



Blue REVIEWSM

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS

NOVEMBER 2013

WHAT'S INSIDE?

- Spacers Improve Asthma Outcomes..... **3**
- Pharmacy Program Introduces Electronic Prior Authorization Process **4**
- The *Choosing Wisely*[®] Campaign..... **5**
- Ancillary Provider Network Consultants **6**
- Professional Provider Network Consultant Assignments **6, 7**
- Reducing Elective Preterm Deliveries **9**
- Risk Adjustment..... **10**
- How important is your documentation for ICD-10? **11**
- In the Know: Enhanced Voucher Numbering Process **12**

When is it time to consider palliative care?

Palliative medicine consultants often receive requests from colleagues to see a patient who is finally “ready to go palliative.” Sometimes it means that a patient wants to know more about hospice. Other times, it means that the patient’s family is concerned about the patient’s suffering, and wants more attention paid to pain and symptom management. Many times, providers aren’t quite sure how to help a patient with serious illness who is struggling with the current treatment plan and is not sure what other options exist. While hospice as a model of care, and as an insurance benefit, has been in existence in this country since the early 1980s, palliative care is a relatively new specialty (board certification through the American Board of Medical Specialties became official in 2008). Moreover, the vast majority of the American public has never heard of palliative medicine. Until recently, it was not a topic that was discussed until the very late stages of illness.

Since 2011, Blue Cross and Blue Shield of Illinois (BCBSIL), the Illinois Hospital Association and the Northwestern University Feinberg School of Medicine have implemented PREP, *Preventing Readmissions through Effective Partnerships*. PREP initiatives assist hospitals in addressing issues that may lead to readmissions. Twenty-four Illinois hospitals have participated in the PREP Communication and Palliative Care program, which provides training and a physician mentor to assist hospitals in addressing palliative care needs. Dr. Eytan Szmuilowicz, Director of the Section of Palliative Care at Feinberg, has led this palliative care initiative and provided this information about palliative care for *Blue Review* readers.

Vaccinate Illinois Week

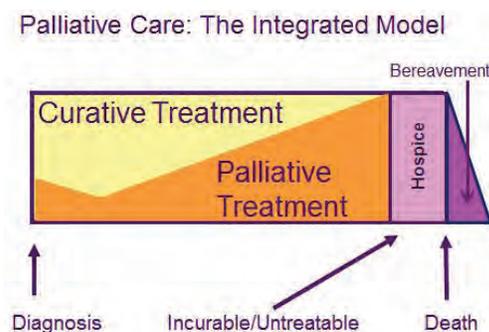
BCBSIL has been working with the Chicago Department of Public Health (CDPH), the Illinois Department of Public Health (IDPH) and other community partners to help promote Vaccinate Illinois Week, Dec. 8 through 14, 2013. Vaccinate Illinois Week is a statewide effort to promote influenza vaccination throughout the influenza season. It’s important to continue promoting influenza vaccines even after Vaccinate Illinois Week ends.

Many of your patients may not be aware that flu season in the U.S. can last into May. Please join us in the ongoing effort to help increase public awareness by reminding your patients that, even though flu season has already begun, it’s not too late to get vaccinated.

Dec. 8 through 14, 2013, is also National Influenza Vaccination Week (NIVW). Additional information on NIVW, along with related links and helpful influenza resources for health care professionals, is available on the Centers for Disease Control and Prevention (CDC) website at cdc.gov/flu/nivw.

Palliative care refers to the active, total care of patients with life-limiting illness, with a focus on relieving or preventing suffering – in all of its forms – related to the underlying illness or related to treatment of the illness. Examples of “life-limiting illness” include COPD, heart failure, dementia and cancer. Palliative care may be provided at any stage of a life-threatening illness. Importantly, patients can receive palliative care concurrently with disease-modifying care and it is not limited to a particular diagnosis (like cancer) or prognosis. Palliative care typically encompasses symptom management including both physical (such as pain, nausea, constipation, breathlessness, fatigue) and psychosocial (including delirium, anxiety, depression, spiritual distress) symptoms. Because suffering is typically so multidimensional, excellent palliative care is usually provided by interdisciplinary teams of providers including physicians, nurses, social workers, chaplains and other allied clinicians.

Figure: Integrated Model of Concurrent Palliative Care



(continued on p. 2)

Coming Soon: Orthonet™ Webinars

As published in the October *Blue Review*, BCBSIL's enhanced PPO physical medicine utilization management program will be effective Jan. 1, 2014, for City of Chicago PPO members with the following group numbers*:

P16705
P68263
P68267
P68265
P68268
P17600
P18600
P18601
P20600
P16628
P16642
P16643
P68266
P68269

The program will be phased in throughout 2014, and providers will be notified of additional member groups joining the program via the *Blue Review*.

In preparation for these program enhancements, BCBSIL will be hosting a series of webinars in December 2013. These webinars will be presented by Orthonet, and contain a walk-through of preauthorization logistics.

All webinars will be from noon to 1 p.m. Webinar dates are listed below:

- Dec. 11, 2013
- Dec. 12, 2013
- Dec. 13, 2013

Be on the lookout for more information about these webinars in the Provider Learning Opportunities section of the December *Blue Review*. Details will also be available on our Provider website in early December.

*The group numbers listed above have been updated since the October *Blue Review*.

OrthoNet is a registered trademark of OrthoNet LLC, an independent third party vendor that is solely responsible for its products and services.

Please note that the fact that a guideline is available for any given treatment, or 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.

When is it time to consider palliative care?

(continued from p. 1)

Philosophically, hospice can be thought of as palliative care for patients at the end of life. The focus on symptom control, maximizing quality of life and optimizing support for the patient and family are the same. The differences are in the details (see Table). A patient is eligible for hospice when the prognosis is thought to be (given the expected course of illness) six months or less *and* the patient has decided to forego further treatment to cure the underlying life-threatening condition (they may still receive treatment for any other illness not related to the terminal condition). A patient must elect to enroll in hospice and must give consent to enroll.

Table: Comparing Palliative Care and Hospice*

	Palliative Care	Hospice
Goal of Care	<ul style="list-style-type: none"> • Improve Quality of Life • Provide Support for Patient and Family 	<ul style="list-style-type: none"> • Improve Quality of Life • Provide Support for Patient and Family
Prognosis	Independent of Prognosis: May be provided at any point of a life-limiting illness trajectory	Prognosis (six months or less): Patient may remain in hospice beyond six months as long as prognosis is still believed to be limited if the disease runs its expected course
Funding	While many BCBSIL members have benefits for services that comprise palliative care, benefits can vary and should be verified if there are questions.	While many BCBSIL members have benefits for hospice care, benefits can vary and should be verified if there are questions.
Care Team	Usually interdisciplinary (including any combination of physician, nurse, nurse practitioner, social worker, chaplain)	<ul style="list-style-type: none"> • Must be interdisciplinary (including physician, nurse, social worker) • May also include chaplain, volunteers, home health aides, therapists (art, music, massage, physical)
Location of Care	<ul style="list-style-type: none"> • Outpatient consultation/co-management, Inpatient consultation, Inpatient unit (all if available within the community or hospital system) • Home visits, if available 	<ul style="list-style-type: none"> • Home, Skilled nursing facility • Inpatient Hospice (either at hospital or dedicated hospice unit) is for limited time and requires documented need for specialty care
24-hour home care included?	No – Home visits possible, but typically much less frequent than hospice home visits	No – Hospice is a “visiting” service, with frequency determined by patient need and plan of care; families may need to consider hiring additional caregivers if needed

*The description of what benefits may be available for the care noted above is not a guarantee of benefits. Members should refer to their certificate of coverage to determine what, if any, benefits are available and more details regarding terms, conditions, limitations and exclusions.

It is never too early to “go palliative.” Whenever a potentially life-threatening illness is affecting a patient's quality of life, it is time to consider adding palliative care to the treatment plan. If available, an expert palliative care team can help manage symptoms, coordinate care and facilitate complex decision-making planning that may include preparing for end-of-life care, even if it may be months or years away.

Spacers Improve Asthma Outcomes



The National Institute of Health’s National Asthma Education and Prevention Program recommends that patients on medium to high doses of inhaled corticosteroids use a spacer/holding chamber with a metered dose inhaler (MDI).

Research shows that spacers/holding chambers decrease the amount of medication in the back of the throat and reduce systemic absorption of the medicine.^{1,2,3,4} Additionally, spacers/holding chambers have been shown to increase delivery of medicine to the lungs in those patients with poor MDI technique.^{5,6} While simple blue tubes are free and better than no spacer at all, they are not as effective in improving delivery in patients who have difficulty coordinating actuation and inhalation. Valved-holding chambers are preferred and are also recommended for use with albuterol MDI rescue inhalers.

Physicians and pharmacists can facilitate usage of spacers/holding chambers by their patients with asthma. It is recommended that practitioners write a prescription for a valved-holding chamber.

Providers should always verify patient benefits. In most cases, spacers and multiple rescue inhalers are a covered benefit for BCBSIL members. Multiple rescue inhalers may be needed for children that live in two households, need one for the school health office, and/or attend childcare. If you are prescribing multiple rescue inhalers, be sure to describe the locations in which the medication is kept.

BCBSIL is committed to working with communities to help improve pediatric asthma care. Through a collaboration with the American Lung Association of the Upper Midwest (ALAUM), BCBSIL is supporting the “Enhancing Care for Children with Asthma Project,” a program that implements community-based interventions to improve the health outcomes of children with asthma. For more information about the “Enhancing Care for Children with Asthma Project,” visit the ALAUM at lung.org. If you have questions about spacers and holding chambers, please contact the ALAUM at 651-227-8014 or 800-LUNG-USA.

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.

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.

¹Newman SP, Millar AB, Lennard-Jones TR, Moren F, Clarke SW. Improvement of pressurized aerosol deposition with Nebuhaler spacer device. (1984) *Thorax* 39:935-41.
²Brown PH, Blundell G, Greening AP, Crompton GK. Do large volume spacer devices reduce the systemic effects of high doses inhaled corticosteroids? (1990) *Thorax* 45:736-9.
³Lipworth BJ. New perspectives on inhaled drug delivery and systemic bioactivity.(1995) *Thorax* 50:105-10.
⁴Selroos O, Halme M. Effect of early vs late intervention with inhaled corticosteroids in asthma.(1991) *Chest* 108:1228-34.
⁵Ahrens R, Lux C, Bahl T, Han SH. Choosing the metered-dose inhaler spacer or holding chamber that matches the patient’s need: evidence that the specific drug being delivered is an important consideration. (1995) *J Allergy Clin Immunol.* 96:288-94.
⁶Kim CS, Eldridge MA, Sackner MA. Oropharyngeal deposition and delivery aspects of metered-dose inhaler aerosols. (1987) *Am Rev Respir Dis* 135:157-64.

Immunization Administration: Single Claim Submission

BCBSIL performs periodic audits to help ensure claims have been adjudicated and reimbursed accurately. In the January 2011, and October 2012, issues of *Blue Review*, providers were notified that as of Jan. 1, 2013, a multiple vaccine administration reduction would be applied on subsequent initial vaccine/toxoid component and each additional vaccine/toxoid component provided on the same date of service.

The vaccine administration reduction applies to the following Current Procedural Terminology (CPT®) codes:

90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
+90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (list separately in addition to code for primary procedure)

According to the CPT codebook, 90460 is reported for each vaccine administered, and for vaccines with multiple components (combination vaccines), 90460 is reported in conjunction with 90461 for each additional component in a given vaccine.

BCBSIL expects providers to submit a single claim for a single date of service. Submitting multiple claims for a single date of service can result in the incorrect adjudication of a claim and the incorrect allocation of a member’s benefits. BCBSIL has identified that billing in this manner for immunization administration has resulted in reimbursement greater than what would have been received if the claim were properly filed on a single claim.

Providers may be receiving refund requests for those claims identified as being paid incorrectly. Provider-identified overpayments for immunization administration can be refunded to BCBSIL via the Electronic Refund Management (eRM) tool. Additional eRM information can be found in the Education and Reference/Provider Tools section of our Provider website.

CPT copyright 2012 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

2013 Blue Star Hospital ReportSM

BCBSIL is committed to helping members make informed health care decisions. As part of BCBSIL's transparency initiative, the 2013 Blue Star Hospital Report is now available on the BCBSIL website.

The purpose of the Blue Star Hospital Report is to provide employers and members with information about indicators for which hospitals have demonstrated high levels of performance.

The 2013 Blue Star Hospital Report, based on the 2013 Annual BCBSIL Hospital Profile, summarizes the results related to quality, patient safety and efficiency measures for 104 Illinois hospitals.

Hospital profiles are compiled using data collected from multiple sources, including BCBSIL claims data, information provided by the hospitals and publicly available information from entities such as the Centers for Medicare & Medicaid Services (CMS). BCBSIL uses the most current data available at the time the Profile is prepared. However, there may be more current information for the Experience, Outcome and Process measures available at medicare.gov/hospitalcompare and healthcarereportcard.illinois.gov.

For the 2013 Blue Star Hospital Report, each hospital's performance is reported for indicators in six categories: Structure, Process, Outcome, Patient Experience, Efficiency and Informed Decision-Making. One blue star can be earned for each indicator, for a maximum of six blue stars.

The 2013 Blue Star Hospital Report can be found on the BCBSIL website at: bcbsil.com/pdf/clinical/blue_star_report.pdf.

The Blue Star Hospital Report is not a guarantee of a particular outcome or the quality of care rendered by any hospital. Individual results may vary.

Pharmacy Program Introduces Electronic Prior Authorization Process

As mentioned in last month's *Blue Review*, BCBSIL has enhanced the process for submitting Prior Authorization (PA) requests for drugs that are part of our PA program.

Previously, the only option was to download and print a PA form, complete it by hand and submit it via fax. With this process, providers had no confirmation upon receipt, often causing needless resubmission. Additionally, the fax request process typically resulted in phone calls to providers regarding deletion of duplicate requests, member ineligibility, missing or illegible information.

We're pleased to announce an alternative to faxed PA requests. Now, when you visit our website at bcbsil.com/provider, you'll find a new Electronic Prior Authorization link in the Pharmacy Program/Prior Authorization and Step Therapy section. This link takes you to the login page for CoverMyMeds®, an online tool with a list of BCBSIL forms that can be completed and submitted electronically.

Electronic Prior Authorization requests have many advantages, including:

- Immediate confirmation upon receipt
- No need to resubmit or call to check status
- Connects the pharmacy with the physician

HERE'S HOW IT WORKS:

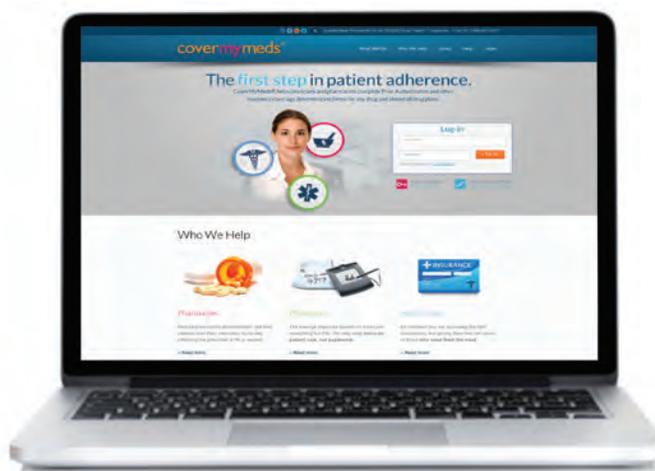
From the CoverMyMeds login page, new users can select *Create an Account* to sign up and create a password. CoverMyMeds will confirm that you are a BCBSIL contracted provider prior to granting access. If there are any questions, a live chat feature is available. There is no cost to use CoverMyMeds.

When a request is initiated, CoverMyMeds will first check eligibility to verify that the patient is a BCBSIL member who has Prime Therapeutics as their pharmacy benefit manager. After you submit your request, you'll receive an immediate confirmation with details on when the determination will occur. Upon approval, you'll receive an electronic notification from CoverMyMeds. Likewise, the member's pharmacy is contacted with the decision and pending claims can then be processed accordingly.

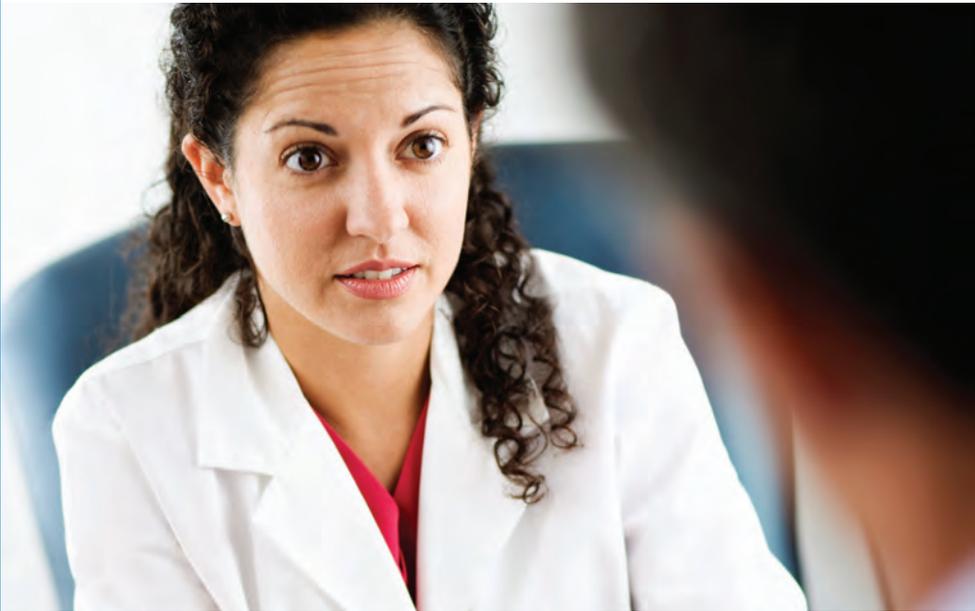
Additional enhancements will be announced in the coming months. Watch for more details in the *Blue Review* and News and Updates section of our Provider website.

CoverMyMeds is a registered trademark of CoverMyMeds LLC, an independent third party vendor that 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. If you have any questions regarding the products or services they offer, you should contact the vendor(s) directly.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSIL contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.



The *Choosing Wisely*[®] Campaign



Can improved communication in health care be a key component to improved use of finite clinical resources? A current initiative of the American Board of Internal Medicine (ABIM) concludes, yes. *Choosing Wisely* is an ABIM program designed to foster the appropriate and cost-effective use of health care resources by conveying to all physicians and their patients key insights from 50 clinical specialty groups. In recognition of the considerable waste in the U.S. health care system, ABIM has compiled those insights in the form of five recommendations from each specialty group that identify tests or treatments whose appropriateness should be critically assessed by doctor and patient rather than assumed.

While recognizing that there are situations in which the identified services are appropriate, *Choosing Wisely* seeks to limit their use to medically necessary situations, thereby promoting medical professionalism, physician-patient dialogue and care that is best suited to the individual. The medical practices in question include the use of antibiotics to treat apparently viral respiratory infections (the American Academy of Pediatrics), electroencephalography (EEG) to diagnose headaches (the American Academy of Neurology) and induced labor or cesarean section delivery before 39 weeks of gestation when not medically indicated (the American College of Obstetricians and Gynecologists).

Choosing Wisely is an outgrowth of a pilot project conducted by the National Physicians Alliance (NPA), working through a grant by the ABIM, in which NPA members in the fields of family medicine, internal medicine and pediatrics identified and field tested a dozen of the most common clinical activities in their fields that could be used more judiciously.

The non-profit organization, Consumer Reports, is supporting the *Choosing Wisely* campaign by coordinating the efforts of other consumer organizations to inform the public of the need for patients to engage in conversations with their physicians about the most safe, effective and efficient care.

Information about *Choosing Wisely*, including the specialty society Lists of Five Things Physicians and Patients Should Question, is available at choosingwisely.org.

Choosing Wisely is an initiative sponsored by the ABIM Foundation that is solely responsible for the program. BCBSIL makes no representations or warranties regarding the *Choosing Wisely* program or any of its components.

Annual Physician/ Practitioner Surveys

We want to hear from you! HMO Primary Care Physicians (PCPs) and randomly selected independently contracted PPO physicians will be receiving our 2013 Physician/Practitioner surveys.

The surveys are performed annually to help analyze physician experience with BCBSIL and with the practitioner's primary hospital. The HMO survey includes questions about operational, service and reporting activities that HMO Medical Groups/Independent Physician Associations (MGs/IPAs) and BCBSIL conduct. PCPs that contract with more than one HMO IPA site will receive a separate survey for each entity for which they are contracted. The PPO surveys include questions about operational, service and reporting activities that BCBSIL conducts.

BCBSIL has consistently maintained the confidentiality of all respondents to the surveys. A number on the survey identifies the respondent to assure that we do not record more than one set of answers per respondent. Aggregate results are reported to BCBSIL operating areas and the HMO MG/IPA sites without identification of individual physicians.

The survey questions are addressed directly to the practitioners. However, office staff may be more familiar with some activities, and they may provide assistance in completing the survey. Some questions may not apply to the experience of the practitioner or their office staff. "No experience" is always an acceptable response when it applies.

Please return all completed surveys in the postage-paid envelope within 10 business days of receipt.



Ancillary Provider Network Consultants

BCBSIL contracts with more than 2,000 ancillary providers in Illinois and Northwest Indiana. Our Ancillary Provider Network Consultant (PNC) team focuses specifically on the services provided by Skilled Nursing Facilities, Home Health Agencies, Hospice, Home Infusion Therapy, Durable Medical Equipment suppliers, Orthotics and Prosthetics, Dialysis Centers and Private Duty Nursing agencies.

Meet your Ancillary PNC:

The following Ancillary PNC is available to meet with you and your staff regarding BCBSIL policies and procedures, billing and contractual issues:

- **Elaine Williams, 312-653-4305**

You may also direct your requests and inquiries to our general email box at ancillarynetworks@bcbsil.com, or leave a message at 312-653-4820.



BlueCross BlueShield of Illinois

Professional Provider Network Consultant Assignments (Revised September 2013)

Our Professional Provider Network Consultants (PNCs) serve as the liaison between BCBSIL and our independently contracted professional provider community, developing and maintaining cooperative working relationships with professional providers in our network throughout Illinois and Northwest Indiana.

If you are an ancillary provider (DME, home infusion therapy, skilled nursing facility, home health, hospice, orthotics/prosthetics, dialysis, private duty nursing), your PNC is Elaine Williams at 312-653-4305 or ancillarynetworks@bcbsil.com.

To find your Professional PNC, refer to this Illinois county map. PNCs for professional providers in Cook and DuPage Counties (Codes 16 and 22) are assigned by either Chicago ZIP code or city, as listed below.

ILLINOIS TERRITORY BREAKDOWN BY COUNTY CODE

Northern (8, 43, 49, 81, 89 and 98) – **Gina Plescia**

Southern (2, 3, 12, 13, 14, 15, 17, 18, 24, 25, 26, 28, 30, 33, 35, 39, 40, 41, 44, 51, 60, 61, 64, 67, 73, 76, 77, 79, 80, 82, 83, 84, 87, 91, 93, 95, 96, 97 and 100) – **Teresa Trumbley**

West-Central (1, 5, 7, 9, 11, 29, 31, 34, 36, 42, 55, 59, 63, 65, 66, 68, 69, 75, 85, 86 and 94) – **Roy Pyers**

East-Central (10, 20, 21, 23, 27, 38, 53, 54, 57, 58, 70, 72, 74, 90, 92 and 102) – **Amanda Williams**

North Metro (4, 6, 19, 37, 45, 47, 48, 50, 52, 56, 62, 71, 78, 88 and 101) – **Cathy Dismuke**

South Metro (32, 46 and 99) – **Adam Kwiecien**

Northwest Indiana – **Lynn Sorensen**

Cook County (16) – See below for Cook and DuPage County Breakdown

DuPage County (22) – See below for Cook and DuPage County Breakdown

COOK AND DUPAGE COUNTY BREAKDOWN BY CITY AND ZIP CODE

Adam Kwiecien – City: Lemont

Ana Hernandez – ZIP Codes: 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610, 60611, 60612, 60614, 60616, 60622, 60634

Cathy Dismuke – Cities: Addison, Bartlett, Bloomingdale, Hanover Park, Hillisburg, Medinah, Roselle, Streamwood, Wayne

Gina Plescia – Cities: Arlington Heights, Elk Grove Village, Hoffman Estates, Schaumburg

Lynn Sorensen – Cities: Aurora, Burr Ridge, Calumet City, Chicago Heights, Darien, Dolton, Flossmoor, Ford Heights, Glen Ellyn, Glendale Heights, Glenwood, Homewood, Lansing, Lisle, Lynwood, Matteson, Naperville, Olympia Fields, Park Forest, Richton Park, Riverdale, Sauk Village, South Holland, Steger, Summit, Thornton, Warrenville, Willowbrook, Woodridge

Michelle Brownfield-Nance – Cities: Calumet Park, Carol Stream, Country Club Hills, Countryside, Crestwood, Downers Grove, Harvey, Hazel Crest, Hickory Hills, Homer Glen, Markham, Midlothian, Oak Forest, Orland Hills, Orland Park, Palos Heights, Palos Hills, Palos Park, Posen, Robbins, Tinley Park, West Chicago, Wheaton, Willow Springs, Winfield, Worth

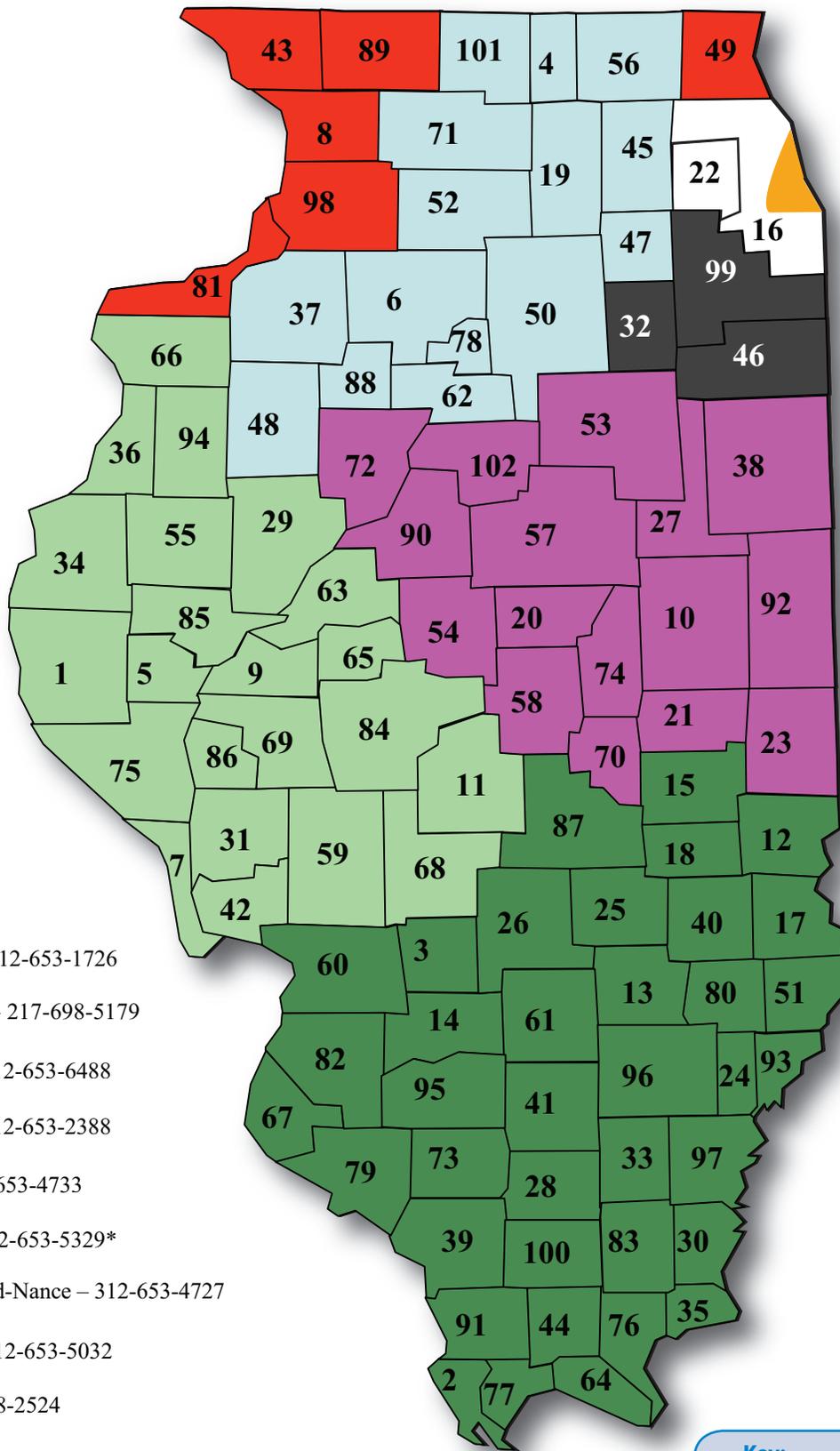
Ramona Espino – Cities: Bensenville, Clarendon Hills, Des Plaines, Elmhurst, Evanston, Glencoe, Glenview, Golf, Hinsdale, Inverness, Itasca, Kenilworth, Lincolnwood, Lombard, Morton Grove, Mt. Prospect, Neenah, Niles, Northbrook, Northfield, Oak Brook, Oak Brook Terrace, Palatine, Prospect Heights, Rolling Meadows, Rosemont, Skokie, South Barrington, Villa Park, Westmont, Wheeling, Wilmette, Winnetka, Wood Dale

Tyrone Sturgis – ZIP Codes: 60608, 60609, 60613, 60615, 60617, 60618, 60619, 60620, 60621, 60623, 60624, 60625, 60626, 60627, 60628, 60629, 60630, 60631, 60632, 60633, 60635, 60636, 60637, 60638, 60639, 60640, 60641, 60642, 60643, 60644, 60645, 60646, 60647, 60648, 60649, 60650, 60651, 60652, 60653, 60654, 60655, 60656, 60657, 60658, 60659, 60660, 60661, 60666, 60668, 60669, 60670, 60673, 60674, 60675, 60676, 60677, 60678, 60680, 60681, 60686, 60689, 60690, 60693, 60694, 60695, 60696

Vickey Jones – Cities: Alsip, Bellwood, Berkeley, Berwyn, Blue Island, Bridgeview, Broadview, Brookfield, Burbank, Chicago Ridge, Cicero, Elmwood Park, Evergreen Park, Forest Park, Franklin Park, Harwood Heights, Hillside, Hines, Hometown, Indian Head Park, Justice, Knoxville, La Grange, La Grange Park, La Grange Highlands, Lyons, Maywood, Melrose Park, Merrionette Park, Norridge, North Riverside, Northlake, Oak Lawn, Oak Park, Park Ridge, River Forest, River Grove, Riverside, Schiller Park, Stone Park, Summit Argo, Westchester, Western Springs

Code	County
1	Adams
2	Alexander
3	Bond
4	Boone
5	Brown
6	Bureau
7	Calhoun
8	Carroll
9	Cass
10	Champaign
11	Christian
12	Clark
13	Clay
14	Clinton
15	Coles
16	Cook
17	Crawford
18	Cumberland
19	DeKalb
20	Dewitt
21	Douglas
22	DuPage
23	Edgar
24	Edwards
25	Effingham
26	Fayette
27	Ford
28	Franklin
29	Fulton
30	Gallatin
31	Greene
32	Grundy
33	Hamilton
34	Hancock
35	Hardin
36	Henderson
37	Henry
38	Iroquois
39	Jackson
40	Jasper
41	Jefferson
42	Jersey
43	JoDavies

Code	County
44	Johnson
45	Kane
46	Kankakee
47	Kendall
48	Knox
50	LaSalle
49	Lake
51	Lawrence
52	Lee
53	Livingston
54	Logan
58	Macon
59	Macoupin
60	Madison
61	Marion
62	Marshall
63	Mason
64	Massac
55	McDonough
56	McHenry
57	McLean
65	Menard
66	Mercer
67	Monroe
68	Montgomery
69	Morgan
70	Moultrie
71	Ogle
72	Peoria
73	Perry
74	Piatt
75	Pike
76	Pope
77	Pulaski
78	Putnam
79	Randolph
80	Richland
81	Rock Island
83	Saline
84	Sangamon
85	Schuyler
86	Scott
87	Shelby
82	St Clair
88	Stark
89	Stephenson
90	Tazewell
91	Union
92	Vermilion
93	Wabash
94	Warren
95	Washington
96	Wayne
97	White
98	Whiteside
99	Will
100	Williamson
101	Winnebago
102	Woodford



- Adam Kwiecien – 312-653-1726
- Amanda Williams – 217-698-5179
- Ana Hernandez – 312-653-6488
- Cathy Dismuke – 312-653-2388
- Gina Plescia – 312-653-4733
- Lynn Sorensen – 312-653-5329*
- Michelle Brownfield-Nance – 312-653-4727
- Ramona Espino – 312-653-5032
- Roy Pyers – 217-698-2524
- Teresa Trumbley – 618-998-2528
- Tyrone Sturgis – 312-653-4208
- Vickey Jones – 312-653-6321

Key:

- Cook County (16) and DuPage County (22) are split between Ana, Cathy, Gina, Lynn, Michelle, Ramona, Tyrone and Vickey.
- City of Chicago is split between Ana and Tyrone.
- *NW Indiana is assigned to Lynn.

Provider Learning Opportunities

BCBSIL WEBINARS AND WORKSHOPS

Below is a list of complimentary training sessions sponsored by BCBSIL. For details and online registration, visit the Workshops/Webinars page in the Education and Reference Center of our website at bcbsil.com/provider.

WEBINARS

iEXCHANGE® Webinars

iEXCHANGE is a Web-based application that can be used to submit transaction requests for inpatient admissions and extensions, treatment searches, provider/member searches and select outpatient services and extensions. Customized training is available upon request.

To view available topics, visit the Workshops/Webinars page in the Education and Reference Center on our website at bcbsil.com/provider.

To request training, contact us at ixchange_helpdesk@bcbsil.com and include your name, telephone number and the topics of interest.

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 for details; or call Availity Client Services at 800-AVAILITY (282-4548) for assistance.

Availity is a registered trademark of Availity, L.L.C., an independent third party vendor.

BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by Availity. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

NEW ACCOUNT GROUPS

Group Name	Group Number	Alpha Prefix	Product Type	Effective Date
Abbott Laboratories	053607, 054632, 053634	LRX	BlueEdge HSA SM (Portable)	Jan. 1, 2014
Advocate Health Care Network	P64547	EAD	PPO (Portable)	Jan. 1, 2014
Century Aluminum	652380, 652381 P57870, P57892, P57894, P57896, P57897, P57900, P57901, P57918, P57926, P57934	XOT CFR	CMM PPO (Portable)	Jan. 1, 2014
Columbia College of Chicago	257276	CCF	PPO (Portable)	Jan. 1, 2014
Diversified FoodService Supply Inc.	P58051, P67148 P67157	DFZ DFZ	PPO (Portable) BlueEdge HSA (Portable)	Jan. 1, 2014
Domtar Corporation	775851	DMA	PPO (Portable)	Nov. 1, 2013
Evergreen Packaging	757641 - 757649	EMG	BlueEdge HCA (Portable)	Jan. 1, 2014
Fuchs Lubricant Company	P63089	XOF	PPO (Portable)	Jan. 1, 2014
Graham Packaging	775703 - 775710	GPA	PPO (Portable)	Jan. 1, 2014
Grant Thornton	053691	GTH	BlueEdge HSA (Portable)	Jan. 1, 2014
Komatsu America Corporation	053584	KOM	PPO (Portable)	Jan. 1, 2014
Med HQ, LLC	P64297, P64314, P64315, P64316	XOF	BlueEdge HSA (Portable)	Nov. 1, 2013
Pacific Langham Chicago Corporation	B00594	XOH	Blue Advantage HMO SM	Oct. 1, 2014
Sears Hometown and Outlet Stores	463629 463630, 463631	SED SED	BlueEdge HSA (Portable) PPO (Portable)	Jan. 1, 2014
United Stationers	721730-721733	UTC	BlueEdge HSA (Portable)	Jan. 1, 2014
Walgreens	887641-887650	WAG	PPO (Portable)	Jan. 1, 2014
Wolters Kluwer	759677	WLM	PPO (Portable)	Jan. 1, 2014

NOTE: Some of the accounts listed above may be new additions to BCBSIL; some accounts may already be established, but may be adding member groups or products. The information noted above is current as of the date of publication; however, BCBSIL reserves the right to amend this information at any time without notice. The fact that a group is included on this list is not a guarantee of payment or that any individuals employed by any of the listed groups, or their dependents, will be eligible for benefits. Benefit coverage is subject to the terms and conditions set forth in the member's certificate of coverage.

Reducing Elective Preterm Deliveries



Obstetrical practice in recent decades has been marked by two conflicting trends. The rate of induced deliveries or cesarean sections before 39 weeks when not medically indicated has risen sharply, but so has the clinical evidence that elective deliveries before full term increase medical risks to baby and mother.

From 1990 to 2008, the U.S. rate of elective preterm deliveries jumped from less than 10 percent to over 23 percent, for a variety of reasons. Physicians may favor such deliveries for scheduling, liability, reimbursement and patient satisfaction reasons. Some patients appreciate the flexibility of early elective deliveries in allowing their preferred physician or family members to attend the delivery, ending the discomforts of pregnancy, avoiding certain dates or enabling an income tax deduction. Hospitals may seek to facilitate scheduling and staffing, increase patient and provider satisfaction and maximize market share.

However, clinical research shows that elective preterm deliveries present greater health risks than full-term deliveries. Elective births between 37 and 39 weeks of gestation raise rates of NICU admission, ventilator support, transient newborn tachypnea, respiratory distress syndrome, suspected or confirmed sepsis and newborn feeding issues. Morbidity rates double for elective delivery each week prior to the 38th week of gestation, and even during the 38th week, elective deliveries raise the NICU admissions rate by a factor of 2.3. Women with elective deliveries in the 37th and 38th week have a much higher risk of cesarean delivery than women with spontaneous delivery and this can lead to cesarean sections with subsequent deliveries. Elective early deliveries have been associated with other post-partum complications, including hematoma, wound dehiscence, anemia, endometriosis, urinary tract infection and sepsis.

There has been limited success in reducing the rate of elective early deliveries through programs informing women of their increased risks or informing providers about the relevant AAP and ACOG guidelines. Likewise, certain “soft-stop” physician peer review programs have been only mildly effective. Greater success has been achieved by hospital “hard-stop” programs that do not allow scheduling or performance of elective preterm deliveries. One hospital system with such a program decreased its rate of those deliveries over four years from 30 percent to two percent. The compelling evidence of the greater risks of elective early deliveries is persuading many hospitals to implement policies that discourage or prohibit their use.

For further information on this issue, visit <http://www.marchofdimes.com/mission/39-weeks-quality-improvement.aspx>.

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.

Effective Oct. 1, 2013, code 90688 was updated.

Effective Feb. 1, 2014, all allowances that are currently \$00.01 will be updated to be \$00.00.

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 Provider website at bcbsil.com/provider.



Claim Number Format Change on Electronic Payer Responses

BCBSIL assigns a Document Control Number (DCN) to each claim we receive. This DCN allows us to monitor claim volumes while tracking the progress of each individual claim throughout the process.

For electronic claims, you or your billing service or clearinghouse can find the DCN on the electronic payer response report. Currently, the DCN on your payer response contains a combination of 12 alpha and numeric characters, such as 123456A7891X.

Effective Oct. 13, 2013, the DCN was enhanced so that the second to last character in the sequence will always be a zero as in the following example: 123456A78910X. When you are conducting research on a particular claim, be sure to reference the enhanced DCN for faster, more accurate results.

If you have any questions regarding this notice, please contact our Electronic Commerce Center at 800-746-4614.



Risk Adjustment

Risk Adjustment is a provision of the ACA and is intended to help promote the success of the law's new Health Insurance Marketplace. Risk Adjustment levels the playing field by discouraging adverse selection of members and is accomplished via a two-step process: risk assessment, which evaluates the health risk status of an individual to create a clinical profile; and rate adjustment, which determines the resource utilization needed to provide medical care to an individual. The Risk Adjustment methodology serves as a mechanism to convey the illness burden a provider is managing within their patient population, thus allowing for a fairer comparison of quality outcomes and cost performance.

Comprehensive documentation and accurate diagnosis coding is critical for accurate risk assessment, which is the basis of Risk Adjustment. Accurate coding assists in the following matters:

- Identification of patients that may benefit from disease and medical management programs
- Appropriation of health care needs based on accurate health status representation
- Ability to convey a complete picture of a patient's conditions to facilitate assignment of diagnosis codes to the highest level of specificity
- An accurate picture of the patient's health status
- Clinical documentation programs to provide guidance with regards to documentation standards

Another consideration is the Oct. 1, 2014, transition from ICD-9-CM to ICD-10-CM. As we draw closer to the Jan. 1, 2014, implementation date for the Risk Adjustment provision of ACA, we will take a deeper dive into compliant ICD-9-CM and ICD-10-CM diagnosis coding and documentation for four of the most common chronic conditions.

Over the next several months, the *Blue Review* will feature documentation and coding information for behavioral/mental health disorders, chronic kidney disease, diabetes mellitus and pulmonary disorders. The goal of the series is to provide a review of accurate and compliant documentation to support best coding practices. The series will:

- Provide an overview of each chronic condition
- Identify common examinations/tests that aid in diagnosing each chronic condition
- Feature common signs and symptoms associated with each chronic condition
- Take a closer look at risk factors, comorbidities and complications of each chronic condition
- Identify common medications associated with each chronic condition
- Provide differences and similarities of ICD-9-CM and ICD-10-CM diagnosis code structure

Please watch for upcoming issues of the *Blue Review* featuring additional information and updates on documentation and coding information.

For additional background information related to Risk Adjustment and the potential impact to Provider Practices, please refer to the September 2012, *Blue Review*.

How important is your documentation for ICD-10?

The countdown to the transition to ICD-10 has begun, and we are less than a year away. The U.S. Department of Health and Human Services (HHS) has required all HIPAA-covered entities to make the switch from ICD-9 to ICD-10 on Oct. 1, 2014. In previous issues of the *Blue Review*, we've shared resources for planning, tips for evaluating technology vendors, information about education, training and more. All of these elements are part of one core objective that links ICD-10 to many other health care initiatives: improving documentation.

Many larger practices and hospitals have already implemented Clinical Documentation Improvement (CDI) programs as more quality initiatives and compliance requirements are implemented across the industry. Even without a formal CDI program, smaller practices should assess their documentation processes as they prepare for ICD-10, Risk Adjustment and other initiatives dependent on accurate documentation.

A patient's diagnoses and procedures performed is documented in their medical record, and this information often travels from the front desk to physicians, nurses, coding professionals, billing staff, insurance carriers, government entities and accreditation organizations. Transitioning from ICD-9 to ICD-10 requires everyone involved along the continuum of patient care to understand the greater specificity of ICD-10, and to be able to capture the relevant new information that needs to be recorded with ICD-10.

The good news is that if providers are currently documenting accurately, coders will have much of the information they need to code with ICD-10. If physicians aren't providing detailed documentation now, this is the time to make those documentation improvements to help coders accurately describe the information from the medical record.

One of the major changes in ICD-10 is the ability to record laterality in many applicable diagnoses. Many codes also require identifying the encounter— whether it is initial, subsequent or sequela.

Consider the following example: A patient was treated for a compound fracture of the right tibia and fibula after being struck by a car. The ICD-9 code would likely be 823.92, fracture of tibia and fibula unspecified part, open. For ICD-10 coding, the coder must know:

- Which leg and which specific bone(s) the patient injured (in this example, the right tibia and fibula)
- Whether the fracture is open or closed
- Whether the fracture is displaced
- For open fractures – need to know type of trauma to choose the appropriate character from Gustilo-Anderson classification system
- The severity of the soft-tissue damage
- Whether the encounter sequence is initial, subsequent or sequela

This will give the coder the necessary information to determine the ICD-10 codes of S82.201A, unspecified fracture of shaft of right tibia, initial for closed fracture; and S82.401A, unspecified fracture of shaft of right fibula, initial for closed fracture.

Watch for more ICD-10 coding examples and information about documentation practices in upcoming issues of the *Blue Review*. More information about ICD-10 can be found in the Standards and Requirements section of our website at bcbsil.com/provider. And for transition planning resources, visit the CMS website at cms.gov/icd10.

The information in this article is for illustrative purposes only. The actual process and coding of a patient's medical condition will vary based on the individual circumstances and the information contained in the medical records.

Medicare Part D Pharmacy Updates

Every month, we post a new Medicare Part D-related article in the Pharmacy Program section of our website at bcbsil.com/provider. These articles are intended to help keep you up-to-date on Medicare Part D formulary changes, U.S. Food and Drug Administration (FDA) safety updates, Part D Gap strategies, overlapping coverage between Part B and Part D drugs and more.

Why is Estrogen Replacement Therapy Considered a Potentially High Risk Medication?

Recent additions to our online Medicare Part D Pharmacy library include an article titled *Why is Estrogen Replacement Therapy Considered a Potentially High Risk Medication?* This article touches on the following topics:

- Use of potentially High Risk Medications (HRMs) in the elderly population
- The updated 2012 BEERS Criteria current recommendation
- Position statement of the North American Menopause Society (NAMS) on hormone therapy
- Potential risks of estrogen therapy (ET) and estrogen-progestin therapy (EPT)

Visit the Medicare Part D Pharmacy Updates library in the Pharmacy Program section of our website at bcbsil.com/provider for the complete article, along with first and second quarter Medicare Part D Formulary Updates for 2013, and additional articles, such as *Testosterone Therapy in the Elderly, Pharmacy Update: FDA Issues New Dosing Recommendations for all zolpidem-containing Products* and *Pharmacy Update: Ranbaxy Pharmaceuticals atorvastatin Recall*.



Enhanced Voucher Numbering Process

BCBSIL is enhancing the numbering system for vouchers used for payments to providers. The current process generates zeros as place holders in the voucher number field when no payment is being issued to a provider. The system will now create a new eight character voucher number beginning with the letter "N" and subsequent unique seven digit number. The generation of a valid voucher number eliminates the problems caused when all zeros were used to indicate no payment on the Electronic Payment Summary (EPS) and paper Provider Claim Summary (PCS).

Additionally, the format for voucher numbers provided in the Electronic Remittance Advice (ERA) data is changing to include a new date prefix and suffix built around the voucher number. In the following example, C13nnnN12345670, the new format reads:

- C (claims)
- 13 (year)
- nnn (Julian calendar date)
- N1234567 (voucher number)
- 0 (sequence number)

This new format will help improve the accuracy and efficiency of these electronic and paper transactions.

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:

BLUE REVIEW

Blue Cross and Blue Shield of Illinois
300 E. Randolph Street – 24th Floor
Chicago, Illinois 60601-5099

Email: blureview@bcbsil.com

Website: bcbsil.com/provider

Publisher:

Stephen Hamman, Vice President, Network Management

Editor:

Wes Chick, Senior Director, Provider Relations

Managing Editor:

Jeanne Trumbo, Senior Manager, Provider Communications

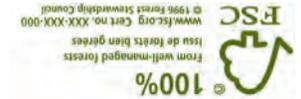
Editorial Staff:

Margaret O'Toole, Marsha Tallerico, Michael Chaney

BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors mentioned in this newsletter. The vendors are solely responsible for the products or services offered by them. If you have any questions regarding any of the products or services mentioned in this periodical, you should contact the vendor directly.

VISIT OUR WEBSITE AT BCBSIL.COM/PROVIDER

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
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.
00014.1113



FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS



PRSR STD
U.S. POSTAGE
PAID
PERMIT NO. 581
CHICAGO, IL