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Rendering services

Be sure to verify Member eligibility and cost-sharing amounts (i.e., Copayments, Coinsurance, and Deductibles) before scheduling and performing services, including preventive ones.

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. Members can access this information by logging onto our secure Member website via *www.ibx.com*. 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 Practice Management (PM) application on the Provider Engagement, Analytics & Reporting (PEAR) 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 & Benefits transaction on PEAR PM.

  If you need assistance using the transaction, please review the training materials on the PEAR Help Center at *www.pearprovider.com*.

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 PEAR PM.

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 in the Benefits & Coverages tab on the Details page when using the Eligibility & Benefits transaction on PEAR PM.
  - 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 & Benefits transaction on PEAR PM should be used to verify your 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.

- Blue High Performance NetworkSM (Blue HPN) for employer groups uses the Personal Choice®/PPO Limited Network. BlueHPN utilizes an EPO product model. Members must receive care from BlueHPN providers to maximize coverage in all BlueHPN markets. Out-of-network coverage is limited to urgent/emergent care only; all other care received from non-BlueHPN providers is not covered. You can see a patient's membership status on their ID card ("BlueHPN in a suitcase" logo) or in the Eligibility & Benefits transaction on PEAR PM. Patients will be guided to BlueHPN providers by their employer or other BlueHPN referring health care providers. You can verify your participation in BlueHPN on our Find a Doctor tool; refer to Blue High Performance 1 within the Medical Plans dropdown. Providers should use the same pre-service review and other procedures as used for BlueCard PPO patients.
- 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 & Benefits transaction on PEAR PM.

- **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 Copayment is greater than the allowable amount, only the allowable amount should be collected from the Member. However, a Member's cost-share is applied *per visit*, not per claim line. Accordingly, in a case where the Member's specified cost-sharing is greater than the allowable amount for a service during a visit, but multiple services are rendered during that visit that have an allowable amount that, in the aggregate, is greater than the Member's specified cost-sharing, the Member cost-sharing should still be collected in full. In the event that the Copayment is collected, and the Provider or facility subsequently determines that the allowed amount is less than the Copayment, the difference between the allowable amount and the Copayment for the service must be refunded 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. The cost-share for Medicare Advantage Members will be reduced to $0 cost-share if during the procedure, the colonoscopy becomes diagnostic.
- 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*

  Note: The Eligibility & Benefits transaction on PEAR PM includes a “Site of Service” indicator. This indicator is to alert Providers that the Member has a plan with a site-of-service benefit.
- 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 Professional Provider Agreement (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 Keystone 65 Basic HMO, Keystone 65 Select HMO, and Keystone 65 Preferred HMO Members enrolled in the Vital Care program, a program for members with both diabetes and congestive heart failure, and Keystone 65 Focus HMO-POS Members enrolled in the Vital Care Plus program, a program for members with diabetes, the specialist Copayment will vary. Therefore, the Eligibility & Benefits transaction on PEAR PM should be used to verify your patients’ Copayment amount for their office visit.

  - Members can save on cost-sharing (i.e., copayment, deductible, and coinsurance) when accessing care, based on where that care is received. Additional services that Members can save on include:
    - biotech/specialty injectable drugs
    - infusion therapy
  - Certain plans have an added observation room copayment, equal to the emergency room copayment in most cases, or equal to the outpatient hospital copayment for Medicare Advantage plans. This occurs when that service is part of an emergency room visit or an inpatient stay. The Member will not have more than two copayments when the observation room copayment is applied.

- **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*.

    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 can get up to a 90-day supply of maintenance medications at Walgreens pharmacies for the same cost-sharing as mail order. For Medicare Advantage, this applies to tier 1 or tier 2 drugs at any Preferred retail pharmacy.
  - 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 $7,900.00 for an individual, and $15,800.00 for a family. To verify if Members have reached their out-of-pocket maximum for essential health benefits, Providers should use the Eligibility & Benefits transaction on PEAR PM.

    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.

– *Medicare Advantage HMO and PPO Members.* CMS has mandated a maximum out-of-pocket (MOOP) limit for all Medicare enrollees. The MOOP will establish an annual limit on total enrollee cost-sharing liability (e.g., Deductibles, Copayments, Coinsurance) for Medicare Part A and B services. Its dollar amount will be established annually by CMS but will not change during the calendar year.

  Once Medicare Advantage HMO and PPO Members reach their MOOP limit, they will have no liability for the remainder of the calendar year for Medicare Part A and B claims. Use PEAR PM to check all Medicare Advantage HMO and PPO Members' benefits as they relate to cost-sharing for every office visit.

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.*

Missed appointments

Providers are required to conduct affirmative outreach whenever a Keystone HMO Children's Health Insurance Program (CHIP) enrollee misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the enrollee. Such attempts may include but are not limited to: written attempts; telephone calls; and home visits. At least one (1) such attempt must be a follow-up telephone call.

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 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 and individual Medicare Advantage Members seeking services from specified providers as permitted by Independence's medical policies ("Providers") who offer telemedicine services as an additional method of delivery. These encounters allow our Members to interact with Providers 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.

The platform utilized by Providers to furnish telemedicine shall comply with all applicable federal and state laws regarding privacy and security of patient information, including but not limited to HIPAA and 42 C.F.R. Part 2. Within ten (10) days upon Independence's request, a Provider shall be required to submit complete and accurate responses to Independence's standard Supplier Information Privacy & Security Attestation. Providers shall not use the technology platform in contravention of any of Provider's obligations under any federal, state, or local laws, including but not limited to privacy laws or regulations.

Benefits include:

- Gives Providers 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 nonemergency 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 Services policy, which is available on our Medical Policy Portal at *https://medpolicy.ibx.com/ibc/pages/home.aspx*.

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 PEAR PM. Referrals can be accessed at any time. 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 PEAR PM are electronic, you are not required to mail hard copies of these Referrals to Independence.

Medicare Advantage HMO plans

Medicare Advantage HMO Members do not require a Referral from their PCP when they need to see an in-network, participating specialist. PCPs are required to direct Medicare Advantage HMO Members to their capitated site for laboratory services. In addition, Providers are still required to obtain Preapproval/ Precertification for certain services prior to rendering services for all Medicare Advantage Members.

Note: Radiology and physical therapy services for Keystone 65 Focus Rx HMO (Keystone 65 Focus) Member must be directed to a Participating Provider in the Keystone 65 Focus network.

Medicare Supplement plans

Members in one of our Medicare Supplement (Medigap) plans do not require a Referral from their PCP to see another provider.

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/Precertification.
- If a Participating Provider is not available for Referral or direction of the Member, the ordering Provider must obtain Preapproval/Precertification 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 noncovered 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 noncovered 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/Precertified by Carelon Medical Benefits Management (Carelon) or eviCore healthcare (eviCore), independent companies
- dialysis

POS Members may need Preapproval/Precertification 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 PEAR PM using the Referral Search transaction.

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, acupuncture, 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/Precertification 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, acupuncture, and physical/occupational therapy services. For services requiring Preapproval/Precertification through Carelon or eviCore, a separate Referral is not required.
- 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.

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.

CMS prohibits preapproval/precertification for out-of-network services on Medicare Advantage PPO products.

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

Use the Referral Submission transaction in PEAR PM 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/Precertification requirements and/or benefits exceptions. CMS prohibits preapproval/precertification for out-of-network services on PPO products.

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/Precertification. Any pre-admission testing and hospital-based Physician services (e.g., anesthesia) will be covered under the hospital or surgical Preapproval/Precertification. Please ensure the Referral, when required, is on file to the specialist or attending/admitting Physician prior to rendering the surgical/outpatient procedure or other outpatient service or your facility-based portion of the claim may be denied for lack of Referral.

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

Note: Certain products have specialized Referral and Preapproval/Precertification 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

**Referrals are not required for Medicare Advantage Members.*

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/ Precertification. For a list of services that require Preapproval/Precertification, 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 PEAR PM, 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 KHPE Commercial and Medicare Advantage HMO Members residing in an LTC/custodial setting, please contact Provider Network Services 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.
- PCPs should periodically review their office panel rosters to ensure the accuracy of the data. If a PCP is aware that the patient/Member relationship has changed, please follow these steps:
  - If you continue to treat the patient/Member in an LTC setting, contact Provider Network Services to have the patient/Member moved to the LTC's panel.
  - If you are no longer treating the patient/Member, contact Provider Network Services to have the patient/Member removed from the PCP's office panel.
- 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 complete the *Request to move member from PCP to LTC PCP panel* form and send it to Provider Network Services at *pnsproviderrequests@ibx.com*.

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 confirm access to the new record on PEAR PM and set up electronic funds transfer (EFT) — *even if they already use these tools at their current practice location*.

Locating in-network Providers

To find a Provider who participates in our network, use the Find a Doctor tool:

- **Commercial Members:** *www.ibx.com/providerfinder*
- **Medicare Advantage Members:** *www.ibxmedicare.com/providerfinder*

Links to these tools are also available on the PEAR Help Center.

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*. 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.

Non-Covered Services: Participating Providers shall not bill Medicare Advantage Members for items or services that are not Covered Services, unless, prior to furnishing the item or service, Participating Provider requests from Independence prior authorization, and Participating Provider and the Medicare Advantage Members receive a written denial. Participating Provider acknowledges that CMS guidance states that Advance Beneficiary Notices (ABNs) cannot be used for Medicare Advantage Members. In order to bill Medicare Advantage Members for non-Covered Services, Participating Provider must first obtain from Independence an organization determination as addressed in 42 CFR 422.566.

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, use the Eligibility & Benefits transaction on PEAR PM.

A yellow banner will display one of the below messages depending upon the period of delinquency:

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

If you need assistance using the transaction, please review the training materials on the PEAR Help Center at *www.pearprovider.com*.

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 PEAR PM to verify eligibility information.

Preapproval/Precertification guidelines

Preapproval/Precertification 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/ Precertification.

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/Precertification 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/Precertification code.

Responsibility of the PCP

Submit one Referral for the admitting/performing Physician through PEAR PM.

Responsibility of the HMO/POS Member

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

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

Obtain Preapproval/Precertification review for all services requiring Preapproval/Precertification.

Responsibility of the hospital, skilled nursing facility, freestanding ASC, or rehabilitation facility

- To initiate Preapproval/Precertification, Providers should use PEAR PM. Providers can check the status of an authorization on PEAR PM using the Authorization Search transaction.
- PEAR-enabled Providers may submit electronic Preapproval/Precertification 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 – Utilization Management* section of this manual for more information on Preapproval/Precertification requirements. Preapproval/Precertification requirements are also available on our website at *www.ibx.com/preapproval*.

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

Provider Engagement, Analytics & Reporting (PEAR) portal

The PEAR portal offers Providers a single point of entry to access multiple digital tools. It was designed to connect Providers quickly and securely to the plan information they need to deliver high-quality care. Through the various applications within the PEAR portal, Providers can easily access the clinical and financial information specific to their provider organization and plan contracts.

PEAR PM

PEAR Practice Management (PM) is a provider engagement application that connects Providers to the Plan information and transactions that Providers use every day to help deliver high quality care for Members. PEAR PM seamlessly supports Provider's daily interactions to ensure a more streamlined and user-friendly experience, all through a single sign-on to the PEAR portal. PEAR PM allows easy access to many transactions such as:

- member eligibility and benefits
- submission, search, and investigation of claims
- submission and search of authorizations
- submission and search of Referrals

PEAR AR

PEAR Analytics & Reporting (AR) is an on-demand provider reporting application that allows Providers to review and compare their practice's performance with peers and identify gaps in care and opportunities for improvement. A variety of practice-level reports and dashboards provide a real-time view of data specific to each Provider. The reports are for primary care practices with a panel size greater than 50 and certain specialists, such as cardiologists, endocrinologists, and nephrologists. PEAR AR also provides access to view provider capitation and incentive payment rosters.

PEAR CV

PEAR Comprehensive Visit (CV) is a point-of-care application that assists primary care Providers with accurate documentation of a Member's visit, assessment, and treatment plan. PEAR CV replaced the ePASS® tool. Assessments entered in PEAR CV will be considered official medical records that document the comprehensive elements of a Member encounter including vitals, review of systems, diagnoses, quality measures, and social determinants of health. PEAR CV supports the format of a SOAP (Subjective, Objective, Assessment, and Plan) note with logic that offers diagnosis and screening considerations to assist in coordinating care.

Self-service requirements

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

- **Eligibility and claims status.** All Participating Providers and facilities are required to use PEAR to verify Member eligibility and obtain Independence claims status information. The claim detail provided through PEAR PM 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 PEAR PM to submit Referrals. In addition, Providers can submit encounters either using PEAR PM or via Electronic Data Interchange. Members may view and print Referrals by logging on to our secure Member website via *www.ibx.com* or through our IBX App for mobile devices.
- **Authorizations.*** All Participating Providers and facilities must use PEAR PM to initiate the following authorization types: ambulance (land) – non-emergent ambulance transportation (*Note:* Except for ambulance land requests from a facility as part of discharge planning.), AIS therapy, AIS chemotherapy, chemotherapy, durable medical equipment – purchase and rental, Emergency hospital admission notification, home health (dietician, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy), home infusion, infusion therapy, and medical/surgical procedures and specific outpatient physical therapy and occupational therapy services for Medicare Advantage members.

  Requests for medical/surgical procedures can be made up to six months in advance on PEAR PM. 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). PEAR PM 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 PEAR PM using the Claim Search 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.

EFT requirement

All Participating Providers must register for and maintain EFT capability for the payment of claims, capitation, and incentive-based programs. EFT registration enables a direct electronic payment from Independence to the Provider's bank account.

The benefits of EFT

There are several benefits of using EFT over conventional paper-based methods, including:

- higher security
- faster access to funds
- reduced administrative processing time

Registration details

Registration for EFT must be completed through PEAR PM by an individual who is authorized to access and maintain banking information for your organization. This individual will be required to attest as the designated responsible party when first accessing the EFT registration screen.

Out-of-area and FEP Members

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

- **BlueCard® Coordination of Benefits.** This transaction links you to the BlueCard COB Questionnaire that should be completed by all out-of-area Members prior to rendering service to streamline claims processing and expedite payment to Providers.
- **Medical Policy/Pre-Certification Inquiry.** This transaction allows Providers to obtain information regarding the Home Plans' medical policy and Preapproval/Precertification 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/Precertification 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 PEAR AR.

PEAR Organization Administrators

The PEAR Organization Administrator is your office's primary contact with PEAR regarding

security issues with the portal. Offices must designate at least one PEAR Organization Administrator, and may have two. The Organization Administrator also interacts with Location Administrators and End Users in your office and with Independence to ensure that users are getting the most out of PEAR.

HIPAA mandates that each Provider office designate an Organization Administrator to be aware of the electronic storage and transmission of patient information within and from your office.

Roles and responsibilities

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

To fulfill these responsibilities, the Organization Administrator undertakes several special tasks, including:

- ensuring that every staff member who accesses PEAR 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 PEAR Location Administrators and End Users in the office, when appropriate;
- resetting user passwords;
- notifying Independence if someone else takes on the role of Organization Administrator;
- 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 PEAR transactions.

For more detailed information on common PEAR Organization Administrator tasks and best practices, please review the training materials on the PEAR Help Center at *www.pearprovider.com*.

PEAR resources

Training materials are available on the PEAR Help Center at *www.pearprovider.com*. If you need technical assistance, contact the PEAR Support Line at 1-833-444-7327 or use our online form: *www.pearprovider.com/providerinquiry/form*.

**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 Preapproval/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 Preapproval/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 PEAR PM for Independence Administrators plan Members. For more information or to get iEXCHANGE for your office, visit *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 PEAR PM.

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.

Lead time requirements:

- **30-day notice.** Independence requires 30 days advance written 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 advance written notice for closure of a PCP practice or panel to additional patients.
- **90-day notice.** Independence requires 90 days advance 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.

Provider Demographic Profile

It is critical that you regularly review your demographic information in the Provider directory to ensure that all the information is accurate. We may periodically send you a Provider Demographic Profile for review. We collect information regarding your racial, cultural, and ethnic identity as well as languages spoken fluently. Providing this information is voluntary. 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.

Submitting updates and/or changes*

Professional Providers can quickly and easily submit most changes to their basic practice information by contacting us. Professional Providers may perform the following functions as they relate to their practice:

- Add/Delete a participating practitioner to/from an existing practice
- Add/Delete an address (i.e., doing business as [DBA], check, mailing, main, or practice)
- Add/Delete contact name, title, or communication device type/number
- Add/Delete office hours
- Update “Walk-in” acceptance status
- Update Patient and Appointment Options (i.e., accepting new patients)
- Update General Practice Availability (i.e., Urgent, Routine Visits, etc.)
- Update Member Access number (i.e., the telephone number that appears on the Member's identification card – which must be the location-specific telephone number for a patient to make an appointment)
- Update Electronic Medical Records (EMR) status
- Update the availability of other clinical staff (i.e., midwife, nurse practitioner, etc.)

- Update office accessibility and services (i.e., handicapped, parking, and communication and language services)

Changes can be submitted using the *Provider Change Form* at *www.ibx.com/providerforms*.

If you are unable to submit your request electronically, use one of these methods:

- **Email:** *PracticeUpdates@ibx.com*
- **Fax:** 215-761-9561

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 Provider Network Services 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 Provider Network Services at pnsproviderrequests@ibx.com.

Age limitations on a PCP practice

If your practice subscribes to minimum and/or maximum age limits for Members, notify Provider Network Services 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 via *www.ibx.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 Provider Network Services 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 to terminate network participation.

Written notice can be sent to:

Independence Blue Cross
Attn: Senior Vice President, Total Value Contracting and Reimbursement
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. The Member should be notified first.

To notify Independence, the Physician must send an email to *pnsproviderrequests@ibx.com* indicating the intent to terminate the Member. A copy of the termination letter that was sent to the Member showing this notification must be included in the email.

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, sexual orientation, 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/training-education/medicare-learning-network/compliance* 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 and Members can access the Hospital Advisor tool through the Find a Doctor tool at *www.ibx.com*.