BlueCross BlueShield of Illinois

BLUE REVIEW℠

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS DECEMBER 2016

Government Programs Claims Handling and Post-adjudication Process Changes, Effective Jan. 1, 2017

Last month's *Blue Review* included a preview of changes that will become effective Jan. 1, 2017, as part of a Blue Cross and Blue Shield of Illinois (BCBSIL) initiative to improve efficiencies in claim-related processes for Blue Cross Medicare Advantage (PPO)℠ (MA PPO), Blue Cross Medicare Advantage (HMO)℠ (MA HMO), Blue Cross Community MMAI (Medicare-Medicaid Plan)℠, Blue Cross Community Integrated Care Plan (ICP)℠, Blue Cross Community Family Health Plan℠ (FHP) and Blue Cross Community Managed Long Term Supports and Services℠ (MLTSS) members. This month, we're following up with additional details, important reminders and related resources.

	BLUE CROSS MEDICARE ADVANTAGE℠ *(MA PPO, MA HMO members with alpha prefixes XOD, XOJ)*	**BLUE CROSS COMMUNITY OPTIONS℠** *(MMAI, ICP, FHP, MLTSS members with alpha prefix XOG)*
Electronic Eligibility and Benefits via Availity™ *(for services rendered on or after Jan. 1, 2017)*	New **Blue Cross Medicare Advantage** option in dropdown menu on Availity Web portal for registered users	Same **Blue Cross Community Options** payer in dropdown menu on Availity Web portal for registered users
Electronic Payer ID *(for claims received as of Jan. 1, 2017)*	**New Payer ID – 66006** Effective Jan. 1, 2017, MA PPO and MA HMO claims received with the commercial Payer ID (00621) will not be accepted. If you use a practice management/hospital information system or billing service, and/or a clearinghouse other than Availity or Passport/Experian for electronic claim submission, contact your vendor to confirm they are using the new Payer ID, rather than assigning their own unique number.	There will be **no change** to the current Payer ID – MCDIL – for Availity or Passport/ Experian users. However, if you use a practice management/hospital information system or billing service, and/or a clearinghouse other than Availity or Passport/Experian, contact your vendor for the correct Payer ID to use on electronic claims submitted for MMAI, ICP, FHP and MLTSS members.
Paper Claim Submission – Mailing Address and Fax Number for Non-delegated Providers* **Effective Feb. 1, 2017, claims received at the old mailbox will be rejected with a letter informing providers to resubmit to the correct mailbox.*	**New mailing and fax information for MA PPO and MA HMO claims:** Blue Cross Medicare Advantage c/o Provider Services P.O. Box 3686 Scranton, PA 18505 Fax: 855-674-9192	**New mailing and fax information for MMAI, ICP, FHP and MLTSS claims:** Blue Cross Community Options c/o Provider Services P.O. Box 4168 Scranton, PA 18505 MMAI Fax: 855-674-9193 ICP Fax: 855-297-7280 FHP Fax: 855-426-5335 MLTSS Fax: 855-426-5339
Claim Payment Cycles and New Format for Electronic Funds Transfer (EFT)	Effective Jan. 1, 2017, Blue Cross Medicare Advantage claim payments will be made on a **weekly** basis (every Monday). On electronic payments for MA PPO and MA HMO claims, the EFT trace number will start with a source code of "M" instead of "C."	Effective Jan. 1, 2017, Blue Cross Community Options claim payments will be made on a **twice-weekly** basis (every Monday and Wednesday). On electronic payments for MMAI, ICP, FHP and MLTSS claims, the EFT trace number will start with a source code of "T" instead of "C."

(continued on next page)

HFS Requirement for Long Term Care Providers to Submit Monthly Billing – Delayed Implementation

On Oct. 24, 2016, the Illinois Department of Healthcare and Family Services (HFS) delayed the implementation of the new monthly billing process for Long Term Care (LTC) services until Dec. 1, 2016. BCBSIL changed its processes to match the HFS revised timeline.

For more information about the new HFS monthly billing process, visit the Provider Notices page at Illinois.gov/HFS.

Checking Eligibility and Benefits: Don't Skip this Important First Step

It is extremely important to check eligibility and benefits prior to rendering services or assuming that you or your practice/medical group are out-of-network for a particular member. Conducting this step will help you identify the member's product/plan, the network(s) they may use, benefit preauthorization requirements, and other important details.

Checking eligibility and benefits electronically through Availity, or your preferred vendor portal, is strongly encouraged. Electronic eligibility and benefits inquiries may be conducted for local BCBSIL members, as well as out-of-area Blue Plan and Federal Employee Program (FEP) members.

For additional information, such as a library of online transaction tip sheets organized by specialty, refer to the Claims and Eligibility/Eligibility and Benefits section of our website at *bcbsil.com/provider*. BCBSIL also offers educational webinars with an emphasis on electronic transactions, including eligibility and benefits inquiries. Refer to the Provider Learning Opportunities on page 8 for upcoming webinar dates, times and registration information.

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Verification of 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, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered, including benefit limitations and exclusions.

(Government Programs Claims Handling and Post-adjudication Process Changes, continued from page 1)

The following changes will apply to **all** government programs claims for Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO) members, alpha prefixes XOD, XOJ; **and** Blue Cross Community Options (MMAI, ICP, FHP and MLTSS) members, alpha prefix XOG:

Electronic Claim Status	Submit electronic claim status inquiries (HIPAA 276 transactions) through Availity or your preferred vendor portal. ***Effective Jan. 1, 2017, the Claim Research Tool on the Availity Web Portal will no longer be available for government programs claims***.
Electronic Remittance and Provider Claim Summary (PCS)	• 835 Electronic Remittance Advice (ERA) files will be distributed to the address/Receiver ID associated with the billing provider's Tax ID, rather than being distributed to multiple locations/receivers. • The Electronic Payment Summary (EPS) from BCBSIL will no longer be sent along with the 835 ERA for MA PPO, MA HMO, MMAI, ICP, FHP and MLTSS claims. **Effective Jan. 1, 2017, paper PCSs will be sent by mail for all government programs claims to ERA and non-ERA receivers**. • The electronic Payer ID on the 835 ERA will now match the Payer ID that is submitted on the claim. **(Effective Jan. 1, 2017, the new Payer ID is 66006 for MA PPO and MA HMO claims. Availity and Passport/Experian users: Continue to use Payer ID MCDIL for MMAI, ICP, FHP and MLTSS claims.)** • For current 835 ERA receivers, there is no need to re-enroll to continue receiving electronic remittance information for government programs claims.
Overpayment Recovery	Effective Jan., 1, 2017, a new process will be implemented for claims overpayment recovery. • The Electronic Refund Management and Claim Inquiry Resolution tools on Availity will no longer be available for government programs claims. • Request for refund letters will be sent by mail for all providers. • Beginning Jan. 1, 2017, providers may submit requested and voluntary refunds to the following **new lockbox:** Health Care Service Claims Overpayment 29068 Network Place Chicago, IL 60673-1290

FOR MORE INFORMATION

We appreciate your patience during this transition. As of Jan. 1, 2017, Provider Manuals, 835 ERA/EFT Companion Guides and other resources will be updated. Also watch the *Blue Review*, as well as the News and Updates section of our website at *bcbsil.com/provider* for details on upcoming educational webinars specific to government programs. If you have questions or need assistance, contact your BCBSIL Provider Network Consultant (PNC).

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.

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Coordination of Care Between Medical and Behavioral Health Providers

BCBSIL continually strives to promote coordination of member care between medical and behavioral health providers. We understand that communication between providers regarding the treatment and coordination of a patient's care may pose difficult challenges, so we want to remind you of a few resources that may be helpful.

COORDINATION OF CARE FORM

To provide assistance when coordinating care, BCBSIL has created a Coordination of Care form that is available on our website at *bcbsil.com/provider*. This form may help in communicating patient information:

- To provide member treatment information **to** another treating provider
- To request member treatment information **from** another treating provider

It is important to note that a written release to share clinical information with the member's medical provider(s) must be obtained prior to the use of this form. BCBSIL recommends obtaining a written release prior to the onset of treatment.

If you are requesting member treatment information from another provider, it is recommended that the Patient Information and Referring Provider sections of the form be completed in order to expedite the care coordination process for the receiving provider.

The Coordination of Care form is available in the Education and Reference Center/Forms/Behavioral Health section of our Provider website.

FINDING A BEHAVIORAL HEALTH PROVIDER FOR YOUR PATIENT

If you would like to refer a patient to a behavioral health provider and need help finding one in your patient's network, call the number on the member's BCBSIL card to receive assistance in finding an outpatient provider or behavioral health facility.

BEHAVIORAL HEALTH OR MEDICAL CASE MANAGEMENT SERVICES

If you believe your patient has complex health needs and could benefit from additional support and resources from a clinician, you may want to make a referral to one of the BCBSIL Case Management Programs by calling the number on the member's BCBSIL card. The Case Management programs may also provide you and the member with information about additional resources provided by their insurance plan.

The provision of this form is for informational purposes only and is not intended, nor should it be construed as legal advice. If you have any legal questions you should consult with your legal advisor.

2016 - 2017 Medicare Part D Formulary Changes

Blue Cross MedicareRx (PDP)SM
Blue Cross Medicare Advantage (HMO)
Blue Cross Medicare Advantage (HMO-POS)SM
Blue Cross Medicare Advantage (PPO)

Based on Centers for Medicare & Medicaid Services (CMS) mandates (i.e., safety concerns, drugs that no longer meet the CMS definition of a "Part D medication," etc.) and a regular review of changes in the pharmaceutical marketplace, the Blue Cross MedicareRxSM/Blue Cross Medicare Advantage 2017 Part D plans will have formulary and utilization management changes for 2017. Members were alerted of these changes in late November 2016 via targeted mailings as well as in the Annual Notice of Change (ANOC) sent to all current members with Blue Cross MedicareRx/Blue Cross Medicare Advantage Medicare Part D plans. Visit the Pharmacy Program/Medicare Part D Updates section of our website at *bcbsil.com/provider* for a quick reference that includes the "Top 30" medications impacted by these formulary changes. For the full 2017 formulary, please refer to *bcbsil.com/medicare*.

Blue Cross Medicare Advantage plans are HMO, HMO-POS, and PPO plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.

Blue Cross MedicareRx is a prescription drug plan provided by HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal.

Utilization Management Decisions Are Not Financially Influenced

BCBSIL is dedicated to serving our members through the provision of health care coverage and related benefit services. BCBSIL prohibits decisions based on financial incentives. Utilization management decisions are based on appropriateness of care and service, and existence of benefit coverage. BCBSIL does not specifically reward practitioners or clinicians for issuing denials of benefit coverage, nor is there compensation based on the number or frequency of telephone calls or other contacts that occur with health care providers, members or subscribers. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Member Rights and Responsibilities Notification

BCBSIL will provide members with a written statement of the Member Rights and Responsibilities. Members will receive the document through the Member Handbook and via hard copy upon request. This information is also found on the BCBSIL website. Providers can review the complete listing of Member Rights and Responsibilities in the BCBSIL Provider Manual, located in the Standards and Requirements section of our website at *bcbsil.com/provider*.

Note: Information contained in the BCBSIL Provider Manual is password protected. Please follow the instructions given on our Provider website to gain access to this secure information. Then select "HCM Rights and Responsibilities Policy and Procedure" under the Policy and Procedure section.

Star Measures for Blue Cross Medicare Advantage Members

CMS posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their areas. CMS rates Medicare Advantage plans on a scale of one to five stars, with five stars being the highest rating in terms of plan performance. Quality scores for Medicare Advantage plans are based on performance measures derived from sources such as Healthcare Effective Data and Information Set (HEDIS®) results, along with CMS administrative data (such as information on member satisfaction, appeal processes, audit results and customer service).

BCBSIL strives to achieve the highest possible CMS star rating for the HMO and PPO Blue Cross Medicare Advantage plans we offer. These ratings reflect our performance as a health insurance carrier, and also serve as a testimony to the care and services you provide to our members. In support of this quality initiative, we ask that you review the information below with your patients during each visit.

CMS created the Star Ratings Program strategy to help provide greater consistency in improving the patient experience of care, improving the health of populations and communities and reducing the per capita cost of health care through quality improvements. The Star Ratings System is based on an assessment of various health care metrics for Medicare Advantage HMO and PPO plans. To gauge quality and performance measures, CMS collects data from Medicare Part C and Part D health plans in five categories, including outcomes, immediate outcomes, patient experience, access to care and process or method in which health care is provided.

Each year CMS changes and/or updates metrics and issues guidance to the industry. Stars are assigned for each domain category and related measures. Below is a listing of health care metrics that providers need to review with each Blue Cross Medicare Advantage member during each visit. For more information on the CMS Star Rating Program, visit cms.gov.

ALL BLUE CROSS MEDICARE ADVANTAGE MEMBERS SHOULD BE REVIEWED FOR THE FOLLOWING:

- Body Mass Index (BMI) assessment
- Fall risk assessment
- Bladder leakage assessment
- Physical activity assessment
- Flu shot
- Medication review (annually and high risk, if applicable)
- Cancer screenings – mammogram and/or colonoscopy, flexible sigmoidoscopy, Fecal Occult Blood Test (FOBT)

MEMBERS WITH HYPERTENSION (HTN) SHOULD BE REVIEWED FOR THE FOLLOWING:

- Blood pressure check
  - Diabetics age 60-85 ≤ 139/89
  - Non-diabetics age 60-85 ≤ 149/89
  - Members ages 18-59 ≤ 139/89
- Medication adherence (anti-hypertensives)

(continued on page 5)

(Star Measures for Blue Cross Medicare Advantage Members, continued from page 4)

MEMBERS WITH DIABETES SHOULD BE REVIEWED FOR THE FOLLOWING:

- A1c screening
- Eye exam
- Nephropathy screening
- Medication adherence – diabetes medications, statins, angiotensin-converting enzyme (ACE)/ angiotensin-receptor blockers (ARB)

For additional information, refer to the Blue Cross Medicare Advantage (HMO) and Blue Cross Medicare Advantage (PPO) Provider Manuals, located in the Standards and Requirements section of our website at *bcbsil.com/provider*.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

This material is for informational purposes only and is not to be construed as medical advice. Health care providers are instructed to exercise their own independent medical judgment based upon all available information and the patient's condition at the time of treatment.

2016 Annual HMO and PPO HEDIS Reports

Each year, BCBSIL reports audited HEDIS results. HEDIS is a nationally standardized set of measures related to important areas of care and service. Developed by the National Committee for Quality Assurance (NCQA), it is one of the most widely used set of health care performance measures in the U.S.

The 2016 BCBSIL HMO and PPO HEDIS Reports, which are based on 2015 data using HEDIS 2016 specifications, include measures across domains of care that reflect: effectiveness of care, access/availability of care and utilization. The 2016 Quality Compass National Averages are provided to compare the HMO and PPO's performance to the performance of other health care organizations submitting data to NCQA. Audited HMO HEDIS results are reported for HMO Illinois® and Blue Advantage HMO℠ combined. The complete HMO and PPO HEDIS Reports are available in the Clinical Resources/HEDIS section of our website at *bcbsil.com/provider*.

Reminder: Outpatient Molecular and Genomic Tests and Outpatient Radiation Therapy Benefit Preauthorization Requirements Through eviCore

BCBSIL has contracted with eviCore healthcare (eviCore) to provide benefit preauthorization services for Blue Choice PPO℠, Blue Choice Preferred PPO℠ and PPO for select services including **outpatient molecular and genomic tests and outpatient radiation therapy**. Services performed without benefit preauthorization may be denied.

When checking for eligibility and benefits for a member's lab service or radiation therapy service on the Availity Web Portal or submitting an electronic eligibility and benefits inquiry (HIPAA 270 transaction) via Availity or your preferred vendor portal, a message will appear indicating eviCore may need to be contacted for benefit preauthorization. If eligibility and benefits are unable to be verified online, the same information is often readily accessible through the BCBSIL Interactive Voice Response (IVR) automated phone system.

You will continue to use iExchange® for all other services that require a benefit preauthorization.

Benefit preauthorizations for lab service or radiation therapy service may be obtained through the eviCore portal at eviCore.com or by calling eviCore toll-free at 855-252-1117, between 7 a.m. and 7 p.m. (CT), Monday through Friday.

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for BCBSIL.

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 of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.

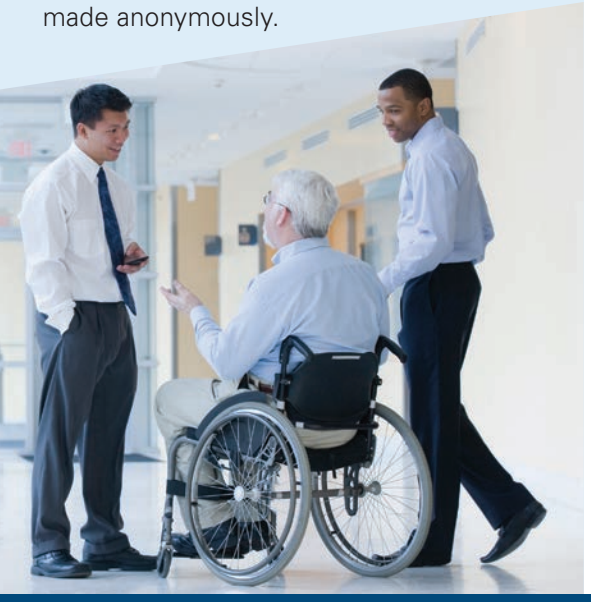
Reminder: Reimbursement for Durable Medical Equipment

Periodically, BCBSIL reviews billing practices of contracted providers to help ensure that contracted providers are billing in ways that are consistent with their contracts as well as the BCBSIL Provider Manual. Recently, BCBSIL has reviewed billings related to one or more durable medical equipment (DME) suppliers. In reviewing these billings, BCBSIL determined that in some instances, billings from DME suppliers reflected requests for reimbursement for DME used at the time of a surgery to treat patients who are BCBSIL members.

As a reminder, unless otherwise specified, provider contracts allow for reimbursement of claims from facilities for DME supplied by a DME supplier that is used at the time of surgery, to the extent the DME is allowed under BCBSIL Medical Policy. Providers may not allow a DME supplier to seek reimbursement directly in addition to the provider's reimbursement.

If you have questions about DME reimbursements, please contact your assigned PNC.

Additionally, providers and members may call the BCBSIL Fraud Hotline at 800-543-0867 to report suspicions of potential health care fraud and abuse. The Fraud Hotline is available 24 hours a day, seven days a week. All calls are confidential and may be made anonymously.



Opioids: Pharmacy Benefit Prior Authorization Requirement for ICP and FHP Members, Effective Jan. 1, 2017

As of Jan. 1, 2017, ICP and FHP members will have a Morphine Equivalent Dose (MED) quantity limit of 120 mg per day over a rolling 90-day period. Providers prescribing quantities of opiates at doses more than 120 MED per day, over a 90-day period, will need to obtain a benefit prior authorization (PA) for their patients.

In studies it has been shown that people who use opiates at daily doses greater than 100 to 120 MED have a substantially higher risk of accidental overdose when compared with patients receiving less than a 100 to 120 MED per day.[1,2]

A standard conversion table is used to translate the dose and route of each opioid a patient has received over a 24-hour period to a MED. For patients taking more than one opioid, the MED of different opioids must be added together to determine a cumulative dose. An MED calculator can be found online at easycalculation.com/medical/opioid-conversion-calculator.php.

The Centers for Disease Control and Prevention (CDC) recommends nonpharmacologic and nonopioid therapy as the preferred treatment for chronic pain. In terms of pain relief and function, clinicians should weigh the benefits versus the risk when using opioid therapy.[3]

Providers may submit pharmacy benefit PA requests online via the CoverMyMeds® site at covermymeds.com. While electronic options are preferred, pharmacy benefit PA requests also may be called in to 800-285-9426, followed by a statement with supporting documentation, which may be faxed to 877-243-6930, or mailed.

[1] Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med. 2010;152(2):85-92.

[2] Braden JB, Russo J, Fan MY, et al. Emergency department visits among recipients of chronic opioid therapy. Arch Intern Med. 2010;170(16):1425-1432.

[3] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. MMWR Recomm Rep 2016; 65:1-49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1.

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The information referenced above is for educational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Members are advised to discuss diagnosis and treatment options with their 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.

Aspirin: Help Your Patients Understand the Risks and Benefits

The use of aspirin as an anti-platelet drug has become prevalent in the prevention of heart attacks and strokes. The CDC states, "About 610,000 people die of heart disease in the United States every year – that's 1 in every 4 deaths."[1] According to the U.S. Preventive Services Task Force (USPSTF), which provides reference for the BCBSIL Preventive Care Guidelines, men between the ages of 45 and 79 should use aspirin when the potential benefit of reducing the risk of myocardial infarction outweighs the potential harm of gastrointestinal bleeding. Women between the ages of 55 and 79 should use aspirin when the potential benefit of reducing ischemic stroke outweighs the potential harm of gastrointestinal bleeding. The USPSTF recommends against the use of aspirin for stroke prevention in women younger than 55 years of age and for myocardial infarction prevention in men younger than 45 years of age.[2]

BCBSIL's 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey addressed aspirin using a rolling average methodology of 2015 and 2016 data. As part of this survey, 33 percent of ICP members surveyed stated that they take aspirin daily or every other day. Thirteen percent of members surveyed stated they have a health problem or take medication that makes aspirin unsafe for them. Lastly, 42 percent of members surveyed stated that a doctor or health care provider has discussed the risks and benefits of aspirin to prevent heart attack or stroke. While there are no current benchmarks in place for comparison of this measure, there are still opportunities for further improvement. Educating patients on the risks and benefits of aspirin use is essential, as is education regarding diagnoses that make taking aspirin unsafe. Emphasizing extra caution when aspirin is used by patients on other blood thinners, such as warfarin or clopidogrel, should be included. It is crucial that members understand the risks as well as the benefits of aspirin use dependent upon their medical condition, age, gender and other factors.

To read more about the benefit vs. harm of aspirin use visit the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) website at ahrq.gov/professionals/clinicians-providers/resources/aspprovider.html.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[1] CDC, National Center for Health Statistics (NCHS). Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed Sept. 21, 2016.

[2] USPSTF. Aspirin for the primary prevention of cardiovascular disease March 2009. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsasmi.htm. Accessed April 15, 2014.

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 final decision about any medication is between the member and their health care provider.

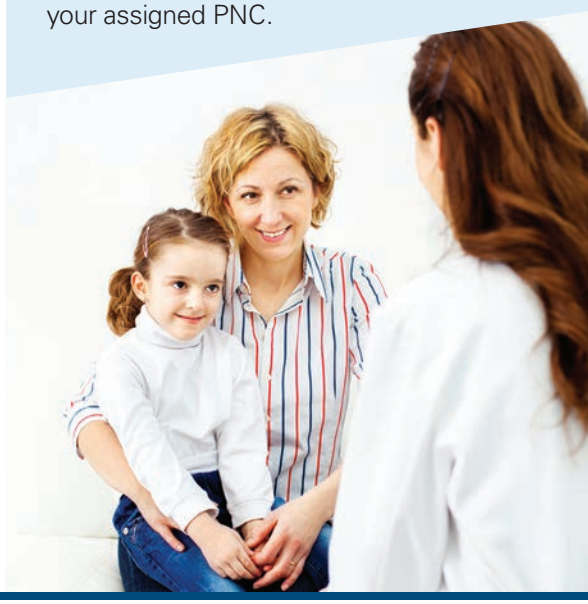
Blue FocusCare℠: A New HMO in Cook County

Effective Jan. 1, 2017, BCBSIL will offer the Blue FocusCare plan, a unique HMO that promotes quality care at a low cost for members. The Blue FocusCare network is a narrow network of independently contracted providers designed around several physician organizations in Cook County. Blue FocusCare will be BCBSIL's lowest-cost insurance offering, with low monthly premiums and low out-of-pocket costs for covered services for eligible members.

Like other HMOs, members choose a primary care physician (PCP) to help navigate and coordinate their care and refer them to appropriate specialists. The Blue FocusCare plans offer access to an independently contracted network of providers that includes 12 hospitals with over 700 primary care and specialty physicians across Cook County.

The Blue FocusCare plans will be offered both on and off the Get Covered Illinois℠ exchange during open enrollment, which began Nov. 1, 2016, and concludes on Jan. 31, 2017. If members want coverage to start on Jan. 1, 2017, they must enroll by Dec. 15, 2016.

Blue FocusCare furthers BCBSIL's commitment to building affordable, quality networks for our members across Illinois. For more information about Blue FocusCare and other networks and products, contact your assigned PNC.



Provider Learning Opportunities

BCBSIL offers complimentary educational webinars with an emphasis on electronic options that can help create administrative efficiencies for the independently contracted providers who conduct business with us. A snapshot of upcoming training sessions is included below. To register online, visit the Workshops/Webinars page in the Education and Reference Center on our website at *bcbsil.com/provider*.

BCBSIL WEBINARS

BCBSIL Back to Basics: 'Availity 101'

A review electronic transactions, provider tools and online resources.

Dec. 13, 2016
Dec. 20, 2016

All sessions: 11 a.m. to noon

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Information about the BCSBIL Quality Improvement Program

The BCBSIL Quality Improvement (QI) Program addresses both care and service provided to members. To learn more about the BCBSIL QI Program, call 312-653-3465 to request a QI program summary. The summary includes information about the structure of the QI program, outcomes of the program and its success in meeting goals.

This specific information only applies to non-government programs. For information regarding government programs such as Medicare and Medicaid, please refer to the applicable provider manual.

Enroll Online Now Through Availity for Electronic Payment and Remittance Options

Did you know providers can enroll and make necessary changes to the EFT and ERA set up through the Availity Web portal?

Effective Jan. 1, 2017, the BCBSIL EFT and ERA enrollment process will be available online only, through Availity. The online EFT and ERA enrollment process through Availity can be completed in near real-time, without the inconvenience of downloading and faxing or mailing paper enrollment forms. Providers will receive a confirmation letter acknowledging the enrollment effective date and related information.

ADVANTAGES OF ENROLLING FOR EFT:

- Quicker receipt of payments
- Greater security – no more risk of lost or stolen paper checks
- Direct deposit into the bank account of your choice

ADVANTAGES OF ENROLLING FOR ERA:

- Faster remittance delivery
- Automatic posting capabilities
- Designate delivery to a specific clearinghouse or vendor

Once an organization is enrolled for ERA, providers and billing services also gain access to the Availity Remittance Viewer. This online tool permits users to search, view, save and print remittance information, even if the ERA is delivered to an appointed receiver. To learn more about the Remittance Viewer, go to the Remittance Viewer page in the Education and Reference Center/ Provider Tools section of our website at *bcbsil.com/provider*.

Online EFT and ERA enrollment is available to registered Availity users. To register for Availity, simply go to availity.com and sign up today. There is no cost to register for Availity. For assistance with EFT and ERA enrollment through Availity, or to learn more about how to use the remittance viewer tool, contact a BCBSIL Provider Education Consultant at *ECommerceHotline@bcbsil.com* or 800-746-4614.

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Provider Claim Summary Paper-to-Electronic Conversion Coming March 1, 2017

BCBSIL recognizes immediate access to the PCS is vital for posting patient accounts and reconciling financials. Often times, providers who receive this information via postal mail are waiting on delivery, which delays administrative processes.

As of Dec. 12, 2016, a new report viewer application will be available in the BCBSIL branded Payer Spaces section on the Availity Web portal. This new tool permits registered Availity users to readily view, download, save and/or print the PCS online, as often as needed. This report viewer offers you the opportunity to obtain claim outcome results for multiple patients, in one central location.

Effective March 1, 2017, claim summary information will be delivered through this online report viewer application, rather than distribution via paper mailing. This online alternative is an additional offering to our other online electronic tools that may be accessed through Availity. If you currently rely on paper claim summaries, Availity registration is strongly recommended to gain access to the report viewer application.

Providers who are already enrolled for the ERA from BCBSIL will continue receiving their remittances electronically, but will have an additional opportunity to view, download, and/or print the claim summary using the report viewer as a complimentary option.

Exceptions to continue receiving paper PCSs by mail may be considered for extenuating circumstances. To submit this type of exception or request training for online applications, contact *PECS@bcbsil.com*. Otherwise, beginning March 1, 2017, claim summary information will be accessible exclusively through the report viewer application on Availity. Additionally, providers will be directed to make use of the BCBSIL report viewer application if an exception request is not received by Feb. 17, 2017. The exception review process may require up to five business days before a response is returned.

BCBSIL supports an array of online tools for registered Availity users, including the report viewer, at no additional cost. To register, simply go to availity.com, select "Register," and complete the online application today.

Additional communications regarding the above-referenced change may be published in upcoming *Blue Review* editions, as well as on our Provider website.

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BLUE REVIEW℠

A newsletter for contracting institutional and professional providers

A Fond Farewell to the Paper Newsletter

After many years of printing and mailing the *Blue Review*, we are making the transition to an online-only format, beginning with the January 2017 issue.

There are many reasons for this transition. In addition to being more environmentally friendly, an online newsletter will help us make information available to our readers in a more timely and efficient manner. You and your staff are likely bombarded with numerous communications from multiple audiences on a daily basis. With an online *Blue Review*, our intent is to offer useful content that is clear, concise and easy to navigate.

The *Blue Review* will continue to be one of our primary channels for increasing awareness of BCBSIL programs, products, network news, important dates, key changes and reminders. While the newsletter will no longer be printed and mailed, it will remain available in the Education and Reference Center/*Blue Review* section of our website at *bcbsil.com/provider* for your convenience.

The masthead for our online newsletter will look a bit different from the paper version – see above for a preview. Also watch the News and Updates section of our Provider website for additional announcements.

Fairness in Contracting

In an effort to comply with fairness in contracting legislation and keep our independently contracted providers informed, BCBSIL has designated a column in the *Blue Review* to notify you of any significant changes to the physician fee schedules. Be sure to review this area each month.

On Jan. 1, 2017, BCBSIL will implement Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) procedure code additions, deletions and revisions. Please note that codes to be deleted will not be accepted for payment for dates of service on or after Jan. 1, 2017.

The information above is not intended to be an exhaustive listing of all the changes. Annual and quarterly fee schedule updates can also be requested by using the Fee Schedule Request Form. Specific code changes that are listed above can 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 in the Education and Reference Center/Forms section of our website at *bcbsil.com/provider*.

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The Holidays May Be 'SAD' for Some BCBSIL Members

The holiday season comes with many joyous celebrations, but it can also be a difficult time of year.

The air turns chilly. The skies darken earlier. For many people, winter's arrival brings feelings of sadness, fatigue and gloom.

According to a December 2012 American Family Physician article, as many as one in five Americans experiences winter blues, and about five percent of the population develops a more serious condition known as seasonal affective disorder (SAD).[1] For them, winter sadness often goes hand in hand with a craving for carbohydrates, weight gain, trouble concentrating, sleep disruptions and a loss of interest in activities they usually enjoy.

BCBSIL reminds our members that if they have symptoms of SAD or thoughts of harming themselves, they should talk to you, their doctors. You can assess the member's condition and recommend a treatment that's right for each individual, which may range from simply eating differently and thinking positively, to getting more exercise, light therapy, cognitive behavioral therapy or medication.

[1] Kurlansik SL, Ibay A. Seasonal Affective Disorder, Am Fam Physician, Dec. 1, 2012. 86(11):1037-1041. Retrieved from the American Academy of Family Physicians website at http://www.aafp.org/afp/2012/1201/p1037.html.

The information given to members is for informational purposes only, and is not a substitute for the sound medical judgment of a doctor. Members are encouraged to talk to their doctor if they have any questions or concerns regarding their health.

Upcoming Changes to the Claim Review Form

Effective Jan. 1, 2017, the paper Claim Review Form for BCBSIL will be updated to help simplify the process for providers when submitting written claim inquiries.

The most efficient way to request a claim review for specific inquiries is electronically through the Claim Inquiry Resolution tool, which is accessible through the Availity Web portal. For providers who need to submit claim review requests via paper, the current process involves using one universal Claim Review Form. As a result, this form has been utilized for several different reasons, such as paper corrected claims, requested medical records, claim check denials, or even basic claim reviews.

BCBSIL is streamlining the paper claim review process to help facilitate more accurate processing of incoming requests. As of Jan. 1, 2017, written claim inquiries must be submitted on one of the specific Claim Review Forms listed below. Each Claim Review Form must include the BCBSIL claim number (the Document Control Number, or DCN), along with the key data elements specified on the forms. These forms will be available later this month on our Provider website at *bcbsil.com/provider* in the Education and Reference Center/Forms section, under Post-claim Processing Requests.

NEW CLAIM REVIEW FORMS:

- Additional Information Form
- Claim Review Form
- Corrected Claim Form

Online verification of claim status is strongly encouraged prior to submitting claim review requests. The most effective way to determine claim status is electronically through your preferred Web vendor, or by using the Availity Claim Research Tool (CRT). Making use of electronic options allows retrieval of needed information in near real-time.

As indicated above, Availity users have access to the Claim Inquiry Resolution tool, which delivers a method of online assistance for specific inquiries on finalized claims. This tool is designed to help save you time by reducing the amount of calls and written inquiries submitted.

To learn more about these and other electronic options, visit the Provider Tools section in our online Education and Reference Center at *bcbsil.com/provider*. For personalized online training regarding electronic tools, contact our Provider Education Consultants at *PECS@bcbsil.com*.

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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 on a quarterly basis and are not considered changes to the software version. BCBSIL will normally load this additional data to the BCBSIL claim processing system within 60 to 90 days after receipt from the software vendor and will confirm the effective date via the News and Updates section of our website at *bcbsil.com/provider*. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) also will be posted on our Provider website.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSIL's code-auditing software. Refer to Clear Claim Connection page in the Education and Reference Center/Provider Tools section of our Provider website for additional information on gaining access to C3. This section of our website also includes answers to frequently asked questions about ClaimsXten. Additional information may be included in upcoming issues of the *Blue Review*.

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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. *Blue Review* is located on our website at *bcbsil.com/provider*.

The editors and staff of *Blue Review* welcome letters to the editor. Address letters to:

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