September 2019

What’s New

New Online Case and Credentialing Status Checkers
Have you submitted a provider onboarding form to add a new provider to your practice, applied for credentialing, or recently updated your existing demographic information on our website? If so, you can now get real-time information about the status of these requests online.

Read More

The Provider Onboarding Form and User Guide
Blue Cross and Blue Shield of Illinois (BCBSIL) welcomes you to apply and join our provider networks. Our new Provider Onboarding Form is designed to help streamline the application process. See tips for using the Provider Onboarding Form and upcoming training webinars in this issue.

Read More

Blue Review Readership Survey: Your Ideas and Input in Action
We had a great response to our 2018 readership survey, conducted in October and November of last year. Your ratings and feedback helped us form a clearer picture of the type of information that is important to you.

Read More

CMO Perspective

Focus on Quality: Overcoming Low-Value Care
In this month’s CMO Perspective, our Vice President and Chief Medical Officer, Dr. Derek J. Robinson, M.D., MBA, FACEP, CHCQM, and William A. Frese, M.D., MPH, discuss clinical quality improvement (QI) programs and steps to overcoming low-value care.
Wellness and Member Education

Millennials May Be the Largest Group in the Workforce, but They Aren't the Healthiest
A recent Blue Cross and Blue Shield Association (BCBSA) study compares the current health of millennials to the prior generation and reveals interesting and possibly concerning facts about this younger generation.

CMS Star Ratings Matter: Encourage Members to Schedule Annual Wellness Visits
The Centers for Medicare & Medicaid Services (CMS) uses five categories to rate plan performance. One of those categories is “Staying Healthy.” Annual wellness visits may help our members stay healthy by finding problems before they start.

Mammography Screening for Early Detection of Breast Cancer
In 2018, the American Cancer Society estimated that around 266,000 new cases of breast cancer in women were reported and about 41,000 of those resulted in mortality. The best defense for survival is early detection through screening.

Claims and Coding

BCCHP℠ Providers: What You Need to Know About Maternal and Child Health vs. Primary Care Physician (PCP) Add-on Codes
On Feb. 11, 2019, BCBSIL identified a system issue involving PCP add-on fee payments. Since then, all identified affected claims have been reprocessed.

Faulty Neulasta Onpro Devices: Billing and Reimbursement Reminders
The Neulasta Onpro device makes life a little easier for chemotherapy patients by allowing them to administer the drug Neulasta at home. When a device fails, the patient must go to the doctor’s office for the injection to avoid infection.
Government Programs: Resubmit Claims Previously Incorrectly Rejected for Invalid NDCs
BCBSIL has worked with the Illinois Department of Healthcare and Family Services (HFS) to confirm that we have the correct National Drug Codes (NDCs) validation process in place so claims with compliant codes are received and processed correctly. If you have claims you believe were rejected incorrectly, resubmit them following instructions in this article.

Pharmacy Program
Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Oct. 1, 2019 – Part 1
Based on the availability of new prescription medications and Prime’s National Pharmacy and Therapeutics Committee’s review of changes in the pharmaceuticals market, some additions, revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) were made to the BCBSIL drug lists. Changes effective Oct. 1, 2019, are outlined here.

Focus on Behavioral Health
Geriatric Behavioral Health: Helping Seniors Weather the Storm
We want to offer more articles on behavioral health-related topics that may be of interest to our readers, based on feedback expressed during our annual newsletter survey. This article is the third in a series of articles written in collaboration with the Illinois Psychological Association.

Clinical Updates, Reminders and Resources
Government Programs Update: Removal of Benefit Preauthorization Requirement for Cardiology and Specialty Therapy Services, Effective Sept. 1, 2019
There are important changes to the benefit preauthorization requirements for your BCBSIL patients enrolled in any of the following government programs plans: Blue Cross Medicare Advantage (PPO)SM (MA PPO), Blue Cross Community MMAI (Medicare-Medicaid Plan)SM (MMAI) and Blue Cross Community Health PlansSM (BCCHP).

Notice of Change in the Pre-service Appeals Process for Government Programs, Effective Nov. 1, 2019
There are important changes to the pre-service appeals process for your BCBSIL patients enrolled in the following government programs plans: MA PPO and MMAI. These changes are designed to help streamline workflows and lead to an improved member and provider
Electronic Options

Enhancement to Automated Phone System: Consolidated Benefit Response
Checking eligibility and benefits electronically through the Availity® Provider Portal or your preferred web vendor is still the quickest way to access coverage information for BCBSIL members. If you do not have online access and need to call BCBSIL to verify benefits, we want to make you aware of an enhancement to the Interactive Voice Response (IVR) phone system, an alternative way to check eligibility and benefits.

Reminder: Verify Procedure Code Benefit Preauthorization Requirements Online
In a December 2018 News and Updates notice, we announced a new online capability that allows providers to verify benefit preauthorization requirements for specific Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes via an eligibility and benefits inquiry in the Availity Portal. Since implementation, many updates have been made to improve articulation.

New and Exciting Functionality Coming to the Claim Research Tool (CRT) via Availity Provider Portal
The Availity CRT provides enhanced, real-time claim status details to help you manage and resolve your BCBSIL claims electronically. As of Aug. 26, 2019, the CRT now returns out-of-network patient responsibility in the service line details, when applicable.

Respond Electronically to Medical Record Requests for Quality and Risk Adjustment, and Soon Claims, via Availity Provider Portal
Currently, the Medical Attachments application within the Availity portal allows you to electronically respond to quality and risk adjustment medical record requests from BCBSIL. After Oct. 1, 2019, you will also be able to use this optional application to electronically respond to medical record requests from BCBSIL to more efficiently support claims processing.

Provider Education
Are you familiar with BluePrint PPO℠?
BluePrint PPO is a product offered by BCBSIL. You may be an in-network provider through your PPO contract for BCBSIL members with this product.

Provider Learning Opportunities
BCBSIL offers free workshops and webinars for the independently contracted providers who work with us. A list of upcoming training sessions is included in this month’s issue.

Notification and Disclosure

Important Dates and Reminders
Check here each month for a quick snapshot of recent implementations, upcoming changes, special events, important deadlines and other reminders.

Procedure Code and Fee Schedule Updates
As part of our commitment to informing our independently contracted providers of certain developments, BCBSIL has designated a specific section in the Blue Review to notify you of any significant changes to the physician fee schedules.

ClaimsXten™ Quarterly Updates
New and revised CPT and HCPCS codes are periodically added to, or deleted from, the ClaimsXten code auditing tool software by the software vendor.

Quick Reminders

Stay informed!
Watch the News and Updates on our Provider website for important announcements.

Update Your Information
Do you need to update your location, phone number, email or other important details on file with BCBSIL? Use our online forms to request an information change.

Provider Training
For dates, times and online registration, visit the Workshops/Webinars page.
September 2019

New Online Case and Credentialing Status Checkers

Have you submitted a provider onboarding form to add a new provider to your practice, applied for credentialing, or recently updated your existing demographic information on our website? If so, you can now get real-time information about the status of these requests online.

Case Status Checker
The Case Status Checker provides information on the progress of your Provider Onboarding applications, Demographic Change requests and certain email inquiries. When you initiate any of the above processes, you will receive an email from us with a unique case number. To check the status, enter the case number in our Case Status Checker.

Credentialing Status Checker
The Credentialing Status Checker provides information on the progress of your credentialing request. To check the progress, enter your National Provider Identifier (NPI) or state license number where indicated in the Credentialing Status Checker.

For more information, refer to the Join Our Network, Update Your Information or Credentialing pages on our Provider website.

bcbsil.com/provider
The Provider Onboarding Form and User Guide

Blue Cross and Blue Shield of Illinois (BCBSIL) welcomes you to apply and join our provider networks. We want to help make the application process as efficient as possible. Our new Provider Onboarding Form is designed to help streamline the application process.

Tips for Using the Provider Onboarding Form

- For best results, use the Google Chrome browser. Individual and Medical Groups/Clinics that want to apply to join our networks should fill out the online Provider Onboarding Form. For more information on completing the form, refer to the Provider Onboarding Form User Guide.
- On the first step: Select Participation, be certain to have all information listed in the blue box on the left side of the screen before getting started. On the right side of the screen, the fields represent the contact information of the person completing the form on behalf of the provider (office manager, biller, etc.).
- Be sure to know your billing (type 2 organizational) National Provider Identifier (NPI) as listed in the NPI Registry.
- If you are a New Group or an Existing Group adding additional providers, on step two: Enter Your Information, pay special attention to the “Provider Roster Instructions” box on the right side of the screen. Proceed to download and complete only the roster provided by BCBSIL.
- You must submit the roster as an Excel file. If the appropriate roster is not used, your information will be rejected. You must complete all the data elements on the roster. The second tab of the roster Excel sheet serves as an example of the Standardized Template Grid.

Check the Status of Your Form

After you complete the onboarding form, you will receive an email from us with a unique case number. To check the status, enter the case number in our Case Status Checker.

Need help? Training coming soon!

We are hosting training sessions to help you complete our Provider Onboarding Form on the following dates:

- Sept. 24, 2019: 10 - 11:30 a.m. CST
- Oct. 8, 2019: 10 - 11:30 a.m. CST
- Oct. 22, 2019: 10 - 11:30 a.m. CST
The training will include:

- New Group/Provider Contracting
- Requesting the Addition of a Provider to your Group
- How to submit Demographic Changes

You may also register by visiting the [Webinars and Workshops](#) section of our Provider website.
September 2019

Blue Review Readership Survey: Your Ideas and Input in Action

As we reported previously, we had a great response to our 2018 readership survey, conducted in October and November of last year. Your ratings and feedback helped us form a clearer picture of the type of information that is important to you. We trust that you've noticed some positive changes in 2019.

We've added more articles on certain topics, such as behavioral health. Participants also suggested regular follow-ups, such as confirmation of completed implementations. This idea prompted our new Important Dates and Reminders section, which now appears in every issue.

Beyond the changes we've already made, we're using your input to get the ball rolling on other initiatives. We want to tailor the Blue Review to provide the information you need to stay connected, up-to-date and in the know.

Watch for the 2019 Readership Survey, Coming in October
We're gearing up for another round to gather new ideas and input. A link to the 2019 survey will be available on our Provider website in October. If you participated last year, we look forward to hearing from you again on this year's survey. If you missed the 2018 survey, now's your chance to be heard. The Blue Review is your newsletter, so we're relying on you to let us know how we're doing.

Have an idea that can't wait?
Remember, you're always welcome to email the Blue Review editor with any feedback. Did you find a particular article really helpful? Would you like to hear more on a particular topic? Please let us know!

bcbsil.com/provider
The Institute of Medicine (IOM) categorizes challenges delivering quality health care within three domains: issues of underuse, misuse and overuse.¹ Most clinical quality improvement (QI) programs mainly focus on underuse, or ensuring “gap closure,” for various evidence-based, cost-effective, higher-value services (e.g., immunization, various cancer screenings, asthma and diabetes care compliance).

But over time, QI programs are increasingly evolving to address overuse, or what may also be referred to as low-value care (LVC) for both patient care and cost reasons. LVC may be defined as the use of care that is unlikely to benefit the patient, given the relative cost, available alternatives and preferences of the patient.²

The IOM estimates that up to 30% of health care costs, or $210 billion annually, is wasted on LVC.¹ Considered from a patient perspective, researchers estimate 33 to 45 low-value services are provided per 100 Medicare enrollees annually.³ And, these LVC rates are not exclusive to Medicare. They have been shown to be comparable between Medicare, Medicaid and commercial, including Accountable Care Organizations (ACO) patient populations.⁴

While the above data suggests LVC is prevalent, certain provider and practice characteristics are shown to have stronger tendencies with LVC service rates, suggesting an enhanced or targeted QI approach may be helpful. Research shows that LVC practice patterns follow certain trends by local region, medical group and hospital referral affiliations.³,⁴ To a lesser degree, certain provider-level characteristics (e.g., sex, specialty, years in practice, patient panel size, medical degree type, etc.) are also associated with higher LVC rates.⁵ Certain ethnic minority patient populations are also more likely to receive certain LVC services, even when adjusted for factors like income and insurance enrollment, suggesting a need and benefit for providers to receive health equity and unconscious bias training.⁵

Three Recommendations to Build a Quality Culture around LVC:

1. **Leverage existing LVC Quality indicators and Performance Data.** Although smaller in number than indicators focusing on
underuse, Healthcare Effectiveness Data and Information Set (HEDIS) and National Quality Forum (NQF) databases already contain available LVC-focused indicators. Specific providers or medical groups performance can then be compared to existing regional and national Quality Compass® benchmarks. Examples of such LVC quality indicators include the following, some of which are already incorporated into BCBSIL’s HMO, Accountable Care Organizations (ACOs) and government product quality and utilization programs:

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Frequency of Select Surgical Procedures – Back Surgery, Bariatric Surgery, Coronary Artery Bypass Grafting (CABG), Cardiac Catheterization, Cholecystectomy, Hysterectomy, Mastectomy, Prostatectomy, and several others
- Various Condition-specific Inpatient Utilization Indicators regarding Hospital Days, Length of Stay, and Readmission
- Non-Recommended Cervical Cancer Screening in Adolescent Females
- Use of Imaging Studies for Low Back Pain

2. **Support Providers.** A systematic review revealed that multicomponent programs containing provider education, feedback and clinical decision support to be effective interventions against LVC. Regularly educate providers about best practice and U.S. Preventive Services Task Force (USPSTF) updates (e.g., universal prostate specific antigen (PSA) or Vitamin D screenings are not recommended). Choosing Wisely is another practice change resource. Providing ongoing performance feedback is also key after initial educational interventions. Finally, creating decision support either in the form of evidence-based written protocols or electronically, such as electronic medical records (EMRs) offering cautionary/redirectional pop-ups (e.g., ordering an x-ray for acute, nonproblematic low back pain), can also help change provider behavior.

3. **Educate Patients.** Patient-preference and consumerism can also drive LVC services. Educating patients in the form of media, written or verbal-based interventions have all been shown to be effective. Employing a shared decision-making approach to individual educational efforts can be effective modifying preference sensitive LVC.

Ultimately addressing low-value services and overuse is about quality improvement and good patient care in addition to, cost containment and medical stewardship. As said by Joel Tieder, Division of General Pediatrics and Hospital Medicine, Department of Pediatrics, Seattle Children’s Hospital and University of Washington, "We have an ethical and moral obligation to address overuse. More is not always better and, in many cases, is potentially harmful. Overuse stewardship should be an integral part of organizations’ quality-improvement and patient-safety initiatives."

Do you have ideas you’d like to share to keep the conversation going? You’re always welcome to email our Blue Review editor with any thoughts or feedback.

---


The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. References to third party sources or organizations are not a representation, warranty or endorsement of such organizations. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.
Millennials comprise the largest portion of today’s workforce.¹ That means their health will have economic effects on the American economy in the future. A recent Blue Cross and Blue Shield Association (BCBSA) study compares the current health of millennials to the prior generation (Generation X) and reveals interesting and possibly concerning facts about this younger generation.

The study by BCBSA and Blue Health Intelligence® (BHI) titled, The Health of Millennials, looked at the millennial generation’s overall health. The study evaluated 2017 claims data from 55 million individuals born between 1981 and 1995 covered by commercial insurance.²

The study looked at the top 10 conditions affecting millennials. When 2017 results were compared to those from 2014, there was significant worsening. From 2014 to 2017, millennials had an increase in all 10 of the following conditions:²

- Major Depression – 31%
- Hyperactivity – 29%*
- Type 2 Diabetes – 22%
- Hypertension – 16%
- Psychotic conditions – 15%*
- High cholesterol – 12%
- Substance use disorder – 10%*
- Chron’s/Ulcerative colitis – 10%
- Tobacco use disorder – 7%
- Alcohol use disorder – 1%*

* More common in millennials than the general population

The following occurred in at least five out of 100 millennials between 21 and 36 years old in 2017. The numbers have been rounded to the nearest whole number:²

- Hypertension – 8 per 100
- Hyperactivity – 7 per 100
- High cholesterol – 6 per 100
To understand if millennials are less healthy than previous generations, the report compared like age groups of Gen Xers who were ages 34-36 in 2014 with millennials who were ages 34-36 in 2017.²

<table>
<thead>
<tr>
<th>Condition</th>
<th>Gen Xers (2014) (Rate per 100)</th>
<th>Older Millennials (2017) (Rate per 100)</th>
<th>Rate of Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperactivity</td>
<td>3.6</td>
<td>4.9</td>
<td>37%</td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td>3.4</td>
<td>4.1</td>
<td>19%</td>
</tr>
<tr>
<td>Major depression</td>
<td>4.7</td>
<td>5.6</td>
<td>18%</td>
</tr>
<tr>
<td>Chron’s disease or Ulcerative colitis</td>
<td>1.2</td>
<td>1.3</td>
<td>15%</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>1.6</td>
<td>1.8</td>
<td>12%</td>
</tr>
<tr>
<td>Tobacco use disorder</td>
<td>6.5</td>
<td>7.2</td>
<td>11%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>12.5</td>
<td>13.7</td>
<td>10%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>10.8</td>
<td>11.6</td>
<td>7%</td>
</tr>
</tbody>
</table>

To address these concerns, Blue Cross and Blue Shield companies are launching Millennial Health Listening Sessions across the country to learn from experts, employers, digital leaders and millennials to create a path toward better health for this generation.


The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. References to third party sources or organizations are not a representation, warranty or endorsement of such organizations. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

bcbsil.com/provider

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

© Copyright 2019 Health Care Service Corporation. All Rights Reserved.
September 2019

CMS Star Ratings Matter: Encourage Members to Schedule Annual Wellness Visits

The Centers for Medicare & Medicaid Services (CMS) uses five categories to rate plan performance. One of those categories is “Staying Healthy.” Annual wellness visits may help our members stay healthy by finding problems before they start.

Some of your patients who are Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM members may not know that their annual wellness visits may be free of charge, although additional services may result in member cost-sharing. They also may not know that they could earn a $50 gift card to Amazon, Starbucks, Walmart or one of many other retailers just for completing their annual wellness visit.

If you get questions from our members, you could:

- Remind them to schedule their annual wellness visit before Dec. 31, 2019.
- Encourage them to bring along medical records, including immunization records, family health history, and a list of any prescription drugs, over-the-counter drugs, vitamins, and supplements they currently take.
- Remind them that they may earn a $50 gift card just for completing their annual wellness visit.

The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.
Mammography Screening for Early Detection of Breast Cancer

In 2018, the American Cancer Society (ACS) estimated that around 266,000 new cases of breast cancer in women were reported and about 41,000 of those resulted in mortality. The best defense for survival is early detection through screening. The U.S. Preventive Services Task Force (USPSTF) recommends annual breast cancer screening, and in most patient situations, the National Comprehensive Cancer Network and ACS agree.

Breast cancer screening is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA) to standardize and measure quality for all patients. The Office of Personnel Management (OPM) reviews HEDIS performance of certain measures for Federal Employee Program® (FEP®) members.

Strategies for improving HEDIS measure for breast cancer screening include:

- Utilizing NCQA coding tips to actively reflect care rendered.
- Educating women, starting at age 50, about the importance of early detection and treatment.
- Referring women to local mammography imaging centers and following up to verify completion.
- Using reminder systems for check-ups and screenings.

Blue Cross and Blue Shield of Illinois (BCBSIL) FEP members who are female and 40 years old and older are eligible for one breast cancer screening per calendar year as a covered benefit. Mammography screenings are part of the FEP’s preventive care benefits and are recognized by the plan on the first claim processed in a calendar year, regardless of when in the previous calendar-year the screening exam was performed. Preventive care benefits include unilateral or bilateral mammography screening or digital breast tomosynthesis screening.

For information purposes only, the below chart shows Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®) codes for your review and easy access when designating mammography screening for early detection of breast cancer. For a complete list, please refer to the NCQA website.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODING SYSTEM AND CORRESPONDING CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed (G0202)  
HCPCS: G0202

Screening mammography, including computer-aided detection (CAD) when performed; bilateral (G0204)  
HCPCS: G0204

Screening mammography, including computer-aided detection (CAD) when performed; unilateral (G0206)  
HCPCS: G0206

Mammography  
CPT: 77055-77057  
or  
77061-77063  
or  
77065-77067

Other mammography  
See NCQA website

Thank you for your dedication to help ensure that all your patients including FEP members receive exceptional care. If you have any questions regarding FEP members, please do not hesitate to reach out to the Federal Employee Quality Improvement Program.

HEDIS is a registered trademark of NCQA.
CPT copyright 2018 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.
The material presented here is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients’ conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials. References to other third party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.
September 2019

**BCCHP℠ Providers: What You Need to Know About Maternal and Child Health vs. Primary Care Physician (PCP) Add-on Codes**

Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to educating and informing providers of certain highly discussed topics throughout the year. This month’s topic, Maternal and Child Health (MCH) and PCP add-on codes, is specific to providers who provide care and services to our Blue Cross Community Health Plans℠ (BCCHP) members. The MCH and PCP add-ons are codes on the Illinois Department of Healthcare and Family Services (HFS) fee schedule that give an increased reimbursement amount. The add-on amount may vary depending on whether the patient is a child or adult.

In a [News and Updates](#) article posted April 11, 2019, we stated that, on **Feb. 11, 2019**, BCBSIL identified a system issue involving PCP add-on fee payments. **Since then, all identified affected claims have been reprocessed**. Below is a review of the MCH vs. PCP criteria and examples.

**Criteria to Include MCH Add-On Fees**

According to HFS, increased reimbursement rates for selected MCH services are available to physicians who meet the following criteria and sign the HFS MCH Primary Care Provider Agreement, in addition to being enrolled as a Medical Assistance Provider:

- Maintain hospital admitting privileges;
- Provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and primary care as needed;
- Provide obstetrical care and delivery services as appropriate;
- Perform risk assessment for pregnant women and/or children;
- Maintain 24-hour telephone coverage for consultation including ensuring “sick” children and “at-risk” pregnant women are treated as needed, based on a triage of need;
- Schedule diagnostic consultant and specialty visits as appropriate; and
- Provide adequate equal access to medical care for clients in cooperation with the department or its designated case management entity.

**Criteria to Include PCP Add-On Fees**

According to HFS, the Affordable Care Act (ACA) allows increased payment for certain Medicaid primary care services provided by certain qualified primary care providers.

To receive the enhanced payments, physicians must attest to providing primary care services within a specialty designation of
family medicine, general internal medicine or pediatric medicine. In addition, the physician must attest that they meet at least one of the following criteria:

- Hold board certification from the American Board of Medical Specialties, the American Board of Physician Specialties or the American Osteopathic Association in pediatric medicine, internal medicine or family medicine or an associated subspecialty; and
- Physicians who have furnished primary care services (see procedures on HFS site) that equal at least 60% of the Medicaid codes paid during the most recently completed calendar year, or for newly eligible providers, the prior month.

**Maternal and Child Health Procedure Codes**
The following Current Procedural Terminology (CPT®) codes are eligible for the MCH Add-Ons from the HFS practitioner fee schedule:

90791, 90792, 99241, 99242, 99243, 99244, 99245, 99291

**Example 1:** Per the HFS fee schedule below, CPT code 90791 has a state maximum reimbursement of $70, but it indicates that there is an add-on of $52.11 for a child or adult. Therefore, the total reimbursement for this code is $122.11.

![Image of the HFS fee schedule for 90791 CPT code]

**Primary Care Physician CPT Codes**
The following CPT codes are eligible for the PCP Add-Ons from the HFS practitioner fee schedule:

99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99341, 99342, 99343, 99344, 99345, 99347, 99489, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395

**Example 2:** Per the HFS fee schedule below, CPT Code 99201 has a state maximum reimbursement of $27.95, but it indicates that there is an add-on of $1.60 for a child or adult. Therefore, the total reimbursement for this code is $29.55. Notice that the PCP add-on code has a “P” in the note field.

![Image of the HFS fee schedule for 99201 CPT code]

CPT copyright 2018 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA. The material presented here is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients’ conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials. References to other third party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.
September 2019

Faulty Neulasta Onpro Devices: Billing and Reimbursement Reminders

The Neulasta Onpro device makes life a little easier for chemotherapy patients by allowing them to administer the drug Neulasta at home. When a device fails, the patient must go to the doctor’s office for the injection to avoid infection.

As a reminder, if this happens, a failed device may not be reimbursable. Please check with the manufacturer or contact your distributor for information on failed devices and drug waste.

As always, only administered drugs along with appropriately related wastage are eligible for billing. Billing that resembles duplicate payment for a failed device may be indicated on your statement and may be recouped. If this occurs, please contact the manufacturer for possible replacement.

Trademarksm are the property of their respective owners.

The material presented here is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients’ conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials. References to other third party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.
September 2019

Government Programs: Resubmit Claims Previously Incorrectly Rejected for Invalid NDCs

This notice applies to providers submitting electronic claims for the following Blue Cross and Blue Shield of Illinois (BCBSIL) members:

- Blue Cross Community Health PlansSM (BCCHPsm)
- Blue Cross Community MMAI (Medicare-Medicaid Plan)SM

BCBSIL has worked with the Illinois Department of Healthcare and Family Services (HFS) to confirm that we have the correct National Drug Codes (NDCs) validation process in place so claims with compliant codes are received and processed correctly.

BCBSIL has updated its systems based on directions from HFS and as of July 25, 2019, BCBSIL is prepared to accept any claims previously rejected for invalid NDCs.* The earliest possible rejection for this issue would have occurred on a claim with a March 15, 2017, date of service (DOS). Claims may continue to reject and will not be adjusted if the submitted codes on claims remain non-compliant.

Summary of change and compliant submission requirements:
Prior to this change, BCBSIL was validating all NDCs submitted on claims. BCBSIL has modified our process to align with HFS. On 837I claim submissions, BCBSIL will only validate NDCs that are present and valid based on the Healthcare Common Procedure Coding System (HCPCS) billed on the claim line. This same process will be followed to validate 837P claim lines if a given procedure code on the claim line requires an NDC per HFS guidance. If HFS requires the NDC for the procedure code, the NDC will be evaluated accordingly. The NDC will be evaluated for correct formatting of the 11-digit NDC number. The MediSpan® database comparison to obsolete status will be removed and BCBSIL will allow the claim to enter into the claim adjudication system.

BCBSIL validates NDCs using MediSpan. Providers should ensure NDCs used in billing processes are validated against a similar pharmacy database and the NDC is valid on the DOS.

What You Need to Do

1. Submit any claim previously accidentally rejected for invalid NDCs through the Availity® Provider Portal or your preferred vendor portal. This should not be marked as a corrected claim. For claims that are past the BCBSIL timely filing limits, the claim will
deny for timely filing. Please disregard this denial. We need to capture the claim in our system to waive the timely filing requirement.

2. BCBSIL will run reporting to identify claims that previously rejected for invalid NDCs in error that tie to claims that are now denying for timely filing in the system. This will be done monthly for a period of three months beginning on Sept. 1, 2019 to Nov. 30, 2019.

3. We will then adjust the claims that were previously rejected in error for invalid NDCs within 30 days and send a report of all adjusted claims to impacted providers at the end of each month through November 2019.

Providers are advised that the following rejections may still occur following implementation of this change in the 277CA:

**Invalid NDC**

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>X12 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>STC01-1</td>
<td>A3</td>
<td>Acknowledgement/Returned as unprocessable claim - The claim/encounter has been rejected and has not been entered into the adjudication system.</td>
</tr>
<tr>
<td>STC01-2</td>
<td>218</td>
<td>NDC Number</td>
</tr>
<tr>
<td>STC12</td>
<td></td>
<td>BCCHP will indicate the invalid NDC submitted inbound that caused the error.</td>
</tr>
</tbody>
</table>

**Missing NDC**

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>X12 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>STC01-1</td>
<td>A6</td>
<td>Acknowledgement/Returned for Missing Information -The claim/encounter is missing the information specified in the Status details and has been rejected.</td>
</tr>
<tr>
<td>STC01-2</td>
<td>218</td>
<td>NDC Number</td>
</tr>
</tbody>
</table>

Refer to the [IAMHP Comprehensive Billing Manual](#) for further education on NDC submission rules for Illinois Medicaid.

Please share this notice with your practice management/hospital information system software vendor, billing service or clearinghouse, if applicable.

If you have any questions, contact your assigned Provider Network Consultant (PNC). To locate your PNC, refer to the [Provider Network Consultant Assignments page](#).

*Inconsistencies related to "OBSOLETE" NDC codes were noticed after July 25, 2019. If you feel any claims submitted and failed incorrectly between July 25, 2019 and Aug. 13, 2019, please resubmit those claims following the guidance in the "What You Need to Do" section above.*

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. Medi-Span is a trademark of the Health division of Wolters Kluwer, an independent third party vendor that is a leading global provider of information and point of care solutions for the healthcare industry. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity or Wolters Kluwer. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

The material presented here is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients’ conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.
We want to offer more articles on behavioral health-related topics that may be of interest to our readers, based on feedback expressed during our annual newsletter survey. This article is the third in a series of articles written in collaboration with the Illinois Psychological Association. We hope you find this information relevant and useful.

It has been reported that the fastest growing age group in Illinois overall is the 60- to 79-year-old population. An article in Crain’s Chicago Business last year noted that, “The state – like the rest of the country – is getting older as birth rates decline and people live longer.”1 Rather than looking forward to their golden years, however, some older adults may be skeptical, perhaps adopting a sense of resignation to the inevitabilities of aging. After all, as Golda Meir said, “Old age is like a plane flying through a storm. Once you’re aboard, there’s nothing you can do.” Quietly, aging seniors may anxiously contemplate the thought: I am only one fall away from ending up in a nursing home.

What some seniors may not realize is that, while the turbulence of old age can’t be prevented, there are things they can do to help navigate, increase their level of comfort with, and maybe even help enjoy, the journey. Unfortunately, some geriatric patients may have difficulty understanding or fulfilling minor safety adjustments within the home that could enhance their own wellbeing.

In clinic settings, a casual inquiry, for example, as to the presence of throw rugs in the home could be misinterpreted or misunderstood, potentially causing a strain in the aging patient-provider relationship. Provider advocacy for the safety of at-risk older adults may create tension or loss of rapport between patients and their doctors. Seniors’ memory issues may be overemphasized, while impaired judgment may create a larger peril for them.

Within geriatrics, impaired judgment may be a critical concern when laboring to minimize threats to enhance personal safety. Even small changes may seem difficult for many seniors and therefore resistance to recommended modifications (e.g., removing throw rugs to prevent a fall) can be a common response. Ordinarily, providers may strive to respect intact decision-making ability in their patients. Yet, when the importance of recognizing physical risks to their wellbeing is minimized by vulnerable patients, close collaboration with influential family members may be necessary to enhance informed decision-making.

Four-legged family members might be helpful, too. For seniors with pets, the family dog or cat could hold viable negotiating potential for caregivers and clinicians trying to help prevent falls in the older adult home. Seniors may typically dread any potential separation from their animal companions. Therefore, some of your patients may stop and think twice about safety advice, if presented with one hypothetical situation: Upon a fall with an unwelcome fracture, my favorite pet cannot accompany me to the hospital or nursing
Impaired judgment risks also may be lurking in the vicinity of the medicine cabinet. Older adults may be juggling several prescriptions, perhaps from multiple providers who may not be aware if their patients don’t provide updated lists of current medications. Notably, over-the-counter polypharmacy (adding unprescribed medications and/or supplements), often under-reported by geriatric patients, may increase vulnerabilities, including falling with related injuries.

As noted in a Washington Post article titled, *An Overlooked Epidemic: Older Americans Taking Too Many Unneeded Drugs*, “At least 15 percent of seniors seeking care annually from doctors or hospitals have suffered a medication problem; in half of these cases, the problem is believed to be potentially preventable. Studies have linked polypharmacy to unnecessary death. Older patients, who have greater difficulty metabolizing medicines, are more likely to suffer dizziness, confusion and falls.”

One study showed that, at age 85, when a patient falls and breaks a hip, there’s an approximate 50% risk of death within one year.

While psychotropic medication may be useful to help improve health outcomes, behavioral health providers are wise to seek a general medical work-up via the patient’s primary care provider for patients over 55 years of age. Medication management information is available to help assist non-prescribing behavioral health providers in their work with geriatric patients who experience co-morbid medical conditions. Here are some examples of informational resources you may wish to consider for reference purposes:

- **Epocrates.com** is a practice tool app for providers to help identify common medication side effects, using evidenced-based information.
- The **American Geriatric Society (AGS) Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults** offers tips on warning signs to watch for.
- **GeriatricsCareOnline.org** is an extensive online library offered by AGS for geriatric health care professionals.
- The **Medications & Older Adults** page on the AGS **HealthinAging.org** site includes medication safety information for senior patients and their caregivers.

If a geriatric patient becomes increasingly incapacitated, additional resources may be needed. The following sites may offer a variety of materials, such as free brochures, easy-to-read booklets, handouts, fact sheets and other tools that may be helpful to your patients and their caregivers:

- U.S. Department of Health & Human Services, **National Institutes of Health (NIH), National Institute on Aging (NIA)** – **Order Free Publications online**
- **NIH National Institute of Mental Health (NIMH)** – See the **Brochures and Fact Sheets** page
- **U.S. Department of Veterans Affairs (VA)** – Refer to the **Self-help Toolkit** with **Handouts for Patients**
- U.S. Advance Care Plan RegistrySM (USACPR), Powered by U.S. Living Will Registry® – Refer your patients and their caregivers to uslivingwillregistry.com
- **American Bar Association (ABA)** – This site includes a **Tool Kit for Health Care Advance Planning** among other patient resources
- **National Hospice and Palliative Care Organization** – See the **Advance Care Planning** section for patient resources such as **Advance Directives** and **How to Talk With Your Loved Ones**

The above lists represent only a sampling of the large number of websites and downloadable resources offered by organizations that serve older adults and their families, caregivers and health care providers.

Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to increasing awareness and educating our members of all ages, with special emphasis on potentially fragile populations that may face extra challenges. One example is our **Seasons of Life™** program, which is available to many of our members to help provide support. We want to be there for our members throughout the normal progression of events in their health care journeys, as well during times of unexpected crises. If your patients have questions about programs that may be available to help them receive the right care at the right time and in the right place, please remind them to call...
the customer advocate number on their BCBSIL member ID card.


Beers Criteria is a trademark of AGS, a nationwide, not-for-profit society of geriatrics health care professionals. For more information, visit AmericanGeriatrics.org.

U.S. Advance Care Registry is a trademark of the U.S. Living Will Registry, a privately held organization that electronically stores advance directives, organ donor information and emergency contact information, and makes them available to health care providers across the country 24 hours a day through an automated system.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. References to third party sources or organizations are not a representation, warranty or endorsement of such organizations. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.
September 2019

**Government Programs Update: Removal of Benefit Preauthorization Requirement for Cardiology and Specialty Therapy Services, Effective Sept. 1, 2019**

There are important changes to the benefit preauthorization requirements for your Blue Cross and Blue Shield of Illinois (BCBSIL) patients enrolled in any of the following government programs plans: Blue Cross Medicare Advantage (PPO)SM (MA PPO), Blue Cross Community MMAI (Medicare-Medicaid Plan)SM (MMAI) and Blue Cross Community Health PlansSM (BCCHPSM).

As of **Sept. 1, 2019**, benefit preauthorization through eviCore, an independent specialty medical management company, is **no longer required** for the following services/BCBSIL members:

- Cardiology services for MA PPO, MMAI and BCCHP members
- Specialty therapy (chiropractic, physical, occupational and/or speech therapy) services for MA PPO members

As always, it is critical to check eligibility and benefits first, prior to rendering care and services, to confirm coverage, network status and other important details. When you check eligibility and benefits online by submitting an electronic 270 transaction through the *Availity® Provider Portal* or your preferred web vendor portal, you may determine if benefit preauthorization/pre-notification may be required. Payment may be denied if you perform procedures without benefit preauthorization when benefit preauthorization is required. If this happens, you may not bill our members.

For more information, refer to the [Eligibility and Benefits](#) and [Prior Authorization](#) pages of our Provider website.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized/pre-notified for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member’s ID card.

eviCore healthcare is an independent specialty medical benefits management company that provides utilization management services for BCBSIL. Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as eviCore or Availity. The vendors are solely responsible for the products or services they provide. If you have any questions regarding any of the products or services they provide, you should contact the vendor(s) directly.

bcbsil.com/provider
September 2019

**Notice of Change in the Pre-service Appeals Process for Government Programs, Effective Nov. 1, 2019**

There are important changes to the pre-service appeals process for your Blue Cross and Blue Shield of Illinois (BCBSIL) patients enrolled in the following government programs plans: Blue Cross Medicare Advantage (PPO)SM (MA PPO) and Blue Cross Community MMAI (Medicare-Medicaid)SM (MMAI). These changes are designed to help streamline workflows and lead to an improved member and provider experience.

Beginning **Nov. 1, 2019**, eviCore® healthcare (eviCore) will no longer administer the pre-service appeals process for denied or partially denied benefit preauthorizations that are submitted through eviCore for MA PPO and MMAI members. Instead, BCBSIL will be administering the pre-service appeals process for these members, from pre-service appeal intake to appeal determination.

eviCore will, however, continue its role in administering the initial determination of preauthorization requests.

**Note:** The medical policies being used for these pre-service appeal reviews will not change. Remember, when submitting a pre-service appeal, always follow the directions included within the denial letter.

As always, it is critical to check eligibility and benefits first, prior to rendering care and services to confirm coverage, network status and other important details. When you check eligibility and benefits online by submitting an electronic 270 transaction through the Availity® Provider Portal or your preferred web vendor portal, you may determine if benefit preauthorization/pre-notification may be required.

Payment may be denied if you perform procedures without obtaining benefit preauthorization when benefit preauthorization is required. If this happens, you may not bill our members. For more information, refer to the Eligibility and Benefits and Prior Authorization pages of our Provider website.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized/pre-notified for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member’s ID card.

eviCore healthcare is an independent specialty medical benefits management company that provides utilization management services for BCBSIL. Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as eviCore or Availity or eviCore. The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.
September 2019

Enhancement to Automated Phone System: Consolidated Benefit Response

As always, checking eligibility and benefits electronically through the Availity® Provider Portal or your preferred web vendor is a quick and convenient way to access coverage information for Blue Cross and Blue Shield of Illinois (BCBSIL) members. If you do not have online access and need to call BCBSIL to verify benefits, we want to make you aware of an enhancement to the Interactive Voice Response (IVR) phone system, an alternative way to check eligibility and benefits. As of Aug. 26, 2019, the IVR phone system will now consolidate benefit responses for services that have the same benefit details.

This IVR enhancement will improve provider efficiencies and ultimately reduce your call time. Previously, for example, if a caller requested chemotherapy benefits in the IVR, the system would return coverage for each individual provision of chemotherapy, radiation therapy and office visit. Now the IVR combines these services and returns one benefit quote for all provisions when the coverage level is the same. The IVR main menu options have not changed and providers will continue to navigate the phone system as they have in the past.

For IVR navigational assistance, refer to the Eligibility and Benefits Caller Guide.

To verify eligibility and benefits via phone for government programs (Medicare Advantage and Illinois Medicaid) members, refer to the number on the member’s ID card.

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member’s ID card.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.
September 2019

Reminder: Verify Procedure Code Benefit Preauthorization Requirements Online

In a December 2018 News and Updates notice, we announced a new online capability that allows providers to verify benefit preauthorization requirements for specific Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes via an eligibility and benefits inquiry in the Availity® Provider Portal. Since implementation, many updates have been made to improve articulation.

How to Receive Accurate Results
To ensure code-specific benefit preauthorization requirements are returned online, valid CPT/HCPCS code(s)* and associated place of service must be submitted in the electronic eligibility and benefits inquiry (270). If a CPT/HCPCS code is not entered, then the place of service and benefit/service type are required. If a benefit/service type is not selected, the place of service and at least one CPT/HCPCS code are required. Additionally, no benefit or benefit preauthorization information will return for the benefit/service type if one is not selected.

The eligibility and benefit inquiry response (271) displays benefit preauthorization requirements in the Pre-Authorization Info tab. In some instances, providers may receive a “Auth Info Unknown” response for the requested benefit/service type. If benefit preauthorization is required or unknown, contact information for completing the request and other important details are included.

As a reminder, the CPT/HCPCS code inquiry option is for benefit preauthorization determination only and is not a code-specific quote of benefits.

Exceptions
Online code-specific benefit preauthorization information is not yet available for the following Blue Cross and Blue Shield of Illinois (BCBSIL) members:

- Federal Employee Program® (FEP®)
- Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM
- Blue Cross Community MMAI (Medicare-Medicaid Plan)SM and Blue Cross Community Health PlansSM

Resources
Learn how to successfully verify benefit preauthorization requirements for benefits and procedure online by referencing the General
Eligibility and Benefits Expanded Tip Sheet. For additional assistance, contact the Provider Education Consultants at PECS@bcbsil.com.

*Providers may enter up to eight procedure codes in the inquiry.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate or contract of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.

CPT copyright 2018 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by independent third-party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.
September 2019

**New and Exciting Functionality Coming to the Claim Research Tool (CRT) via Availity® Provider Portal**

The CRT provides enhanced, real-time claim status details to help you manage and resolve your Blue Cross and Blue Shield of Illinois (BCBSIL) claims electronically. As of Aug. 26, 2019, the CRT now returns out-of-network patient responsibility in the service line details. This enhancement helps you identify if the patient liability was applied to the out-of-network co-payment, coinsurance and/or deductible.

**Effective Sept. 23, 2019, two additional features will become available.**

First, the CRT will be enhanced to offer greater specificity for Cotiviti, INC. (formerly known as Verscend) claim denials. Once implemented, you will see the Cotiviti code-auditing logic descriptions for finalized claims. These expanded claim details will be available for claims finalized Aug. 26, 2019, and after.

Second, you will see additional action(s) that will provide instruction for specific denials for finalized claims. These instructions will help providers understand what further action may be needed as a result of how the initial claim processed.

**CRT Reminders:**

- The CRT is not yet available for government programs (Medicare Advantage and Illinois Medicaid) claims.
- Locate duplicate claims, along with the original by performing a Patient ID search.
- When using the Patient ID search to locate Federal Employee Program® (FEP®) claims, use group number 0FEP00.
- When using the Patient ID search to locate out-of-state member claims, use generic group number 123456.
- Claim adjustments are identified by a two-digit suffix on the claim number. For example, claim number 123456789D10X indicates it is an original submission. Claims ending with suffix 01 indicate the claim has been adjusted once.

For additional information, refer to the CRT tip sheet. As a reminder, you must be registered with Availity to use the CRT. For registration information, visit availity.com, or contact Availity Client Services at 800-282-4548.

**Stay Informed!** Continue to watch for future News and Updates announcements and helpful resources.

If you have questions about these enhancements, contact our Provider Education Consultants team at PECS@bcbsil.com.
Cotiviti, INC. is an independent company that provides medical claims administration for BCBSIL. Cotiviti is solely responsible for the products and services that it provides. Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Cotiviti and Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.
September 2019

Respond Electronically to Medical Record Requests for Quality and Risk Adjustment, and Soon Claims, via Availity® Provider Portal

Currently, the Medical Attachments application within the Availity portal allows you to electronically respond to quality and risk adjustment medical record requests from Blue Cross and Blue Shield of Illinois (BCBSIL). After Oct. 1, 2019, you will also be able to use this optional application to electronically respond to medical record requests from BCBSIL to more efficiently support claims processing.

Submitting requested medical record information online is easy. Once logged into the Availity portal, medical record requests from BCBSIL will display in the Notification Center. You may then respond by uploading and submitting documentation using the Medical Attachments application. You may also track and audit your submissions within the Medical Attachment application.

You must be a registered Availity user to receive and respond to these requests online using the Medical Attachments application. To enable this feature, practice administrators must first log into Availity, select Enrollment Center, then choose Medical Attachments Setup and enter the required data. Administrators are encouraged to complete this online setup now to ensure your organization is ready to receive new medical record requests for claims processing, once this new feature is implemented.

We are excited to offer more payer provider solutions within your daily Availity workflow. Integrating this new electronic medical records submission capability has the potential to reduce in-person visits to retrieve medical records and administrative challenges associated with mailing or faxing paper submissions. (Mailing and faxing medical records remain options for all participating providers.)

Continue to watch our News and Updates for upcoming online training sessions and other educational resources. If you have questions, contact our Provider Education Consultants at PECS@bcbsil.com.

Not registered with Availity? Go to availity.com and complete the online application, at no charge. For more information, refer to Availity Portal Attachments Tools – Getting Started Guide.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

Providing requested medical records is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member’s policy certificate and/or benefits booklet and or summary plan description. Regardless of any preauthorization or benefit determination, the final decision regarding any treatment or service is
between the patient and their health care provider.
Are you familiar with BluePrint PPO℠?

BluePrint PPO is a product offered by Blue Cross and Blue Shield of Illinois (BCBSIL). You may be an in-network provider through your PPO contract for BCBSIL members with this product.

BCBSIL members may refer to their benefit booklet for more details. As always, it is important to check eligibility and benefits for each patient before every scheduled appointment. The best way to check eligibility and benefits is electronically through the Availity® Provider Portal or your preferred vendor portal.

Eligibility and benefit quotes include important information about BluePrint PPO patients’ benefits, such as membership verification, coverage status and applicable copayment, coinsurance and deductible amounts. Also, the benefit quote may include information on applicable benefit preauthorization/pre-renotification requirements. When services may not be covered, you should let the BluePrint PPO member know that they may be billed directly.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

Checking eligibility and benefits and/or obtaining preauthorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member’s policy certificate and/or benefits booklet and or summary plan description. Regardless of any preauthorization or benefit determination, the final decision regarding any treatment or service is between the patient and their health care provider.
Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois (BCBSIL) offers free workshops and webinars for the independently contracted providers who work with us. These trainings focus on electronic options and other helpful tools and resources. A preview of upcoming training sessions is included below. For more information, refer to our Webinars and Workshops page.

### BCBSIL WEBINARS

**To register now for a webinar on the list below, click on your preferred session date.**

<table>
<thead>
<tr>
<th>Descriptions:</th>
<th>Dates:</th>
<th>Session Times:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCBSIL Back to Basics: ‘Availity® 101’</strong></td>
<td><strong>Sept. 3, 2019</strong></td>
<td>11 a.m. to noon</td>
</tr>
<tr>
<td>Join us for a review of electronic transactions, provider tools and helpful online resources.</td>
<td><strong>Sept. 10, 2019</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sept. 17, 2019</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sept. 24, 2019</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Introducing Availity Remittance Viewer</strong></td>
<td><strong>Sept. 12, 2019</strong></td>
<td>11 a.m. to noon</td>
</tr>
<tr>
<td>Have you heard? This online tool gives providers and billing services a convenient way to retrieve, view, save/print and reconcile Electronic Remittance Advice (835 ERA) data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>iExchange®: New Enrollee Training</strong></td>
<td><strong>Sept. 19, 2019</strong></td>
<td>11 a.m. to 12:30 p.m.</td>
</tr>
<tr>
<td>Learn how to gain access to and begin using our online benefit preauthorization/predetermination of benefits tool.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blue Cross Community Health PlansSM (BCCHPSM) for Behavioral Health/Medical Providers</strong></td>
<td><strong>Sept. 26, 2019</strong></td>
<td>9 to 10 a.m.</td>
</tr>
<tr>
<td>This webinar is intended for the following provider types: Community Mental Health Centers (CMHC), Substance Use Prevention and Recovery (SUPR), Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Medical Group/Independent Practice Association</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Managed Long Term Services and Supports (MLTSS) Orientation**
This webinar offers LTSS providers more information about the MLTSS program as it relates to our BCCHP product and how to navigate BCBSIL requirements, electronic options and online Provider Resources.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 10, 2019</td>
<td>10 to 11 a.m.</td>
</tr>
<tr>
<td>Sept. 24, 2019</td>
<td></td>
</tr>
</tbody>
</table>

**BCBSIL Monthly Virtual Provider Workshop**
These monthly webinars will be held through December 2019. They are customized for the BCBSIL contracted provider community. BCBSIL Provider Network Consultants (PNCs) will use this format to share upcoming initiatives, program changes and updates, as well as general network announcements.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 11, 2019</td>
<td>10 to 11 a.m.</td>
</tr>
</tbody>
</table>

**Provider Onboarding Form Training**
These sessions will assist providers in effectively navigating the Provider Onboarding Form. Discussion topics will include: New Group/Provider Contracting, Request Addition of Provider to Group and how to submit Demographic Changes.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 24, 2019</td>
<td>10 to 11:30 a.m.</td>
</tr>
</tbody>
</table>

**AVAILITY WEBINARS**
Availity also offers free webinars for their registered users. For a current listing of webinar topics, dates and times, registered Availity users may log on to the secure Availity provider portal – the Live Webinar Schedule is located under the Free Training tab. Not yet registered with Availity? Visit their website for details; or call Availity Client Services at 800-AVAILITY (282-4548) for assistance.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity and Medecision. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

**bcbsil.com/provider**
Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
© Copyright 2019 Health Care Service Corporation. All Rights Reserved.
### September 2019

## Important Dates and Reminders

Check here each month for a quick snapshot of recent implementations, upcoming changes, special events, important deadlines and other reminders. Blue Cross and Blue Shield of Illinois (BCBSIL) understands that provider offices are extremely busy and, while this list should not be interpreted as all-inclusive, we hope this abbreviated summary format is useful to you and your staff.

## Confirmation of Recent Implementations

<table>
<thead>
<tr>
<th>Topic</th>
<th>Brief Description</th>
<th>Target Implementation Date:</th>
<th>For More Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Research Tool (CRT) Enhancement (Commercial Claims)</strong></td>
<td>The CRT now returns out-of-network patient responsibility in the service line details, when applicable.</td>
<td><strong>Aug. 26, 2019</strong></td>
<td><a href="#">New and Exciting Functionality</a> <strong>Announcements for Claim Research Tool (CRT) via Availity® Provider Portal</strong> (September 2019, <em>Blue Review</em>)</td>
</tr>
<tr>
<td><strong>Automated Phone System Enhancements (Commercial)</strong></td>
<td>Our interactive voice response (IVR) phone system will now consolidate benefit responses for services that have the same benefit details.</td>
<td><strong>Aug. 26, 2019</strong></td>
<td><a href="#">Enhancement to Automated Phone System: Consolidated Benefit Response</a> (September 2019, <em>Blue Review</em>)</td>
</tr>
<tr>
<td><strong>Changes to Benefit Preauthorization Requirements Through eviCore healthcare (eviCore) for Government</strong></td>
<td>Benefit preauthorization through eviCore is no longer required for certain government programs members for services in select care categories, such as cardiology and/or specialty therapy</td>
<td><strong>Sept. 1, 2019</strong></td>
<td><a href="#">Government Programs Update: Removal of Benefit Preauthorization Requirement for Cardiology and Specialty Therapy</a></td>
</tr>
</tbody>
</table>
Upcoming Changes to Watch For

<table>
<thead>
<tr>
<th>Topic</th>
<th>Brief Description</th>
<th>Target Implementation Date:</th>
<th>For More Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity Claim Research Tool (CRT) Enhancements*</td>
<td>Cotiviti, INC. (Cotiviti) code-auditing logic descriptions and additional action(s)/instructions will be added to the Availity CRT to help providers manage and resolve specific BCBSIL commercial claim denials.</td>
<td>Sept. 23, 2019</td>
<td>New and Exciting Functionality Coming to the Claim Research Tool (CRT) via Availity® Provider Portal (September 2019, Blue Review)</td>
</tr>
<tr>
<td>Respond Electronically to Claim-related Medical Record Requests from BCBSIL via Availity</td>
<td>The Medical Attachments application will allow electronic responses to claim-related medical record requests from BCBSIL, in addition to electronic responses to quality and risk adjustment medical record requests.</td>
<td>After Oct. 1, 2019</td>
<td>Respond Electronically to Medical Record Requests for Quality and Risk Adjustment, and Soon Claims, via Availity® Provider Portal (September 2019, Blue Review)</td>
</tr>
<tr>
<td>Government Programs: Changes to Pre-service Appeals Process</td>
<td>For some government programs members, denied or partially denied benefit preauthorizations, BCBSIL will be the administrator instead of eviCore.</td>
<td>Beginning Nov. 1, 2019</td>
<td>Government Programs Update: Removal of Benefit Preauthorization Requirement for Cardiology and Specialty Therapy Services, Effective Sept. 1, 2019 (September 2019, Blue Review)</td>
</tr>
</tbody>
</table>

Special Events and Activities

<table>
<thead>
<tr>
<th>Topic</th>
<th>Brief Description</th>
<th>Important Dates</th>
<th>For More Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Competency and Implicit Bias Training Program</td>
<td>Online training modules; currently in progress for select HMO network primary care physicians.</td>
<td>through October 2019</td>
<td>Health Equity: Bold Strategies, Unique Solutions (April 2019, Blue Review)</td>
</tr>
<tr>
<td>2019 Blue Review Readership Survey</td>
<td>Watch for this year’s survey to provide your feedback and ideas.</td>
<td>October and November 2019</td>
<td>Information will be posted in the News and Updates once the survey is available.</td>
</tr>
</tbody>
</table>
### Monthly Virtual Provider Workshops

Our Provider Network Consultant team will be hosting one-hour online training sessions to help keep you informed of important BCBSIL updates and initiatives through December 2019. Watch the [Provider Learning Opportunities](#) or visit the [Webinars and Workshops page](#) on our Provider website for upcoming dates and online registration.

### Deadlines and Other Reminders

<table>
<thead>
<tr>
<th>Topic</th>
<th>Brief Description</th>
<th>Important Dates</th>
<th>For More Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email Validation Survey</td>
<td>If you’re on our distribution list to receive the electronic <em>Blue Review</em>, you may receive a request from BCBSIL to validate your email information.</td>
<td>Ongoing through 2019</td>
<td><a href="#">We’re Conducting an Email Validation Survey</a> (May 2019, News and Updates)</td>
</tr>
<tr>
<td>Some of our Blue Choice Preferred PPO members may receive Fecal Immunochemical Test (FIT) Kits for in-home colorectal cancer screening</td>
<td>Access Health Corporation (an independent company specializing in in-home diagnostic testing) will process tests and send results to our members and their specified primary care providers.</td>
<td>Members have until Nov. 15, 2019, to complete and submit their in-home colorectal cancer screening tests for processing.</td>
<td><a href="#">In-home Colorectal Cancer Screening Test Provided to Select Members</a> (June 2019, <em>Blue Review</em>)</td>
</tr>
<tr>
<td>Government Programs Providers: Resubmit Claims Previously Incorrectly Rejected for Invalid National Drug Codes (NDCs)</td>
<td>BCBSIL has updated its systems per the Illinois Department of Health and Family Services (HFS); we are running reports to identify claims that rejected in error for invalid NDCs (dates of service on or after March 15, 2017).</td>
<td>Submit any claim previously incorrectly rejected for invalid NDCs through Availity or your preferred vendor portal by Nov. 30, 2019.</td>
<td><a href="#">Update: Government Providers, Resubmit Claims Previously Incorrectly Rejected for Invalid NDCs</a> (September 2019, News and Updates)</td>
</tr>
<tr>
<td>Remind your Medicare and Medicaid patients to schedule their annual wellness visits.</td>
<td>Providers may increase Star ratings by promoting preventive care; participating members could receive $50 gift cards.</td>
<td>Before Dec. 31, 2019</td>
<td><a href="#">CMS Star Ratings Matter: Encourage Members to Schedule Annual Wellness Visits</a> (September 2019, <em>Blue Review</em>)</td>
</tr>
</tbody>
</table>

Checking eligibility and benefits and/or obtaining preauthorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member’s policy certificate and/or benefits booklet and or summary plan description. Regardless of any preauthorization or benefit determination, the final decision regarding any treatment or service is between the patient and their health care provider.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. eviCore is an independent specialty medical benefits management company that provides utilization management services for BCBSIL. Cotiviti, INC. is an independent company that provides medical claims administration for BCBSIL. Cotiviti is solely responsible for the products and services that it provides. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity, eviCore or Cotiviti. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.
September 2019

Procedure Code and Fee Schedule Updates

As part of our commitment to help inform our independently contracted providers of certain developments, Blue Cross and Blue Shield of Illinois (BCBSIL) has designated a specific section in the Blue Review to notify you of any significant changes to the physician fee schedules. It’s important to review this section each month.

Effective Sept. 1, 2019, the following Current Procedural Terminology (CPT®) code ranges were updated: 90630-90756 and Q2034-Q2039. Please note that not all CPT codes in these ranges were updated.

Effective Jan. 1, 2020, CPT codes J7324 and J7327 will be updated.

The information above is not intended to be an exhaustive listing of all the changes. Annual and quarterly fee schedule updates may also be requested by using the Fee Schedule Request Form. Specific code changes that are listed above may also be obtained by downloading the Fee Schedule Request Form and specifically requesting the updates on the codes listed in the Blue Review. The form is available on the Forms page on our Provider website.

CPT copyright 2018 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

bcbsil.com/provider

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

© Copyright 2019 Health Care Service Corporation. All Rights Reserved.
ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes are periodically added to, or deleted from, the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and aren’t considered changes to the software version. Blue Cross and Blue Shield of Illinois (BCBSIL) will normally load this data to the BCBSIL claim processing system after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSIL Provider website. We will also post advance notice of ClaimsXten software updates on our website.

To help determine how some coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to use Clear Claim Connection™ (C3). C3 is a free, online reference tool. Refer to the Clear Claim Connection page on our website for more information about C3, including frequently asked questions about ClaimsXten. Updates may be included in future issues of the Blue Review. Please note that C3 doesn’t contain all of the claim edits and processes used by BCBSIL in adjudicating claims, and results from use of the C3 tool aren’t a guarantee of the final claim determination.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent company providing coding software to BCBSIL. McKesson Information Solutions, Inc. is solely responsible for the software and all the contents. Contact the vendor directly with any questions about the products, software and services they provide.

CPT copyright 2018 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.