



# BlueREVIEW<sup>SM</sup>

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS

FEBRUARY 2015

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## 2014 HEDIS<sup>®</sup> Antidepressant Medication Management Results

According to the National Committee for Quality Assurance (NCQA) website, the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans, and it measures performance on selected important dimensions of care and service, including behavioral health. Because so many plans collect HEDIS data and the measures are so specifically defined, HEDIS makes it possible to compare performance among health plans.

The Antidepressant Medication Management HEDIS metric includes members who:

- Are 18 years of age or older,
- Have been diagnosed with major depression,
- Were newly treated with antidepressant medication, and
- Remained on an antidepressant medication treatment.

To evaluate if members are receiving the maximum benefit from an initiated antidepressant medication regimen, two measurements are reported:

- Effective Acute Phase: Those who reportedly stayed on an antidepressant for at least 12 weeks (84 days)
- Effective Continuation Phase: Those who reportedly stayed on an antidepressant for at least 6 months (180 days)

### WHAT WERE THE BCBSIL MEMBER RESULTS?

HEDIS measurements are calculated annually and compared to national averages. For patients who stayed on an antidepressant for at least 12 weeks, the 2014 national average was 64.26 percent, and the average for Blue Cross and Blue Shield of Illinois (BCBSIL) members was 68.12 percent. For patients who stayed on an antidepressant for at least six months, the 2014 national average was 48.70 percent, and the average for BCBSIL members was 53.06 percent.

### WHAT IS BCBSIL DOING TO HELP?

We have provided an educational article to members about the importance of staying on antidepressant medication, and we continue to work with our pharmacy and reporting departments to develop programs to assist members with their medications. If you have a patient who you believe is not fully compliant with an antidepressant regime and you believe therapy would also be beneficial, we can help.

You or the patient can contact us via the BCBSIL number on the back of the member's ID card. We can help them locate a behavioral health therapist, enroll them in one of our case management programs, or help coordinate care with health care providers so that the patient is more successful with their antidepressant medication regime.

For additional information, visit the Clinical Resources/Behavioral Health Care Management Program section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

HEDIS is a registered trademark of the NCQA.

The Behavioral Health Care Management Program is not a substitute for the independent medical judgment of health care providers. Providers are instructed to exercise their own independent medical judgment. The final decision about any care or treatment is between the member and their health care provider.



## Urine Drug Testing Policy, Effective Dec. 15, 2014

BCBSIL Medical Policy MED207.154 (Urine Drug Testing Including Pain Management and Substance Abuse Monitoring) became effective Dec. 15, 2014. This new policy is intended to address the utilization of quantitative/confirmatory urine drug testing as a routine screening tool. With few exceptions, the routine use of quantitative/confirmatory testing will be considered not medically necessary under the terms of the member's benefit plan and therefore, ineligible for benefits. The most prominent exception occurs when a patient tests positive on a qualitative test and the physician determines that quantitative/confirmatory urine drug testing is medically necessary for treatment decisions to know the quantity of the drug in the patient's system.

BCBSIL independently contracted providers are encouraged to review this new policy as soon as possible to ensure they only submit claims that are consistent with this new policy. The BCBSIL Special Investigations Department will be monitoring provider compliance and may initiate investigations as appropriate. Independently contracted providers found billing inappropriately, contrary to this policy, may be subject to overpayment refunds and other actions as deemed appropriate based on the circumstances of each case.

Please visit the Standards and Requirements/ Medical Policy section of our website at [bcbsil.com/provider](http://bcbsil.com/provider) for access to the up-to-date medical policy information.



## 2014 HMO Primary Care Physician Survey Results

Results are in from the 2014 HMO Illinois® and Blue Advantage HMO<sup>SM</sup> Primary Care Physician (PCP) Survey. BCBSIL received completed questionnaires from 1,101 HMO physicians, which represents a response rate of 20 percent.

The table below shows select highlights of the results from the 2014 survey. The survey used a 5-point Likert scale, from Excellent to Poor. The results are based on combined responses in the "Top 3 Box scores" (Excellent, Very Good, and Good), with the exception that results from the Hospital Information section of the survey are based on the top two box scores (Excellent/Very Good or Strongly Agree/Disagree).

HMO PCP Survey Questions	HMO PCPs
	2014
<b>Survey Response Rate</b>	20%
<b>Medical Group/Independent Practice Association Overall Rating (MG/IPA)*</b>	93%
<b>MG/IPA Utilization Management (UM)*</b>	
• Case Management	93%
• Timeliness of UM decisions	91%
• Overall UM process	92%
<b>MG/IPA Referral Process*</b>	
• Adequacy of Specialist network	90%
• Quality of Specialist network	95%
• Overall process	90%
<b>MG/IPA Claims Payment*</b>	
• Timeliness	90%
• Accuracy	92%
<b>BCBSIL Services</b>	
• Experience with NDAS Online/eCare® or Availity™	91%
• Blue Star Hospital Report <sup>SM</sup> overall	92%
• Blue Star MG/IPA Report <sup>SM</sup> overall	92%
<b>BCBSIL Quality On-Site Audit</b>	
• Knowledge of BCBSIL Quality On-Site Audit staff	97%
• Courtesy of BCBSIL Quality On-Site Audit staff	98%
<b>After-Hours Access</b>	
• Response Time <30 minutes	93%
<b>Hospital Information (Top 2 Box scores)</b>	
• Overall quality of care in primary hospital	84%
• Physician agreed that timeliness of imaging and/or lab reports usually meets my needs for clinical decision-making	92%
• Physician agreed that hospital takes appropriate steps to protect the safety of my patients	92%
• Physician agreed that nursing staff have the necessary clinical skills to provide appropriate care in the specific units in which they work	89%

\*HMO physicians were asked to evaluate the MG/IPA on these attributes

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## 2014 HMO Primary Care Physician Survey Results

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The 2014 survey included questions regarding physician participation in the Cultural Competence Physician Education Continuing Medical Education (CME) Credit program offered by QUALITY INTERACTIONS® in 2013 and 2014. Ninety-nine percent of PCPs surveyed indicated that, after participation in the education program, they are more familiar with the concept of Cultural Competence; and 98 percent indicated that they are able to communicate more effectively with patients whose cultural backgrounds differ from their own.

### MEDICAL RECORDS

In 2014, 84 percent of PCPs utilized electronic medical records (EMRs). Of those who reported non-utilization, 29 percent anticipate implementing an EMR by 2015. The top two electronic tools utilized by PCPs include electronic prescribing (87 percent) and electronic orders (75 percent).

### CONTINUITY AND COORDINATION BETWEEN MANAGED CARE PHYSICIANS AND HEALTH CARE FACILITIES

In 2014, 90 percent or more PCPs participating in the HMO survey rated the reports they received from hospitals, outpatient surgery/surgicenters, skilled nursing facilities, and home health care facilities as Excellent, Very Good or Good. More than 93 percent of PCPs rated feedback from several specialists, including but not limited to, cardiologists, orthopedic surgeons, ophthalmologists and otolaryngologists as Excellent, Very Good or Good; 81 percent of PCPs gave Excellent, Very Good or Good ratings to feedback from behavioral health specialists. Rating of feedback from Hospitalists, which was new in 2013, had a result of 90 percent.

In summary, positive ratings for many HMO PCP survey indicators significantly increased, including several of the indicators regarding BCBSIL services, electronic medical records and specialist feedback to PCPs. We are pleased that these satisfaction rates continue to climb, showing that the MG/IPAs and their contracting physicians are increasing their communications to better coordinate the care of HMO members.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. eCare is the registered trademark of Nebo Systems, a division of Passport Health Communications, Inc. (Passport/Nebo Systems offers the NDAS Online product to independently contracted BCBSIL providers). Passport/Nebo Systems is an independent third party vendor and is solely responsible for its products and services.

QUALITY INTERACTIONS is a trademark of Quality Interactions, Inc., a separate company that operates educational software featuring instruction in cross-cultural care and cultural competency in the healthcare setting. The Cultural Competence Physician Education Continuing Medical Education (CME) Credit program offered by QUALITY INTERACTIONS is an evidence-based, case-based learning program is accredited by Tufts University School of Medicine for 2.5 hours Continuing Medical Education (CME) Credits. Quality Interactions is solely responsible for its products and services.

BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors such as Availity, Passport/Nebo Systems or QUALITY INTERACTIONS. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

## New Effective Date for Revised Sleep Study Medical Policy

On page 7 of our January 2015 *Blue Review*, we included an article titled, "Diagnosis and Medical Management of Sleep Related Breathing Disorders." This article outlined medical policy revisions to be effective for dates of service beginning April 15, 2015. **This effective date has been changed to May 1, 2015.**

The January 2015 article addressed recent revisions to the BCBSIL Medical Policy (MED205.001), Diagnosis and Medical Management of Sleep Related Breathing Disorders. These revisions align our medical policy with nationally recognized clinical criteria and current industry standards.

The revised policy establishes the medically appropriate utilization of home sleep apnea testing and polysomnography (PSG) in the diagnosis of Obstructive Sleep Apnea (OSA). For services rendered on or after May 1, 2015, PSG and facility-based sleep study tests related to OSA will be subject to medical necessity review under the updated BCBSIL Medical Policy criteria.

You may obtain a medical necessity determination prior to services being rendered by submitting a benefit Predetermination Request Form. This form is available in the Education and Reference Center/Forms section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

To view the full medical policy, visit the Standards and Requirements/ Medical Policy section of our Provider website.

The above article does not apply to HMO members.

The BCBSIL Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient's health care needs. Some benefit plans administered by BCBSIL, such as some self-funded employer plans or governmental plans, may not utilize BCBSIL Medical Policy. Members should contact their local customer service representative for specific coverage information.

## Annual BCBSIL Hospital Survey, Hospital Profile and Blue Star Hospital Report to Retire

The Annual BCBSIL Hospital Survey, Hospital Profile and Blue Star Hospital Report will retire in 2015. The purpose of the BCBSIL Profile was to provide hospitals with a summary of data from multiple sources. In recent years, other entities such as the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Public Health have made hospital data publicly available. As a result, there is no longer a need for the BCBSIL Hospital Survey, Hospital Profile and Blue Star Hospital Report. If you would like to access hospital-specific data, refer to the <http://medicare.gov/hospitalcompare/> and <http://healthcarereportcard.illinois.gov/> websites.

If you have questions about the BCBSIL Hospital Profile, please contact BCBSIL at 312-653-3465.



## Legislative Updates: Formulary Exception Review for Exigent and Non-exigent Circumstances, Step Therapy and Dispensing Limits



### FEDERAL REGULATION

On May 27, 2014, the Department of Health and Human Services issued a final regulation entitled, Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond.

Beginning with coverage years on or after Jan. 1, 2015, issuers providing essential health benefits must provide consumers with an expedited formulary exception process for exigent circumstances that exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

After receiving a request from an enrollee or the prescribing physician, a health plan issuer must make its coverage determination on these expedited reviews and notify the enrollee or the prescribing physician of its coverage determination no later than 24 hours after it receives the request. A health plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

For additional information, we encourage you to refer to the Final Rule on the Federal Register website at <https://www.federalregister.gov/articles/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and>.

### STATE LEGISLATION\*

On Aug. 25, 2014, Governor Pat Quinn signed into law Public Act 98-1035 (House Bill 3638) – the Health Insurance Consumer Protection Act of 2014.

Insurers that offer Qualified Health Plans (QHPs) and that provide prescription drug benefits must provide a medical exception process that allows members or their authorized representatives to request any clinically appropriate non-covered drug when:

- The drug is not covered on the Plan's formulary,
- The insurer is removing a drug from the formulary for reasons other than for safety or a manufacturer's withdrawal from the market, **or**
- Step therapy or a dose restriction has been ineffective or is likely to cause harm to the member or affect the drug's effectiveness.

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## Legislative Updates: Formulary Exception Review for Exigent and Non-exigent Circumstances, Step Therapy and Dispensing Limits

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In the above scenarios, insurers must respond to a verbal or written request from a member or the member's authorized representative for any clinically appropriate drug. The insurer must either approve or deny the medical exception request within 72 hours of receipt or, in the case of an expedited request, within 24 hours from receipt. In the case of a denial, the insurer must provide the member and their prescriber with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for appeal.

Additionally, on or after Jan. 1, 2015, any insurer that provides prescription drug benefits must either approve or deny a prior benefit authorization request for approval of coverage within 72 hours after receipt of a paper or electronic request; or within 24 hours in the case of an expedited coverage determination. In the case of a denial, the insurer must provide the prescriber with the reason for the denial, an alternative covered medication, if applicable, and information regarding the denial. **This requirement does not apply to beneficiaries of Medicare or Medicaid plans.**

For additional information, refer to the Illinois General Assembly website at <http://ilga.gov/legislation/publicacts/fulltext.asp?name=098-1035>.

BCBSIL is committed to achieving full compliance by reviewing and responding to formulary exception requests and/or prior authorization requests within the timeframes according to the law.

\*Information on this topic was included in our December 2014 *Blue Review*. The content above has been enhanced to include additional details regarding response time for expedited requests.

The information provided above is only intended to be a brief summary of legislation that has been proposed or laws that have been enacted and is not an exhaustive description of the law or a legal opinion of such law. This material is for informational purposes only and is not legal advice. If you have any questions regarding this legislation, you should consult with your legal advisor.

## Anthem® Blue Cross and Blue Shield Introduces Cancer Care Quality Program

Effective Jan. 1, 2015, Anthem Blue Cross and Blue Shield implemented a Cancer Care Quality Program administered through AIM Specialty Health<sup>SM</sup> (AIM). While this program is not applicable to other Blue Plan members, we are sharing information about this program since it is offered to both national and local Anthem members.

This innovative quality initiative is an evidence-based cancer treatment program designed to support provider decision making as it relates to selecting cancer treatment regimens that are consistent with current evidence and consensus guidelines. According to Anthem, these Cancer Treatment Pathways (Pathways) have been developed based on medical evidence and best practices from leading cancer experts to support oncologists to identify therapies that are highly effective and affordable.

Claim information collected may help identify members for Anthem's Case Management programs which may result in maximizing the impact to the patients' overall health. Additional information about this program can be found on AIM's website at: <http://www.aimspecialtyhealth.com/solutions/clinical-specialties/oncology>.

Anthem is a registered trademark of Anthem Insurance Companies, Inc. Anthem is a separately incorporated company that offers health benefit products in certain states. Anthem is solely responsible for its products and services. BCBSIL makes no representations or warranties with respect to any of the products or services offered or administered by Anthem.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions.

## Flu Season Reminder

With the Centers for Disease Control and Prevention (CDC) expecting an increase in flu activity in 2015, BCBSIL recommends that you encourage your patients to get an annual flu shot.

The CDC recommends a yearly flu vaccination for everyone 6 months of age and older as the first and most important step in protecting against this potentially serious disease. While there are many different flu viruses, the flu vaccine is designed to protect against the main flu strains expected during the current flu season. Some children younger than age 9 may require two doses of influenza vaccine.

Please note that, while many BCBSIL members' health benefit plans include influenza vaccination coverage with no member cost sharing, there are some exceptions. It is important to check eligibility and benefits information for details regarding copays, coinsurance and deductibles before administering the influenza vaccine to BCBSIL members.

Additional information such as flu prevention, treatments, and free resources may be viewed on the CDC's Influenza (Flu) page at <http://cdc.gov/flu>.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

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 back of the member's ID card.



## Medical Policy Updates

Approved, new or revised BCBSIL Medical Policies and their effective dates are usually posted on our website the first day of each month. Medical policies, both new and revised, are used as guidelines for benefit determinations in health care benefit programs for most BCBSIL members, unless otherwise indicated. These policies may impact your reimbursement and your patients' benefits.

Although medical policies can be used as a guide, HMO providers should refer to the HMO Scope of Benefits in the BCBSIL Provider Manual, which is located in the Standards and Requirements section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

You may view active, new and revised policies, along with policies pending implementation, by visiting the Standards and Requirements/Medical Policy section of our website at [bcbsil.com/provider](http://bcbsil.com/provider). Select "View all Active and Pending Medical Policies." After confirming your agreement with the Medical Policies disclaimer, you will be directed to the Medical Policies Home page.

You may also view draft medical policies that are under development, or are in the process of being revised, by selecting "View and comment on Draft Medical Policies." After confirming your agreement with the Medical Policies disclaimer, you will be directed to the Draft Medical Policies page. Just click on the title of the draft policy you wish to review, and then select "Comments" to submit your feedback to us.

Please visit the Standards and Requirements/Medical Policy section of our website at [bcbsil.com/provider](http://bcbsil.com/provider) for access to the most complete and up-to-date medical policy information.

The BCBSIL Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient's health care needs. Some benefit plans administered by BCBSIL, such as some self-funded employer plans or governmental plans, may not utilize BCBSIL Medical Policy. Members should contact their local customer service representative for specific coverage information.

## Provider Learning Opportunities

### BCBSIL WEBINARS

In addition to being more environmentally friendly, paperless payment, electronic remittance and refund management transactions offer greater convenience, efficiency and security of information. Below you'll find details on complimentary online educational webinars designed to train billing, utilization and administrative professionals about using our electronic tools and the advantages of using electronic options throughout the entire claims process.

A listing of upcoming training opportunities sponsored by BCBSIL and their descriptions is also available in the Workshops/Webinars page in the Education and Reference Center of our website at [bcbsil.com/provider](http://bcbsil.com/provider). To register for a webinar, visit us online.

<p><b>Introducing Remittance Viewer</b>  <i>The remittance viewer is an online tool that offers providers and billing services a convenient way to retrieve, view, save or print claim detail information.</i></p>	<p>March 18, 2015</p>	<p>11 a.m. to noon</p>
<p><b>iExchange® Training</b>  <i>Join us for an overview of this online benefit preauthorization tool.</i></p>	<p>Feb. 25, 2015</p>	<p>2 to 3 p.m.</p>
	<p>March 11, 2015</p>	<p>2 to 3 p.m.</p>
	<p>March 25, 2015</p>	<p>2 to 3 p.m.</p>

### 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 at [availity.com](http://availity.com) for details; or call Availity Client Services at 800-AVAILITY (282-4548) for assistance.



# 2014-2015 Medicare Part D Formulary Changes

Blue Cross MedicareRx (PDP)<sup>SM</sup>/Blue Cross Medicare Advantage (HMO)<sup>SM</sup>/  
Blue Cross Medicare Advantage (HMO-POS)<sup>SM</sup>/Blue Cross Medicare Advantage (PPO)<sup>SM</sup>



The 2015 Medicare Part D annual Open Enrollment Period (OEP) began Oct. 15, 2014, and ended on Dec. 7, 2014. On Aug. 8, 2014, the BCBSIL 2015 Blue Cross MedicareRx<sup>SM</sup>/Blue Cross Medicare Advantage<sup>SM</sup> Medicare Part D Value and Ideal formularies were granted conditional approval by CMS.

As with all Medicare Part D drug plans, you can expect a number of formulary and utilization management changes for 2015. Some of the changes were mandated by CMS (such as safety concerns, drugs that no longer meet the CMS definition of a “Part D medication,” etc.) while others were a result of dynamic changes in the pharmaceutical marketplace. The Blue Cross MedicareRx/Blue Cross Medicare Advantage 2015 Part D formulary changes include the addition of some new drug therapies as well as the migration to some important generic equivalents (e.g., DETROL LA, EVISTA, CYMBALTA, ACTONEL, MICARDIS, AVELOX, etc.) that have and/or will become available in 2015.

A summary of all relevant changes to the 2014-2015 formulary (i.e., drug removals and new Prior Authorization and Step Therapy utilization management programs) was included in the Annual Notice of Change (ANOC) that was sent to all current members with Blue Cross MedicareRx/Blue Cross Medicare Advantage Medicare Part D plans. In addition, individual member letters were mailed in late November 2014, to alert our members of important 2015 formulary changes that may affect them.

Visit the Pharmacy Program/Medicare Part D Updates section of our website at [bcbsil.com/provider](http://bcbsil.com/provider) for a quick reference guide that includes the “Top 30” medications that are impacted by changes to the 2015 Blue Cross MedicareRx/Blue Cross Medicare Advantage Value and Ideal formularies and therefore, have the most potential to affect current members.

HMO, HMO-POS and PPO Medicare Advantage plans are provided by BCBSIL, a Division of 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.

Prescription drug plans are provided by BCBSIL, which refers to 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.

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## Pharmacy Disclaimer

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member’s certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

## Reminder: Insulin Formulary Changes and New Prior Authorization Program for 2015

Starting Jan. 1, 2015, for non-Medicare Part D or Medicaid members with BCBSIL prescription drug coverage, Novolin, Novolog, Lantus and Levemir are preferred insulin brands and the member’s preferred brand copay will apply. Humulin and Humalog are non-preferred brands, and in most cases, depending on the member’s benefit plan, will require a pharmacy prior benefit authorization request to be submitted and approved for coverage consideration. For more information, see the News and Updates article posted on our website at [bcbsil.com/provider](http://bcbsil.com/provider) as of Jan. 19, 2015.

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Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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## Correction to Blue Cross Community Family Health Plan<sup>SM</sup> (FHP) Phone Number

On pages 6 and 7 of our December 2014 *Blue Review*, we included an article titled, “Blue Cross Community Options<sup>SM</sup>: Quick Tips, Guidelines and Reminders for Providers.” This article included an incorrect phone number for FHP inquiries. **Please note that the correct phone number for FHP (Customer Services, Medical Management and Provider Network Services) is 877-860-2837.**

For your convenience, a new tip sheet is available in the Network Participation/ Blue Cross Community Options of our website at [bcbsil.com/provider](http://bcbsil.com/provider). This tip sheet includes billing guidelines, reminders and resources for FHP, as well as Blue Cross Community MMAI (Medicare-Medicaid Plan)<sup>SM</sup> and Blue Cross Community ICP<sup>SM</sup>, or Integrated Care Plan (ICP).



*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](http://bcbsil.com/provider).

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

### BLUE REVIEW

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