# blueREVIEW

For Contracting Institutional and Professional Providers

BlueCross BlueShield of Illinois

www.bcbsil.com/provider


## THIN Online Now Has Out-of-Area Capabilities

Beginning November 1, 2005, providers who utilize THIN Online will be able to verify eligibility, benefits, and claim status for out-of-area Blue Cross and Blue Shield (BCBS) members. Access to this new functionality will be available to providers who currently check eligibility, benefits and claim status for local Blue Cross and Blue Shield of Illinois (BCBSIL) members.

### How does this work?

If a Blue Cross and Blue Shield of Florida member seeks services from your facility through our BlueCard Program, you can log on to THIN Online and check the Florida member's eligibility status and benefits. Please note that the input screens for out-of-area eligibility, benefits, and claim status look-up will slightly differ from the current look-up screens. Sample screens are located on our BCBSIL Web site under What's New at www.bcbsil.com.

Join the growing number of providers who take advantage of our online solutions. Sign up for THIN Online today by contacting our EDI Help Desk at (312)653-7954.

## BCBSIL Provider Finder® Is Looking For You

Have you changed locations? Moved to a different practice? Changed your name? If so, it is important to keep BCBSIL up-to-date on these changes. The information we have about you affects our ability to:

- Provide the correct reimbursement
- Report your tax ID to the Internal Revenue Service
- Publish an accurate listing for you in our provider directories and on our Provider Finder® Web site.

### Access to Provider Finder®

To ensure that we have the most accurate information on file, you can find your listing online by following these quick, easy steps, and verifying that the information is correct (name, address, specialty, telephone number, hospital affiliations, etc.)

- Log in to www.bcbsil.com
- Choose "Provider Finder®"
- Select your network from the Group Products List and select "continue"
- Enter your address and select "continue"
- Choose "Physician by Name"
- Enter your name and select "continue"
- Choose your specialty and view the results

If there has been a change in your practice information, or if you find discrepancies or the wrong information in your file, you need to communicate those changes to us promptly so that we can update your file. We accept the following file changes:

- Address (relocation)
- Name (individual provider or group)
- Telephone number
- E-mail address
- New tax ID number
- Payee address location
- Hospital affiliations (changes, additions)
- Moving from group practice to single practice or from single to group
- New physicians joining an existing group practice
- Retirement

Most changes can be made online. However, changes in name or tax ID must be submitted by fax or mail. A copy of Form W-9 or SS-4 must accompany all Tax ID and Group Name changes.

### To Update Your File

Making revisions to your file is simple when using the Provider Update Form online. You may access this form by following these procedures:

- Log in to www.bcbsil.com/provider
- Select the "Change It Online" icon at the bottom left hand corner of the page
- Complete the Provider Update Form, populating all required fields
- Select "submit"

If there are any errors or if you need to make changes or additions, you may use the online form. You also have the option to fax the information to (312) 856-1946 or mail it to us using your own letterhead. Mail to:

Blue Cross and Blue Shield of Illinois
300 E. Randolph Street
Chicago, Illinois, 60601-5000
Attn: Provider Services, 23rd Floor

# Electronic Solutions

## Direct Data Entry (DDE)/Provider Terminal System (PTS) Users

Effective November 1, 2005, providers/users who dial into the Blue Cross and Blue Shield's mainframe computer system CICS applications to submit professional claims via SSCE and BCBS applications will be issued instructions to begin using a new application Provider Claim Entry System (PCES) for the submission of professional claims.

The new screens will now allow you to submit Medicare Primary, Blue Shield Secondary claims electronically when they do not crossover. Use the following instruction to enter a BlueShield claim that is secondary to Medicare:

Go to the Other Subscriber Info section on the bottom of page one:

1. Enter all information in iteration A of OTHR SUBSCRIBER INFO
2. Enter information in corresponding iteration (A) of OTHR-PAYR-NM to include payer name, Payer ID and Payer type. (i.e., the Medicare Part B Payer ID Number for the Illinois Carrier, WPS, is **C00952**. The Payer Type code for WPS is **MB**.
3. The INS TYP CODE identifies the type of insurance policy within a specific insurance program. For example, the Insurance Type Codes for the Medicare program are:

   MB = Medicare Part B

   MI = Medigap Part B

   MP = Medicare Primary

   CP = Medicare Conditionally Primary
4. The ASGN-BEN: This field should be "Y" or "N" to indicate which assignment of benefits indicator was used on the Medicare claim.
5. If the Paid Amount and the Approved Amounts do not match, then you must enter the related adjustment reason code and amount fields from the Medicare payment data you received from the Carrier. Some adjustment reason/group codes only have 5 digits and others have only 4. For example, a common group/reason code appears as C0-42 on your Medicare Remittance Notice, key in the code leaving out the dash so that it appears as CO42 in the in the GRP/ADT-RSN field on the screen. Also, be sure to enter the adjustment amount in the next field.

More information on PCES is located on our BCBSIL Web site under What's New at www.bcbsil.com.

## THIN's Deadline for Illinois Department of Public Aid (IDPA) Claims

As previously indicated in several *Blue Review* articles, the Centers for Medicare & Medicaid Services (CMS) implemented a contingency plan on October 16, 2003, that allowed providers and electronic billers to continue sending pre-Health Insurance Portability and Accountability Act (HIPAA) format electronic claims for Medicare and Medicaid. Although many electronic submitters sending their claims through The Health Information Network (THIN) are transmitting their claims in the HIPAA-compliant formats, Expanded National Standard (T0301) and 837, version 4010A1, the THIN Clearinghouse is still receiving claims in non-HIPAA compliant formats from some of the submitters.

Effective ***December 1, 2005***, any incoming electronic claim files that are not in a HIPAA compliant format will be rejected through the THIN front-end edits. A message will be shown on the THIN Response Reports indicating that the claim file was rejected because it was not submitted in any of the following THIN HIPAA compliant versions, T0301 and 4010A1.

## Thanksgiving Electronic Media Claims (EMC) Holiday Reminder

Electronic Media Claims (EMC) transmitted through the rEDI-link Blue Bulletin Board System and/or Direct Data Entry (DDE) on November 23, 2005, will be "processed" the following business day on November 28, 2005. Electronic payment files for claims processed on November 28, 2005, will be available for retrieval on November 29, 2005.

Electronic Funds Transfer (EFT) is also delayed an additional business day during corporate and banking holidays. Below is a list of holidays that will delay the processing of claims and EFTs:

| Claims Processed Date: | Sent To Bank | EFT Payment Available |
|---|---|---|
| November 23, 2005 | November 29, 2005 | December 1, 2005 |
| November 24, 2005* | Closed—Thanksgiving Day | |
| November 25, 2005* | Closed—Day After Thanksgiving | |
| November 28, 2005 | November 29, 2005 | December 1, 2005 |

*Note: Claims will not be processed during corporate holidays. If you have any questions, please call our EDI Hotline at: (312) 653-7954.

# Electronic Solutions

## Illinois Department of Public Aid (IDPA)—Third Party Liability (TPL) Update

For IDPA Third Party Liability claims (**TPL**), the three (3) digit TPL Code and the two (2) digit TPL Status is required on the HIPAA-compliant formats. Please see requirements listed below:

### HIPAA-Compliant Formats

**837I/837P, Version 4010A1:**
**Note:** TPL information must be submitted in Loop 2330B. A secondary identification number will be required when loop 2320 is used. It must be the three (3) digit TPL code followed by the two (2) digit Status code assigned by IDPA to other payers. See sample: REF*2U*91001~

### TPL Code

REF*2U*<u>910</u>01~
Code 910 = Medicare Part B
For TPL codes reference Appendix 9 in the Chapter 100

### TPL Status

REF*2U*910<u>01</u>
Code 01=Status code
For Status Codes reference Appendix 1 in Chapter 200 of the Handbook for your provider type.

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**Note:** Please be sure to include the "prior payment" information in the AMT segment, Loop 2320, and "Date Claim Paid" in the DTP segment, Loop 2330B with a 573 qualifier. For further information, please reference the IDPA Handbook, Section 302.43 COB – Reporting Prior Payment Section.

# RealMed Improves... Patient Registration and Increases Cash Flow

Practices, like other businesses today, are asking their staff to do more in an effort to maximize revenue and reduce operating costs. Whether your practice is struggling to do more with less or you are just interested in increasing your cash flow by improving front end processes, RealMed can help.

Capturing accurate patient information at registration ensures proper billing to the payer and patient, but this step is often skipped or done haphazardly due to time constraints and other responsibilities that registration personnel undertake. The result typically includes denials from payers, delays in payment, and inaccurate patient statements. Consequently, days in accounts receivable (A/R) increase and cash flow decreases.

RealMed is a web-based tool that can help manage your complete revenue cycle beginning with properly registering patient information and comparing that to the payers' records.

Eligibility checks can be done by importing batch files from your practice management system or individually checking eligibility when the patient presents. Either way, you can instantly retrieve information about the patient's coverage and fix patient information that is incorrect or inconsistent with the payer's records. When the eligibility information is correct, the practice can accurately bill both the payer and the patient and eliminate many of the causes—up to 60%—of claim denials.

Because most practices do not check patient registration information up front, there may be a learning curve for staff as responsibilities shift from the "back of the house" to the registration area. However, the long-term effects of the new front end processes should include saving money as a result of fewer denials and less follow up with payers.

For more information on RealMed, please call Teresa Luciano at (773) 867-8304.

# Managed Care Corner

## HMO and *BlueChoice* POS 2004 HEDIS® Results

HEDIS, the Health Plan Employer Data and Information Set, includes a number of clinical measures that are used to assess and compare health plans. Blue Cross and Blue Shield of Illinois reports audited HEDIS results for HMO Illinois/BlueAdvantage HMO and Blue*Choice* POS. For some HEDIS measures, random samples of members are selected using HEDIS methodology, while the entire population is used for other measures. All identified members who meet the selection criteria are included, even those who have never been seen by a network practitioner. HMO Medical Groups/IPAs, Blue*Choice* POS network PCPs, and hospitals supply much of the necessary data. We appreciate the assistance provided by the contracting provider network during the HEDIS data collection process.

NCQA allows health plans to rotate specified measures annually. For *BlueChoice* POS, 2003 results were utilized for all rotatable measures. For the HMOs, Adolescent Immunization Status, Beta Blocker Treatment after a Heart Attack and Cholesterol Management after Acute Cardiovascular Event were rotated.

The HMOs showed substantial improvement in the Childhood Immunization, Breast Cancer Screening, and many elements in the Comprehensive Diabetes measure, including Eye Exam, Lipid Profile and Lipid Control. *BlueChoice* POS improved in Postpartum Care and in Advising Smokers to Quit.

Flu shot results for both the HMOs and *BlueChoice* POS declined in 2004, likely due to the shortage of flu shot vaccine.

| Indicator | HMO Illinois and BlueAdvantage HMO | Blue*Choice* (POS) |
|---|---|---|
| Adolescent Immunization Rate: | | |
| Combination 1 | 56.2% | 63.8% |
| Combination 2 | 41.1% | 45.0% |
| Beta Blocker Treatment After a Heart Attack | 95.5% | 89.6% |
| Breast Cancer Screening | 75.1% | 65.8% |
| Cervical Cancer Screening | 76.9% | 69.5% |
| Childhood Immunization Rate: | | |
| Combination 1 | 74.2% | 76.1% |
| Combination 2 | 67.9% | 67.1% |
| Cholesterol Management After Acute Cardiovascular Events: | | |
| LDL-C Screening | 81.5% | 74.8% |
| LDL-C Control < 130 | 66.4% | 61.0% |
| LDL-C Control < 100 | 45.9% | 44.5% |
| Comprehensive Diabetes Care: | | |
| HbA1c Testing | 82.9% | 83.2% |
| Poor HbA1c Control | 28.1% | 43.1% |
| Eye Exam | 51.2% | 33.1% |
| Lipid Profile | 87.7% | 85.9% |
| Lipid Control <130 | 72.3% | 53.3% |
| Nephropathy Monitoring | 38.1% | 29.2% |
| 30 day Follow Up After Hospitalization for Mental Illness | 80.0% | NA |
| Timeliness of Prenatal Care | 92.0% | 87.9% |
| Postpartum Care | 80.1% | 76.3% |
| Advising Smokers to Quit | 67.4% | 62.4% |
| Flu Shots | 34.0% | 28.0% |

HEDIS is a registered trademark of NCQA

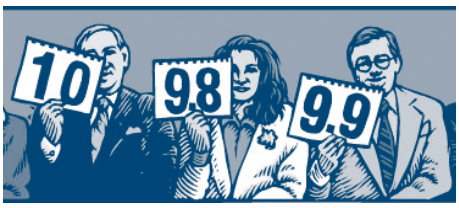
# Managed Care Corner

## BCBSIL HMOs* and Blue*Choice* POS Network PCP Satisfaction Surveys

Primary Care Physicians (PCPs) in our HMO and Blue*Choice* POS products are now receiving 2005 satisfaction surveys. The surveys are performed annually to analyze physician satisfaction with HMO and BlueChoice POS activities, and to evaluate physician experience with primary hospital services. The HMO survey includes questions about activities that both Contract Entities and BCBSIL conduct. PCPs that contract with more than one Contract Entity in the HMO will receive a separate survey for each Contract Entity. The BlueChoice POS survey includes questions about BCBSIL activities.

BCBSIL has a long record of maintaining the confidentiality of all PCPs who respond to the surveys. A number on the survey identifies the physician to assure that we do not record more than one set of responses per physician. The results are reported to BCBSIL operating areas and the HMO Contract Entities at group levels only, without identification of individual physicians.

Though survey questions are addressed directly to PCPs, you may have office staff more familiar with some activities. PCPs are encouraged to obtain assistance from your office staff to complete the survey. Some questions may not apply to the experience of the PCP or your office staff. "No experience" is always an acceptable response when it applies.




We look forward to receiving responses from HMO and Blue*Choice* POS physicians. If you have questions about this survey, please contact Marion Myers at (312) 653-6834.

*HMO Illinois and Blue Advantage HMO

### HMO and Blue*Choice* POS Appointment/Reappointment Report on Web

On a monthly basis we post a report of the Appointed and Reappointed providers on our Web site. To access log on to www.bcbsil.com/provider. Select "Appointed/Reappointed PCPs/PSPs" under the Credentialing/Contracting section. The data provided is cumulative and is updated by the 3rd Wednesday of each month.

### Blue*Choice* POS/Blue*Choice* Select

**Updated Depart List**—A listing of all specialists no longer participating in the Blue*Choice* POS/Blue*Choice* Select product can be found at: www.bcbsil.com/provider/referenceguide.htm. Also listed is the most current product information.

# Medical Policy

### Medical Policy Disclosure Statement

When approved, new or revised Medical Policies will be posted in the "Pending Policies" section of the Medical Policy site on the Blue Cross and Blue Shield of Illinois Web site. The new or revised policies will be available on the first day of each month. The specific effective or implementation date will be noted for each policy that is posted.

To review these policies, view the Web site at www.bcbsil.com/provider. Click on "Medical Policies." After reading the Medical Policies Disclaimer, click on "I Agree." The policies that are awaiting implementation can be found at the "Pending Policies" selection of the Medical Policy site.

*Blue Review* is a monthly newsletter published for Institutional and Professional Providers contracting with Blue Cross and Blue Shield of Illinois. We encourage you to share the content of this newsletter with your staff. The ***Blue Review*** is located on our Web site at www.bcbsil.com/provider/bluereview.htm and on THIN Online.

*Blue Review* is published monthly by:
Blue Cross and Blue Shield of Illinois
Operations/Education/Communications Dept.
300 E. Randolph Street – 25th Floor
Chicago, IL 60601-5099
(312) 653-4019, or fax (312) 938-8021

Publisher: Phil Lumpkin, VP, Provider Affairs
Editor: Carol Pjosek, Director
Managing Editor: Jeanne Trumbo, Senior Manager
Production & Copy Editors:
Margaret A. O'Toole and Allene Walker

# Account Information

## New Account Groups

| Group Name | Group Number | Alpha Prefix | Product Type | Effective Date | BlueCross | BlueShield |
|---|---|---|---|---|---|---|
| **Accuride** | 107731 | TPI | PPO(Portable) | November 1, 2005 | X | X |
| **American Bar Association** | 993128 | ABA | PPO(Portable) CDHP w/ HSA | January 1, 2006 | X | X |
| **Canadian National Railways** | 017362 | CNL | PPO(Portable) | January 1, 2006 | X | X |
| **Chef Solutions** | 017961-62 | CHX | PPO(Portable) | January 1, 2006 | X | X |
| **Chicago Plastering Institute** | P60631 | CPI | PPO(Portable) | November 1, 2005 | X | X |
| **Enersys** | 017232-33 | EYR | PPO(Portable) | January 1, 2006 | X | X |
| **KONE Inc.** | 981219-21 | KON | PPO(Portable) CDHP w/ HCA | January 1, 2006 | X | X |
| **Mid South Iron Workers Welfare Fund** | P17963 | MRW | PPO(Portable) | November 1, 2005 | X | X |
| **Pactiv Corporation** | 002051, 002062 | PTV | PPO(Portable) CDHP w/ HSA | January 1, 2006 | X | X |
| **Panduit Corporation** | P06050 | PDU | PPO(Portable) CDHP w/ HSA | January 1, 2006 | X | X |
| **Sheet Metal Workers Local 91** | P17628 | MWL | PPO(Portable) | January 1, 2006 | X | X |

**Key:**

BA HMO = BlueAdvantage HMO
BlueEdge℠ Participating Provider Option (PPO) = Consumer Driven Healthcare Product (CDHP)
BlueChoice Select = Point of Service
CMM = Comprehensive Major Medical
POS = Point of Service (Blue*Choice*)
PPO = Participating Provider Option (Hospital and Physician Network)
PPO Hospital Network = Participating Provider Option (Hospital Network Only)
PPO(Portable) = BlueCard PPO
HMOI = Health Maintenance Organization of Illinois
HMOI AFHC = HMOI Away From Home Care

## Magellan to Handle Behavioral Services for Carpenters Union

Effective, January 1, 2006, the Chicago Regional Council of Carpenters will be subcontracting all office inpatient and outpatient behavioral health benefit administration to Magellan Behavioral Health. All behavioral health claims, including mental and chemical dependency (PPO and non-PPO) must be filed with Magellan at:

P.O. Box 1129
Maryland Heights, MO 63043

Magellan PPO network providers must pre-certify services by calling (800) 495.4422 at least one day before a scheduled admission, or within two days after an emergency admission. The Fund will deny any behavioral health claims received from Blue Cross and Blue Shield of Illinois.

The Chicago Regional Council of Carpenters provides health care coverage for its' 26,000 active participants in the Chicago area. The group number associated with this population is **P50422** and the alpha prefix is **"CGO".**

# Provider Workshops

### Fourth Quarter Workshop Schedule

Don't delay! Sign-up now for one of our **free** workshops and begin to grow. You'll be glad you did! Go to www.bcbsil.com/provider/training.htm for workshop times, agendas and to register online. A confirmation or "Request to Reschedule" form will be e-mailed to you.

**Experienced Contracting Provider**
**In-House Workshop—Half Day**
November 2, 2005

**Experienced Contracting Provider**
**Off-site Workshop—Half Day**
November 8, 2005
Mercy Hospital and Medical Center—Chicago

**Blue*Choice* Workshop**
**In-House—Half Day**
November 16, 2005

**HMO Administrative Forum**
**In-House—Half Day**
November 30, 2005

### Managed Care Roundtable 2006 Schedule

In 2006, there will be three Managed Care Roundtables:
February 15, 2006
May 17, 2006
October 18, 2006
**Note:** In order for a HMO Medical Group/IPA to earn this portion of the QI Fund, attendance by the Medical Director or a Physician representative at two of the three meetings is required.

# Reimbursement

### Telemedicine Service Codes not Reimbursable

As technology changes in the public communications sector, it was only natural that uses for this technology would be found in health care. The term *telemedicine* (often used interchangeably with the term *telehealth*) has a number of definitions. A simple definition of telemedicine is the exchange of clinical information and data between locations via multimedia telecommunications equipment.

It has come to our attention that claims are being submitted with codes for telemedicine services. These HCPCS codes include:

- Code Q3014 - Originating site facility fee
- Code T1014 - Telehealth transmission, per minute, professional services bill separately
- Modifier GQ - Via an asynchronous telecommunications system
- Modifier GT - Via interactive audio and video telecommunications systems

BCBSIL does ***not*** cover telemedicine services as a substitute for face-to-face, interactive provider-patient encounters that are usually offered in a direct provider-patient setting. We will not reimburse a facility or provider for the cost of telecommunications equipment or line charges, as they are not medical expenses.

### Fairness In Contracting


In order to comply with the Fairness In Contracting Legislation, and in an effort to inform our contracting providers, BCBSIL has designated a column in the *Blue Review* to notify you of any changes to the physician fee schedules. Be sure to review this new area each month.

- Effective September 10, 2005, reimbursement for E0571 has changed.
- Reimbursement for Durable Medical Equipment (DME) will be updated November 1, 2005.
- Codes 90710, 90655, 90656, 90657, 90658, and 90669 were updated on October 1, 2005.
- The Independent Lab fee schedule was updated on October 1, 2005.
- Reimbursement for the Usual and Customary fee schedule will be updated November 1, 2005.

Providers can request fees by downloading the Fee Schedule Request Form at www.bcbsil.com/provider/forms.htm.

### Ultra Fast CT Scans

Ultra Fast CT Scans must be billed using the Level II HCPC code **S8092** Electron beam computed tomography (also known as Ultrafast CT, Cine CT). Claims have been previously submitted for Ultra Fast CT Scans using 71250, 76499 and/or 76497. The use of these codes is considered misleading and inaccurate.

Additionally, BCBSIL does not cover Ultra Fast CT Scans. Please refer to the Medical Policy RAD604.006, Computed Tomography (CT) Scan or Imaging as a Screening Technique, at www.bcbsil.com.

# Provider Claims Processing Reminder

BCBSIL is committed to reducing health care costs and increasing administrative efficiencies. Advancements in technology and the need to reduce paper transactions have had a significant impact on this effort. Please take note of the following process improvements that we have initiated:

### Original Claim Submissions

Original claims should be filed electronically to BCBSIL. If you are not equipped to file electronically and need information on how to submit claims using this method, you should contact our Electronic Data Interchange Department (EDI) at 312-653-7954.

Paper claims should be forwarded to:
Blue Cross and Blue Shield of Illinois
P O Box 805107
Chicago IL 60680-4112

### Claim Status Inquiries

To find out the status of a claim, you may:

1. Review your electronic reports
2. Access our electronic inquiry data base - THIN Online
3. Call the Provider Telecommunications Center's (PTC) Automated Information System (AIS) at 800-972-8088. If claim status is not available on the AIS, the system will provide the prompt for you to speak with a customer service representative.

### Requests for Review

Claim reviews can be requested on the Provider Review Form found on our Web site at www.bcbsil.com/providers, Use the Provider Review Form for the following types of reviews:

1. Claim Check
   - Claims that have been denied as mutually exclusive or incidental to the primary procedure code
   - Claims with code bundling issues.
2. Predeterminations
   - Fax to: **(217) 698-2144**
3. Review Requests, such as:
   - BlueCard Claims.
   - Medical Records
   - COB - including Blue on Blue claims
   - DX Codes
   - Medicare Exhaust claims
   - Itemized Bills (speech, occupational and physical therapies)
   - Explanation of Benefits from other carriers

Please include all required information, such as claim and provider data, the reason for the review and any necessary documentation. **Note:** *Inquiries received without the member's group and ID number cannot be completed, and may be returned to you to supply this information.*

Once complete, submit the Provider Review Form to:
Blue Cross and Blue Shield of Illinois
P O Box 805107
Chicago IL 60680-4112

Original claims should not be attached to the Provider Review Form. If attached, they will be returned back to you with a letter explaining the correct procedures for submitting claims.

If you do contact the PTC for a claim status inquiry and it becomes a claim review, please understand if the adjustments are not processed while you wait. Making adjustments over the telephone can become a complex issue, that slows down our system's telephone response time. You will be notified via your Provider Claims Summary when any adjustments are made.

Please remember these important reminders to help make the claims process operate efficiently:

1. Submit original claims electronically
2. Send paper claims to: BCBSIL, P.O. Box 805107, Chicago, IL. 60680-4112.
3. Check claim status electronically, or by using our AIS.
4. Send claim reviews on the Provider Review Form to BCBSIL, P.O. Box 805107, Chicago, IL. 60680-4112.

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## *Inside*



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