Partners in Health update

Working together for quality health care

September 2019 Recap

This publication contains articles previously published on our Provider News Center.

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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New resources to improve physical accessibility for people with disabilities

Published September 12, 2019

The Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH) is offering new resources to people with disabilities and their care providers. CMS OMH created the following resources to help improve access to high-quality health care and to support independent living:

- **Getting the Care You Need: A Guide for People with Disabilities.** This guide highlights the approaches some beneficiaries with disabilities have implemented to help providers and office staff better meet the needs of people with disabilities. The guide includes a brief overview of the following:
  - tips on preparing for medical appointments;
  - information on what to do if a patient has trouble when accessing care;
  - an appointment checklist with tips on how individuals can work with their provider to get the care they need before, during, and after an appointment.

- **Modernizing Health Care to Improve Physical Accessibility - Resources Inventory.** This packet is a summary of resources and tools for health care professionals to reduce barriers and provide access to high-quality care for people with disabilities, which includes:
  - guidance on how to increase physical accessibility of medical services;
  - tools to assess a practice or facility’s accessibility;
  - tips and training materials.

Learn more

For more information and to access these materials, visit the CMS OMH website.


Required lead time when updating your provider information

Published September 24, 2019

Independence would like to remind you that submitting changes in a timely manner helps to ensure prompt payment of claims, delivery of critical communications, seamless recredentialing, and accurate listings in our provider directories.* In accordance with your Provider Agreement, the Provider Manual for Participating Professional Providers, and/or Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers, as applicable, you are required to notify Independence whenever key provider demographic information changes.

Please review our dedicated webpage to review the specific lead-time requirements, exceptions, and/or additional information for:

- Professional providers
- Facility and ancillary providers
- Authorizing signature and W-9 Forms

Independence will not be responsible for changes not processed due to lack of proper notice. Failure to provide proper advance written notice to Independence may delay or otherwise affect provider payment.

If you have questions related to updating your provider information after reviewing the webpage, please email us at provider_communications@ibx.com.

*Behavioral health providers contracted with Magellan Healthcare, Inc. (Magellan), an independent company, must submit any changes to their practice information to Magellan via their online Provider Data Change form by selecting the “Display/Edit Practice Info” link. Magellan Healthcare, Inc. manages mental health and substance abuse benefits for most Independence members.
Staying connected with you through Provider Engagement Forums

Published September 17, 2019

As part of our commitment to provider connection, Independence has held provider engagement forums at our Center City Philadelphia campus on a variety of topics including communications, demographics, and the provider network service experience.

Hundreds of attendees, representing a cross-section of network providers and billing agencies, have taken part in our Provider Engagement Forums since they began last year. We are pleased to share the changes we’ve implemented based on feedback from the providers who attended our spring session on the provider network service experience.

You spoke, we listened

We collected providers’ feedback at each session this spring, collated it, and identified several common themes. We then determined key areas of focus for immediate action and others to research and develop long-term plans for improvement.

Provider Call Center

- **Wait time.** We have added capability to deploy a front-end message to make the caller aware of anticipated wait times. If the hold times in the queues for claims, benefits, and eligibility are longer than expected, the caller will hear a message with an approximate wait time.
- **Claims training.** The team is assessing knowledge gaps and developing action plans for additional claims training for call center representatives.
- **Surveys.** We will send out quick email surveys on a periodic basis to our network to maintain a pulse on your overall experience and to obtain feedback as we implement enhancements – your response is important!
- **Self-service requirements.** We’re revisiting our self-service requirements and associated workflow and will implement retraining of call center representatives.

Claim investigations

- **Quality.** We will be enhancing quality review of claim investigation responses to improve response language.
- **Support.** We will implement enhanced support for claim investigations requiring further review.

Provider Network Services

- **Staff.** We are in the process of adding and training new staff to assist with handling provider issues in a timely manner.
- **Workflow.** We are assessing current workflows within our provider relations team to mitigate process gaps and ensure work is routed appropriately for handling.
- **Follow-ups.** We are reviewing follow-up procedures to ensure providers receive periodic status updates for all outstanding issues.

We hope that these measures result in a better experience for you, our providers.
New resource available! Use our *Demographic Maintenance Guide* to help you update your provider demographics

**Published September 23, 2019**

We are excited to offer you our *Demographic Maintenance Guide*, a one-stop reference tool that provides you with the designated methods for the submission of your demographic changes. This tool was initiated as a result of feedback received at our Fall 2018 Provider Engagement Forum sessions.

It is critical that you regularly review your demographic information in our online *Commercial* and *Medicare Advantage* Find a Doctor tools to ensure that all of your information is accurate. Our members, your patients, rely on provider directories to make informed choices about care.

*Demographic Maintenance Guide*

Our new *Demographic Maintenance Guide* details the three methods available to update your provider information:

- **Primary**: Provider File Management transaction on the NaviNet® web portal (NaviNet Open)
- **Secondary**: Provider Change Form
- **Tertiary**: Email/Fax

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New agreement with CTCA offers more options for cancer care

**Published September 27, 2019**

Independence and Cancer Treatment Centers of America (CTCA) Philadelphia, part of a national network of cancer care providers, have signed a new four-year agreement. The agreement, effective September 1, 2019, demonstrates a commitment between Independence and CTCA to provide members and patients with even more access to quality oncology care and related services.

To read the full press release and learn more about the agreement, visit the *Independence Newsroom*. ◆
Sign up! Receive news and announcements from Independence

Published September 30, 2019

Independence updated the Provider Communications Email Sign-up Form to allow participating providers easier access to our communications. The new form combines previous request forms into one convenient form, with a few added features.

Sign up today to receive information about the Independence provider community, including:

- Partners in Health UpdateSM;
- Medical Director emails (restricted to physicians);
- Provider Bulletins (restricted to contracted providers);
- Changes to claim payment and medical policies;
- Updates to our administrative procedures.

Complete the form by entering your contact and office information, your National Provider Identifier (NPI) number, and select your specialty from the drop-down list.*

New features

The new form captures provider demographic information such as provider type and specialty. This information allows us to send targeted communications based on information related to your provider type and specialty.

Third-party billing agencies can now request Partners in Health Update communications to keep up-to-date on the latest news and information that affects the providers they support.

Sign up today!

To ensure your request is processed in a timely manner, be sure to complete the form in its entirety. To prevent your firewall from marking our email messages as spam, please add provcommrequests@ibx.com to your email address book. All requests are processed in two business days.

* NPI number is not required for third-party billing agencies.

To ensure your privacy, all information will be sent via a secure connection. Independence will not disclose any personal information to outside persons or entities unless we have written consent or unless authorized by law. For more information about our privacy policy, visit the privacy section of our website.
**Now in effect:** Enhanced claim edits to align with industry standard billing rules for injectable drugs and biological agents

Published September 4, 2019

As previously communicated in a series of *Partners in Health Update℠* articles, Independence is expanding the enhanced claim editing process to include additional rules specific to various injectable drugs and biological agents effective for claims processed as of September 1, 2019.

Claims received by Independence on or after June 10, 2018, are subject to an enhanced claim editing process during prepayment review. This process ensures compliance with current industry standards and supports the automated application of correct national and regional coding principles.*

The industry standard sources specific to injectable drugs and biological agents are:

- The manufacturer’s package insert (primary source: U.S. Food and Drug Administration [FDA]-approved indications)
  - Other compendia references include, but are not limited to:
    - Thomson Micromedex® (DRUGDEX®, DrugPoints®)
    - National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium®
    - American Hospital Formulary System (AHFS®) Drug Information®
    - Elsevier Gold Standard Clinical Pharmacology
- ICD-10 Instruction Manual coding guidelines
- Centers for Medicare & Medicaid Services (CMS) Claims Processing Manual

*Self-funded groups have the option to not participate in the enhanced claim edits; therefore, prepayment review may vary by health plan.

**Areas of focus**

The enhanced claim editing process for injectable drugs and biological agents focus on the following areas:

- The diagnosis code(s) billed are consistent with the FDA-approved indications and approved off-label indications. If the ICD-10 code billed on the claim does not match the approved indication, the claim may reject.
- The diagnosis code(s) billed are consistent with the ICD-10 Instruction Manual coding guidelines.
- The dosage and frequency of administration is appropriate for the diagnosis for which it is being used.
- The administration code(s) and hydration services are appropriately reported.

With the implementation of these claim edits, claims submitted with inappropriate coding will be returned or denied. Providers will be notified via the Provider Explanation of Benefits (EOB) (professional) or Provider Remittance (facility), which will include a reason code for the claim return or denial. Any returned claims must be corrected prior to resubmission. These changes should have little or no impact to billing practices for submission of claims that are in accordance with the guidelines listed above and national industry-accepted coding standards.

**Identifying claims that went through the claim editor process**

If you have been submitting claims in accordance with industry standards, you will have no issues with the topics in this article. However, if you have not, please be advised that you may see an increase in claim rejections and/or denials due to the new claim edits. If your claim is affected by one of the new claim edits, the edit explanation will be displayed on your electronic remittance report (835) and/or paper Provider EOB or Provider Remittance (facility), which will include a reason code for the claim return or denial. Any returned claims must be corrected prior to resubmission. These changes should have little or no impact to billing practices for submission of claims that are in accordance with the guidelines listed above and national industry-accepted coding standards.

Unique alpha-numeric codes and messages have been created that begin with E8. Should your claim line contain an E8XXX code/message, it means it was affected by the enhanced claim editor. You can also find the E8XXX codes/messages on the Claim Status Inquiry Detail screen in NaviNet Open. To view, hover your mouse over the service line and select View Additional Detail. If you see an E8XXX code/message, the line went through an edit. Only E8XXX codes/messages are part of the enhanced claim editor. All other codes/messages are unrelated to the enhanced claim editor.

*continued on the next page*
Claim review requests
We recognize there may be times when you have questions regarding the outcome of a claim edit. As with all claim review requests, these questions should be submitted using the Claim Investigation transaction on the NaviNet® web portal (NaviNet Open).

Learn more
Please review the Partners in Health Update article, Reminder: Enhanced claim edits to support correct coding principles, which was posted December 14, 2018.

For further questions about the enhanced claim editing process, review our Claim edit enhancements: Frequently asked questions (FAQ), which can also be found in the Frequently Asked Questions archive on Independence NaviNet Open Plan Central or in the Quick Links menu on the right-hand side of the Independence Provider News Center. The FAQ will be updated as more information becomes available.

If you still have questions after reviewing these resources, please send an email to claimeditquestions@ibx.com.³

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Submit your BlueCard® PPO Host claims to Independence to maximize incentive payments
Published September 24, 2019

You have an opportunity to increase the PPO incentive payments earned through our value-based incentive programs, like the Quality Incentive Payment System (QIPS) program, by sending your professional Host claims to Independence. PPO incentive payments are based on the attributed membership on record as of the payment month. To maximize the attribution of National BlueCard® PPO members, practices should submit professional claims to Independence.

Through the BlueCard Program, providers can render services to patients who are enrolled in a Blue Cross® and Blue Shield® Plan – other than one offered by Independence – and patients can visit physicians or facilities within the Independence five-county service area (i.e., Bucks, Chester, Delaware, Montgomery, and Philadelphia counties) for treatment.

There are two BlueCard PPO networks within the Independence five-county service area:
- Personal Choice® (Independence’s PPO network)
- Premier Blue (Highmark Blue Shield’s [Highmark] PPO network)

Maximize your incentive payments
To get the full benefit of your practice’s Independence incentive program, submit all your out-of-area claims directly to Independence.
**PPO professional providers**

PPO professional providers in the five-county network should submit BlueCard claims to the Plan with which they have a contract. A provider who contracts with both networks can choose to submit to either Highmark or Independence for members not covered by Highmark or Independence. Claims for Highmark or Independence members must be submitted to the Plan insuring the member. Here are examples of scenarios:

<table>
<thead>
<tr>
<th>Networks</th>
<th>Provider’s contract Plan</th>
<th>Member’s coverage Plan</th>
<th>Provider filing instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional PPO</td>
<td>Independence, Highmark, and Capital Blue Cross</td>
<td>Capital Blue Cross</td>
<td>The provider must submit the claim to Capital Blue Cross, the Plan who holds the member’s coverage.</td>
</tr>
<tr>
<td></td>
<td>Independence and Highmark</td>
<td>Capital Blue Cross</td>
<td>The provider can choose to submit to either Independence or Highmark since they are not contracted with the members coverage Plan. Please see information above for an opportunity to increase the PPO incentive programs by sending your professional Host claims to Independence.</td>
</tr>
<tr>
<td></td>
<td>Independence and Highmark</td>
<td>Independence</td>
<td>The provider must submit the claim to Independence, the Plan who holds the member’s coverage.</td>
</tr>
<tr>
<td></td>
<td>Independence and Highmark</td>
<td>Highmark</td>
<td>The provider must submit the claim to Highmark, the Plan who holds the member’s coverage.</td>
</tr>
<tr>
<td></td>
<td>Highmark</td>
<td>Independence</td>
<td>The provider must submit the claim to Independence, the Plan who holds the member’s coverage.</td>
</tr>
<tr>
<td></td>
<td>Independence</td>
<td>Highmark</td>
<td>The provider must submit the claim to Highmark, the Plan who holds the member’s coverage.</td>
</tr>
</tbody>
</table>

**PPO facility providers**

Facility providers in the five-county service area who are contracted with Independence must generally submit BlueCard claims to Independence for adjudication. With limited exceptions (unlike with PPO professional claims), the member’s coverage Plan does not impact which Plan the claim is submitted to for a facility claim. Those exceptions only apply to a PPO facility with a PPO contract with either Highmark or Capital Blue Cross.

If the facility treats a member of Highmark or Capital Blue Cross, then those claims must be submitted to the respective Plans. All other PPO facility claims for BlueCard should come to Independence because there is only one PPO facility network in Southeastern Pennsylvania.

All members are subject to eligibility verification and the applicable precertification requirements of their Home Plan.

**Ancillary providers**

For information and requirements about billing guidelines for lab, DME, and specialty pharmacy providers, please read this [article](#).

**Learn more**

If you have any questions about submitting BlueCard PPO host claims, contact our Provider Network Services team via email at [pnsproviderrequests@ibx.com](mailto:pnsproviderrequests@ibx.com). Please include “BlueCard PPO host claims” in the subject line of the email.

For more information about the BlueCard Program, visit the [BlueCard](#) section. ✦
Encourage pregnant Independence members to enroll in Baby BluePrints®

Published September 12, 2019

The Baby BluePrints program supports expectant mothers and promotes a healthy pregnancy throughout each trimester. We ask that you inform pregnant Independence members about the Baby BluePrints program at their first prenatal visit and encourage them to self-enroll by calling our toll-free number, 1-800-598-BABY (TTY: 711). Upon calling, a Registered Nurse Health Coach will explain the program to the member and ask her a series of questions to complete the enrollment process.

Once enrolled in the program, members will receive a welcome letter that includes information on how to access educational materials on our secure member website and how to use 1-800-598-BABY (TTY: 711) for questions and support during pregnancy. Eligible members enrolled in Baby BluePrints can receive monthly emails or IBX Wire® communications specific to each stage of pregnancy.* In addition, members who are found to have certain health issues or history that may place them at high risk are referred to a Registered Nurse Health Coach who is specially trained in maternity care for additional assessment and follow-up. If the assessment identifies the member as high-risk, they may be followed in our High-Risk Pregnancy Condition Management Program.

Resources available

Upon request, a flyer is available to place in the member’s chart and distribute at the first prenatal visit to encourage her to enroll in Baby BluePrints. To order flyers, please submit a request using our online form.

Postpartum office visits

As a reminder, 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 for new mothers and to answer questions around family planning, if necessary. These visits should be scheduled before members are discharged from the hospital.

If you have any questions about the program, please call Customer Service at 1-800-ASK-BLUE. ♦

*Standard message and data rates may apply. Text STOP to stop and HELP for help. Terms and Conditions available at myhelpsite.net/ibx. Notification messages within IBX Wire are sent via automated SMS. Enrollment in IBX Wire is not a requirement to purchase goods and services from Independence Blue Cross. Wire is a trademark of Relay Network, LLC., an independent company.
Registered Nurse Health Coaches: Supporting providers and their patients
Published September 13, 2019

Independence recognizes that the physician-patient relationship is at the heart of patient care. Our Registered Nurse Health Coaches can assist your practice and help provide coordination of care for your patients enrolled in an Independence benefit plan (members). We provide information for Independence members, their families, and physicians, as well as share community resources.

Coordination of care
Our highly skilled Registered Nurse Health Coaches and licensed Social Workers are available to support your practice in a variety of ways, including:

- coordinating community resources not covered by insurance, such as medication assistance, transportation services, food resources, and home modification programs;
- educating your patients on the importance of medication and plan-of-care adherence;
- assisting your patients in making appointments;
- reporting medication discrepancies and your patients’ needs that are otherwise unreported, such as the need for potential home care;
- assisting with closing gaps in care;
- educating your patients about shared decision-making, which leads to improved adherence to treatment plans;
- supporting your patients post-discharge;
- providing your patients with education about managing a new or chronic condition;
- encouraging your patients to discuss concerns and questions with their health care provider(s).

If you would like to refer an Independence member to a Registered Nurse Health Coach, please complete the online Physician Referral Form or call 1-800-313-8628.

Independence members who are covered through fully insured employer groups are automatically considered eligible for health coaching. Members covered through certain self-insured employer groups may not be eligible for all components of health coaching including condition management. Members can call Customer Service at 1-800-ASK-BLUE to verify their eligibility.
Now in effect: New claim payment policies for multiple therapies

Published Month September 3, 2019

As of September 1, 2019, Independence implemented new claim payment policies for multiple therapies for outpatient facility providers, specifically to include physical, occupational, and speech therapy services. These claim payment policies apply to specific CPT® and HCPCS codes that are designated by the Centers for Medicare & Medicaid Services (CMS) as “Always Therapy” for these services. Independence will include full payment for the procedure with the highest total allowance and reduced payment as described below for each subsequent procedure.

The following policies were posted to our Medical Policy Portal and went into effect September 1, 2019:
- **Commercial:** #00.01.68: Multiple Procedure Payment Reduction Guidelines for Physical, Occupational, and Speech Therapy Services
- **Medicare Advantage:** #MA00.050: Multiple Procedure Payment Reduction Guidelines for Physical, Occupational, and Speech Therapy Services

**Claims processing**
Facility outpatient therapy claims when multiple physical, occupational, and speech therapy services are reported by the same provider, for the same member, on the same date of service will be processed as follows:
- The procedure code with the highest total allowance is eligible for reimbursement at 100 percent of the provider’s applicable contracted rate.
- Each subsequent procedure code is eligible for reimbursement at 50 percent of the provider’s applicable contracted rate.

In addition, multiple procedures may be submitted on one claim or on multiple claims. These claim payment policies for services designated as “Always Therapy” are based on the date of service regardless of the date the claim was submitted or received.

**Learn more**
To view these policies, visit our Medical Policy Portal.

Refer to Attachment A of these policy documents to see the list of CPT and HCPCS codes for multiple therapies to which the claim payment policies described above apply.

For further questions about these new claim payment policies, review our New claim payment policy for multiple therapies: Frequently asked questions (FAQ), which can also be found in the Frequently Asked Questions archive on Independence NaviNet® web portal (NaviNet Open) Plan Central or in the Quick Links menu on the right-hand side of the Independence Provider News Center. The FAQ will be updated as more information becomes available.

If you still have questions after reviewing these resources, please call 1-800-ASK-BLUE.

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Reminder: Tysabri® added to the Most Cost-Effective Setting Program
Published September 3, 2019

As of September 1, 2019, Independence added the multiple sclerosis drug Tysabri® (natalizumab) to our Most Cost-Effective Setting Program for members enrolled in our commercial products. This program ensures that requests for certain high-cost specialty drugs are clinically appropriate and are being administered in settings that are safe and cost-effective. Recent expansions to our network of ambulatory (freestanding) infusion suite providers now give our members increased access to these cost-effective, convenient treatment sites.

Independence considers the following settings to be cost-effective for Tysabri:

- a physician’s office;
- an ambulatory (freestanding) infusion suite, not owned by a hospital or health system in our network.

*These settings must comply with a Risk Evaluation and Mitigation Strategies (REMS) program in order to be approved by Independence to administer Tysabri.

The hospital outpatient facility is still considered for members who are receiving an initial dose of Tysabri or if there is a clinical rationale that requires the member to receive Tysabri in the hospital outpatient facility.

Member and provider impact
In June 2019, Independence sent letters to notify members and prescribing providers affected by this change.

Members who have precertification approval from Independence to receive Tysabri in a hospital outpatient facility may continue treatment in this setting until their current precertification approval for Tysabri expires. At the next precertification review, Independence will evaluate the requested setting and make a coverage determination.

New requests for Tysabri received on or after September 1, 2019, are subject to Independence review for both setting and medical necessity during the precertification process.

The Independence precertification team will help providers identify treatment locations that are convenient for our members.

Learn more
Providers can find additional information about Tysabri in the Independence Medical Policy #08.00.64f: Natalizumab (Tysabri®). To access this medical policy, visit our Medical Policy Portal.

Visit our Most Cost-Effective Setting Program webpage for more information, including a downloadable list of all drugs in the program. ◆
Clinical Appropriateness Guidelines for Radiology to be updated

Published September 3, 2019

Effective November 10, 2019, AIM Specialty Health® (AIM), an independent company, will be using updated Clinical Appropriateness Guidelines for Radiology for Independence members.

Independence has contracted with AIM to perform utilization management activities for outpatient non-emergent diagnostic imaging services and certain high-technology radiology services for our managed care members. AIM will use the updated Clinical Appropriateness Guidelines for Radiology to determine the medical necessity for these services. To view current and future guidelines, go to the Resources section of AIM’s website.

Summary of the changes

Effective November 10, 2019, changes will be implemented to the following sections of the Clinical Appropriateness Guidelines for Radiology:

- Oncologic imaging
- Vascular imaging
- Imaging of the heart

To review the specific changes, please read the following News & Announcements articles announcing the updates that were posted to our Medical Policy Portal on August 8, 2019:

- Clinical Appropriateness Guidelines for Radiology to be updated for Independence Commercial Members
- Clinical Appropriateness Guidelines for Radiology to be updated for Medicare Advantage Members

Policies and guidelines

The following policies were posted as Notifications on August 16, 2019, and will go into effect on November 10, 2019. These policies include a list of procedure codes and a link to current and future radiology guidelines on AIM’s website:

- **Commercial**: #09.00.46x: High-Technology Radiology Services
- **Medicare Advantage**: #MA09.002j: High-Technology Radiology Services

To view Notifications for these policies, go to our Medical Policy Portal.
AIM to allow pre-service review for arterial ultrasounds

Published September 4, 2019

As of July 13, 2019, AIM Specialty Health® (AIM), an independent company, updated their internal process for arterial ultrasounds. AIM now allows pre-service requests for extremity arterial duplex imaging.

The CPT® codes for services impacted by this update are:
- 93978
- 93882
- 93924
- 93930
- 93979
- 93922
- 93925
- 93931
- 93880
- 93923
- 93926

These services can still be submitted to AIM for post-service review.

Background
Independence has contracted with AIM to perform utilization management activities for cardiovascular tests/diagnostic procedures and nonsurgical treatments for our managed care members. AIM uses the Clinical Appropriateness Guidelines for Arterial Ultrasound to determine the medical necessity for these services. To view AIM’s current guidelines, go to the Resources section of AIM’s website.

Policies and guidelines
The following medical policies include a list of procedure codes and a link to the cardiology guidelines on AIM’s website:
- Commercial: #11.02.27b: Percutaneous Coronary Intervention, Coronary Angiography, and Arterial Ultrasound
- Medicare Advantage: #MA11.113b: Percutaneous Coronary Intervention, Coronary Angiography and Arterial Ultrasound

To access these medical policies, visit our Medical Policy Portal.

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Updates to the medical benefit specialty drug cost-sharing list for 2020

Published September 30, 2019

Effective January 1, 2020, Independence will update its list of specialty drugs that require member cost-sharing (e.g., copayment, deductible, and coinsurance). Cost-sharing applies to select medical benefit specialty drugs for members who are enrolled in Commercial FLEX products and other select plans. The member’s cost-sharing amount is based on the terms of the member’s benefit contract. In accordance with your Provider Agreement, it is the provider’s responsibility to verify a member’s individual benefits and cost-share requirements.

The cost-share list will be expanded to include 186 drugs, including the following additions:
- abicipar*
- brolucizumab*
- cabotegravir*
- cosyntropin depot*
- crizanlizumab*
- eptacog-beta*
- eptinezumab*
- Lapelga (pegfilgrastim)*
- leuprolide mesylate*
- luspatercept*
- RVT-802*
- Synojoynt™ (1% sodium hyaluronate solution)
- Triluron™ (sodium hyaluronate)
- Xembify® (immune globulin subcutaneous, human-klhw)
- Zynteglo™ (betibeglogene darolentivec)*

The updated list of specialty drugs with cost-sharing is available on our website.

*Pending approval from the U.S. Food and Drug Administration (FDA).
Coverage criteria for the annual Synagis® (palivizumab) distribution program

Published September 9, 2019

The Synagis® (palivizumab) distribution program for the 2019-2020 respiratory syncytial virus (RSV) season, which is November through March in the northeastern United States, begins next month. RSV is the most common cause of bronchiolitis and pneumonia among children younger than one year.

During the RSV season, Independence will approve the monthly administration of Synagis for infants and children in accordance with the current recommendations from the American Academy of Pediatrics (AAP). These recommendations are subject to change based on updates in the AAP policy statement and Red Book®.

Medical necessity criteria for coverage

Synagis is a humanized monoclonal antibody that provides passive immunity against RSV. It is intended to decrease the morbidity and mortality associated with RSV lower respiratory tract disease in high-risk infants and children. Synagis is not effective in the treatment of RSV disease, and it is not approved for this indication.

Immune prophylaxis using Synagis is considered medically necessary and covered for a maximum of five doses during the RSV season for infants and children who meet medical necessity criteria and who have any of the following high-risk conditions (according to the AAP criteria):

- chronic lung disease (CLD) of prematurity;
- history of preterm birth (born before 29 weeks, 0 days) for infants who are younger than 12 months at the start of the RSV season;
- congenital heart disease;
- congenital abnormalities of the airway or certain neuromuscular diseases;
- cystic fibrosis with nutritional compromise and/or CLD;
- immunocompromised status (e.g., due to transplantation or chemotherapy).

An additional postoperative dose of Synagis is considered medically necessary and covered for infants or children younger than 24 months who are medically stable, meet any of the AAP criteria for immune prophylaxis, and have undergone one of the following procedures during the RSV season:

- surgical procedures that use cardiopulmonary bypass;
- cardiac transplantation.

If an infant or child receiving monthly prophylaxis with Synagis experiences a breakthrough RSV hospitalization, continued monthly prophylaxis with Synagis is considered not medically necessary due to the low likelihood of a second RSV hospitalization during the same season.

How to obtain Synagis for office use

Synagis is covered under the member’s medical benefit. For the 2019-2020 RSV season, it is mandatory for all participating providers to obtain Synagis for Independence members through PerformSpecialty®, an independent company.

The following guidelines apply when ordering Synagis:

- Providers should go to the Independence Direct Ship Drug Program webpage to download the new Synagis form. Our website now has a writeable form, which allows the information to be typed directly into the form online, rather than printing and faxing.
- The RSV form must include sufficient clinical information to meet our Synagis medical policy criteria, which are based on current AAP recommendations.
- If you opt to print, the completed form should be faxed to 1-855-851-4056, along with any necessary documentation to support the request. Incomplete forms may result in ordering delays.
- Since Independence pays PerformSpecialty directly, providers neither pay for doses ordered through PerformSpecialty nor receive reimbursement for the actual pharmaceutical.
- Synagis will generally be approved for office administration only, unless a patient is receiving home nursing services for a separate indication.
- Upon approval of the request, Synagis will be shipped to the provider’s office monthly during the RSV season. Shipping for the 2019-2020 RSV season begins on Thursday, October 31, 2019, and continues through Tuesday, March 31, 2020. Up to five doses (one dose every 30 days) will be shipped per member.

Learn more

Review Medical Policy #08.00.22m: Immune Prophylaxis for Respiratory Syncytial Virus (RSV) to learn more. To view this policy, visit our Medical Policy Portal.

If you have questions about the Synagis distribution program, please call Customer Service at 1-800-ASK-BLUE.
Certified registered nurse practitioners (CRNPs) provide healthcare to all age groups of patients based on their training. For example, CRNPs perform comprehensive and focused physical examinations, diagnose and treat common illnesses and injuries, provide immunizations and education, and manage high blood pressure, diabetes, and other chronic health problems. CRNPs can order and interpret diagnostic tests, such as X-rays, EKGs, and laboratory tests. They can also prescribe medications and therapies and can perform certain procedures (based on state/national practice guidelines).

Contracting and credentialing requirements
A CRNP must meet all of the requirements of Independence’s credentialing criteria and have a collaborative agreement with a participating physician who holds a current and unrestricted license. The training and scope of practice of the collaborating physician must be consistent with the practice of the CRNP. The agreement must comply with current applicable state and federal regulations.

Contracting and credentialing scenarios
CRNPs are only permitted to be contracted and credentialed with Independence under the following scenarios:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Allowed/Not allowed</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician PCP office</td>
<td>Allowed</td>
<td>CRNPs bill under their own NPI number unless service meets “incident to” guidelines (physician does not need to be in the office for CRNP to see members).</td>
</tr>
<tr>
<td>CRNP-only PCP office (no physician present)</td>
<td>Allowed</td>
<td>CRNPs must have a collaborative physician agreement.</td>
</tr>
<tr>
<td>Physician specialist office</td>
<td>Allowed</td>
<td>CRNPs bill under their own NPI number unless it meets “incident to” guidelines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A physician must be present in the office for at least 75 percent of the hours in which the office is scheduling patients for a CRNP to be contracted and credentialed with Independence.</td>
</tr>
<tr>
<td>CRNP-only specialist office</td>
<td>Not allowed</td>
<td></td>
</tr>
<tr>
<td>CRNP-only hospital or nursing home practice</td>
<td>Not allowed</td>
<td></td>
</tr>
</tbody>
</table>

Learn more
More information about our credentialing process can be found on our Professional Provider Credentialing webpage.

FAQ
The information in this article has also been added to our Updated credentialing requirements and reimbursement position for CRNPs and PAs (FAQ), which can also be found in the Frequently Asked Questions archive on Independence NaviNet® web portal (NaviNet Open) Plan Central or in the Quick Links menu on the right-hand side of the Independence Provider News Center. Note: The FAQ will be updated as more information becomes available.

Policies
As a reminder, as of June 1, 2019, Independence updated the following policies on reimbursing CRNPs:

- **Commercial**: #00.10.40c: Incident To and Non-Incident To Services Performed by Certified Registered Nurse Practitioners (CRNPs) and Physician Assistants (PAs)
- **Medicare Advantage**: #MA00.045c: Incident To and Non-Incident To Services Performed by Certified Registered Nurse Practitioners (CRNPs) and Physician Assistants (PAs)

To view these policies, visit our Medical Policy Portal.
View up-to-date policy activity on our Medical Policy Portal

Published September 24, 2019

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

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

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

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

To access the Site Activity section, go to our Medical Policy Portal and select Accept and Go to Medical Policy Online. From there you can select Commercial or Medicare Advantage under Site Activity to view the monthly changes. To search for active policies, select either the Commercial or Medicare Advantage tab from the top of the page. To access policies from the NaviNet® web portal (NaviNet Open), go to Independence NaviNet Open Plan Central and select Medical Policy Portal under Quick Links in the right-hand column.  

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News & Announcements

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

Recently published News & Announcements include:

- Updated Preventive Coverage of Human Papillomavirus (HPV) Vaccine and Serogroup B Meningococcal (MenB) Vaccines (commercial only)
- Coverage of Interprofessional Internet Consultation (Medicare Advantage only)

Save the date! Pennsylvania will host Medication-Assisted Treatment Regional Summits this fall

Published September 19, 2019

Pennsylvania’s Department of Drug and Alcohol Programs and Department of Health are holding a series of eight regional summits to address medication-assisted treatment (MAT) of opioid use disorder.

Attendees will receive four hours of live buprenorphine waiver training, followed by education that addresses the potential challenges for clinicians who offer MAT to patients.

Register

For more information, such as summit dates for Pennsylvania regions and registration information, please visit the Pennsylvania Medical Society website.

Learn more

Visit our Opioid Awareness page for additional resources to assist you in managing your patients who are prescribed opioid medications.
Expanding preventive coverage of HPV vaccine

Published September 27, 2019

The Advisory Committee of Immunization Practices (ACIP), a committee within the Centers for Disease Control and Prevention, previously considered the human papillomavirus (HPV) vaccine preventive for individuals aged 9 through 26 years. However, on August 15, 2019, the ACIP updated their recommendation to include an expanded age recommendation for HPV vaccination and now recommends HPV vaccination based on shared clinical decision making for individuals aged 27 through 45 years who are not adequately vaccinated.

As of August 15, 2019, Independence began covering the HPV vaccine as a preventive service with $0 cost-share (i.e., copayment, deductible, and coinsurance) for individuals aged 9 through 45 years, consistent with the ACIP recommendations listed below.

ACIP recommendations

9-valent human papillomavirus vaccine (9vHPV) is considered medically necessary and, therefore, covered for the following individuals:

- Routine two-dose regimen of 9vHPV for individuals 11 years or 12 years of age administered 6 – 12 months apart. The vaccination series is covered beginning at 9 years.
- Individuals who begin the vaccination series at age 15 years through 26 years are covered for the three-dose regimen of 9vHPV vaccine.
- Catch-up vaccination for females age 13 years through 26 years who have not been vaccinated previously, who have not completed the three-dose series, or with primary or secondary immunocompromising conditions that might reduce immunity. If a female reaches age 26 years before the vaccination series is complete, remaining doses will be covered after age 26 years.
- Catch-up vaccination for males 13 years through 26 years of age who have not been vaccinated previously, who have not completed the three-dose series, or with primary or secondary immunocompromising conditions that might reduce immunity.
- Vaccination when indicated by shared clinical decision-making for individuals 27 years through 45 years who are not adequately vaccinated.

Learn more

For more information, refer to the following news article and medical policies:

- Updated Preventive Coverage of Human Papillomavirus (HPV) Vaccine and Serogroup B Meningococcal (MenB) Vaccines
- #08.01.04u: Immunizations
- #00.06.02z: Preventive Care Services

To view the news article and these policies, visit our Medical Policy Portal.
Coverage update for surgical and minimally invasive treatments for urinary outlet obstruction due to BPH

Published September 27, 2019

Effective December 2, 2019, Independence will update its policies regarding surgical and minimally invasive treatments for urinary outlet obstruction due to benign prostatic hyperplasia (BPH) for both commercial and Medicare Advantage members. This update is to reflect changes in coverage criteria.

Summary of changes

Here is a summary of the changes that will occur:

- Transurethral destruction of prostate tissue by radiofrequency generated water vapor thermotherapy (Rezum System) is considered experimental/investigational for both commercial and Medicare Advantage members by Independence and, therefore, not covered because the safety and/or effectiveness in the treatment of urinary outlet obstruction due to BPH has not been established by review of the available published peer-reviewed.
- Prostate artery embolization is considered experimental/investigational for both commercial and Medicare Advantage members by Independence and, therefore, not covered because the safety and/or effectiveness in the treatment of urinary outlet obstruction due to BPH has not been established by review of the available published peer-reviewed.
- Medically necessary coverage language for transurethral needle ablation (TUNA) is removed from the commercial and Medicare Advantage policies. This procedure is no longer recommended per American Urological Association (AUA) guidelines for the treatment of lower urinary tract symptoms (LUTS) attributed to BPH.
- Simple prostatectomy and transurethral incision of the prostate (TUIP) are considered medically necessary and, therefore, covered when medical necessity criteria are met for both commercial and Medicare Advantage members.
- Coverage of medically necessary procedures will be for individuals 45 years or older with a diagnosis of lower urinary tract symptoms secondary to benign prostatic hypertrophy.
- Removal of prostate specific antigen (PSA) language from the medical necessity language for prostatic urethral lift (Urolift).

The following policies were posted to our Medical Policy Portal as Notifications on September 3, 2019, and will go into effect December 2, 2019:

- **Commercial:** #11.17.06m: Surgical and Minimally Invasive Treatments for Urinary Outlet Obstruction due to Benign Prostatic Hyperplasia (BPH)
- **Medicare Advantage:** #MA11.004f: Surgical and Minimally Invasive Treatments for Urinary Outlet Obstruction due to Benign Prostatic Hyperplasia (BPH)

To view the Notifications for these policies, visit our Medical Policy Portal.
Claim investigation and corrected claim submission procedures

Published September 17, 2019

To help expedite your claim review requests submitted through the Claim Investigation transaction on the NaviNet® web portal (NaviNet Open), we would like to remind providers that claim edits and claim corrections are not permitted. If you need to edit any data field on a claim, a corrected claim must be submitted with the new information, and you need to note the original claim number on the corrected claim.

Corrected claims

The term “corrected claim” is meant for corrections to claims that were processed and finalized in the adjudication system and for which a claim number was assigned. By submitting a corrected claim the provider wishes to have the following performed on the original claim:

- replacement of prior claim (correction of the charges/services/diagnosis/modifier originally submitted by the provider);
- void/cancellation of prior claim (reflecting the elimination of a previous claim in its entirety);
- addition of late charges to an inpatient claim after the original claim was processed.

The corrected claim must be submitted under the same National Provider Identifier (NPI) as the original claim. If a claim was originally submitted under the wrong NPI, you must then submit a void request for the original claim number. Once the claim has been voided, you can submit a new claim under the correct NPI.

Providers must follow the instructions detailed in the following sections to ensure their corrected claims are accurately processed in a timely manner. A common billing error is to resubmit an original claim type versus following the corrected claim submission instructions below. If more than one original claim type is received for the same encounter, it may be denied as a duplicate with reference to rebill as a corrected versus original claim submission.

Electronic claims

As a reminder, there are specific guidelines in the *Independence Blue Cross HIPAA Transaction Standard Companion Guide* that providers must follow when resubmitting a claim for an adjustment.

In order for the adjustment to occur, the following Loop ID/Reference segments must be populated accordingly:

- Loop ID: 2300, Reference: CLM05-3 (Claim Frequency Type Code);
- If CLM05-3 contains 5 (Late Charge(s) – institutional only), 7, or 8, prior claim information is required. The following segments are required in Loop 2300:
  - REF – Payer Claim Control Number (REF01 = F8 and Independence Claim Number in REF02)
  - NTE – Billing Note (NTE01 = ADD and detailed description regarding the adjustment in NTE02)

Claim resubmission

Claim Frequency Type Codes that tie to a “prior claim” or “finalized claim” refer to a previous claim that has completed processing in the payer’s system and has produced a final paper/electronic Provider Explanation of Benefits (professional) or Provider Remittance (facility).

Please note the following:

- Previous claims that are pending due to a request from the payer for additional information are not considered a “prior claim” or “finalized claim.”
- An 837 professional claim transaction is not an appropriate response to a payer’s request for additional information. Rather, providers must follow the instructions within the request for returning the additional information. At this time, there is no EDI transaction available to return the requested information.
- Previous claims that were rejected for “front-end” edits via the 277CA (electronic) or rejection letter (paper) are not considered candidates for “corrected claim” submission. These previous claims did not have claim numbers assigned nor was a final Provider Explanation of Benefits (professional) or Provider Remittance (facility) produced. Net new claims will need to be submitted with the updated data resolving the reason for rejection.

- When submitting “corrected claims,” please be sure to include:
  1. all services originally billed and not just the service that needs correction;
  2. the original claim number.

continued on the next page

NaviNet Open transaction: 1500 Claim Submission

Providers may submit certain corrected claims through the 1500 Claim Submission transaction. This transaction can be used to expedite local professional corrected claims with a frequency code: 7 = Replacement of prior claim or a frequency code: 8 = Void/cancellation of prior claim.

When using Claim Frequency Type Code 7 (Replacement of prior claim) or 8 (Void/cancellation of prior claim), the provider must complete the Original Claim Number field.

A notes field is available in the Remarks section of the 1500 Claim Submission – Header to provide a detailed description.

For further instructions on how to use the 1500 Claim Submission transaction, please read the Claim Submission Guide, which can be found under User Guides and Resources in the NaviNet Open section.

Paper claims

CMS-1500 claim form

Box 22 – Resubmission and/or Original Reference Number

Follow the instructions from the National Uniform Coding Committee (NUCC) billing requirements:

- List the original reference number for resubmitted claims.
- When submitting a claim, enter the appropriate resubmission code in the left-hand side of the field.
  - 7 = Replacement of prior claim
  - 8 = Void/cancellation of prior claim

Example:

![Image of CMS-1500 claim form]

For more information, please refer to the 1500 Claim Form Reference Instruction Manual, which is available by selecting 1500 Instructions from the 1500 Claim Form tab on the NUCC website.

UB-04 claim form

Field location 4 – Type of Bill – Frequency Code

When submitting a claim, enter the appropriate Frequency Code in the fourth position of the Type of Bill:

- 5 = Late Charge(s) only
- 7 = Replacement of prior claim
- 8 = Void/cancellation of prior claim

Field location 64 – Document Control Number

This field is used to capture the original reference/claim number, which is required for corrected claims.

Learn more

If you have additional questions, please contact our Provider eBusiness team through our online Provider eBusiness Inquiry form.

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Action needed! NaviNet® Open email validation

Published September 23, 2019

In the coming weeks, all NaviNet web portal (NaviNet Open) end users will be asked to provide and verify a valid email address. A prompt response will be required to avoid potential disruption of access to NaviNet Open.

For detailed information on the email validation, please read the Email Address - Frequently Asked Questions document, which can also be accessed from the NaviNet Open logon screen as shown below.

Learn more

If you have questions about this process or about NaviNet Open, please contact our Provider eBusiness team through our online Provider eBusiness Inquiry form.

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$0 cost-share program for certain prescription medications through December

Published September 23, 2019

Beginning October 1, 2019, Independence will offer a $0 cost-sharing (i.e., no copayment or coinsurance) to certain Independence members for many medications used to treat certain chronic conditions when filled at Walgreens or most in-network independent pharmacies through December 31, 2019.*

*Members in plans with a deductible applicable to the drug being dispensed are still responsible for meeting the deductible before receiving eligible medications at a $0 cost-share. Medicare Advantage members are not eligible for the $0 cost-share program.

How the program works

Independence is continually trying to find new and innovative ways to help our members live healthier lives and get the most value from their health plan. We encourage our members to take preventive medications and manage their chronic conditions. This can help prevent complications or avoid costly trips to the emergency room or hospital. This $0 cost-share program is open to most large group (51+) commercial fully insured members with prescription benefits through Independence with the following stipulations:

- specific to many medications used to treat the following:
  - asthma/COPD
  - diabetes
  - high blood pressure
  - high cholesterol
  - mental health related
  - osteoporosis
  - pre-natal vitamins
- limited to 30-day fills of preferred brand and generic medications (no non-preferred or specialty drugs).

This month, Independence will contact members who have recently been dispensed an eligible medication to provide them with more details on the $0 cost-share program.

Learn more

Providers and members can contact the Pharmacy Benefits phone number on the back of an Independence member’s ID card to verify eligibility for the $0 cost-share.

To see a list of many of the commonly prescribed medications used to treat the identified chronic conditions that will be available to qualifying members at a $0 cost-share, visit our dedicated webpage.

Walgreens is an independent pharmacy retailer.
Contact numbers
Please visit the Contact Information section of the Providers section of our website for a complete list of important telephone numbers.

Websites

NaviNet® Open
The NaviNet web portal (NaviNet Open) is our secure, online provider portal that gives you and office staff access to critical administrative and clinical data. To help you navigate the portal and various transactions, we have created a central location for a variety of NaviNet Open resources, including user guides, webinars, and a communications archive.

Utilization Management
Certain utilization review activities are delegated to different entities. Here you will find detailed information on our utilization management programs and common resources used among them.

Opioid Awareness
We have created a repository of tools and resources to assist you in managing your patients who are prescribed opioid medications.

Quick Links
- Bulletins
- Forms
- Frequently Asked Questions
- Medical Policy
- NaviNet Open Login
- Provider Home
- Services that require precertification
  - Commercial
  - Medicare Advantage

Archives
- Partners in Health Update past edition PDFs
- Cumulative Index
- ICD-10 Transition

Email sign up
- Sign up for email from Provider Communications

Provider Communications
Independence Blue Cross
1901 Market Street
28th Floor
Philadelphia, PA 19103

provider_communications@ibx.com

Partners in Health UpdateSM is a publication of Independence Blue Cross and its affiliates (Independence) created to provide valuable information to the Independence-participating provider community that provides Covered Services to Independence members. This publication may include notice of changes or clarifications to administrative policies and procedures that are related to the Covered Services you provide in accordance with your participating professional provider, hospital, or ancillary provider/ancillary facility contract with Independence. Refer to the Provider News Center to stay up to date on news and information from Independence.

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

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