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Capitated services

Within the HMO/POS benefit plans, the following outpatient services are included in designated (capitated) programs:

- diagnostic radiology*
- short-term rehabilitation therapy (occupational, physical, and speech)*
- laboratory

Generally, a Primary Care Physician (PCP) must refer Members to their capitated sites only for these services, as described in the *Radiology services* and *Laboratory services* headers in this section. Capitated Providers are contracted to provide a full range of services, including treatment of pediatric Members. However, not all capitated providers treat pediatric patients.

Note: Radiology and physical therapy services are not capitated for Keystone 65 HMO (Keystone 65 Preferred, Select, Basic HMO, and Focus HMO-POS) Members. These Members must be directed to a Participating Provider in the Keystone 65 HMO network for radiology and physical therapy services.

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

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

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

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

Radiology services

*HMO/POS Members**

- Outpatient nonemergent radiology services are provided through a network of contracted Providers.
- Each PCP is required to select one site as his or her capitated radiology site. PCPs should refer their Independence Commercial Members to this site for outpatient radiology services. POS Members may self-refer to a site other than the PCP's capitated radiology site but will be subject to Deductibles and Coinsurance.
- HMO specialists should refer Members back to their PCP for a Referral for any needed radiology services with the exception of CT or CTA scans, PET scans, MRIs, MRAs, or nuclear cardiology services, which should be precertified. See the *Preapproval/Precertification for diagnostic imaging services* section for details. The exceptions also include fracture care and X-rays performed to rule out a fracture by a specialist Physician who is contracted to perform these services.

- Members may receive mammography and breast ultrasound services by a participating radiologist or outpatient department of a hospital. This service is not part of the Diagnostic Radiology Program; therefore, there are no capitated site or Referral requirements.
- General ultrasounds for a normal pregnancy must be referred to the capitated site selected by the Member's PCP. PCP-capitated radiology sites can be found using the Eligibility & Benefits transaction within Practice Management (PM) on the Provider Engagement, Analytics & Reporting (PEAR) portal.
- OB/GYNs must use PEAR PM to submit OB/GYN Referrals to refer patients to their PCP's capitated radiology Provider for general and diagnostic ultrasounds for pregnancy.
- Ultrasounds and testing for identified high-risk patients may be referred to a Participating Perinatal Provider, antenatal testing unit, or any participating hospital when certain conditions are met based on diagnosis and servicing Provider.
- Pediatric Members (newborn through age 12) may obtain a Referral to any radiology facility in the HMO network. These Members are not required to use capitated radiology sites.
- Medicare Advantage HMO benefit plans do not require Referrals to see a specialist.

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

Radiology and physical therapy services **are not capitated for Keystone 65 HMO Members. These Members must be directed to a Participating Provider in the Keystone 65 HMO network for their plan.*

PPO Members

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

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

Precertification for diagnostic imaging services

Carelon Medical Benefits Management (Carelon), an independent company, performs Preapproval/Precertification for outpatient nonemergent diagnostic imaging services and certain high-technology radiology services for our HMO, POS, and PPO Members.

Ordering Physicians — PCPs or specialists — are required to obtain Preapproval/Precertification from Carelon for the following outpatient nonemergent diagnostic services:

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

Initiate Preapproval/Precertification for these services in one of the following ways:

- **Carelon's *ProviderPortal℠*.** *https://www.providerportal.com*
- **PEAR PM.** Select *Carelon* from the Transactions tab (under Authorizations).

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

To avoid delays and denials due to lack of information supporting medical necessity, Providers must submit the necessary clinical information with the request. For more information and a complete list of our high-technology radiology services, please review our policies at *www.ibx.com/medpolicy*.

Note: If the above-listed services are being ordered as mapping and planning for surgery or are ordered as part of a guided procedure (such as a needle biopsy), the ordering Provider should call the Preapproval/Precertification telephone number listed on the Member's ID card. Ordering Providers should not call Carelon under these circumstances.

For HMO/POS Members, Preapproval/Precertification replaces the need for a PCP Referral. Therefore, a PCP Referral for these services is not needed. The Preapproval/Precertification is valid for 30 days from the initial request date for the service.

For radiology services not included in the previous listing, a Referral is required for claim payment.

Review authorized procedure codes and descriptions

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

Both ordering and performing Providers can access Carelon's ***Provider****Portal* through PEAR PM or by visiting *https://www.providerportal.com*.

The Carelon ***Provider****Portal* is available 7 days a week and offers Providers the following:

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

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

Short-term rehabilitation therapy services

For conditions subject to significant improvement within the benefits period, Members in a Non-Flex HMO plan are *generally* eligible for a maximum of 60 consecutive days of short-term outpatient rehabilitation therapy. Therapy beyond the benefits period is not covered. Chronic conditions, such as Multiple Sclerosis, that are not likely to significantly improve within the benefits period are not eligible for coverage.

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

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

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

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

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

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

HMO/POS Members[‡]

- Outpatient physical therapy and occupational therapy (PT/OT) services are provided through a network of contracted Providers.
- PCPs are required to select one site as their capitated PT/OT site. PCPs should refer their Independence HMO Members to this site for all PT/OT services. POS Members may self-refer to a site other than the PCP's capitated PT/OT site, but will be subject to a self-referred cost-share (e.g., Deductible, Coinsurance). For a complete list of services included in the capitated PT/OT program, refer to our policy on physical medicine and rehabilitation services eligible for reimbursement above capitation at *www.ibx.com/medpolicy*.

[‡]Radiology and physical therapy services are not capitated for Keystone 65 HMO and HMO-POS Members. These Members must be directed to a Participating Provider in the Keystone 65 HMO network for their plan.

Services excluded from capitation

The following services are excluded from capitation requirements:

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

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

Referral and Preapproval/Precertification requirements

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

- Under most circumstances, one Referral per Member per condition is sufficient.
- All HMO Referrals are valid for 90 days from the date they are issued.
- Medicare Advantage HMO plans do not require Referrals to see a specialist.
- No Preapproval/Precertification is required for Referrals made to the capitated Provider. Our UM department must Preapprove services provided by any Provider other than the PCP's capitated Provider based on a determination of Medical Necessity and not on convenience factors.
- Speech therapy services do not require Preapproval/Precertification.

Evaluation and treatment

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

Treatment required

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

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

Interrupted therapy

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

For coverage information related to rehabilitation therapy services, review our policies on the Medical Policy Portal, which is available at *www.ibx.com/medpolicy*.

Laboratory services

Laboratory Corporation of America® Holdings (Labcorp) is our exclusive nationally based provider of outpatient laboratory services.

General guidelines

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

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

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

In addition to Laborp, the following participating contracted laboratories for outpatient services are available for capitation:

Laboratory name	Laboratory indicator on ID card	Phone number
Abington Memorial Hospital Laboratory	A	215-481-5406
Atlantic Diagnostic Laboratories, Inc.	D	866-464-6763
Health Network Laboratories	N	1-877-402-4221
Hospital of the University of Pennsylvania (and Penn Medicine at Radnor)	H	1-800-789-7366
Laboratory Corporation of America® Holdings (Labcorp)	L	1-800-631-5250
Mercy Health Laboratory	M	610-237-4175
Pottstown Memorial Hospital	P	610-327-7522
SMA Medical Laboratories	F	215-322-6590
Thomas Jefferson University Laboratory§	T	215-955-6545

§Available to specific practices only.

You can find laboratory indicators on the front of the Member ID card or through PEAR PM.

Specialized pathology testing for HMO, POS, and PPO Members is offered by the capitated laboratories as well as by the following specialized laboratory Providers:

Laboratory name	Specialty	Phone number
Aculabs, Inc.	Performs mobile draws in long-term care facilities	732-777-2588
Agendia, Inc.	Breast Cancer Risk-of-Recurrence Test – MammaPrint	888-321-2732
ASPiRA Labs, Inc.	Risk assessment testing for ovarian cancer	884-277-4721
Assurex Health, Inc.	GeneSight®	888-987-9913
Biodesix, Inc.	VeriStrat test – proteomic test for non-small cell lung cancer	866-432-5930
Brookside Clinical Laboratories	Performs mobile draws in long-term care facilities	610-872-6466
CareDx, Inc.	Organ transplant rejection testing; AlloMap and Allosure	888-255-6627

Laboratory name	Specialty	Phone number
CBL Path, Inc.	Pathology, oncology, genetic testing	877-225-7284
Crescendo Biosciences, Inc.	Vectra	877-743-8639
Decipher Corporation	Genomic prostate biopsy/Prostate cancer	888-792-1601
DermTech, Inc.	Pigmented Lesion Assay (PLA) – melanoma rule-out test	858-450-4222
DIANON Pathology *Dianon Pathology is a brand used by Dianon Systems, Inc., a wholly owned subsidiary of Laboratory Corporation of America® Holdings*	Surgical pathology, including uropathology, gastrointestinal pathology, dermatopathology, and breast pathology	800-328-2666
Exact Sciences Laboratories, LLC	Colorectal cancer screening and Cologuard	844-870-8870
Foundation Medicine, Inc.	Comprehensive genomic profiling – FoundationOne® CDx (FDA approved)	888-988-3639
GeneDx, LLC	Exome and genome sequencing. Diagnostic genetic testing – pediatrics, neurology, rare conditions, and hereditary cancer	888-729-1206
Genomic Health, Inc.	Oncotype DX® breast cancer assay	866-662-6897
Guardant Health, Inc.	Guardant360 – detects cell-free circulating tumor DNA (ctDNA) in blood specimens of advanced solid-tumor cancer patients and evaluates 74 genes	855-698-8887
Institute of Dermatopathology, PC/ AmeriPath® New York, Inc.	Dermatopathology	800-553-6621
Integrated Genetics *Integrated Oncology is a brand used by Esoterix Genetic Laboratories, LLC, a wholly owned subsidiary of Laboratory Corporation of America® Holdings*	Reproductive genetic testing: prenatal & postnatal testing, prenatal diagnostics, genetic testing	800-848-4436
Integrated Oncology *Integrated Oncology is a brand used by Accupath Diagnostic Laboratories, Inc. and Esoterix Genetic Laboratories, LLC, wholly owned subsidiaries of Laboratory Corporation of America® Holdings*	Hematopathology, complex solid tumors, molecular oncology, and genetics	800-447-8881
Labcorp	Specialty testing includes genetic testing, molecular oncology, HLA testing, esoteric coagulation, infectious disease, immunoassays, and microbiology	800-631-5250
Litholink wholly owned subsidiary of *Laboratory Corporation of America® Holdings*	Testing and clinical decision support for kidney stone prevention	800-338-4333
MDxHealth, Inc.	ConfirmMDx® for prostate cancer, molecular, and epigenetic diagnostics for urologic cancers	866-259-5644

Laboratory name	Specialty	Phone number
MedTox Laboratories wholly owned subsidiary of *Laboratory Corporation of America® Holdings*	Specialized toxicology and medical drug monitoring	800-832-3244
Monogram BioSciences wholly owned subsidiary of *Laboratory Corporation of America® Holdings*	HIV and HCV drug resistance assays and molecular oncology	650-635-1100
Myriad Genetics Laboratories, Inc.	myRisk Hereditary Cancer, BRACAnalysis, BRACAnalysis CDx, Colaris Plus, Colaris AP, EndoPredict, myChoice CDx, myPath Melanoma, and Prolaris	800-469-7423
Myriad Women's Health, Inc.	Prequel and Foresight	888-268-6795
NeoGenomic Laboratories	Oncology genetic testing	866-776-5907
Penn Cutaneous Laboratory	Dermatopathology	866-337-6522
Penn Cytogenetic Laboratory	Cytopathology	800-789-7366
Professional Technicians, Inc.	Performs mobile home draws	215-364-4911
Sequenom Center for Molecular Medicine, LLC d/b/a Sequenom Laboratories is a wholly owned subsidiary of Sequenom Inc. *Sequenom Inc. is a wholly owned subsidiary of Laboratory Corporation of America® Holdings*	Highly sensitive laboratory genetic tests for noninvasive prenatal testing (NIPT) and carrier screening	877-821-7266
Therapath, Inc.	Neuropathology	800-681-4338
Veracyte, Inc.	Genomic diagnostics (endocrinology; pulmonology)	650-243-4300

HMO/POS Members

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

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

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

Medicare Advantage HMO-POS plans do not require Referrals to see a specialist. However, Preapproval/Precertification from the Plan is required if care is needed from an out-of-network Provider.

PPO Members

Routine laboratory services for PPO Members must be sent to one of the in-network laboratories. For PPO Members, select laboratory codes may be performed in the Physician's office or outpatient setting in accordance with Independence's claim payment policy. For a complete listing of laboratory codes allowed in the office or outpatient setting refer to *www.ibx.com/medpolicy*. If a laboratory test is not allowed in the office or outpatient setting, it must be referred to a commercial laboratory or one of the network hospitals that has contracted with the Personal Choice® network to perform outpatient laboratory services.

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

Traditional Members

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

Requesting laboratory services

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

To locate drawing stations for capitated laboratories, use the Find a Doctor tool:

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

Select the Member's desired location and plan type from the drop-down options, then type "independent laboratory" in the text field next to All Categories to conduct a search.

Keep in mind the following:

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

- **Capitated laboratory change requests.** Capitated laboratory change requests should be submitted in writing to your Network Coordinator, on office letterhead, with the name and signature of the appropriate PCP clearly noted. If a capitated laboratory change request is received on or before the 15th day of the current month, it will be effective the first day of the following month. Capitated laboratory change requests received on the 16th or later will not be effective until the following month. For example: A change request received January 15 becomes effective February 1. A change request received January 16 does not become effective until March 1.
- **STAT laboratory services.** For HMO, POS, and PPO Members, STAT laboratory services that are specifically listed on the STAT laboratory listing may be performed at one of the participating hospital facilities. Routine laboratory services and those not listed on the approved STAT listing must be sent to the PCP's capitated laboratory for HMO Members. Refer to the current STAT laboratory listing, which is located at *www.ibx.com/medpolicy*. If routine laboratory services are provided by a hospital, those services will not be reimbursed and the Member may be billed if he or she has been informed that routine laboratory services provided in a hospital are not Covered Services and if he or she agrees, in writing, to be financially responsible for those services.
- **Home phlebotomy.** Home phlebotomy is available when Members are homebound. Services may be arranged by contacting one of the contracted home phlebotomy Providers listed in the following table. These Providers perform home phlebotomy services for all Members. These Providers will perform the home draw and may process the draw in their own laboratory or deliver the sample to the participating capitated laboratory (HMO) or participating laboratory/hospital (PPO). Some participating laboratories also offer home phlebotomy for patients who reside in assisted living or nonskilled nursing homes. This service is covered only as defined by Medicare guidelines, which are applied for all Members regardless of coverage.

Laboratory name	Service	Phone number
Aculabs, Inc.	Performs mobile draws in long-term care facilities	732-777-2588
Brookside Clinical Laboratories	Performs mobile draws in long-term care facilities	610-872-6466
Professional Technicians, Inc.	Performs mobile home draws	215-364-4911
US Lab & Radiology, Inc.	Performs mobile draws in long-term care facilities	267-759-6052

Requesting genetic testing

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

Keep in mind the following:

- Independence's laboratory network has extensive genetic testing capabilities; therefore, Providers should refer Members only to participating laboratories for Covered Services.
- In the unusual circumstance that a specific test and related services are not available through a participating laboratory, Providers must contact Independence to obtain Preapproval/Precertification. Preapproval/Precertification is required for use of a nonparticipating laboratory. Providers are also required to notify Members that a nonparticipating laboratory may be used, and the Member may be subject to an out-

of-network cost-sharing amount.

- When applicable under the terms of your Independence Professional Provider Agreement (Agreement), if a Provider uses a nonparticipating laboratory for HMO Members and does not obtain Preapproval/Precertification from Independence, the Provider is required to hold the Member harmless. The Provider will be responsible for any and all costs to the Member and shall reimburse the Member for such costs or be subject to claims offset by Independence for such costs.

Contractual obligation to use Participating Providers

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

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

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

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

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

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

Cardiology Utilization Management Program*

Preapproval/Precertification for the following non-emergent tests and procedures is required through Carelon for all commercial and Medicare Advantage Members for the evaluation of Medical Necessity:

- Cardiovascular tests/diagnostic procedures:
  - Coronary angiography
  - Peripheral arterial ultrasound
- Nonsurgical treatments for obstructive coronary artery disease:
  - Percutaneous coronary intervention (PCI), including:
    - Balloon angioplasty
    - Stents
    - Atherectomy

Note: The following services and associated CPT® codes will be reviewed post-service in accordance with Carelon's clinical criteria:

- Duplex Scan Lower Extremity Arteries
- Duplex Scan Upper Extremity Arteries
- PCI
  - **Exception:** When the results of the coronary angiogram are known and the coronary angiogram and PCI are not performed at the same time, Preapproval/Precertification of the PCI must be obtained prior to the service being performed.

Initiate Preapproval/Precertification for these services in one of the following ways:

- **Carelon's *Provider*Portal.** *https://www.providerportal.com*
- **PEAR PM.** Select *Carelon* from the Transactions tab (under Authorizations).

For additional information on this utilization management program, please refer to our medical policy at *www.ibx.com/medpolicy*.

**Self-funded groups can elect not to include this utilization management program as part of their group health plan.*

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

Preapproval/Precertification for certain genetic/genomic tests is required through eviCore healthcare (eviCore), an independent specialty benefit management company, for all commercial and Medicare Advantage Members.

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

Initiate Preapproval/Precertification for genetic/genomic tests in one of the following ways:

- **PEAR PM.** Select *eviCore* from the Transactions tab (under Authorizations).
- **Telephone.** Call eviCore directly at 1-866-686-2649.

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

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

For additional information on this utilization management program, please refer to our medical policy at *www.ibx.com/medpolicy*.

†Self-funded groups can elect not to include this utilization management program as part of their group health plan.

Musculoskeletal Utilization Management Program*

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

- **Interventional pain management procedures,** including the following:
  - Epidural injections
  - Facet joint injections/medial branch blocks
  - Facet joint radiofrequency nerve ablation
  - Sacroiliac joint injections
  - Implanted spinal cord stimulators
- **Spinal surgical procedures.** Cervical, thoracic, lumbar, and sacral (including all concurrent spinal procedures and all associated revision surgeries):
  - Cervical Decompression with or Without Fusion
  - Cervical Disc Arthroplasty
  - Lumbar Disc Arthroplasty
  - Lumbar Discectomy, Foraminotomy, and Laminotomy
  - Lumbar Fusion and Treatment of Spinal Deformity (including Scoliosis and Kyphosis)
  - Lumbar Laminectomy
  - Noninvasive Electrical Bone Growth Stimulation
  - Vertebroplasty/Kyphoplasty
  - Bone Graft Substitutes and Bone Morphogenetic Proteins
- **Surgical procedures of the joint.** Including all associated revision surgeries:
  - Shoulder Arthroplasty
  - Shoulder Arthroscopy and Open Procedures
  - Hip Arthroplasty
  - Hip Arthroscopy and Open Procedures
  - Knee Arthroplasty
  - Knee Arthroscopy and Open Procedures
  - Meniscal Allograft Transplantation of the Knee
  - Treatment of Osteochondral Defects

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

Please note the following important information regarding the Musculoskeletal Utilization Management Program:

- **Sending additional clinical documentation.** Providers can send additional clinical documentation to Carelon by fax to 1-844-425-3738.
- **Requesting a peer-to-peer review.** Providers can request peer-to-peer review by calling 1-866-745-1791.

- **Smoking cessation recommendation.** Independence's policies and Carelon's orthopedic surgery guidelines contain recommendations for smoking cessation and confirmatory blood work prior to surgical procedures of the spine and joint. Please note that for most surgical procedures of the spine and joint, these are purely recommendations and failure to comply will not result in a denial. The only exception is for revision rotator cuff repair, where smoking cessation and confirmatory blood work are mandatory.

Initiate Preapproval/Precertification for these services in one of the following ways:

- **Carelon's ProviderPortal.** *https://www.providerportal.com*
- **PEAR PM.** Select *Carelon* from the Transactions tab (under Authorizations).

For additional information on this utilization management program, please refer to our medical policy at *www.ibx.com/medpolicy*.

**Self-funded groups can elect not to include this utilization management program as part of their group health plan.*

Radiation therapy

Preapproval/Precertification for nonemergent outpatient radiation therapy services is required through eviCore for all commercial and Medicare Advantage Members. Preapproval/Precertification is not required when radiation therapy is rendered in the inpatient hospital setting or for OON services in a Medicare Advantage PPO plan.

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

Initiate Preapproval/Precertification for nonemergent outpatient radiation therapy in one of the following ways:

- **PEAR PM.** Select *eviCore* from the Transactions tab (under Authorizations).
- **Telephone.** Call eviCore directly at 1-866-686-2649.

To avoid delays and denials due to lack of information supporting medical necessity, providers must submit the necessary clinical information with the request. For additional information on nonemergent outpatient radiation therapy services, please refer to our medical policies at *www.ibx.com/medpolicy*.

†Self-funded groups can elect not to include this utilization management program as part of their group health plan.

Routine eye care/vision screening

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

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

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

eye is covered, subject to applicable specialist Copayment.

Sleep studies

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

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

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

Initiate Preapproval/Precertification for these services in one of the following ways:

- **Carelon's *Provider*Portal.** *https://www.providerportal.com*
- **PEAR PM.** Select *Carelon* from the Transactions tab (under Authorizations).

For additional information on sleep testing services, please refer to our medical policy at *www.ibx.com/medpolicy*.

Specialty medical drugs

Specialty medical drugs are typically injectable and infusion therapy drugs that must be given by a health care Provider, usually in a Physician's office, outpatient facility, infusion suite, or in the Member's home through a home infusion Provider. These drugs are typically eligible for coverage under the Member's medical benefit and require Preapproval/Precertification from Independence.

Specialty medical drugs meet certain criteria including, but not limited to, the following:

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

For more information about specialty medical drugs, go to *www.ibx.com/web/ibx/resources/for-providers/policies-and-guidelines/pharmacy-information/specialty-drugs*. This site provides information about how Independence manages medical specialty drugs. This site also contains other resources, including a list of all Independence-designated specialty drugs, grouped by their most common therapeutic class.

Direct Ship Drug Program

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

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

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

- Independence places the order with the vendor based on the Physician's request and handles all payments for the drugs.
  - Note: Member cost-share, copayments, or coinsurance are still applicable, in accordance with the terms of the member's benefit contract.
- Physicians do not have to submit reimbursement forms for the cost of the drugs.
- Physicians do not have to dedicate office space to long-term drug storage.

A complete list of specialty medical drugs that are available through the Direct Ship Drug Program is available on our website at *www.ibx.com/resources/for-providers/policies-and-guidelines/pharmacy-information/direct-ship-drug-program*. There Providers will also find drug request forms and instructions for ordering.

Most Cost-Effective Setting Program

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

During the Preapproval/Precertification review, each Member's medical needs and clinical history are evaluated to determine if the drug requested by the Provider is appropriate. As part of our Most Cost-Effective Setting Program, Independence also reviews the requested treatment setting for certain drugs covered under the Member's medical benefit to ensure that they are administered in settings that are both safe and cost-effective.

Covered settings for drugs in this program include:

- a Physician's office;
- the Member's home, where the drug is administered by an in-network home infusion Provider;
- an ambulatory (freestanding) infusion suite that is not owned by a hospital or health system in our network.

A hospital outpatient facility will be considered for Members who are receiving an initial dose of any drug in this program. It may also be considered if there is a clinical rationale that requires the Member to receive intensive monitoring and care uniquely available in a hospital outpatient facility. The Provider must submit documentation to Independence to support any request for ongoing coverage in the hospital outpatient facility. This information will be reviewed and a coverage determination on setting will be made.

For more information about the Most Cost-Effective Setting Program, including a complete list of all drugs on the program, go to *www.ibx.com/resources/for-providers/policies-and-guidelines/operations-management/cost-effective-setting*.