Members who qualify, based on their disease state and number of medications they are taking, will be automatically enrolled in the MTM program and will receive the following:

- **Outreach call.** Participants in the program will receive an outreach phone call from a pharmacist for a brief medication consultation, to be arranged around Members’ schedules. There is no limit to how much time Members can spend talking with the pharmacist during the consultation.
During the call, the pharmacist will review the medications Members are taking to:
- address goals for medication therapy;
- raise awareness of cost-effective alternatives, such as generics;
- answer any questions Members may have about their medication.

- **Medication review package.** After the consultation, the pharmacist will provide Members with a medication review package. This package contains information about their personal medication therapy, which can be brought to their future doctor visits for discussion.

- **Continuous review.** Members will have their Independence prescription claims data continuously reviewed and analyzed to determine if there are any areas for therapeutic intervention. Their doctor will receive a fax containing potential intervention opportunities.

If you have any questions regarding the MTM program, please contact the FutureScripts MTM Department at 1-855-380-1228.
# Quality Management Provider Manual

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Overview

We consider our relationship with our network Providers a partnership because we share a common goal — improving the quality of the care our Members receive. Since Providers actually deliver care, our role is to assist their efforts and to provide the tools and information they need to maintain a high standard of care. Our Quality Management (QM) department was developed according to this mission.

QM Program goals and objectives

The goals and objectives of the QM Program include the following:

▪ to improve the quality of medical and behavioral health care and service provided to Members. This is achieved through administrative simplification and an ongoing system of monitoring measurable performance indicators. Indicators are based on high-volume, high-risk, problem-prone services, data from customer satisfaction surveys, complaints/occurrences, and appeals. Other relevant sources are also evaluated to establish goals and benchmarks to promote improvement.

▪ to maintain a process for adopting and updating both preventive health guidelines and nonpreventive (e.g., acute and chronic) clinical practice guidelines for medical and behavioral health-related conditions. These guidelines are evidence-based and are distributed to Independence practitioners and Members to facilitate decision-making regarding appropriate health care for specific clinical circumstances.

▪ to maintain the Member Safety Program to improve the safety of medical and behavioral health care and services provided to Members and to promote a reduction in medical and medication errors through a comprehensive program of educational initiatives and through the monitoring of Member safety data;

▪ to be a resource for Member safety issues with Members, practitioners/Providers, various Independence departments, and external organizations;

▪ to ensure a network of qualified practitioners/Providers by demonstrating compliance with all applicable accrediting bodies and regulatory credentialing/recredentialing requirements;

▪ to include language in practitioner/Provider contracts requiring participation in the QM Program and access to medical records;

▪ to promote partnerships with practitioners/Providers by communicating quality activities, providing feedback on results of plan-wide and practice-specific performance assessments, and collaboratively developing improvement plans;

▪ to distribute information on practitioner/Provider performance to promote transparency to customers, inclusive of Members and employers/purchasers, for informed decision-making;

▪ to ensure that the quality of care and service delivered by delegates meets standards established by Independence and relevant regulatory and accrediting agencies, and that delegates maintain continuous, appropriate, and effective quality improvement programs through ongoing oversight activities and regular performance assessments;

▪ to document and report the results of monitoring activities, barrier analyses, recommendations for improvement activities, and other program activities to the appropriate committees;

▪ to comply with all regulatory requirements and maintain accreditation and necessary certifications;

▪ to ensure that the appropriate resources are available to support the QM Program.
For more information about our QM Program, including information about program goals and a report on our progress in meeting these goals, please visit our website at www.ibx.com/providers. Select Resources for Patient Management from the “Providers” drop-down menu, then Standards of Care. You may also contact Customer Service at 1-800-ASK-BLUE. Members should call the Customer Service telephone number listed on their ID card.

QM Program activities

Through our QM Program, we monitor, evaluate, and act to improve the quality and safety of clinical care and the quality of service provided to Members by Participating Practitioners/Providers and by delegates across our HMO/POS, PPO, and Medicare Advantage product lines. We identify meaningful clinical and service issues that are likely to impact enrolled Members and establish performance indicators, goals, and benchmarks that correspond to topics falling within the scope of the QM Program.

The mechanisms used to identify meaningful clinical and service issues include, but are not limited to:

▪ the results of analysis of demographics, claims, and other data to identify high-volume, high-risk, and problem-prone services and acute and chronic conditions;
▪ the results of data from internal performance monitoring activities and satisfaction survey results;
▪ data from complaints and Member appeals and direct input from Members, practitioners/Providers, and Independence staff.

Through ongoing review of performance data* with respect to established goals, benchmarks, and formal annual evaluations of the effectiveness of the QM Program, Independence confirms that existing clinical quality, network, and service improvement initiatives remain appropriate and identifies new topics for inclusion in the program.

*Providers must allow the plan to use performance data in plan Quality Programs for internal plan purposes only.

Member safety activities

The Member Safety Program promotes a corporate strategy to reduce medical and medication errors to improve the safety of Members by:

▪ Providing an environment that fosters safe clinical practice. Identifying activities, monitoring the process, and collecting data that demonstrates commitment to safe clinical practices within our network that are performed in the practitioner and Provider care setting;
▪ Developing, implementing, and disseminating information to drive the Member safety agenda;
▪ Educating and assisting Members and Providers in the promotion of Member safety and medical/medication error reduction;
▪ Evaluating and incorporating quality data for the development of Member safety initiatives;
▪ Translating evidence-based practice recommendations for improving patient safety and evaluating the impact of these interventions on patient health outcomes;
▪ Collecting data and supporting contracted practitioners’ and Providers’ actions to improve patient safety practices and working toward ensuring performance data is publicly available to Members and practitioners;
▪ Developing a collaborative regional safety platform with representation from various internal and external resources.
**Member complaint process**

The QM department investigates all quality-of-care and service concerns/complaints. All quality-of-care and service concerns/complaints are triaged, categorized, analyzed, and reported on a semi-annual basis. Recommendations are used for practitioner/Provider improvement activities. Complaints are also reviewed from a quarterly, as well as a rolling year, perspective for identification and analysis of potential practitioner/Provider outliers. An outlier is defined as a practitioner, facility, ancillary Provider, or pharmacy benefits manager against whom there are three or more complaints or a complaint that is assigned a severity level of two or higher. Members may file a concern/complaint by calling Customer Service at the number listed on their ID card, by sending their complaint in writing to us, or by emailing us through our website at www.ibx.com.

**Medicare Advantage HMO grievance**

A Medicare Advantage HMO grievance is any complaint or dispute raised by a Medicare Advantage HMO Member or the Member’s representative, other than a dispute involving an organizational determination. Medicare Advantage HMO grievances may include disputes regarding such issues as office waiting times, Physician behavior, adequacy of facilities, involuntary disenrollment situations, or coverage decisions by Independence to process a Medicare appeal request under the standard 30-day timeframe rather than as an expedited appeal. A resolution will be issued no later than 30 days after the grievance is received.

**Monitoring of continuity and coordination of care**

Continuity and coordination of care services is the facilitation, across transitions and settings of care, of:

- Patients getting the care or services they need;
- Practitioners or Providers getting the information they need to provide the care patients need.

Transitions in care refers to Members moving between health care practitioners and across settings as their conditions and care needs change during the course of a chronic or acute illness. This may include movement of Members between practitioners (i.e., primary care and specialists, behavioral health practitioner and primary care), and movement across settings of care.

Our goal is for Members to receive seamless, continuous, and appropriate care. On an annual basis, we collect data about the coordination of care across settings or transitions in care. Data is also collected related to the coordination between medical and behavioral health care. A quantitative and causal analysis of data is conducted to facilitate the identification of improvement opportunities. Based on the results of the analysis, we identify opportunities to improve continuity and/or coordination of care and implement appropriate initiatives to address opportunities for improvement.

Examples of different settings include:

- **Outpatient facilities:** rehabilitation centers, Physician offices, surgery centers, urgent care centers, Emergency centers, home health, and hospice;
- **Inpatient facilities:** hospitals (acute or rehab), skilled nursing facilities, extended care facilities, and inpatient hospice.

Examples of the type of data collected to improve coordination of care and promote collaboration between medical and behavioral health care include:

- exchange of information;
Quality Management
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- appropriate diagnosis, treatment, and Referral (when required) of behavioral health disorders commonly seen in primary care;
- appropriate use of psychopharmacological medications;
- management of treatment access and follow-up for Members with co-existing medical and behavioral health disorders, including Members with severe or persistent mental illness;
- primary and secondary preventive behavioral health programs.

Examples of the type of data collected to promote the identification of improvement opportunities and facilitate the design and implementation of improvement initiatives include:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member survey data relating to primary and specialty care;
- Healthcare Effectiveness Data and Information Set (HEDIS®) data for management of certain conditions and medications;
- Qualified Health Plan Enrollee Experience Survey (QHP EES) relating to primary and specialty care;
- practitioner record reviews relating to communication and coordination of care;
- claims processing.

QM works with the Clinical Services department to monitor the coordination of the care of Members when they move from one setting to another, such as when they are discharged from a hospital. Without coordination, such transitions often result in poor quality care and risks to patient safety.

**PCP and behavioral health Provider communication**

Coordination of care between medical and behavioral health Providers is an important aspect in achieving optimal outcomes for our Members. Our Clinician Collaboration Form gives Providers the opportunity to communicate vital information to behavioral health Providers. The form can be downloaded from our website at [www.ibx.com/providerforms](http://www.ibx.com/providerforms) or from the NaviNet® web portal under Health and Wellness in the Administrative Tools & Resources section of Independence Plan Central. The form can also be filled out electronically for medical record keeping and electronic transmission purposes.

The form can aid Providers in discussions with patients about behavioral health treatments and promote collaboration in care between primary care Providers and behavioral health Providers.

The form also enables Primary Care Physicians (PCP) to communicate relevant health information to the behavioral health Provider. Relevant health information includes medication use (to avoid contraindications), past and present medical conditions, allergies, relevant laboratory results, and contact information for the referring Physician.

Physicians must secure patient consent to forward personal information. We recommend that the completed form be given to the Member to take to the behavioral health Provider.

Resources for behavioral health conditions commonly seen in primary care are available on our website at [www.ibx.com/providers/resources/worksheets/index.html](http://www.ibx.com/providers/resources/worksheets/index.html) or on NaviNet under Health and Wellness in the Administrative Tools & Resources section of Independence Plan Central. These resources are reviewed and updated annually and include topics such as:

- alcohol screening
- antipsychotic medication management
- depression
• smoking cessation

Also available is Magellan’s Behavioral Health Disorders Toolkit, which is designed to give medical practitioners the resources needed to identify potential behavioral health concerns and assist them in making behavioral health referrals.

Blue Distinction Centers for Specialty Care®

Blue Distinction® was created by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield plans, to give consumers more information to make informed health care decisions and to work with Providers to improve health care quality outcomes and affordability. Associated with Blue Distinction are the Blue Distinction Centers for complex and rare cancers, bariatric surgery, cardiac care, knee and hip replacement, spine surgery, maternity care, and transplants. All of the Centers must offer specific, evidence-based criteria on Provider qualifications, best practices, and outcomes. In addition to the Blue Distinction designation (quality-only), the BCBSA offers a Blue Distinction+ designation (quality and cost) awarded to facilities that first meet more stringent quality measures, focused on patient safety and outcomes, but also meet cost measures that address market demand for affordable health care.

For more information about the Blue Distinction Centers for Specialty Care, visit www.bcbs.com/why-bcbs/blue-distinction/.

Credentialing/recredentialing

Please refer to the following policy information on credentialing/recredentialing.

Policy

We require Participating Providers to be credentialed and recredentialed at periodic intervals. The credentialing policy applies to contracted PCPs, specialty Physicians, Physician Assistants (PA), Certified Registered Nurse Practitioners (CRNP), and other allied health practitioners as defined by State or federal law/regulation.

CRNPs and PAs, practicing independently within a PCP-participating practice or participating specialty Physician group, can be recognized as a Participating Provider. To elect this option, a CRNP or PA must complete the credentialing and contracting process. Once completed, CRNPs or PAs may bill directly, according to their contracted fee schedule, for their services as the performing Provider using their newly assigned Provider number.

Providers must have completed all residency/fellowship training for the specialty in which they are applying in order to be considered for credentialing or contracting with Independence. Independence will only accept applications from fellows if they have completed residency training in the specialty for which they are applying.

Credentialing and recredentialing decisions are not based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes. All information collected during the credentialing/recredentialing process is kept confidential in accordance with applicable State and/or federal law/regulation and our corporate confidentiality policy.

We reserve the right to determine network need based on existing access and availability standards and participation criteria. In the event that an applicant does not meet either access and availability standards or participation criteria, the application will not be considered. No appeal rights are available as a result of the pre-application determination.
Locum tenens

Under certain circumstances, Independence allows for locum tenens arrangements. Locum tenens status is that of independent contractor rather than an employee. In addition, locum tenens provisions apply only to Physicians. Services of non-Physician practitioners (e.g., Certified Registered Nurse Anesthetists, Nurse Practitioners, and PAs) may not be billed under the locum tenens guidelines from the Centers for Medicare & Medicaid Services (CMS). These provisions apply only to Physicians.

If a regular Physician is absent longer than 60 days without returning to work, the locum tenens must be credentialed and enrolled as if he or she were joining your practice as a new Physician.

The 60 days is a “consecutive” 60-day period. For example, a locum tenens Physician providing coverage three days a week beginning on September 1 can still only provide services for the same absentee Physician through October 30. This also applies even if several different locum tenens Physicians are used to provide coverage during the 60-day period, because the limitation is tied to the billing of the Q6 modifier, not to the number of days that any particular locum tenens Physician provides coverage.

Therefore, a new 60-day period for billing the services of a locum tenens Physician does not commence as a result of a break in service of the locum tenens Physician. Instead, a new 60-day period commences only by a break in the absence of the Physician for whom a locum tenens Physician is necessary. After the regular Physician returns to work and provides services for at least one day, then a locum tenens Physician can provide services as a substitute for that regular Physician again at some point in the future, if necessary, for up to 60 consecutive days.

CAQH credentialing process*

Independence requires the use of the Council for Affordable Quality Healthcare (CAQH) electronic credentialing application for new Providers. Paper applications are not accepted.

All Participating Professional Providers must use CAQH ProView™, a completely electronic solution that allows Providers to easily submit information through a more intuitive, profile-based design. The CAQH electronic credentialing application is free to Providers and available on the CAQH website at https://proview.caqh.org/pr.

To learn more about CAQH, visit www.caqh.org.

*This information does not apply to Providers contracted with Magellan Healthcare, Inc.

Standards

We select qualified applicants in accordance with our credentialing standards, as well as all applicable State, federal, and accreditation requirements such as:

- State/federal law/regulation;
- U.S. Department of Health & Human Services (HHS) standards;
- CMS standards;
- National Committee for Quality Assurance (NCQA) and other applicable accrediting agencies’ requirements.

Practices

Practitioners have the right to review information submitted in support of their credentialing application with the exception of references or recommendations or other information that is peer-protected. The Credentialing Operations Department will notify the practitioner in writing if erroneous information is
discovered during the verification process from any primary source. Practitioners have the right to correct any material omission or erroneous information within 30 calendar days of the request for clarification.

Practitioners should submit supporting information or corrections in reference to their initial credentialing application in writing to the Credentialing Operations Department:

- **Email:** CredOps@ibx.com
- **Fax:** 215-238-2549

Practitioners should submit information or corrections in reference to their recredentialing application in writing to the Credentialing Operations Department:

- **Email:** CredOps@ibx.com
- **Fax:** 215-238-2501

Material omissions and/or failure to respond to all questions on the application may result in denial of new or continued participation in our networks. The organization documents receipt of corrected information in the practitioner’s credentialing file.

Practitioners have the right to be informed of their credentialing or recredentialing application status, upon request. To request the status of their application, practitioners may contact the Credentialing Operations Department by phone at 215-988-6534 or email at CredOps@ibx.com. The credentialing staff will respond to the practitioner within two business days of receiving the practitioner’s request. The credentialing staff may discuss and provide information to the practitioners or designated primary contact for the practitioner as it applies to their credentialing or recredentialing application with the exception of references or recommendations or other information that is peer-protected.

Applicants must have a current unrestricted license, not subject to probation, proctoring requirements, or other disciplinary action, to practice his or her specialty in each state in which the practitioner is licensed. Participating practitioners who no longer meet these licensing requirements will be administratively terminated from further participation in the network, based upon contractual requirements that practitioners must meet. Applicants are notified in writing of determinations regarding approval or denial of participation.

Practitioners are recredentialed every 36 months to ensure that time-limited documentation is updated, that changes in health and legal status are identified, and that practitioners comply with our guidelines and processes and to assess Member satisfaction with the Provider. Failure to complete timely recredentialing may result in administrative termination from the network. We may reinstate a practitioner if all recredentialing requirements are met and the break in credentialing does not exceed 30 calendar days.
Denial appeal and/or review rights

Listed below is important information about the types of denials.

<table>
<thead>
<tr>
<th>Application denials</th>
<th>No appeal or review rights are available when an applicant fails to submit a timely, completed application.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative denials</td>
<td>Administrative appeal/review rights are set forth in the “Appeal/review process for administrative denials” section. Applicants have a right to appeal to the Credentialing Committee denials of participation that are based on initial credentialing verifications or that are based on the professional conduct or competence of an initial credentialing applicant. See the “Appeal/review process for administrative denials” section. There are no appeal rights for initial credentialing applicants if it is determined that the applicant’s license is restricted, subject to probation, proctoring requirements, or other disciplinary action, or otherwise does not meet the participation requirements as previously noted. The applicant may reapply once the restriction is removed.</td>
</tr>
<tr>
<td>Participation denials</td>
<td>A Participating Practitioner who is denied continued participation based on failure to meet recredentialing criteria has appeal rights as set forth in the “Appeal/review process for administrative denials” section. A Participating Practitioner who is denied continued participation based on professional conduct or competence has appeal rights as set forth in the Due Process Policy. Participation denials or summary suspensions are considered Professional Review Actions in accordance with the Due Process Policy. A Participating Practitioner who is denied continued participation based on a license that is restricted, subject to probation, proctoring requirements, or other disciplinary action has a limited right to a review to correct factual inaccuracies regarding the practitioner’s licensure status. However, there are no appeal rights if a Participating Practitioner’s license is restricted, subject to probation, proctoring requirements, or other disciplinary action. The Participating Practitioner may reapply once the restriction is removed.</td>
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</table>

Appeal/review process for administrative denials

A credentialing applicant or a Participating Practitioner is notified by certified mail that he or she has been administratively denied. The letter includes a clear rationale for the decision and instructions on how to submit a written request for an appeal or review, as applicable with additional information, as appropriate, within 30 calendar days of the date of the denial notification letter. Appeal or review requests received after 30 calendar days will not be accepted.

The Credentialing Committee reviews the submitted information and makes a determination of the applicant’s participation status at the next scheduled Committee meeting following receipt of the appeal request. The practitioner is notified within five business days of the final determination via certified mail.

Practitioners who are denied continued participation may reapply after a period of six months. However, under all circumstances, reapplication time frames are solely at our discretion.

Failure to complete timely recredentialing is considered a voluntary withdrawal from our network and is not subject to an appeal. The practitioner may submit the required information to be reinstated or may submit a credentialing application if the break in service exceeds 30 calendar days.
Credentialing criteria

Please refer to the following credentialing criteria.

▪ A completed, signed, and dated application includes, but is not limited to:
  – work history for immediate previous five years from the date the application was signed, including month and year, with a written explanation of gaps greater than six months;
  – education and training completed (e.g., medical school, residency training, and fellowships)
  – statement of chemical dependency or substance abuse;
  – loss or limitation of license or felony convictions;
  – loss or limitation of hospital privileges or disciplinary action;
  – reasons for any inability to perform the essential functions of the position, with or without accommodation;
  – an attestation to the correctness and completeness of the application;

▪ Physicians and other health care practitioners must have a current, unrestricted license, not subject to probation, proctoring requirements, or other disciplinary action, to practice his or her specialty in each state in which the practitioner is licensed to practice his or her profession and specialty. A copy of current license(s) and applicable certifications must be submitted with the application when required by State or federal law/regulation. Therapeutic optometrists must also have a Therapeutic Pharmaceutical Agent (TPA) license. Chiropractors who perform physical therapy must also have the required adjunctive license as applicable in order to perform those services.

▪ Board certification:
  – Primary care and specialty care Physicians including podiatrists must be board certified in their area of practice. Exceptions may be allowed for non-board certified applicants who complete an ACGME/AOA accredited residency or fellowship board certification training program in the same specialty and when Member access issues are identified. A practitioner, whose board provides a clinical pathway for board certification must either obtain the certification directly from the board or obtain written confirmation from the board indicating that the practitioner has met all of the eligibility requirements for the certification of interest. The plans will not assume the role of the board in reviewing a practitioner’s qualifications for the purposes of determining eligibility for a clinical pathway for board certification.
  – Physicians must be board certified as recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) the area of practice.
  – Podiatrists must be certified by the American Board of Podiatric Surgery or the American Board of Podiatric Medicine.
  – Lactation Consultants must be certified by the International Board of Certified Lactation Consultants (IBCLC).

▪ In June 2012, practitioners who were credentialed as General Practice specialists were grandfathered into the specialty “General Practice.” Practitioners are no longer able to be credentialed or recredential in the “General Practice” specialty (except those that were previously grandfathered) as this is not a specialty recognized as a board by the ABMS or the AOA.

▪ Drug Enforcement Agency and Controlled Dangerous Substances certification must be included, when applicable.

▪ Liability insurance coverage specified by the requirements of the State(s) in which the applicant practices is required.
Hospital affiliation as required by State law/regulation.

Practitioner must provide a report detailing malpractice history during the past five years, beginning with the date of the signature on the application. This includes professional liability claims that resulted in settlements, arbitrations, or judgments paid by, or on behalf, of the practitioner.

Applicants must be currently eligible to participate in any Medicare/Medicaid or any federal program.

Provider termination with cause

We may terminate the Professional Provider Agreement immediately upon notice to the Provider in accordance with the Agreement for causes including, but not limited to:

- Provider’s violation of any applicable law, rule, or regulation;
- Provider’s failure to meet and maintain our credentialing requirements including, but not limited to, maintaining the professional liability insurance coverage, licensure, and credentialing status;
- Provider action that, in our reasonable judgment, constitutes gross misconduct;
- Provider action that we determine places the health, safety, or welfare of any Member in jeopardy.

We will not sanction, terminate, or fail to renew a Provider’s participation for any of the following reasons:

- discussing the process that we, or any entity contracting with us, use or propose to use to deny payment for a health care service;
- advocating for Medically Necessary and appropriate care with or on behalf of Members, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations, or tests;
- discussing our decision to deny payment for a health care service;
- filing a grievance on behalf of, and with the written consent of, a Member or helping a Member file a grievance;
- taking another action specifically permitted by Pennsylvania Act 68.

Participating Provider office standards

Access and availability standards

The QM Program establishes an annual access and availability plan to ensure that its managed care networks are sufficient in number, type, and geographic location of practitioners who practice primary and specialty care as defined by regulatory and accreditation standards. The cultural needs of Independence Members are taken into consideration, and mechanisms are implemented to provide adequate access to primary and specialty care practitioners. Availability of practitioners is assessed annually by the Provider Network Contracting department.

The QM Program also establishes and measures the accessibility of services, such as regular and routine appointments, urgent care appointments, after-hours care, emergent care, and access to customer service.

The CAHPS survey, quality of care/service concerns, and telephone service indicators serve as mechanisms to monitor performance. We collect and analyze this data to identify opportunities for improvement. Interventions are implemented to improve performance.

Magellan Healthcare, Inc., an independent company that is our delegated behavioral health Provider, assesses and monitors access and availability of behavioral health practitioners. Performance against
measures such as routine, urgent, and emergent care are assessed on an annual basis in accordance with accreditation standards and regulatory requirements.

Access standards for PCPs and specialists are as follows:

**Appointment availability**

**PCPs and CRNPs**
- emergent/immediate – call 911, or go to the nearest emergency room
- urgent – 24 hours
- routine – 2 weeks
- routine physical – 4 weeks

**Specialists/chiropractors/podiatrists/CRNPs/PAs**
- emergent/immediate – call 911, or go to the nearest emergency room
- urgent – 24 hours
- routine – 2 weeks
- OB/GYN routine – within 2 months

**Minimum office hours per practice per week**

**PCPs and CRNPs**
- solo – 20 hours
- dual – 30 hours
- group – 35 hours

**Specialists/chiropractors/podiatrists/CRNPs/PAs**
- specialty – 12 hours
- chiropractor – 20 hours
- podiatry offices – 20 hours

PCP, OB/GYN, and high-volume, high-impact specialists are encouraged to have at least one evening or weekend session/practice per week included in the hours listed.

**Maximum patients scheduled per hour per practitioner**
- PCPs, CRNPs, podiatrists, and chiropractors – 6 patients
- Specialists, CRNPs, and PAs – 4 patients

**Internal waiting time**

Patients should be seen within 30 minutes from the time of the scheduled appointment.

**Availability**

Coverage must be provided 24 hours per day, 7 days per week, for our Members.

Covering practitioner must be a Participating Provider. Providers who use answering machines for after-hours service are required to include:
- urgent/emergent instructions as the first point of instruction;
- information on contacting a covering Physician;
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▪ telephone number for after-hours Physician access.

**After-hours phone response**
For an urgent/emergent problem, practitioner should respond within 30 minutes.

**Patient no-show**
According to CMS, Medicare Advantage plans, and their contracted Providers, may charge Members administrative fees for missed appointments under certain circumstances. However, if a Provider charges for missed appointments, he or she must charge the same amount for all patients (i.e., Medicare or non-Medicare).

According to the Professional Provider Agreement for Independence-participating Providers, although the Provider may charge for a missed appointment, he or she **may not** charge a “surcharge,” such as an added fee – above and beyond their Member liability – for services rendered. Such a practice creates a barrier to access to care and violates CMS anti-discrimination regulations.

If a patient does not show for a scheduled appointment, it should be documented in his or her medical record.

**Member rights and responsibilities**

**Commercial Member rights**
A commercial Member has the *right* to:

▪ receive information about the health plan, its benefits, services included or excluded from coverage policies, and participating practitioners/Providers’ and Members’ rights and responsibilities. Written and Web-based information that is provided to the Member will be readable and easily understood.

▪ be treated with respect and be recognized for his or her dignity and right to privacy;

▪ participate in decision-making with practitioners regarding his or her health care. This right includes candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage.

▪ voice complaints or appeals about the health plan or care provided and receive a timely response. The Member has a right to be notified of the disposition of appeals/complaints and the right to further appeal, as appropriate.

▪ make recommendations regarding our Member rights and responsibilities policies by contacting Customer Service in writing;

▪ choose practitioners, within the limits of the Independence network, including the right to refuse care from specific practitioners;

▪ have confidential treatment of personally identifiable health/medical information. The Member also has the right to have access to his or her medical record in accordance with applicable federal and State laws.

▪ be given reasonable access to medical services;

▪ receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, or source of payment;

▪ formulate advance directives. Independence will provide information concerning advance directives to Members and practitioners and will support Members through our medical record-keeping policies;
▪ obtain a current directory of participating practitioners in the plan’s network, upon request. The directory includes addresses, telephone numbers, and a listing of Providers who speak languages other than English.
▪ file a complaint or appeal about the health plan or care provided with the applicable regulatory agency and to receive an answer to those complaints within a reasonable period of time. To be notified of the disposition of an appeal or complaint and further appeal, as appropriate.
▪ appeal a decision to deny or limit coverage, first within the plan and then through an independent organization for a filing fee as applicable. The Member also has the right to know that his or her doctor cannot be penalized for filing a complaint or appeal on the Member’s behalf.
▪ Members with chronic disabilities have the right to obtain assistance and Referrals to Providers who are experienced in treating their disabilities.
▪ have candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage, in terms that the Member understands, including an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the Member is unable to easily understand this information, he or she has the right to have an explanation provided to his or her next of kin or guardian and documented in the Member’s medical record. Independence does not direct practitioners to restrict information regarding treatment options.
▪ have available and accessible services when Medically Necessary, including availability of care 24 hours a day, 7 days a week, for urgent and Emergency conditions;
▪ call 911 in a potentially life-threatening situation without prior approval from Independence; the right to have Independence pay per contract for a medical screening evaluation in the emergency room to determine whether an Emergency medical condition exists;
▪ continue receiving services from a Provider who has been terminated from the Independence network (without cause) in the time frames as defined by applicable State requirements. This continuation of care does not apply if the Provider is terminated for reasons that would endanger the Member, public health or safety, breach of contract, or fraud.
▪ have the rights afforded to Members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands;
▪ receive prompt notification of terminations or changes in benefits, services, or Provider network.
▪ have a choice of specialists among Participating Providers following an authorization Referral as applicable, subject to their availability to accept new patients.

**Commercial Member responsibilities**

A commercial Member has the responsibility to:
▪ communicate, to the extent possible, information that Independence and Participating Providers need in order to care for him or her;
▪ follow the plans and instructions for care that he or she has agreed on with his or her practitioners. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
▪ understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
▪ review all benefits and membership materials carefully and to follow the rules pertaining to the health plan;
▪ ask questions to assure understanding of the explanations and instructions given;
▪ treat others with the same respect and courtesy expected for him or herself;
▪ keep scheduled appointments or give adequate notice of delay or cancellation.

Medicare Advantage HMO and PPO Member rights
A Medicare Advantage HMO or PPO Member has the right to:
▪ be treated with fairness, respect, and recognition of his or her dignity and right to privacy;
▪ confidential treatment of personally identifiable health/medical information. The Member also has the right to have access to his or her medical record in accordance with applicable federal laws.
▪ see Independence Providers and get Covered Services within a reasonable period of time;
▪ know treatment choices and participate with Providers in decisions about his or her health care;
▪ have a candid discussion of appropriate or Medically Necessary treatment options for his or her medical conditions, regardless of cost or benefits coverage;
▪ receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin or source of payment;
▪ use advance directives (such as a living will or a power of attorney);
▪ voice complaints or appeals about the health plan or care provided and receive a timely response. The Member has a right to be notified of the disposition of appeals/complaints and the right to further appeal, as appropriate.
▪ get information about health care coverage and costs;
▪ get information about Independence, its services, its Providers, and Member rights and responsibilities;
▪ make recommendations regarding the Independence Member Rights and Responsibilities policy;
▪ have a choice of specialists among Participating Providers, subject to their availability to accept new patients.

Medicare Advantage HMO and PPO Member responsibilities
A Medicare Advantage HMO or PPO Member has the responsibility to:
▪ give Independence and Participating Providers the information they need to provide care (to the extent possible) and to follow the treatment plans and instructions agreed upon;
▪ act in a way that supports the care provided to others and helps smooth the running of Providers’ offices and facilities;
▪ pay premiums and any cost-sharing that he or she may owe for Covered Services and meet his or her other financial responsibilities as described in the Evidence of Coverage;
▪ understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
▪ advise the plan of any questions, concerns, problems, or suggestions;
▪ notify Providers that he or she is enrolled in the health plan when seeking care (unless it is an Emergency);
▪ notify the health plan if he or she has additional health insurance;
▪ notify the health plan if he or she moves out of the service area.
Medical record keeping standards

A medical record documents a Member’s medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. As such, we established medical records standards in 1996 and routinely distribute these standards to PCPs and specialists.

We regularly assess compliance with these standards and monitor the processes and procedures that Physician offices use to facilitate the delivery of continuous and coordinated medical care. We have established a performance goal of 90 percent compliance with our medical record standards.

The standards are as follows:

Medical record content
Medical records should include the following content:
- significant illnesses and medical conditions indicated on the problem list;
- documentation of medications – current and updates;
- prominent documentation of medication allergies and adverse reactions. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- past medical history (for patients seen three or more times) easily identified, including serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- for patients 12 years and older, appropriate notations concerning use of cigarettes, alcohol, and substance abuse (for patients seen three or more times);
- the history and physical documents appropriate subjective and objective information for presenting complaints;
- working diagnoses consistent with findings;
- treatment plans consistent with diagnoses;
- unresolved problems from previous office visits addressed in subsequent visits;
- documentation of clinical evaluation and findings for each visit;
- appropriate notations regarding the use of consultants;
- no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure;
- an immunization record for children that is up to date or an appropriate history in the medical record for adults;
- evidence that preventive screening and services are offered in accordance with Independence Clinical Practice Guidelines.

Medical record organization
Medical records should be organized as follows:
- Each page in the record contains the patient’s name or ID number.
- The record containing the patients personal/biographical data, including his or her address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record contain the author’s identification. Author identification may be a handwritten signature, a unique electronic identifier, or initials.
- All entries are dated.
The record is legible to someone other than the author.

**Information filed in medical records**
Ensure that the following information is filed in medical records:
- laboratory and other studies ordered, as appropriate;
- encounter forms or notes that have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or on a schedule deemed necessary.
- if a consultation is requested, a note from the consultant is in the record;
- specialty Physician, other consultation, laboratory, and imaging reports filed in the chart and initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement.
- if the reports are presented electronically, or by some other method, there is also representation of review by the ordering practitioner;
- consultation and abnormal laboratory and imaging study results include an explicit notation in the record of follow-up plans;
- the existence of an advance directive is prominently documented in each adult (18 and older) Member’s medical record. Information as to whether the advance directive has been executed is also noted.
- records of hospital discharge summaries, emergency department visits, home health nursing reports, and physical therapy reports maintained in the Member’s record.

**Ease of retrieving medical records**
- Medical records are to be made available to us as defined in the Professional Provider Agreement.
- Medical records are to be organized and stored in a manner that allows easy retrieval.

**Confidentiality of information**
- Protected Health Information (PHI) is protected against unauthorized or inadvertent disclosure.
- Medical records are safeguarded against loss or destruction and are maintained according to State requirements. At a minimum, medical records must be maintained for at least 11 years or age of majority plus 6 years, whichever is longer.
- Medical records are stored in a secure manner that allows access by authorized personnel only.
- Staff receives periodic training in Member information confidentiality.

**Maintenance of records and audits**

**Medical and other records**
Providers must maintain all medical and other records in accordance with the terms of their Professional Provider Agreement with Keystone Health Plan East and QCC Insurance Company (collectively, “Independence”) and this *Provider Manual for Participating Professional Providers*. Subject to applicable State or federal confidentiality or privacy laws, Independence or its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Independence, shall have access to Provider records, on request, at Provider’s place of business during normal business hours, to inspect, review, and make copies of such records.

*When requested by Independence or its designated representatives, or designated representatives of local, State, or federal regulatory agencies, the Provider shall produce copies of any such records and will*
permit access to the original medical records for comparison purposes within the requested time frames and, if requested, shall submit to examination under oath regarding the same.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records within 30 days as requested, Independence reserves the right to require Selective Medical Review before claims are processed for payment to verify that claims submissions are eligible for coverage under the benefits plan.

**Provider due process and fair hearing**

**Definitions**

**Professional Review Action:** Any reduction, restriction, suspension, revocation, or denial of a Practitioner’s status as a Participating Practitioner with Independence based on quality and/or professional competence of the Practitioner.

**Summary Suspension:** Adverse action taken against a Practitioner before a hearing is held. Independence may initiate a Summary Suspension where we determine that failure to suspend or restrict the Practitioner’s participation may result in imminent danger to the health, welfare, or safety of an Independence Member.

**Practitioner:** Currently licensed health care Practitioner in an independent practice who contracts with Independence and who has been credentialed by us.

**Procedures**

1. **Hearings**
   1.1 **Procedural Rights**

   All hearings shall be conducted in accordance with the procedural safeguards set forth in this Policy to ensure that the affected Practitioner is accorded all rights to which he or she is entitled. Notwithstanding any other provision of this Policy, no Practitioner shall be entitled, as of right, to more than one hearing with respect to a Professional Review Action or Summary Suspension taken against that Practitioner.

   1.2 **Notice to Practitioner, Request for Hearing and Waiver**

   The Senior Vice President of Health Services or his or her designee shall give prompt written notice of a proposed Professional Review Action or a Summary Suspension to an affected Practitioner. The notice shall provide the reasons for the action and a summary of hearing rights and procedures set forth in Paragraphs 1.2.1, 1.2.2, 1.2.3, 1.3, 1.4, 1.5, 1.6, and 1.7 of this Policy and all subparts thereof. Notice to the Practitioner as set forth herein does not apply when (i) there is no adverse Professional Review Action taken, or (ii) a suspension or restriction of clinical privileges does not exceed fourteen (14) days during which an investigation is conducted to determine the need for a Professional Review Action.

   1.2.1 **Practitioner’s Request for Hearing – Form and Time Limit**

   Any request for a hearing by a Practitioner must be in writing and delivered (by hand delivery or certified mail, return receipt requested) to the person designated in the notice, within thirty (30) days of the date of the notice.

   1.2.2 **Waiver of Hearing**
The failure of a Practitioner to request a hearing to which he or she is entitled by this Policy within thirty (30) days of the date of the Professional Review Action or Summary Suspension and in the manner herein provided shall be deemed a waiver of his or her right to such hearing.

1.2.3 Effect of Waiver of Hearing

When a hearing is waived, the Senior Vice President of Health Services or his or her designee shall decide whether a proposed Professional Review Action shall become effective or a Summary Suspension shall remain in effect against the Practitioner. The decision of the Senior Vice President of Health Services or his or her designee on a Professional Review Action or Summary Suspension shall become final, binding, and unreviewable with the same force and effect as if a hearing had been requested and duly held and a decision rendered by a Hearing Committee. The decision of the Senior Vice President of Health Services or his or her designee shall be communicated in writing to the Practitioner.

1.3 Notice of Hearing

Within thirty (30) days after receipt of a proper request for a hearing, which complies with the provisions of Paragraph 1.2.1 of these procedures, the Senior Vice President of Health Services or his or her designee shall schedule and arrange for such a hearing and shall notify the Practitioner in writing of the time, place, and date so scheduled.

1.3.1 Date of Hearing

The hearing date shall not be less than thirty (30) days nor more than sixty (60) days from the date of notice of the hearing, unless such timing is specifically waived by the affected Practitioner and alternative dates are mutually agreed upon by the affected Practitioner and the Senior Vice President of Health Services.

1.3.2 Contents of Notice

The notice of hearing also shall provide a list of the witnesses, if any, expected to testify on behalf of the Plan’s Quality Review Department.

1.4 Notice Regarding Practitioner’s Witnesses

The Practitioner or his or her representative shall provide to the Chair of the Hearing Committee (as hereinafter defined), in writing, a list of those persons, if any, he or she expects to call as witnesses at the hearing at least ten (10) days prior to the date of the hearing. Failure to identify a witness at least ten (10) days prior to the hearing will result in the exclusion of that witness’ testimony absent compelling circumstances.

1.5 Composition of Hearing Committee

The hearing shall be conducted by the Regional Peer Review Hearing Committee ("Hearing Committee"). The Hearing Committee shall be composed of at least five (5) members inclusive of the Senior Vice President of Health Services or designee Physician, a Plan Medical Director. The majority of the Hearing Committee will be comprised of Physician peers of the affected practitioner, preferably from one of the Plan’s Physician committees. The remainder of the members of the Hearing Committee may be appointed by the Senior Vice President of Health Services or his or her designee, who shall then designate one of the members so appointed to be
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the Chair of the Hearing Committee. Network Physicians are the only voting members of the Hearing Committee.

1.5.1 Qualifications

No member of the Hearing Committee shall be in direct economic competition with the practitioner involved. A Hearing Committee member is not disqualified from serving on a Hearing Committee because he or she has heard of the case or has knowledge of the facts involved. The members of the Hearing Committee shall give fair and impartial consideration to the case.

1.6 Conduct of Hearing

The hearing shall be conducted in accordance with the rules set forth herein. If in the course of the hearing a matter arises that this Policy does not address, the Chair of the Hearing Committee is authorized to determine the applicable procedure(s).

1.6.1 Committee Presence

At least five (5) members of the Hearing Committee shall be present when the hearing takes place.

1.6.2 Practitioner Presence

The personal appearance of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his or her right to a hearing and the right shall be forfeited.

1.6.3 Rights of Parties

During a hearing, each party may:

(a) call, examine, and cross-examine witnesses on any matter determined by the Chair of the Hearing Committee to be relevant to the issues;
(b) introduce exhibits or otherwise present evidence determined by the Chair of the Hearing Committee to be relevant to the issues;
(c) submit written reports, including but not limited to expert reports or any findings of the Plan committee(s) that investigated the Practitioner in question;
(d) request that a record of the hearing be made by use of a State-certified court reporter. Each party shall bear his or her or its own costs to purchase a transcript;
(e) submit a written statement to the Hearing Committee at the close of the hearing.

If the Practitioner does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.

1.6.4 Witness Fees

Each party shall bear his or her own fees, costs, and expenses with respect to witnesses testifying or other evidence submitted on his or her behalf.

1.6.5 Procedure and Evidence

The hearing need not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which
a responsible person might customarily rely in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. The Chair of the Hearing Committee shall make all determinations regarding the admissibility of evidence. The Chair of the Hearing Committee shall be required to order that oral evidence be taken on oath or affirmation. Any written statement submitted by a party at the close of a hearing shall become part of the hearing record. The Chair of the Hearing Committee may set time limitations for the presentation of evidence and may exclude or limit evidence that is repetitive or cumulative.

1.6.6 Burden of Proof

The Senior Vice President of Health Services or his or her designee shall have the initial responsibility to recite the chronology of the case inclusive of any prior decisions, as well as the documents that are being presented as evidence for each case or issue in support of the proposed Professional Review Action or Summary Suspension. The Practitioner shall be obligated to present evidence in response. After the Senior Vice President Health Services or his or her designee has presented evidence in support of the proposed Professional Review Action or Summary Suspension, the Practitioner has the burden of proving by a preponderance of the evidence that the proposed Professional Review Action or Summary Suspension lacks any reasonable basis or that the conclusions drawn there from are arbitrary and capricious.

1.6.7 Hearing Officer

The Chair of the Hearing Committee shall preside over the hearing to determine the order of procedure during the hearing, to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

1.6.8 Representation

(a) The Practitioner shall be entitled to be accompanied by and represented at the hearing by a representative or an attorney of his or her choice.

(b) The Hearing Committee and Plan also may have its attorney present during the hearing. The Practitioner or one or all members of the Hearing Committee or the Chair of the Hearing Committee or his or her designees may, if they deem it necessary, consult with their attorney during the hearing.

1.6.9 Deliberations, Recesses, and Adjournment

The Hearing Committee may, without prior notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence and submission of any written statements, including receipt of any new or additional evidence or consultation requested by the Hearing Committee, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened and any representatives of the Practitioner. The Hearing Committee’s deliberations may be in person or by telephone conference call.

1.7 Written Report
Within fourteen (14) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation (the “Report”) and shall forward the same together with the hearing record and all other documentation to the Senior Vice President of Health Services or his or her designee. The Report shall state the decision of the Hearing Committee with respect to the proposed Professional Review Action or Summary Suspension, the effective date thereof, and a summary of reasons therefore.

1.7.1 Action on Hearing Committee Report

Within five (5) days after receipt of the Report, the Vice President of Quality Management or his or her designee shall send a copy of the Report to the Practitioner and to his or her representative at the hearing, if any, by hand delivery or certified mail, return receipt requested.

1.7.2 Effect of the Hearing Committee Report

The determination of the Hearing Committee shall be final, binding, and unreviewable.

1.7.3 If a Professional Review Action is deemed final, or if a Practitioner voluntarily relinquishes participation in the Plan or if a Practitioner waives a hearing in exchange for the Plan foregoing an investigation and/or peer review committee action, such actions shall be reported to all appropriate agencies, boards, or other entities in accordance with applicable law/regulation.
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Overview

This section includes information about the process for Member appeals and Provider billing dispute appeals.

*Note:* The procedures described in this section may change due to changes in the applicable State and federal laws and regulations, as well as accreditation standards. Also, a decision at any level is not a determination of eligibility or a guarantee of payment. Payment is contingent upon the Member being eligible for coverage at the time of service/treatment and is subject to the terms, limitations, and exclusions of their benefits contract.

**Commercial Member appeals**

There are two broad types of internal appeals on behalf of Members:

- **Medical Necessity appeals.** Medical Necessity appeals or grievances relate to denials based on Medical Necessity, medical appropriateness, or clinical issues.

- **Administrative appeals.** Administrative appeals or complaints relate to denials or disputes regarding coverage, including contract exclusions, noncovered services, participating or nonparticipating health care provider statutes, or other contractual terms of the health plan.

Appeals can be pre-service or post-service and may be processed within 48 hours (72 hours for PPO) for an expedited appeal or in a standard time frame. Standards for appeals time frames and processes are established by applicable State and federal laws, as well as by national accrediting organization guidelines adopted by Independence Blue Cross (Independence). Appeals procedures are subject to change.

An expedited appeal may be obtained with validation from the Member’s Physician stating that the Member’s life, health, or ability to regain maximum function would be placed in jeopardy or the Member would experience severe, unmanageable pain using the standard appeals process. This validation should include clinical rationale and facts to support the opinion. There is only one level of internal review for an expedited appeal.

**Self-insured groups**

The process for self-insured groups can vary from what is described on the following pages, and the guidelines are not described in this document. Therefore, you should contact the Member’s Independence administrator, consult the Member Handbook, or ask a Customer Service representative about the appeals process for a self-insured group.

**Traditional/CMM Members**

Refer to the Member’s specific benefits plan regarding the Member appeals process for traditional/CMM plans.

**Who may appeal**

A Member, a Member’s authorized representative, or a provider authorized to act on behalf of a Member may appeal decisions related to either Medical Necessity or Administrative denials. In most cases, the Member’s written consent or authorization is required for a provider or another person to act as the Member’s authorized representative. The defined processes are compliant with regulatory statutes and accreditation standards. A Member who consents to the filing of an appeal by a provider may not file a separate appeal.
How to file an internal appeal on behalf of the Member

Providers must first obtain written consent from the Member. Upon receipt of a provider’s request for an appeal of an adverse benefit determination, Independence mails the Member a consent form for a provider to file an appeal on his/her behalf. If the Member designates the provider to represent them in an appeal, the provider is responsible for submitting supporting documentation, such as a copy of the Physician’s office records. Upon receipt of the Member’s written consent, both the provider and Member receive an acknowledgment letter and materials listing the appeal process and applicable time frames.

A provider may file an appeal on behalf of a Member within 180 days from notification of the denial by (1) calling the Member Appeals department at 1-888-671-5276, (2) faxing the Member Appeals department at 1-888-671-5274, or (3) writing to:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820

For standard appeals, an acknowledgment letter is sent. It describes the appeals process and applicable time frames for resolution. For expedited appeals, the combined acknowledgment and resolution letter provides the decision and rationale, as well as details on the appeals process and applicable time frames.

Part C and Part D appeals and grievances

Part C Appeals

The Member’s appointed representative, or the provider on behalf of the Member, may request an appeal of any coverage decision about payment, or the failure to arrange, or to continue to arrange for, what the Member believes are Covered Services under Keystone 65 HMO or Personal Choice 65SM PPO, including noncovered Medicare benefits. Appeals must be filed within 60 calendar days of the original coverage determination, except for good cause.

Pre-service appeals

A decision about medical care that has not already been rendered is called a pre-service appeal.

▪ Standard appeal. Pre-service appeals are resolved as expeditiously as required by the Member’s health condition, but in no more than 30 calendar days after the appeal is received.

▪ Expedited appeal. If the Member’s health, life, or ability to regain maximum function may be jeopardized by waiting for the standard 30-day initial appeal process, an expedited appeal of a pre-service request may occur at the request of the Member, the Member’s appointed representative, or the Member’s Physician. Expedited appeals are resolved as expeditiously as required by the Member’s health condition, but in no more than 72 hours upon receipt of the appeal request.

Post-service appeals

A decision about payment for care is called a post-service appeal and must be resolved no later than 60 calendar days after the appeal is received.

Part D Appeals

Pre-service appeals

The Member’s appointed representative or the prescribing Physician on behalf of the Member may appeal our decision not to cover a drug, vaccine, or other Part D benefits. Appeals must be filed within 60 calendar days of the original coverage determination, except for good cause.
- **Standard appeals.** Pre-service appeals are resolved as expeditiously as the Member’s health condition requires, but no later than seven calendar days after we receive the appeal request.

- **Expedited appeals.** An expedited appeal of a pre-service request is resolved within 72 hours upon receipt of the appeal, or sooner if the Member’s health condition requires.

**Requesting an appeal**

For all Part C and Part D *standard* appeals, the Member or his or her authorized representative should mail the written appeal to:

Keystone 65 HMO/Personal Choice 65 PPO Member Appeals Department  
P.O. Box 13652  
Philadelphia, PA 19101-3652

For all Part C and Part D *expedited* appeals, the Member or his or her authorized representative should contact us by telephone or fax:

Keystone 65 HMO: 1-800-645-3965  
Personal Choice 65 PPO: 1-888-718-3333  
TTY/TDD: 711  
Fax: 215-988-2001

For all Medicare Advantage appeals, if the original denial is upheld after the review by Independence, the case is forwarded for review and determination by an independent review entity (IRE). An IRE is contracted with the Centers for Medicare & Medicaid Services (CMS) to perform second-level independent reviews of Medicare Advantage HMO and PPO Members’ appeals.

**Grievances process**

A Medicare Advantage HMO or PPO grievance is any complaint or dispute raised by a Medicare Advantage HMO or PPO Member or the Member’s representative, other than a dispute involving a coverage determination, including coverage of prescription drugs. Medicare Advantage HMO or PPO grievances may include issues with one of our network pharmacies or disputes regarding such issues as office waiting times, Physician behavior, adequacy of facilities, or involuntary disenrollment situations. A decision will be issued no later than 30 calendar days after the grievance is received. An extension of up to 14 calendar days is permitted if the Member requests or if Independence requires more information and the delay is in the best interest of the Member. In certain cases, the Member has the right to ask for an expedited grievance, meaning we must issue a decision within 24 hours. We may extend the time frame by up to 14 calendar days if the Member requests the extension or if we justify a need for additional information and the delay is in the best interest of the Member.

*Note:* These procedures may change due to changes in the applicable federal laws and regulations.

**Timely submission of medical records**

As part of the federally mandated Medicare Advantage appeals and grievance process, Independence is required to obtain a Member’s medical record in order to make a determination of coverage. If we uphold our determination, we are required to forward the Member’s appeal file, which includes medical records, to an IRE. Medical records must be submitted to us in a timely manner. By doing so, we can submit them to an IRE and ensure compliance with mandated appeal deadlines.

CMS also requires that both Independence and an IRE make their determinations within 72 hours for an expedited appeal and within 30 days for a standard appeal. If a Member requests an expedited review, we will immediately send a request to the provider for medical records. We must receive the records within
24 hours for an expedited appeal and within ten days for a standard appeal. If an appeal is sent to an IRE, the IRE may request additional records, which are required to be sent under the same time frames.

Upon our request, and in accordance with your Professional Provider Agreement, you must provide us with copies of a Medicare Advantage HMO or PPO Member’s medical records to as requested.

Other reasons we may require the timely submission of medical records include:

- facilitating the delivery of appropriate health care services to Medicare Advantage HMO and PPO Members;
- assisting with utilization review decisions, including those related to disease management programs, quality management, grievances (as discussed above), claims adjudication, and other administrative programs;
- complying with applicable State and federal laws and accrediting body requirements (e.g., National Committee for Quality Assurance);
- facilitating the sharing of such records among health care providers directly involved with the Member’s care.

**Skilled nursing facility and home health discharges**

Another type of appeal applies only to discharges related to skilled nursing facility, home health, or comprehensive outpatient rehabilitation facility services. Members receive notice two days before coverage ends. If the Member thinks his or her coverage is ending too soon, the Member must appeal no later than noon the day before coverage ends. The appeals should be sent to the following Quality Improvement Organization (QIO) contractor:

Livanta
BFCC-QIO Program
9090 Junction Drive, Suite 10
Annapolis Junction, MD 20701
Phone: 1-866-815-5440
Fax: 1-855-236-2423

If the Member makes this type of appeal, his or her stay may be covered during the time period Livanta uses to make its determination. The Member must act very quickly to make this type of appeal, and it will be decided quickly.

**Hospital discharges**

Another special type of appeal applies only to hospital discharges. If the Member thinks his or her coverage of a hospital stay is ending too soon, the Member can appeal directly and immediately to Livanta. If the Member makes this type of appeal, his or her stay may be covered during the time period Livanta uses to make its determination.

**Discussion about utilization management decisions**

Information on utilization management decisions can be found in the *Clinical Services – Utilization Management* section of this manual. Note that peer-to-peer discussion is not part of the Member appeals or provider appeals processes described in the previous pages.
Provider billing dispute appeals process

Independence offers a two-level post-service billing dispute appeals process for professional Providers. For services provided to any Independence commercial or Medicare Advantage Member, Providers may appeal claim denials related to general coding and the administration of claim payment policy as billing disputes.

Examples of billing disputes include:
- bundling logic (integral, incidental, mutually exclusive claim edits);
- modifier consideration and application;
- claims adjudication settlement not consistent with the law or the terms of the Provider’s contract;
- improper administration of an Independence claim payment policy;
- claim coding (i.e., how we processed the codes in the claim vs. the Provider’s use of the codes).

The Provider billing dispute appeals process does not apply to:
- utilization management determinations (e.g., claims for services considered not Medically Necessary, experimental/investigational, cosmetic);
- Preapproval/Precertification/authorization/Referral requirements;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the Corporate and Financial Investigations Department (CFID);
- fee schedule concerns.

Submission of billing dispute appeals

To facilitate a first- or second-level billing dispute review, submit inquiries to:

Provider Billing Dispute Appeals
P.O. Box 7930
Philadelphia, PA 19101-7930

All first-level billing dispute appeals must be filed within 180 days of receiving the Statement of Remittance (SOR) or Provider Explanation of Benefits (EOB) and should contain all applicable medical records, notes, and tests, along with a cover letter explaining the appeal. Independence will process first-level appeals within 30 days of receipt of all necessary information. A billing dispute appeal determination letter will be sent to the Provider.

If a Provider disputes the first-level Provider billing dispute appeal determination, he or she may then submit a second-level Provider billing dispute appeal by sending a written request within 60 days of receipt of the decision of the first-level Provider billing dispute appeal. The appeal will be reviewed by an internal Provider Appeals Review Board (PARB) consisting of three members, including at least one Medical Director. The decision will then be communicated to the Provider and will include a detailed explanation. The decision of the PARB will be the final decision of Independence.

If a Member appeal, or Provider appealing on behalf of the Member appeal with the Member’s consent, is filed before or during an open Provider appeal for the same issue, the Provider appeal will be closed and addressed under the Member appeal.
Provider grievance process

Independence offers a one-level post-service grievance process for professional Providers. For services provided to any Independence commercial or Medicare Advantage Member, Providers may appeal claim denials for Medical Necessity, experimental/investigational, or cosmetic reasons, as a Provider grievance.

The grievance process does not apply to:

- lack of Preapproval/Precertification/authorization/Referral;
- benefit/eligibility determinations (e.g., claims for noncovered services);
- audit and investigations performed by the CFID;
- fee schedule concerns;
- billing dispute appeals.

Submission of provider grievances

To facilitate a grievance review, submit to:

Provider Grievances
P.O. Box 7930
Philadelphia, PA 19101-7930

All grievances must be filed within 180 days of receiving the SOR or Provider EOB and should contain all applicable medical records, notes, and tests, along with a cover letter explaining the grievance. All grievances will be processed within 60 days of receipt of all necessary information. A preliminary review will be conducted. If the determination is to pay the claim, a claim adjustment will be processed and a determination letter will be sent to the Provider. All other grievances will be sent to an Independent Review Organization (IRO) for a matched specialty review. A determination letter will be sent to the Provider containing the IRO decision and detailed explanation. The decision of the IRO is final.

If a Member grievance, or Provider filing on behalf of the Member grievance, is filed before or during an open provider grievance for the same issue, the provider grievance will be closed and addressed under the Member grievance. Future Provider grievances for the same issue are ineligible for servicing as a Provider grievance.

Other provider claims review requests

For claims issues excluded from Provider billing dispute or grievance processes, please refer to the Billing section, Provider Claims Inquiry, for procedures on requesting a claims review.

ER service appeals

ER claims that do not meet Independence’s criteria for an Emergency are automatically processed at the lowest ER payment rate in the fee schedule or as otherwise provided in the Agreement. To appeal an ER determination, complete an Emergency Room Review Form (available at www.ibx.com/providerforms), attach the Member’s medical record, and submit to:

Claims Medical Review – Emergency Room Review
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480
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Overview

This section of the manual contains information about BlueCard, including a description of the program, resources to help facilitate communication between the Member’s Home and the Host Plan, and requirements and tips for submitting BlueCard claims for out-of-area Members.

Out-of-area Members are Members of other Blue Cross and Blue Shield plans who travel or live in the Independence five-county service area, which includes Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

About BlueCard

BlueCard is a national program through the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross® and Blue Shield® plans, that enables enrollees of one commercial BCBSA plan to obtain health care service benefits while traveling or living in another BCBSA plan’s service area. The program links participating health care Providers with the various BCBSA plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

As a professional Participating Provider, you are expected to render professional services to PPO patients who (1) are enrolled in Blue Cross and Blue Shield plans other than those offered by Independence and (2) who travel or live in the Independence five-county service area (Bucks, Chester, Delaware, Montgomery, and Philadelphia counties) and present to you for treatment. These Members are subject to eligibility verification and applicable Preapproval requirements.

For detailed information please refer to the BlueCard section of the Independence Provider News Center at www.ibx.com/pnc to find communications specific to the BlueCard Program, such as billing requirements, claim submissions, preapproval requirements, and administrative procedures.

Benefit coverage plans excluded from BlueCard

The following benefit plans are excluded from the BlueCard program:

- stand-alone dental
- prescription drugs
- Federal Employee Program (FEP)
- Medicare Advantage HMO plans (with the exception of urgent/emergent claims)

Identifying BCBSA Plan enrollees

Enrollees in the United States

ID cards for out-of-area enrollees may include:

- an image of a suitcase with “PPO” in it
- an image of a suitcase with “PPO” and “B” in it
- an image of a blank suitcase

The main identifier on ID cards for out-of-area enrollees is the prefix. The three-character prefix at the beginning of the Member ID number is the key element used to identify and correctly route claims to the appropriate BCBSA plan. The prefix identifies the BCBSA plan or national account to which the enrollee belongs and is critical for confirming an enrollee’s membership and coverage.
Prior to providing services to enrollees of other BCBSA plans, be sure to follow these procedures:

▪ Ask the enrollee for the most current ID card each time services are rendered. Since new ID cards may be issued to enrollees throughout the year, this will ensure that you have the most up-to-date information in the patient’s file.
▪ Make copies of the front and the back of the ID card, and share this key information with your billing staff.
▪ ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the ID number. You may remove spaces if the suffix is separated from the ID number by a space on the ID card. A correctly reported ID number includes the prefix and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between three and 14 numbers/letters following the prefix.

To ensure accurate claims processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with claims processing.

Note: FEP enrollees will have the letter “R” in front of their ID number instead of a prefix. These Members are excluded from the BlueCard Program.

International Licensees
BlueCard not only includes Members of Blue Plans in the United States (50 states and the District of Columbia). It also covers Blue Plan Members of international Licensees such as:

▪ Triple-S Salud* (Blue Cross Blue Shield of Puerto Rico)
▪ Blue Cross Blue Shield of the U.S. Virgin Islands*
▪ Blue Cross Blue Shield of Panama*
▪ Blue Cross Blue Shield of Uruguay*
▪ Blue Cross Blue Shield of Costa Rica
▪ GeoBlueSM – the Blue International Solutions Licensee located in King of Prussia, PA, which provides coverage for students and expatriates of other nations while they are in the United States

*Independent licensee of the Blue Cross and Blue Shield Association.

Members enrolled with an international Licensee can access Provider networks of Blue Licensees in the United States, as well as the networks of other international Licensees. These Members carry a Blue ID card with a prefix that has been assigned to the specific international Licensee. Please treat these Members the same as domestic Blue Plan Members and do not collect any payment from them beyond their cost-sharing amounts.

Canadian Association of Blue Cross Plans
The Canadian Association of Blue Cross Plans and its enrollees are separate and distinct from the BCBSA and its enrollees in the United States. Claims for enrollees of the Canadian Blue Cross Plans are not processed through the BlueCard Program.

Please follow the instructions on the enrollee’s ID card when servicing the Canadian Association of Blue Cross Plan enrollees. These plans include the following:

▪ Alberta Blue Cross
▪ Atlantic Blue Cross Care
▪ Manitoba Blue Cross
▪ Pacific Blue Cross
▪ Quebec Blue Cross
▪ Saskatchewan Blue Cross
Claims process flow

Below is an example of how a professional BlueCard claim flows through the BlueCard Program for processing:

▪ An enrollee of another Blue Plan receives services from an Independence-Participating Professional Provider in the Independence five-county service area.
▪ The Provider submits the claim to Independence (i.e., the local Blue Plan).
▪ Independence recognizes the BlueCard enrollee and transmits the claim to the enrollee’s Home Plan.
▪ The Home Plan adjudicates the claim according to the enrollee’s benefit plan.
▪ The Home Plan issues an Explanation of Benefits (EOB) to the enrollee (if applicable).
▪ The Home Plan transmits the claims processing results to Independence.
▪ Independence issues a Provider EOB and payment to the Participating Professional Provider.

Use the following guidelines when submitting claims for enrollees of another Blue Plan:

▪ Verify the enrollee’s cost-sharing amount and collect any applicable Copayment at the time of service. Indicate on the claim any payment you collected from the enrollee.
▪ Do not send duplicate claims. Sending another claim or having your billing agency resubmit a claim automatically will slow down the claims payment process and creates confusion for the enrollee. If out-of-area enrollees contact you, advise them to contact their Home Blue Plan and refer them to their ID card for a customer service number. The Home Plan should not contact you directly regarding claims issues, but if someone from the Home Plan contacts you, refer him or her to Independence.
▪ BlueCard PPO Professional Host claims may be submitted to Independence; however, professional Providers who are contracted with other area Blue Plans (e.g., Highmark Blue Shield, Highmark Blue Cross Blue Shield of Delaware, Highmark West Virginia, Capital Blue Cross, Horizon Blue Cross Blue Shield of New Jersey) must submit claims to the applicable contracted health plan when treating Members from those Plans.
▪ To send claims to Independence electronically, use the 837P HIPAA transaction. For a list of available ISA and GS codes and claim submission addresses, refer to the payer ID grids at www.ibx.com/edi.
▪ Providers should continue to submit professional claims to Highmark Blue Shield for Traditional Indemnity Members and HMO Members (for urgent/emergent situations) enrolled in a Blue Cross and Blue Shield plan other than one offered by Independence.

Other Party Liability (OPL)

In cases where there is more than one payer and a Blue Cross Blue Shield Plan is a primary payer, submit OPL information with the Blue Cross and/or Blue Shield claim. Upon receipt, we will electronically route the claim to the Member’s Blue Plan. The Member’s Plan then processes the claim and approves payment, and we will reimburse you for services.

Verifying eligibility and obtaining Preapproval

To verify eligibility and coverage information for enrollees from other BCBSA plans, do one of the following:

▪ Log on to the NaviNet® web portal. From Independence Plan Central, select BlueExchange® Out of Area from the Workflows menu, and then Eligibility and Benefits Inquiry. Enter all required fields for the search. You will receive real-time responses to your BlueExchange eligibility requests Monday through Saturday, from 5 a.m. to 10 p.m. ET, and on Sundays, from 9 a.m. to 9 p.m. ET.
▪ Submit a HIPAA 270 transaction (eligibility request) electronically to Independence via Passport or HDX. You will receive real-time responses to your eligibility requests for out-of-area enrollees Monday through Saturday, from 7 a.m. to 1 a.m. ET the next day.
- Call the BlueCard Eligibility® line at 1-800-676-BLUE.
  - English- and Spanish-speaking phone operators are available to assist you.
  - Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than Independence. You may be transferred to a voice response system linked to customer enrollment and benefits.
  - The BlueCard Eligibility line is for eligibility, benefits, and Preapproval/Referral authorization inquiries only.

**Obtaining Preapproval**

Remind enrollees that when receiving services out-of-area, they are responsible for obtaining Preapproval from their Home Blue Plan when required. You may also contact the out-of-area enrollee’s Plan on the enrollee’s behalf.

You can obtain Preapproval in one of the following ways:

- Log on to NaviNet. From Independence Plan Central, select BlueExchange Out of Area from the Workflows menu, and then Referral/Auth Submission (HIPAA 278 transaction) or PreService Review for Out of Area Members.
- Call the BlueCard Eligibility line at 1-800-676-BLUE and ask to be transferred to the utilization review area.
- Submit a HIPAA 278 transaction (Referral/authorization request) electronically to Independence.

Detailed guides and webinars are available for many transactions in the NaviNet Resources section of our Provider News Center at www.ibx.com/pmc/navinet. Interactive training demos are also available to all users on NaviNet. Simply select Help from the top of the screen, and then select Independence Blue Cross from the Select a Health Plan drop-down menu.

**BlueExchange®**

BlueExchange is an electronic solution that provides HIPAA compliance for inter-Plan transactions and allows for electronic communication between the Provider and the out-of-area Member’s Home Plan. You can access BlueExchange through NaviNet by selecting the BlueExchange Out of Area transaction and then Eligibility and Benefits Inquiry. You can also access BlueExchange through trading partners that support eligibility and benefit requests.

Using BlueExchange, you can perform the following transactions:

- **Claims Status Inquiry.** This transaction allows Providers to acquire up-to-date claims status information for out-of-area Members for whom a claim has been submitted from a local Provider’s office.
- **Eligibility and Benefits Inquiry.** This transaction allows Providers to submit inquiries on out-of-area Members in real time. Providers can also use procedure codes as part of the criteria when searching for a Member’s benefits information.
- **Referral/Auth Submission and PreService Review for Out of Area Members.** These transactions allow Providers to submit Referral and Preapproval requests for out-of-area Members. All BlueExchange transaction requests submitted by the Provider performing the inquiry or submission are routed from NaviNet to the Member’s Home Plan. The Member’s Home Plan then transmits the requested Member information through NaviNet.
- **Medical Policy/PreCert Inquiry.** Using the Medical Policy Router, you can be routed to the Home Plan’s website that contains medical policies and general Preapproval requirements. This transition happens seamlessly based on the prefix of the Plan, and it gives Providers easy access to medical policy and Preapproval requirements. To view medical policy and Preapproval requirements for
out-of-area Blue Members, select Medical Policy/PreCert Inquiry from the BlueExchange Out of Area transaction. To conduct a search, select Medical Policy or Pre-Certification from the drop-down menu under “Type of Inquiry.” Simply enter the prefix noted on the Member’s ID card, and select Submit. If you have any questions regarding the information, please contact the out-of-area Member’s Home Plan.

**COB Questionnaire**

Coordination of benefits (COB) refers to how the Blue system ensures that its Members receive full benefits and prevents double payment for services if they have coverage from two or more sources. All out-of-area Blue Cross and/or Blue Shield Members should complete the COB Questionnaire prior to services being rendered for the following reasons:

- streamlined claims processing;
- expedited payment to Providers;
- reduction in the number of denials related to COB;
- ability for employer groups to finalize out-of-area claims for their employees.

**Instructions for completing the questionnaire**

The questionnaire is available on our website at [www.ibx.com/providers/claims_and_billing/bluecard.html](http://www.ibx.com/providers/claims_and_billing/bluecard.html) or through NaviNet by selecting BlueCard COB Questionnaire from the BlueExchange Out of Area transaction.

Business Office staff should complete the first two fields of the questionnaire: Provider name and NPI. Then the out-of-area Member should complete the remaining sections of the questionnaire before services are rendered. Immediately process the completed questionnaire by following the instructions on the form.

*Note:* The COB Questionnaire should not be used for local Independence Members or FEP Members.

Detailed guides and webinars are available for many transactions in the NaviNet Resources section of our Provider News Center at [www.ibx.com/pnc/navinet](http://www.ibx.com/pnc/navinet). Interactive training demos are also available to all users on NaviNet. Simply select Help from the top of the screen, and then select Independence Blue Cross from the Select a Health Plan drop-down menu.

**Requests for medical records**

A medical record documents a Member’s medical treatment, past and current health status, and treatment plans for future health care. Requesting these records is a significant operating component in successfully resolving BlueCard claims issues.

There are several reasons why a Home Plan may request medical records from the Host Plan – Independence, in this case. For example, when a claim results in an appeal, medical records may be required to finalize the claim. A Home Plan may request multiple records at a time. Upon receipt of the request from the Home Plan, Independence validates the request and assures there is not a duplicate request on file.

A letter is then mailed to the Provider indicating the type of records required and indicates the address where the medical records should be returned. When we receive medical records from a Provider, they are sent to the Home Plan for review, and a determination is made on how to proceed with the processing of the claim.
When a Host Plan Provider receives a request for medical records, it is very important that the records be sent in a timely manner to ensure that the Provider is reimbursed and the services rendered to the out-of-area Member are covered appropriately. To expedite the handling for these medical record requests, please adhere to the following tips and guidelines:

- Submit by fax or email for the quickest processing.
- Only the medical records that have been requested should be sent.
- Unsolicited medical records cannot be forwarded to another plan by Independence.

Host Plan medical records can be sent in any of the following ways:

- **Fax.** Medical records can be securely faxed to 215-238-7915.
- **Email.** Medical records can be emailed to bluesquaredhostmedicalrecords@ibx.com.
- **Mail.** If you do not have access to fax or email, you can send medical records by mail on a CD or in hardcopy. Please mail the medical records to:
  Independence Blue Cross
  Host Medical Records Department
  1901 Market Street
  Philadelphia, PA 19103

**Medical record request guidelines**

It is important that Providers are aware of the guidelines that support the medical records request process. Please review the following:

- Medical records should be stored in a secure manner accessible to authorized personnel only, with Protected Health Information (PHI) safe against unauthorized or inadvertent disclosure.
- Office staff should receive periodic training about the protection and confidentiality of Member PHI.
- Medical records should be safeguarded against loss or destruction.
- Medical records should be maintained according to state requirements and in accordance with the terms of your Provider Agreement.
- Subject to applicable State or federal confidentiality or privacy laws, Independence or its designated representatives, or designated representatives of local, State, and federal regulatory agencies that have jurisdiction over Independence, must be allowed access to Provider records on request at the Provider’s place of business during normal business hours to inspect, review, and copy those records at no cost to the plan.
- When requested by Independence or its designated representatives, or designated representatives of local, State, or federal regulatory agencies, Providers must produce copies of any such records and permit access to the original medical records for comparison purposes within the requested timeframe. If requested, the Provider will submit to examination under oath regarding the medical records.
- The initial request for medical records will be generated from the Member’s Home Plan through BlueSquared®, a Web-based application that facilitates Inter-Plan business processes in real time.
The third-party websites mentioned throughout this manual are maintained by organizations over which Independence Blue Cross (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.

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