BlueCross BlueShield of Illinois

BLUE REVIEW℠

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS JULY 2016

BCBSIL and Illinois Cancer Specialists Announce First Oncology Intensive Medical Home Pilot in the State

Blue Cross and Blue Shield of Illinois (BCBSIL) and Illinois Cancer Specialists (ICS), a practice in The US Oncology Network, have announced the first oncology intensive medical home (IMH) pilot program in Illinois. The overall goal of the oncology IMH is to provide coordinated, cost-effective care, in part, through the use of evidence-based medical treatment guidelines. The IMH is one of BCBSIL's value-based programs that utilize incentives to engage health care professionals and help facilitate improved health, affordability and customer experience.

To help kick off the program, in late 2015 the parties started identifying BCBSIL PPO patients who were being treated by an ICS physician. To qualify for the program, patients must be receiving chemotherapy or hormone therapy, with a cancer diagnosis of breast, colon, lung, pancreatic, prostate and any non-Hodgkin's lymphoma. Current ICS patients are selected to join the program for six months while receiving treatment at one of the ten ICS sites: Arlington Heights, Bolingbrook, Chicago/Resurrection Hospital, Elgin, Hinsdale, Hoffman Estates, Huntley, McHenry, Niles and Woodstock. The program goal, at present, is to enroll 150-200 patients per year.

Through the new IMH pilot, enrolled patients being treated at ICS will receive the services of an ICS Nurse Care Manager (NCM), an oncology-certified nurse whose primary purpose is to proactively address the challenging needs of oncology patients at no cost to the patient. The NCM will help provide disease and treatment education, schedule follow-up phone calls after treatment, and closely follow symptom management issues. Subsequent meetings may include continued use of chemotherapy, advance care planning and hospice when appropriate. The ICS physicians will continue to assess these patients to develop and implement a plan of care that will attempt to actively address the patients' needs during their treatments and beyond.

KEY ASPECTS OF THE BCBSIL/ICS ONCOLOGY IMH MODEL

ICS helps provide Chicago area patients with advanced, comprehensive, compassionate cancer care in a community setting. Some of the key aspects of the BCBSIL/ICS Oncology IMH model are:

- Access to cancer care that is more coordinated with the focus on patients and their entire medical condition;
- Cancer care that is optimized based on evidence-based medicine to help produce quality outcomes;
- Cancer care that is efficient, with treatment provided in a quality, low-cost setting for the patient;
- Cancer care that is delivered in a patient-centric, caring environment to help optimize patient satisfaction; and
- Cancer care that continuously seeks improvement by measuring and benchmarking results against other facilities providing care, so that best practices "raise the bar" in delivering care.

BCBSIL and ICS physicians will meet quarterly to exchange information and assess the IMH performance. Some of the information discussed will include metrics on hospital admission rates, hospital days, ER visits, office visits and home health visits.

For more information, refer to the article posted May 24, 2016, in the Company Information/News section of our website at *bcbsil.com*.

The IMH program is designed with the goal to assist health care providers and members in better coordinating care and improving health outcomes. The program is not a substitute for the independent medical judgment of a health care provider. Health care providers are instructed to use their own best medical judgment based upon all available information and the condition of the patient in determining a course of treatment. Regardless of any benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

Preventive Care Services are a Benefit for Most Members*

In a continued effort to promote improved health and cost care management to our members, BCBSIL is encouraging members to take advantage of preventive care services that are available under most benefit plans. You can help by using these key messages in communications to your patients.

- *You can help stay healthy year round by taking advantage of important preventive services and screenings such as annual preventive care visits, certain screenings and immunizations.*
- *Early detection is the best defense for staying healthy. With the right preventive care, health problems may be found sooner and treated before they become more serious.*
- *Many preventive services are covered at no cost as a benefit of your health plan membership when services are provided by a doctor in your health plan's network. To find out what your plan covers, call the number on your BCBSIL ID card.*

We encourage you to share this information with your patients, as they may look to you as their primary source for health care information and guidance. For additional information on preventive services, your BCBSIL patients may log in to Blue Access for Members℠ at *bcbsil.com* and click on the My Health tab.

*Not available for all plans. Members should call the customer service number on their ID card to help determine what benefits may be available. This is only a brief summary of some plan benefits. For more complete details, including benefits, limitations and exclusions, please refer to the member's certificate of coverage.

This information is for informational purposes only, and is not a substitute for the sound medical judgment of a health care provider. The final decision about any health care service or treatment is between the member and their health care provider. Members are instructed to talk to their doctor if they have any questions or concerns regarding their health.

CDC Guidelines for Prescribing Opioids for Chronic Pain

Part 2 of a 3-part series describing the new CDC guidelines for prescribing opioids. Part 1 was published in the June issue of the Blue Review.

In March of 2016, the Centers for Disease Control and Prevention (CDC) issued new recommendations for prescribing opioid medications for chronic pain, excluding reasons for cancer, palliative, and end of life care.[1] These recommendations were in response to an increased need for provider education due to a nationwide epidemic of opioid overdose and opioid use disorder.

The CDC has developed 12 recommendations, grouped into three areas of consideration:

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up and discontinuation
- Assessing risk and addressing harms of opioid use

The first area of consideration was discussed in the June 2016 issue of *Blue Review*. The second area of consideration – Opioid selection, dosage, duration, follow-up and discontinuation – is described below. The third area will be discussed in a future issue of the *Blue Review*.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP AND DISCONTINUATION

1. According to the new guidelines released in March 2016, the CDC recommends that providers start with prescriptions for immediate-release (IR) opioids instead of extended-release/long-acting opioids (ER/LA) when initiating treatment for chronic pain.
   - IR opioids include codeine, hydrodone, hydromorphone, morphine and oxydocone.
   - ER/LA opioids include methadone, transdermal fentanyl, and ER versions of oxycodone, oxymorphone, hydrocodone and morphine.
   - ER/LA medications should be reserved for severe, continuous pain and should only be used in patients who have received IR opioids daily for at least one week.
2. The guidelines also state that providers should start opioid therapy with the lowest effective dosage. Morphine milligram equivalents (MME) more than 50 MME/day should be used with caution and MME dosages more than 90 MME/day should be avoided when possible, or carefully justified.
   - Opioid therapy lower than 50 MME/day has been associated with reduced risk of overdose.
   - A morphine equivalent dose calculator can be found at agencymeddirectors.wa.gov/mobile.html.
3. Knowing that long-term opioid use often begins with opioid treatment of acute pain, the CDC recommends that providers use the lowest effective dose of an immediate release product when opioids are being used to treat acute pain. For example, three days of opioid treatment for acute pain is often sufficient but more than seven days may be too much.

- Evidence has shown that a greater amount of early opioid exposure can be associated with a greater risk of long-term opioid usage.

(continued on page 3)

(CDC Guidelines for Prescribing Opioids, continued from page 2)

- Experts have noted that each day of unnecessary opioid use can increase the likelihood of physical dependence without any additional benefit to the patient.
- Prescribing opioids for fewer days can also help minimize the number of extra medication that may be available for potential misuse.

4. Finally, the guidelines note that providers should follow up with patients and evaluate their pain within one to four weeks of starting opioid therapy for chronic pain or after a dose increase. Continued opioid therapy should be evaluated at least every three months to determine the benefits or potential harmfulness. If the benefits do not outweigh the harmfulness, providers should consider tapering the opioid dosing and consider other possible therapies.
    - Contextual evidence has found that patients who do not experience pain relief with opioids in one month are unlikely to experience pain relief with opioids at six months.
    - Providers should re-evaluate patients with potential risk of opioid use disorder or overdose more frequently than every three month.

A review on assessing risk and addressing harms of opioid use will be included in next month's *Blue Review*.

[1] 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.

BCBSA Report Highlights Dramatic Increase in Specialty Drug Spending

Spending on medications used to treat chronic health conditions such as cancer and hepatitis C rose 26 percent across most Blue Cross and Blue Shield (BCBS) companies* from 2013 to 2014 – similar to a national spending rate that is expected to quadruple within four years, according to a new Blue Cross and Blue Shield Association (BCBSA) Health of America report.[1]

Most of the $18.4 billion that BCBS plans spent on these medications in 2014 was driven by rising drug prices and increasing costs of specialty drug treatments. Specialty drugs get their name because they require special monitoring and administration to patients with serious or chronic conditions such as cancer, hepatitis C, hemophilia, multiple sclerosis and more.

BCBSIL has seen a rise in specialty drug spending. Specialty drugs are 50 times more expensive than traditional prescription medications. Nevertheless, specialty drugs, when taken as prescribed, play an important role in members' health by providing both improved health outcomes and sustainable long-term cost reductions (i.e., ER visits, transplants, hospital stays, etc.). Yet, as these high-cost treatment advances emerge, there is an increased need to manage rising drug cost trends in this specialty market.

For more information, including BCBSIL's strategy for managing specialty drugs, refer to the complete article in the Education and Reference Center/News and Updates section of our website at *bcbsil.com/provider*.

* Does not include members who receive coverage through Medicare or Medicaid programs.

[1] http://www.bcbs.com/healthofamerica

Formulary Coverage Change for BCBSIL Medicaid Members

Effective July 18, 2016, BCBSIL members on a Blue Cross Community ICP℠ or Integrated Care Plan, or Blue Cross Community Family Health Plan℠ (FHP) will transition from an all generics covered formulary to a Select Generic formulary. As a result of this change, some generic medications will no longer be included in the formulary.

Decisions to remove these select generic medications from the formulary were based on cost, drug safety, medical necessity and the availability of generic alternatives on the formulary. In most cases, a generic alternative is still available on the formulary. Based on available claims data, letters will be sent from BCBSIL to alert members who may be taking a medication that is affected by this formulary change. The Select Generic formulary is posted on the ICP and FHP member websites.

Benefit prior authorization requests may be submitted online via the CoverMyMeds® site at covermymeds.com. While electronic options are preferred, benefit prior authorization 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.

Back to Basics Webinar for Ancillary Providers

Attention Skilled Nursing Facility, Home Health and Orthotic/Prosthetic providers! You're invited to attend a complimentary Back to Basics Webinar for Ancillary Providers to learn more about electronic options that can help make it easier for you to conduct business with BCBSIL. This webinar will also include an overview of the Blue Cross Community Options℠ and Commercial networks.

A variety of Web vendor portals are available. In this one-hour training session, we'll review online tools and features that can be accessed through the Availity™ Web Portal. Webinar participants will learn how to:

- Check patient eligibility and benefits in real-time for BCBSIL members, using the Availity Eligibility and Benefits tool
- Obtain enhanced claim status information for BCBSIL members, using the Availity Claim Research Tool

Three webinar dates are available and are geared toward specific provider types, as follows: July 19, 2016 (Skilled Nursing Facility providers), Aug. 9, 2016 (Home Health providers) and Sept. 8, 2016 (Orthotic/Prosthetic providers). Refer to the Provider Learning Opportunities on this page for session times. To register online, visit the Workshops and Webinars page in the Education and Reference Center on our website at *bcbsil.com/provider*.

You do not have to be registered with Availity prior to attending. New users are highly encouraged to attend. Existing users needing a refresher are also welcome. If you have questions or need assistance, email our Provider Education Consultants at *pecs@bcbsil.com*.

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.

Provider Learning Opportunities

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

BCBSIL WEBINARS

Back to Basics for Ancillary Providers *Review electronic transactions, provider tools and online resources for Skilled Nursing Facility, Home Health and Orthotic/Prosthetic providers.*	July 19, 2016 (Skilled Nursing Facility Providers) Aug. 9, 2016 (Home Health Providers) Sept. 8, 2016 (Orthotic/Prosthetic Providers)	All sessions: 11 a.m. to noon
BCBSIL Back to Basics: 'Availity 101' *Review electronic transactions, provider tools and online resources.*	July 12, 2016 July 19, 2016 July 26, 2016	All sessions: 11 a.m. to noon
Introducing Remittance Viewer *This online tool offers providers and billing services a convenient way to retrieve, view, save or print claim detail information.*	July 13, 2016 July 20, 2016 July 27, 2016	All sessions: 11 a.m. to noon
iExchange® Training: New Enrollee Training *How to access the tool*	July 28, 2016	2 to 3:30 p.m.
iExchange Training: Predetermination Requests *For inpatient and outpatient services*	July 12, 2016 July 19, 2016 July 26, 2016	All sessions: 11 a.m. to 12:30 p.m.
iExchange Training: 2016 System Enhancements *Overview of new features*	July 14, 2016 July 21, 2016 July 28, 2016	All sessions: 11 a.m. to noon

BCBSIL Professional Provider Workshops

The BCBSIL Provider Relations team is offering specialized workshops for independently contracted providers. Learn about products, benefit preauthorization updates and new PPO credentialing guidelines.

For all workshops, registration is scheduled from 9 to 9:30 a.m. Workshop sessions are held from 9:30 a.m. to noon.

July 13, 2016
Rush-Copley Medical Center
2000 Ogden Ave., Aurora, IL 60504

The registration deadline is July 8, 2016.

Questions? *Contact Kathy Barry at kathleen_barry@bcbsil.com or 312-653-4247.*

July 14, 2016
The State House Inn
101 E. Adams St., Springfield, IL 62701

The registration deadline is July 8, 2016.

Questions? *Contact J'ne Kanady at j'ne_kanady@bcbsil.com or 217-698-5125.*

ClaimsXten™ New Specialty Pharmacy Rule – Notification of Postponement

On April 18, 2016, BCBSIL announced the upcoming implementation of the ClaimsXten Specialty Pharmacy Rule for dates of service on or after July 18, 2016. On June 1, 2016, an updated notification was posted in the News and Updates section of our Provider website to announce that the implementation of this new rule has been postponed and the rule now will apply to professional and outpatient facility claims with dates of service on or after Aug. 15, 2016, for all lines of business except Federal Employee Program (FEP). FEP will implement this new rule Sept. 26, 2016. The new rule is summarized below.

The Specialty Pharmacy Knowledge Pack rule will audit professional and outpatient facility claims involving specialty pharmaceuticals with the following parameters:

- HCPCS J-code and diagnosis as defined by the U.S. Food and Drug Administration (FDA) labeling
- HCPCS J-code and maximum billable units
- HCPCS J-code and age
- HCPCS J-code and gender
- HCPCS J-code and place of service
- HCPCS J-code with any combination of the elements listed above

This rule will deny claim lines found not payable according to guidelines provided by the FDA and National Comprehensive Cancer Network.

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. For more information on C3 and ClaimsXten, including answers to frequently asked questions, refer to the Clear Claim Connection page in the Education and Reference Center/ Provider Tools section of our website at *bcbsil.com/provider*. Additional information also may be included in upcoming issues of the *Blue Review*.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third party vendor that is solely responsible for its products and services.

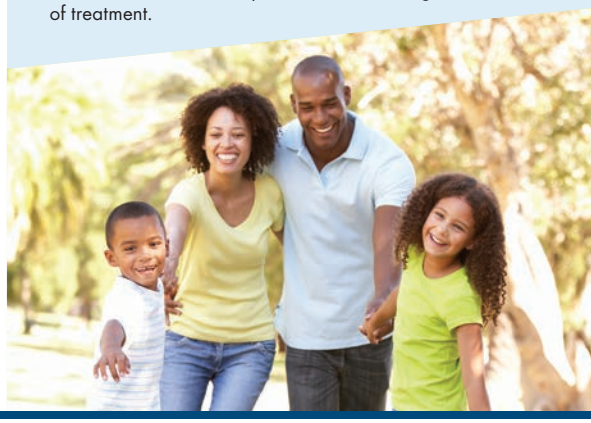
Blue Cross Community Options Complex Case Management and Disease Management Programs

We are pleased to announce the development and implementation of BCBSIL Medicaid Complex Case Management and Disease Management programs to help better serve our Blue Cross Community MMAI (Medicare-Medicaid Plan)℠, ICP and FHP members.

The goal of the Complex Case Management and Disease Management programs is to help MMAI, ICP and FHP members regain more control over their health, achieved through education, support and access to services that may help these members as they work toward accomplishing their individual health goals. The intent of the Disease Management program is to provide education and health care self-management tools for MMAI, ICP and FHP members with chronic conditions such as asthma and diabetes.

We appreciate the care and services you provide to help improve the health and well-being of our members. The Complex Case Management and Disease Management Programs are intended to supplement the services and treatment that members receive from their health care providers. To make referrals or to learn more about the above-referenced programs, please contact Care Coordination at 855-334-4780, Monday through Friday between the hours of 7:30 a.m. and 6 p.m.

The Community Options Complex Case Management and Disease Management programs are not a substitute for the independent medical judgment of health care providers. Health care providers are instructed to use their own best medical judgment based upon all available information and the condition of the patient in determining a course of treatment.



Pharmacy Program Changes, Effective July 1, 2016

BCBSIL Pharmacy Program Updates are typically published on a quarterly basis in the *Blue Review* and/or on our Provider website to help keep you informed of standard drug list (formulary) additions/deletions, dispensing limit changes and utilization management program enhancements.

Most recently, we posted a document titled, *Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2016*, which is available in the Education and Reference Center/ News and Updates section of our website at *bcbsil.com/provider*. This document includes:

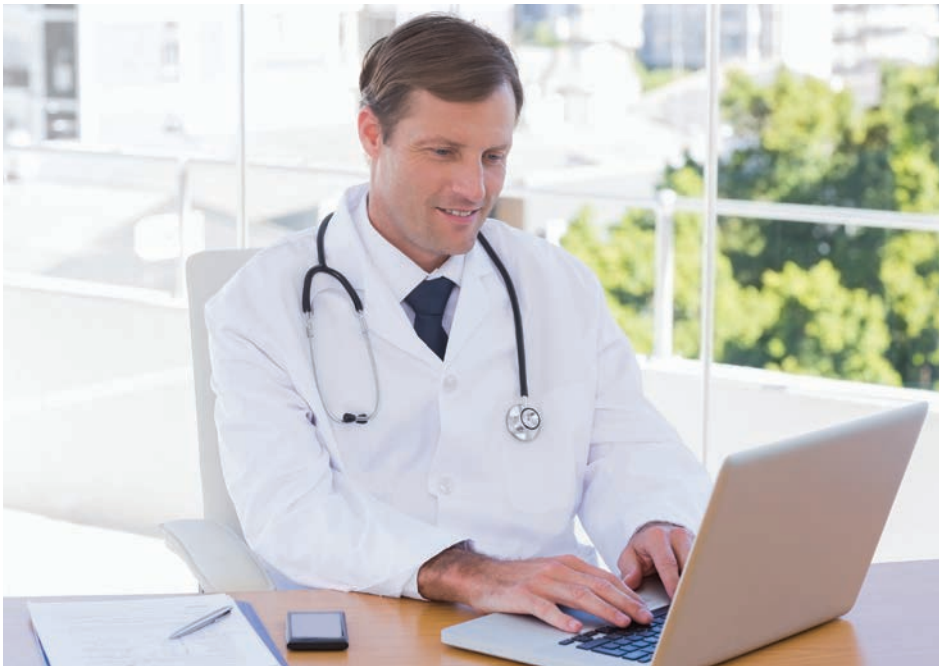
- A listing of brand medications that have been added to the BCBSIL standard and generics plus drug lists, effective July 1, 2016.
- Information on dispensing limits that have been added for certain drugs, effective July 1, 2016. BCBSIL's standard prescription drug benefit program includes coverage limits on certain medications and drug categories.
- A listing of program changes and targeted drugs added to the BCBSIL Pharmacy Prior Authorization and Step Therapy programs effective July 1, 2016, as part of our utilization management program for standard pharmacy benefit plans upon renewal.

Refer to the complete article in the Education and Reference Center/News and Updates section of our Provider website for details.

The Pharmacy Program Updates are published for informational purposes only and are 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.

Certain groups may use different pharmacy vendors. Please refer to the member's ID card to determine if a member has a different prescription benefit vendor.

iExchange Now Accepts Electronic Medical Record Attachments



We are pleased to announce that enhancements have been made to iExchange, our online tool that supports online benefit preauthorization requests for inpatient admissions, medical, behavioral health and clinical pharmacy services. Effective July 1, 2016, iExchange now accepts electronic medical record attachments when necessary in support of benefit preauthorization requests. Electronic medical record documentation also may be submitted via iExchange for predetermination of benefit requests. With these enhancements, iExchange offers providers and facilities a secure, online alternative to faxing their patients' protected health information.

Join us for an iExchange webinar! Do you have questions? Would you like training on how to use iExchange? We welcome the opportunity to share more information about iExchange with you and your staff. Our webinars spotlight recent enhancements, as well as navigation tips and key features of the online tool. *See the Provider Learning Opportunities on page 4 for upcoming webinar dates and times.*

Not enrolled for iExchange? Sign up now. iExchange is accessible to independently contracted physicians, professional providers and facilities that are participating in the various health benefit products offered by BCBSIL. For details and to sign up online, visit the Education and Reference Center/Provider Tools section of our website at *bcbsil.com/provider*.

As a reminder, it is important to check eligibility and benefits, prior to rendering services. This step will help you determine if benefit preauthorization is required for a particular member. For additional information, such as definitions and links to helpful resources, refer to the Claims and Eligibility/Prior Authorization section of our Provider website.

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

Reminder: Corrected Claim Request Change, Effective July 11, 2016

As a reminder, effective July 11, 2016, corrected claim requests for previously adjudicated claims must be submitted as electronic replacement claims, or on the appropriate professional (CMS-1500) or institutional (UB-04) paper claim and Claim Review Form.

ELECTRONIC SUBMISSION

Electronic replacement claims should be submitted with the appropriate claim frequency code. Frequency code 7 will result in BCBSIL adjudicating the original claim number (sometimes referred to as a Document Control Number, or DCN) with the corrections. The replacement claim will be issued a new BCBSIL claim number and will subsequently deny based upon the re-adjudication of the original claim.

Note: Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSIL claim number will not be adjudicated. See below for additional information on claim frequency codes and guidelines to assist you with when and how to use them for making corrections to electronic claims submitted to BCBSIL.

Claim Frequency Codes			
Code	**Description**	**Filing Guidelines**	**Action**
5 Late Charge(s)	Use to submit additional charges for the same date(s) of service as a previous claim	File electronically, as usual. Include only the additional late charges that were not included on the original claim.	BCBSIL will add the late charges to the previously processed claim.
7 Replacement of Prior Claim	Use to replace an entire claim (all but identity information)	File electronically, as usual. File the claim in its entirety, including all services for which you are requesting reconsideration.	BCBSIL will replace the original claim with corrections and the replacement claim will be denied. Refer to the original claim for adjudication.
8 Void/Cancel of Prior Claim	Use to entirely eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period."	File electronically, as usual. Include all charges that were on the original claim.	BCBSIL will void the original claim from records, based on request.

PAPER SUBMISSION

More than 98 percent of the claims BCBSIL receives from providers are submitted electronically. BCBSIL encourages all providers to use electronic options as the primary method for claim submission. There are several multi-payer Web vendors available to providers. If you are a registered Availity Web Portal user, you have access to submit direct data entry replacement claims electronically, at no additional cost.

As of July 11, 2016, any changes to a claim that are specified **only** on the Claim Review Form or via a letter will be returned with a notice advising resubmission on the appropriate CMS-1500 or UB-04 paper claim form. Paper claim submitters are required to indicate "corrected claim" on the paper claim form **and** the accompanying Claim Review Form.

For more information, refer to the Related Resources in the Claims and Eligibility/Claim Submission section of our website at *bcbsil.com/provider*.

Dr. Stephen Ondra: 'Why MACRA is a Big Step Forward for Fee-for-Value Health Care'

As celebrated as the Medicare Access & CHIP Reauthorization Act (MACRA) was, its true impact will be felt in the long term, Dr. Stephen Ondra writes. The law is a clear signal that fee-for-service – for decades the primary way business was done in health care – will one day soon be the exception, not the norm.

Dr. Ondra is senior vice president and enterprise chief medical officer of our health insurance plans in Illinois, Montana, New Mexico, Oklahoma and Texas. He said, "MACRA replaced the Medicare Sustainable Growth Rate formula with a schedule that will increase baseline Medicare Part B payments by 0.5 percent per year until 2019. Then, starting the same year, physicians who want to participate in Medicare must opt into one of two payment tracks: the Merit-Based Incentive Payment System, or MIPS; or the Alternative Payment Model, or APM, track. Doing nothing is not an option."

Read more about MACRA in Dr. Ondra's latest article at *pulse.hcsc.com/category/delivery*. Watch for future articles from Dr. Ondra in this newsletter, and follow him on Twitter at @StephenOndra where he tweets about his work and the future of health care.

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WHAT'S INSIDE?

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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