Table of contents

Contact information

Important telephone numbers

Resource	Contact information
Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707
Baby BluePrints® Perinatal case management	215-241-2198 1-800-598-BABY [2229]
Carelon Medical Benefits Management (Carelon) Preapproval/Precertification requests for CT/CTA, MRI/MRA, PET, nuclear cardiology, facility sleep studies, continuous positive airway pressure titration, sleep equipment (APAP, BPAP, CPAP), related supplies, Cardiology Utilization Management Program, and Musculoskeletal Utilization Management Program	1-866-745-1791
Credentialing Credentialing violation hotline Credentialing and re-credentialing inquiries Credentialing application corrections	Phone: 215-988-1413 *CredInquiries @ibx.com* Fax: 215-238-2549
Customer Service	
Keystone Health Plan East HMO/POS Hours: Mon. – Fri., 8 a.m. – 6 p.m.	1-800-ASK-BLUE
Personal Choice® PPO Hours: Mon. – Fri., 8 a.m. – 6 p.m.	1-800-ASK-BLUE
Federal Employee Program (FEP) Hours: Mon. – Fri., 8 a.m. – 5 p.m.	215-241-4400
Keystone 65 HMO/POS 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)	215-241-2365 1-800-645-3965
Personal Choice 65SM PPO 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)	215-561-4877 1-888-718-3333
MedigapSecurity, MedigapFreedom, and Security 65® 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)	1-888-926-1212
Language Assistance Services Language assistance services are offered for Members who prefer a language other than English.	Customer Service: see telephone numbers above. TTY/TDD: 711

Resource	Contact information
eviCore healthcare (eviCore) Preapproval/Precertification requests for nonemergent outpatient radiation therapy services Preapproval/Precertification and/or prepayment reviews for genetic/genomic tests, certain molecular analyses, and cytogenetic tests	1-866-686-2649
FutureScripts® (Pharmacy Benefits) Hours: Mon. – Fri., 8 a.m. – 6 p.m.	Phone: 1-888-678-7012 Fax: 1-888-671-5285
FutureScripts® Secure (Medicare Part D) Hours: Mon. – Fri., 8 a.m. – 6 p.m.	1-888-678-7015
Blood Glucose Meter Hotline	1-888-678-7012
Health Coaching	
Case management HMO/PPO (Medicare Advantage and Commercial) Hours: Mon. – Fri., 8 a.m. – 5 p.m. **Condition management** Hours: 24 hours a day, 7 days a week	1-800-313-8628
Highmark EDI Operations Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-800-992-0246
Independence Administrators	1-888-356-7899
Independence Blue Cross and Highmark Blue Shield Caring Foundation	1-800-464-5437
Keystone First Hours: Mon. – Fri., 8 a.m. – 5 p.m. Nurse on call 24 hours a day	1-800-521-6007
Mental Health/Substance Abuse	
Magellan Healthcare, Inc. Customer Service and Preapproval/Precertification	1-800-688-1911
For Keystone Health Plan East Members with Caring Foundation benefits	1-800-294-0800
Independence Administrators Hours: 24 hours a day, 7 days a week	1-800-634-5334
Provider Engagement, Analytics & Reporting (PEAR) portal support	1-833-444-PEAR (1-833-444-7327)
Tandigm Health	Phone: 1-844-TANDIGM, option 5 Fax: 215-238-2271

Claims mailing addresses

For a complete list of claims submission addresses, refer to the facility payer ID grid at *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:

> Outer County Claims – Lehigh, Lancaster, Northampton, and Berks County
> Claims Receipt Center
> P.O. Box 211184
> Eagan, MN 55121

Appeals mailing addresses

> Facility appeals (Inpatient Appeals for Hospitals)
> P.O. Box 13985
> Philadelphia, PA 19101-3985

> Outpatient appeals (except ER)
> Provider Appeals
> P.O. Box 41453
> Philadelphia, PA 19101-1453

> ER services appeals
> Claims Medical Review – ER Review
> Independence Blue Cross
> 1901 Market Street
> Philadelphia, PA 19103-1480

> Payment review for lack of Preapproval
> Facility Payment Review
> P.O. Box 13985
> Philadelphia, PA 19101-3985

> Host appeals
> Independence Blue Cross
> 1901 Market Street, 17th Floor
> Philadelphia, PA 19101-1480

Provider Network Services

The Provider Network Service (PNS) team within Independence Blue Cross (Independence) supports Hospitals, individual community professional Providers, and ancillary entities across nine counties within the greater Philadelphia area. PNS's primary customers are its Provider communities that are dedicated to serving the health and well-being of Independence Members.

The PNS team plays a critical role in educating our network Providers and their administrative staff on policies, procedures, and specific billing processes. Network Coordinators within PNS also serve as a liaison for network Providers and may promote or suggest workflow solutions.

To continue to build and sustain a strong working relationship with Participating Providers, PNS supports the Provider community about the following types of inquiries:

- claim payment discrepancies for facility and ancillary Providers;

- capitation roster and/or payment-related inquiries;

- medical policy and procedural issues related to claim payments;

- general education regarding products, networks, and procedural guidelines.

While we encourage our Providers to utilize the self-service tools available through PEAR Practice Management (PM) to expedite requests involving verification of Member eligibility, claims status, and claim inquiry submission, we realize there are occasions when Providers may need to escalate their issues to PNS.

Note: The PNS team cannot revise claims submissions.

To better serve our Provider network, PNS aligns its resources into two distinct teams:

- **IDS.** Our Integrated Delivery System (IDS) team supports practice administrators and payor relations management staff within an IDS, inclusive of owned hospitals, physicians, ancillaries, and other care facilities.

- **Community Providers.** Our Community team supports practitioners or practice administrators (PCP and/or Specialist offices) that are **not owned** by an IDS.

PNS Contact Tool (for IDS only)

The PNS Contact Tool identifies the Network Coordinator that is designated to support each IDS. The tool will display the Network Coordinator's name, direct telephone number, fax number, manager, and the Medical Director who supports the IDS. Inquiries can also be submitted directly to your IDS's designated Network Coordinator through this tool.

To use the PNS Contact Tool, go to *www.ibx.com/providers* and select Contact Us from the "Providers" drop-down menu. The tool will require that you enter your specialty and either your National Provider Identifier (NPI) or your tax ID number to perform a search. The information for your IDS's Network Coordinator will then be displayed.

Inquiry submission guidelines

Below are the steps to follow when submitting an inquiry to PNS.

For claim payment discrepancies:

IDSs	Community Providers
Step 1: Submit your inquiry via PEAR PM. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 2.	**Step 1:** Submit your inquiry via PEAR PM. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 2.
Step 2: Contact Provider Services at 1-800-ASK-BLUE and follow the voice prompts. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 3.	**Step 2:** Contact Provider Services at 1-800-ASK-BLUE and follow the voice prompts. If you are unsuccessful in reaching a satisfactory resolution and require further assistance, please go to Step 3.
Step 3: Contact your IDS's designated Network Coordinator.	**Step 3:** Complete a *Provider Network Services inquiry request* form. A Network Coordinator will be assigned to respond to your inquiry.

For any of the following inquiry types, please follow the steps outlined below:

- capitation roster and/or payment-related inquiries

- medical policy and procedural issues related to claim payments

- general education regarding products, networks, and procedural guidelines

IDSs	Community Providers
Step 1: Contact Provider Services at 1-800-ASK-BLUE and follow the voice prompts. If you are unsuccessful in reaching a satisfactory	**Step 1:** Contact Provider Services at 1-800-ASK-BLUE and follow the voice prompts. If you are unsuccessful in reaching a satisfactory
resolution and require further assistance, please go to Step 2.	resolution and require further assistance, please go to Step 2.
Step 2: Contact your IDS's designated Network Coordinator.	**Step 2:** Complete a *Provider Network Services inquiry request* form. A Network Coordinator will be assigned to respond to your inquiry.

Demographic changes

For IDSs, facilities, skilled nursing facilities, and ancillary Providers, notice of all changes must be submitted in writing to our contracting and legal departments at the following addresses:

> Independence Blue Cross
> Attn: Senior Vice President, Total Value Contracting & Reimbursement
> 1901 Market Street, 27th Floor
> Philadelphia, PA 19103

> Independence Blue Cross
> Attn: Deputy General Counsel, Managed Care
> 1901 Market Street, 43rd Floor
> Philadelphia, PA 19103

or as provided in your Agreement.

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

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 communications 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 identification and resolution of claim inquiries.

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

Provider Communications

To access the most current and updated information regarding Independence and our policies, procedures, and processes, refer to our Provider News Center at *www.ibx.com/providers*, PEAR portal, and this *Hospital Manual*. These resources are designed to work in unison to provide your facility with timely informational updates.

To receive email updates that provide you with the latest information, including 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. You can also find pharmacy information and resources for patient management.

Provider News Center

The Provider News Center, located at *www.ibx.com/providers*, 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 facility.

Provider Engagement, Analytics & Reporting (PEAR) portal

In addition to fast, secure, and HIPAA-compliant access to Provider and Member information and real-time transactions, Providers have access to a valuable source of information on our PEAR portal. The portal contains important tools and resources, including:

- the latest Provider news and announcements;

- the most current version of our publications and manuals;

- links to fee schedule information and resources;

- contact information.

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 Disclose Health Information* form from *www.ibx.com/privacy* or request a copy by calling Customer Service.

Any PHI sent to Independence should be sent in compliance with the Provider's HIPAA privacy and security obligations as a Covered Entity. *Note:* Providers should *not* submit Member Social Security numbers in communications to Independence. Providers should use the Member's unique Member ID (UMI), which is located on the front of each Independence Member's ID card.

When submitting faxes, please ensure the following Member information is included:

- name

- UMI

- address

- age

- Primary Care Physician name

- admission date

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 Act (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.

Additionally, you will need to inform Independence in writing on your company letterhead of any third-party vendors you have granted permission to act on your behalf and submit inquiries pertaining to credentialing, practitioner linkages, claim status, and claim investigations.

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. Any PHI sent electronically to Independence should be sent securely in compliance with the Provider's HIPAA privacy and security obligations as a Covered Entity. 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 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 Member Website and App

We encourage our Members to utilize our digital tools via our member website, ibx.com, and the IBX mobile app, our free smartphone app, which is available for both iPhone and Android phones. Members can easily manage health plan benefits for themselves and covered dependents.

- View benefits and see what's covered

- Review out-of-pocket costs and deductible amounts

- Access and organize claims

- View, share, or order a member ID card

- Get answers specific to a member's plan using an enhanced Ask IBX search bar

- Pay online if a member purchases insurance on their own plan.

The member site also offers expanded Provider search capabilities so members can manage their health. Members can:

- easily find in-network doctors, hospitals, pharmacies, labs and other providers;

- select or change a primary care physician; view open referrals;

- find designated sites for labs, radiology, and more.

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 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

IBX Wire is not currently available for Medicaid or Children's Health Insurance Program (CHIP) Members.

Cost and quality transparency tools

Our Member website, *ibx.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.

The Find a Doctor tool and Care Cost Estimator 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, procedures, and have access to 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.

- Enhanced cost estimator allows Members to search and compare Providers by estimated price, based on the Member's specific health plan. Cost estimates can be found for a variety of common procedures by taking into consideration a Member's current Deductible balance, Copayment amounts, out-of-pocket limits, and, if applicable, Coinsurance.* The tool also displays Provider details and quality information, such as reviews, allowing Members to make more informed decisions about how to spend their health care dollars.

These estimated costs are not a guarantee of your liability. Payment of claims and member liability are based on the terms of your health benefit plan, eligibility at the time the services are provided, co-payments and co-insurance, and the actual services submitted for payment by your provider.