BlueCross BlueShield of Illinois

Blue REVIEW℠

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS

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2014 Annual HMO and PPO HEDIS® Reports

Each year, BCBSIL reports audited Health Care Effectiveness Data and Information Set (HEDIS) results. HEDIS is a nationally standardized set of measures related to important areas of care and service. Developed by the National Committee for Quality Assurance (NCQA), it is one of the most widely used set of health care performance measures in the U.S. ***Read more about the 2014 Annual HMO and PPO HEDIS Reports on pages 6 and 7.***

Open Enrollment: Helping Your Patients Shop with Confidence

For more than 75 years, Blue Cross and Blue Shield of Illinois (BCBSIL) has demonstrated a firm commitment to providing excellent customer service as well as expanding access to cost-effective, quality health care coverage for our members. As a recognized leader in the health insurance industry, our portfolio of product offerings continues to grow and change in response to market innovations and customer demands.

While the majority of our membership comes from employer groups, our retail and government program member population is growing as well. The number of new BCBSIL members increased significantly after the first open enrollment period under the Affordable Care Act (ACA) last year, but there still are millions of uninsured people to reach.

Open enrollment on Get Covered Illinois, the Official Health Marketplace begins Nov. 15, 2014, and BCBSIL is ready. In addition to first-time shoppers, many of our current members will be renewing for the first time. Where applicable, some members may be migrating from their current policies to new ACA-compliant plans. This means that some of your current patients may be shopping for a new plan and will need to know if they can still see you as an in-network provider. Or, you may receive calls from prospective patients who are doing preliminary research before they make a decision.

Educating consumers is critical, particularly during open enrollment. Our October 2014 *Blue Review* included updates on the Be Covered Illinois and Know Your Network℠ educational campaigns, each of which offers a library of online resources and printed materials for you to share with your patients.

We would also like to call your attention to a new brochure that may be helpful if your patients come to you with questions. The brochure is titled, ***Understanding Health Insurance – Your Guide to the Affordable Care Act***. It is available in English and Spanish and offers quick tips and sample scenarios to help your patients understand some of the basics, such as:

- Why health insurance is necessary
- When and how to purchase a health insurance plan
- Financial considerations, special programs and exceptions
- Description of the four plan levels (Bronze, Silver, Gold, Platinum)
- Guaranteed coverage overview (essential health benefits and preventive services)
- Definitions of key terms, such as *premium, deductible, copayment, out-of-pocket maximum* and *in-network provider*

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Reminder: Register for a Remittance Viewer Webinar

BCBSIL is offering complimentary webinars for our independently contracted providers to learn about the new remittance viewer tool. Remittance viewer is an online tool that offers providers and billing services a convenient way to view claim detail information from the 835 Electronic Remittance Advice (835 ERA).

Our webinars are designed to help new users learn how to gain or grant access, conduct a search, view general and payer-specific information, and save or print results. To register for an upcoming webinar, visit the BCBSIL Provider website at *bcbsil.com/provider* where you'll find upcoming webinar dates, times and other helpful resources in the Education and Reference/Workshops/Webinars section.

Open Enrollment: Helping Your Patients Shop with Confidence

(continued from p. 1)

The brochure also includes a list of questions to help the newly insured prepare for next steps, once they've decided on a health care plan. The information is organized to call the reader's attention to important details, such as how to make premium payments, what's on the member ID card, how to find a primary care physician and the importance of confirming in-network provider status.

To view the *Understanding Health Insurance – Your Guide to the Affordable Care Act* brochure, visit the Standards and Requirements/Affordable Care Act/Patient Perspective section of our website at *bcbsil.com/provider*. If you would like to order printed copies of this brochure and other materials you can share with your patients, please contact your assigned Provider Network Consultant.

For additional information on open enrollment and ACA-related resources, please watch upcoming issues of the *Blue Review* as well as the News and Updates section of our Provider website.

This communication is intended for informational purposes only. It is not intended to provide, does not constitute, and cannot be relied upon as legal, tax or compliance advice. The information contained in this communication is subject to change based on future regulation and guidance.

Benefits Value Advisor Program Adds Member Outreach Component

As announced in our August 2014 issue of *Blue Review*, the Benefits Value Advisor (BVA) program was launched on Jan. 1, 2014. BVAs are BCBSIL representatives who are available to assist most BCBSIL PPO members with information to help them better understand their health care benefits, potential savings opportunities, clinical educational support, and appointment scheduling, among other services.

Beginning Jan. 1, 2015, some of your patients may receive an outreach call from a BVA representative regarding certain non-emergency, high-tech radiology imaging services you may have scheduled, such as MRIs and CT/CTA scans.

- The BVA may suggest options for lower cost, in-network imaging services.
- If the member accepts the recommended change, the BVA will help coordinate the services, such as scheduling the service and notifying AIM Specialty Health® (AIM).
- AIM will notify the ordering physician via email regarding the change in servicing facility and related Radiology Quality Initiative (RQI) information.

Please note that, while enhancements are ongoing, there is nothing you need to do differently when submitting RQI requests through AIM for high-tech imaging services. Our BVAs are available to help provide members with more information that may help them make better decisions concerning their health care.

For more information on the BCBSIL RQI program, refer to the Claims and Eligibility/Prior Authorization/High-tech Imaging Services section of our website at *bcbsil.com/provider*.

Member communications and information from Benefits Value Advisors are not meant to replace the advice of health care professionals and members are encouraged to seek the advice of their doctors to discuss their health care needs. Decisions regarding course and place of treatment remain with the member and his or her health care providers.

AIM Specialty Health is an operating subsidiary of WellPoint, Inc., 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 about the products or services offered by such vendors, you should contact the vendors directly.

Please note that the fact that a guideline is available for any given treatment, or that a service has been pre-certified or an RQI number has been issued 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, including, but not limited to, exclusions and limitations applicable on the date services were rendered. Certain employer groups may require pre-certification for imaging services from other vendors. If you have any questions, please call the number on the back of the member's ID card.

Choosing Wisely®: Imaging Tests for Low Back Pain

Most people experience low back pain at some time. Back pain can be severe, and imaging tests (MRI, CT, and/or conventional X-rays) are often performed in an attempt to identify the source of the pain. However, medical specialty groups, including the American Academy of Family Physicians and the American Society of Anesthesiologists – Pain Medicine, recommend not performing imaging tests for low back pain for at least six weeks, unless red flags are present.[1,2] These specialty recommendations were issued through a national program called *Choosing Wisely*. There are several reasons for the recommendations.

Most people with low back pain respond to conservative treatment such as exercise, heat, and over-the-counter pain medications. Use of imaging tests in the first six weeks has not been shown to reduce the length of time for pain to subside. The tests sometimes reveal incidental findings that divert attention and increase the risk of having unhelpful surgery. The radiation from X-rays and CT scans may also increase the risk of cancer.

Choosing Wisely notes that imaging studies should be performed promptly in some situations, such as when there are signs or symptoms of severe or worsening nerve damage (loss of bowel or bladder control, loss of muscle strength or feeling in the legs) or an underlying problem such as cancer or osteomyelitis. Other red flags suggesting that imaging should be considered include a history of trauma, unexplained weight loss, fever, known aortic aneurysm and recent infection.

Choosing Wisely aims to promote conversations between providers and patients in order to help patients choose care that is supported by evidence, truly necessary, free from harm and not duplicative of other tests or procedures. The information from *Choosing Wisely* is not a substitute for professional medical advice, diagnosis or treatment.

For additional information on low back pain and other tests and procedures that are not recommended in specific situations, refer to *Choosing Wisely* website at choosingwisely.org.

Choosing Wisely is an initiative sponsored by the American Board of Internal Medicine Foundation that is solely responsible for the program and its content. The material presented here is for informational purposes only and is not intended to be medical advice. BCBSIL makes no representations or warranties regarding the *Choosing Wisely* program or any of its components.

1. Crownover MD, Brian K. & Bepko MD, Jennifer L. (2013). Appropriate and Safe Use of Diagnostic Imaging. *Am Fam Physician, 87(7).* Retrieved from http://www.aafp.org/afp/2013/0401/p494.html
2. American Society of Anesthesiologists. (2014). Patients suffering from chronic pain should question certain tests and treatments. *The ASA Press Room.* Retrieved from https://www.asahq.org/For-the-Public-and-Media/Press-Room/ASA-News/Choosing-Wisely-2.aspx

Complex Case Management for HMO Members

Attention, HMO Physicians: Complex case management services may be available for your BCBSIL HMO Illinois®, Blue Advantage HMO℠ and Blue Precision HMO℠ members through your Medical Group/Independent Practice Association (MG/IPA). Your HMO patients may be added to this program if the HMO member has a complex chronic condition requiring multiple services and/or a specific acute condition. Please contact your MG/IPA for more information about this program.

The case management program is not a substitute for the sound medical advice of a doctor. Members are instructed to discuss any questions or concerns with their health care provider.

Medicare Part D Pharmacy Updates

Second Quarter 2014 Formulary Changes

The Pharmacy Program/Medicare Part D Updates section of our website at *bcbsil.com/provider* includes articles that are intended to help keep you up-to-date on Medicare Part D issues such as 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.

This month, we added the *Second Quarter 2014, Medicare Part D Formulary Updates* to our online library. This article includes a summary table of some of the more important BCBSIL Medicare Part D Formulary changes that may be of interest to you.

In addition to viewing a summary of recent formulary changes on the BCBSIL website, you may follow the instructions below to visit Prime Therapeutics' "MyPrime" website for a complete listing, along with other Medicare Part D formulary information for your BCBSIL patients.

1. Go to https://www.myprime.com
2. Click on **Continue without sign in**
3. Follow directions to
   - "Select your Health Plan" – **Click on BCBS Illinois**
   - "Medicare Part D Member?" – Select **YES**
   - "Select Your Health plan type"– Select **Blue Cross MedicareRx Value (PDP)**℠
   - Select **Continue to MyPrime**
   - Select **Find Medicines**
4. From this page you will be able to determine the formulary status and applicable utilization management programs for individual drugs or access any of the important databases outlined above.

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 Importance of Medication Adherence

To receive the full benefit of many medications, patients must adhere to the prescribed treatment regimen. However, many prescriptions are never filled, and all too often medication is not continued as prescribed. Medication adherence tends to be best when the patient has a short-term diagnosis and symptoms improve with medication, when medications are only needed once a day, do not have side effects and are low-cost.

BCBSIL member surveys have shown that about 40 percent of patients are concerned about the cost of their prescriptions. However, less than a third of the patients have discussed their concern of the medication cost with their doctor. One study showed that there are three "drivers of self-reported adherence: perceived concerns about medications, perceived need for medications and perceived affordability of medications."[1]

Education may help improve adherence. When prescribing medication, let the patient know:

- What the medicine is and what it is for
- How to take the medication
- Potential consequences if the patient does not take or discontinues the medication
- What side effects may occur
- If and when to anticipate a change in symptoms
- How long to continue the medication

While it is difficult for physicians to recognize non-adherence, this is an important consideration when patients do not respond to therapy as expected. Among the major predictors of poor adherence to medication are: psychological problems (particularly depression), cognitive impairment, treatment of asymptomatic disease, inadequate follow-up, medication side effects, a patient's lack of belief in the benefit of treatment, complexity of treatment, missed appointments and the cost of medication.[2]

Approaches that may help improve adherence include:

- Providing clear instructions
- Simplifying the regimen
- Discussing reminder systems such as pill boxes
- Involving family and friends when necessary
- Listening to the patient, and adjusting the regimen if necessary
- Educating the patient about why medications are important and risks if they don't take their medication
- If the patient is concerned about medication costs, considering whether a less expensive alternative would be appropriate

Work with your patients and develop plans with them for treatment that makes adherence more likely.

[1]McHorney CA, The adherence estimator: a brief, proximal screener for patient propensity to adhere to prescription medications for chronic disease. Curr Med Res Opin 2009;25:215-238.

[2]Osterberg L and Blaschke T, Adherence to medication. NEJM 2005;353:4587-497.

BCBSIL Behavioral Health Team Helps More Members after Program Enhancements

BCBSIL has established the Behavioral Health Case Management program. This program is designed to help members with complex mental health and substance abuse issues manage the unique challenges of their condition. The program also helps increase awareness and provides education to members about their behavioral health condition, benefits and treatment options.

For members who require more frequent interaction, case managers also help monitor medication adherence, coordinate crisis interventions and arrange individual support as needed. They also can assist members with transitions between levels of care and treatment settings.

Other benefits of the program include assisting members with locating specialists who are conveniently accessible, helping members understand how to utilize their behavioral health benefits and helping coordinate referrals between the physicians and other health care providers.

With the goal of increasing member engagement rates, the Behavioral Health team has implemented a number of enhancements to help target specific barriers that may have prevented our members from participating in the program:

- Since case managers were often unable to reach members during the workday, case managers have begun contacting members during nonstandard business hours.
- Additional training has been provided for case managers on motivational interviewing, identification of co-morbid behavioral health and medical conditions, and procedures to make real-time referrals. This additional training has helped case managers capitalize on opportunities to help integrate care between providers and the BCBSIL team.
- Behavioral health case managers have been placed on-site at specific facilities to encourage members to engage in case management during acute admissions.

As a result of these program enhancements, member engagement in the BCBSIL Behavioral Health Case Management program increased from 66.2 percent in December 2011 to 89.4 percent by March 2014.*

To learn more about the Behavioral Health Care Management and Quality Improvement programs, visit the Clinical Resources section of our website at *bcbsil.com/provider*.

The Case Management program is not meant to replace the independent opinion of the member's doctors. The final decision about treatment is made between the treating provider and the member. If you have a BCBSIL member who you believe may benefit from the Behavioral Health Case Management program, please call the number on the back of the member's ID card.

*Figures from quarter ending Dec. 31, 2011, compared to quarter ending March 31, 2014.

BCBSIL Simplifies Benefit Preauthorization Requirements for Psychological and Neuropsychological Testing

To help support member access and decrease the administrative burden for providers, BCBSIL is currently developing an alternative care management program for psychological and neuropsychological testing procedures.

As part of the new program, benefit preauthorization of psychological and neuropsychological testing may be required if BCBSIL determines that a provider's pattern of testing varies significantly from their provider peer group. Additionally, periodic auditing will be conducted by BCBSIL to evaluate that testing is consistent with the presenting clinical issue, medical policy and benefit plan design. If benefit preauthorization is required or testing is not consistent with the presenting clinical issue, medical policy and benefit plan design, BCBSIL will contact the provider to obtain additional information.

In light of the introduction of this new program, effective immediately, except for the situations described above, routine preauthorization of psychological and neuropsychological testing will no longer be required.

Additional details regarding the new care management program for psychological and neuropsychological testing will be announced in upcoming months.

Please note that the fact that a service has been preauthorized/pre-certified 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.

The benefit preauthorization program for psychological and neuropsychological testing is not meant to replace the independent medical opinion of the member's doctors. The final decision about any treatment or testing is between the treating provider and the member, regardless of any benefit determination.

2014 Annual HMO and PPO HEDIS Reports *(continued from p. 1)*

HMO HEDIS REPORT

The 2014 BCBSIL HMO HEDIS Report, which is based on 2013 data using HEDIS 2014 specifications, includes measures across domains of care that reflect: effectiveness of care, access/availability of care and utilization. Audited HEDIS results are reported for HMO Illinois® and Blue Advantage HMO℠ combined. The 2014 Quality Compass National Average rates are also included in this report for comparison of the HMO performance to the performance of other commercial health plans. The following table summarizes the HEDIS 2014 BCBSIL HMO rates for select measures. To learn more about the HMO Illinois and Blue Advantage HMO Quality Improvement Program, including goals, processes and outcomes related to member care and service, call 312-653-3465 and request information about the QI Program. The complete HMO HEDIS Report is available in the Clinical Resources/HEDIS section of the BCBSIL website at *bcbsil.com/provider*.

Care Provided to BCBSIL HMO Members	BCBSIL HMO HEDIS Rate	2014 Quality Compass National Average (excluding PPO)
Effectiveness of Care		
Prevention and Screening		
Adult BMI Assessment	92%	76%
Childhood Immunization Combination 3 Rate: 4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV, 4 PCV Combination 10 Rate: Combination 3 plus 1 Hep A, 2-3 RV, 2 Influenza	 76% 47%	 77% 49%
Breast Cancer Screening	74%	74%
Cervical Cancer Screening	83%	Not Reported
Colorectal Cancer Screening	61%	63%
Chlamydia Screening in Women – Age 16 - 24	42%	46%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: • BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity	 73% 66% 64%	 58% 57% 54%
Respiratory Conditions		
Appropriate Testing for Children with Pharyngitis	77%	81%
Appropriate Treatment for Children with Upper Respiratory Infection	84%	85%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	15%	26%
Use of Spirometry Testing In The Assessment and Diagnosis of COPD	37%	42%
Pharmacotherapy Management of COPD Exacerbation: • Dispensed systemic corticosteroid within 14 days of event • Dispensed bronchodilator within 30 days of event	 79% 85%	 76% 80%
Use of Appropriate Medications For People With Asthma – Total	93%	92%
Asthma Medication Ratio – Total	79%	80%
Cardiovascular Conditions		
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	61%	58%
Controlling High Blood Pressure <140/90 mm Hg	64%	64%
Persistence of Beta Blocker Treatment After a Heart Attack	82%	84%
Comprehensive Diabetes Care		
Hemoglobin A1c Control (<8.0%)	57%	59%
Eye Exam (retinal exam)	59%	56%
LDL-C Control (<100 mg/dL)	48%	47%
Medical Attention for Nephropathy	88%	84%
Blood Pressure Control <140/80 mmHg	42%	43%
Musculoskeletal Conditions		
Use of Imaging Studies in Low Back Pain	73%	75%
Medication Management		
Annual Monitoring for Patients on Persistent Medications – Total	78%	83%
Behavioral Health		
Follow-up After Hospitalization for Mental Illness: 7-Day Rate	63%	55%
Antidepressant Medication Management • Effective Acute Phase Treatment • Effective Continuation Phase Treatment	 66% 50%	 64% 47%
Follow-Up Care For Children Prescribed ADHD Medications (ADD): • Initiation Phase • Continuation & Maintenance Phase	 29% 35%	 40% 47%

Access/Availability of Care		
Adults' Access To Preventive/Ambulatory Health Service – Total	93%	95%
Children and Adolescents' Access To Primary Care Practitioners – Total	87%	Not Reported
Utilization		
Well-Child Visits in the First 15 Months of Life (6+ visits)	72%	79%
Measures Collected Through the CAHPS®* Health Plan Survey		
Flu Vaccinations for Adults Ages 18 - 64	49%	Not Reported
Aspirin Use and Discussion	44%	Not Reported

*Consumer Assessment of Healthcare Providers and Systems
CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

PPO HEDIS REPORT

The 2014 Quality Compass National Average rates are provided for comparison of the BCBSIL PPO performance to the performance of other commercial health plans. The following table summarizes the HEDIS 2014 BCBSIL PPO rates for select measures. The complete PPO HEDIS Report is available in the Clinical Resources/HEDIS section of the BCBSIL website at *bcbsil.com/provider*.

Care Provided to BCBSIL PPO Members Residing in Illinois	BCBSIL PPO HEDIS Rates	2014 Quality Compass National Average – PPO
Effectiveness of Care		
Prevention and Screening		
Breast Cancer Screening	71%	69%
Cervical Cancer Screening	77%	Not Reported
Colorectal Cancer Screening	54%	57%
Chlamydia Screening in Women – Age 16 - 24	39%	42%
Respiratory Conditions		
Appropriate Testing for Children with Pharyngitis	81%	78%
Appropriate Treatment for Children with Upper Respiratory Infections	84%	83%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	23%	24%
Use of Spirometry Testing In The Assessment and Diagnosis of COPD	39%	41%
Use of Appropriate Medications For People With Asthma – Total (Age 5 - 64)	93%	91%
Pharmacotherapy Management of COPD Exacerbation • Dispensed systemic corticosteroid within 14 days of event • Dispensed bronchodilator within 30 days of event	 77% 84%	 73% 79%
Asthma Medication Ratio – Total	81%	78%
Cardiovascular Conditions		
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	84%	83%
Persistence of Beta Blocker Treatment After a Heart Attack	84%	81%
Comprehensive Diabetes Care		
• Hemoglobin A1c (HbA1c) Testing	86%	87%
• LDL-C Screening	79%	81%
• Medical Attention for Nephropathy	69%	79%
Musculoskeletal Conditions		
Use of Imaging Studies in Low Back Pain	74%	74%
Medication Management		
Annual Monitoring for Patients on Persistent Medications – Total	79%	80%
Behavioral Health		
Follow-up After Hospitalization for Mental Illness: 7-Day Rate	52%	50%
Antidepressant Medication Management • Effective Acute Phase Treatment • Effective Continuation Phase Treatment	 68% 53%	 64% 49%
Follow-Up Care For Children Prescribed ADHD Medications • Initiation Phase • Continuation & Maintenance Phase	 44% 49%	 38% 45%
Access/Availability of Care		
Adults' Access To Preventive/Ambulatory Health Service Total	94%	94%

IN THE KNOW

Medical Records Submission 'Dos and Dont's'

In certain cases, BCBSIL may need to request additional information – such as medical records, operative reports or other supporting documentation – to process a claim. In such cases, the company will only request the minimum Protected Health Information (PHI) necessary per the Health Insurance Portability and Accountability Act (HIPAA).

It is very important that you submit only the information that is requested and only if it is requested. Below are some quick reminders on when and how to submit medical records and other information if you receive a request from BCBSIL.

DO:

- Use the letter you receive from BCBSIL as your cover sheet when submitting the requested information to us. This letter contains a barcode that will help the company match the requested information directly to the appropriate file and/or claim.
- Submit **only** the information that pertains specifically to what is requested by BCBSIL.

DON'T:

- Do not submit a Claim Review Form in addition to the letter you receive from BCBSIL, as this could delay the review process.

POST-ADJUDICATION INQUIRIES:

Do not automatically submit medical records for claims that have been denied due to "not a covered benefit" or similar reasons. If you submit medical records for claims that have already been denied for these reasons, you will receive a letter from BCBSIL alerting you that your request will not be reviewed as the services performed are not eligible for coverage under the patient's benefit plan.

New Products Offer More Choices and Potential Savings for Our Members

Our growing selection of new product offerings reflects BCBSIL's commitment to increasing access to affordable, quality health care services for our members. For example, Blue Options℠ and Blue Choice Options℠ are two new PPO products that offer a unique approach for members who prefer more flexibility when choosing a provider. These products will be effective Jan. 1, 2015, and are currently being marketed in the following Chicagoland counties: Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry and Will.

In conjunction with the Blue Options and Blue Choice Options products, BCBSIL is introducing a new Blue Choice OPT PPO℠ network, which will appear on our Provider Finder® as the Blue Choice or Blue Choice Options (BCO) network. The independently contracted providers that are participating in this network are identical to the providers in the Blue Choice PPO℠ network. **Therefore, if you are a participating provider in the Blue Choice PPO network or the broader PPO network, you will also be considered a participating provider in the Blue Choice or Blue Choice Options network**.

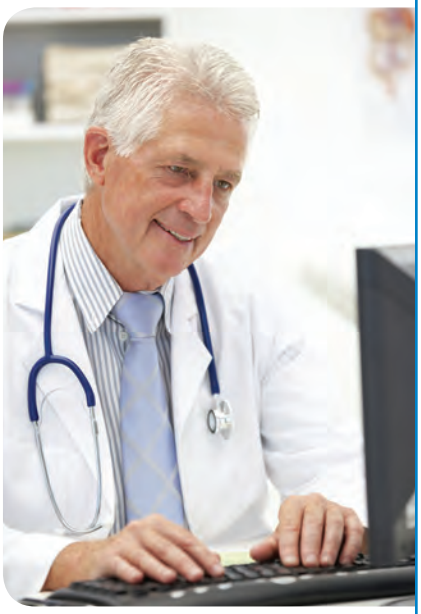
Blue Options and Blue Choice Options members will have the option to choose from three benefit levels or tiers of financial responsibility. To achieve the lowest out-of-pocket expense (tier 1), members must choose a provider from the specified Blue Choice or Blue Choice Options network. Members may also select a provider in the standard PPO network at a higher out-of-pocket cost (tier 2). Finally, members may elect an out-of-network provider, which will result in the highest level of financial responsibility (tier 3) for the member.

Blue Options and Blue Choice Options members will have the following network code on their member ID cards: BCO. The BCO network code also will appear in the Provider Finder to help identify tier 1 providers.

If you see Blue Options or Blue Choice Options members, it will be important to ensure that these members are aware of your network status and related tier or benefit level. If you are directing these members to other providers, it will be important to ensure that those providers fall within the appropriate tier as preferred by the member.

Benefit/Tier Level	Network Offerings	Description
1	Blue Choice or Blue Choice Options (BCO)* **Same providers as those in the Blue Choice PPO network.*	Members will have the lowest-out-of pocket expense by selecting a participating provider in the BCO network.
2	Participating Provider Organization (PPO)	Members will have a higher out-of-pocket expense if they select a participating provider in the broader PPO network.
3	Out-of-network	Members will have the highest out-of-pocket expense and the largest responsibility for cost of care by selecting an out-of-network provider.

Is your information correct?



When seeking health care services, our members often rely upon the information on our online Provider Finder. This is just one of the many reasons why it's important that you inform BCBSIL of changes to your practice, including demographic and provider additions or deletions.

IT'S EASY TO REQUEST YOUR CHANGES!

You can request most changes online by using one of our electronic change request forms. Visit the Network Participation/Update Your Information section of our website at *bcbsil.com/provider* to access instructions along with links to each type of form.

WHAT CHANGES CAN BE REQUESTED ONLINE?

There are three different change request forms to help you organize your information:

1. **Request Demographic Information Changes**
   - Use this form to request changes to practice information currently on file with BCBSIL (such as Address, Email, NPI, etc.).
   - You may specify more than one change within your request as long as all changes relate to the same billing (Type 2) NPI.
   - As a participating provider, your NPI(s) should already be on file with BCBSIL. You may use this online form to request changes, such as deactivation of an existing NPI.
2. **Request Addition of Provider to Group**
   - Use this form to notify BCBSIL when a new individual provider joins your practice. Please remember that new providers are subject to credentialing review and will not be effective until the process is completed.
3. **Request Removal of Provider from Group**
   - Use this form to notify BCBSIL when an individual provider is leaving any or all of your practice locations.

WHAT CHANGES CANNOT BE REQUESTED ONLINE?

The following change requests are more complex and require special handling:

- **Multiple changes, especially changes involving more than one billing (Type 2) NPI**, should be submitted via email to *netops_provider_update@bcbsil.com*.
- **You may not use an online change request form if you need to make a Tax ID change that involves a Legal Business Name change**. This type of change requires a new contract. To request a contract application, visit the Network Participation/Contracting section of our website at *bcbsil.com/provider*.

HOW LONG WILL IT TAKE FOR CHANGES TO TAKE EFFECT?

Please note that changes are not immediate upon submission of an online change request form. Processing can take a minimum of 30 business days. We thank you for your patience!

Note: If you would prefer to mail or fax your changes to BCBSIL, there is a downloadable Provider Information Change Request Form with complete instructions in the Education and Reference/Forms section of our website at *bcbsil.com/provider*.

QUESTIONS?

If you need additional assistance, please contact Provider Network Operations at 312-653-6555, or *netops_provider_update@bcbsil.com*.

Member Rights and Responsibilities Notification

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

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

BCBSIL Guidelines for Appropriate Use of Modifier 50

A recent audit conducted by BCBSIL of claims that included the use of modifier 50 has resulted in refund requests for overpayment of services. This article provides general guidelines to help assist you with proper use of modifier 50 when submitting professional claims to BCBSIL. Also included are reminders on appropriate use of HCPCS Level II RT and LT modifiers, which should **not** be used when modifier 50 applies.

Modifier 50 is used to identify bilateral procedures, which are typically performed on both sides of the body (mirror image) during the same operative session. For BCBSIL claims, bilateral procedures should be reported with one procedure code, appended with modifier 50. This information should appear on the electronic (ANSI 837P) or paper (CMS-1500) claim as one line item, with a unit number of 1. Modifier 50 is appended to the appropriate unilateral code as a one-line entry on the claim to indicate the procedure was performed bilaterally. *(See claim examples below for details.)*

Modifiers LT – Left Side, and RT – Right Side apply to codes identifying procedures that can be performed on paired organs, such as ears, eyes, nostrils, kidneys, lungs and ovaries. Modifiers RT and LT should be used whenever a procedure is performed on only one side. Centers for Medicare & Medicaid Services (CMS) requires these modifiers whenever they are appropriate. If billing as a one-line entry, both modifiers should be used (e.g., 67107 – RT/LT), with a unit number of 1. If billing with two lines, submit the Current Procedural Terminology (CPT®) code (e.g., 67107 – LT and 67107 – RT, each with 1 unit).

This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims for any particular disease, treatment or service. Health care providers are instructed to submit claims using the most appropriate code based upon the medical record documentation and coding guidelines and reference materials.

Changes in Guidelines for Reporting CPT Code 69210

As a reminder, the definition of CPT code 69210 was changed as of Jan. 1, 2014, to read:

69210, removal of impacted cerumen requiring instrumentation, unilateral. (For bilateral procedures, report 69210 with modifier -50.)

The American Medical Association (AMA) and CMS recently published reporting guidelines related to the above change. In support of the AMA and CMS guidelines, BCBSIL is providing the following information.

When a substantial diagnostic or therapeutic procedure is performed, the Evaluation and Management (E/M) service is included in the global surgical period as defined by CMS. Only a separately identifiable E/M service would be payable. Per guidance from the AMA (CPT Assistant October 2013) regarding reporting code 69210:

…an E/M code may be reported if there is a separate and distinct service performed at the same session. In that instance, modifier 25, Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service, should be appended to the E/M code.

Additionally, this position is reflected in the CMS National Correct Coding Initiative (NCCI) edits, which do not allow separate reimbursement for the E/M service when reported with code 69210 unless the visit is identified as a separately identifiable service. Therefore, if the surgical procedure 69210 is reported with an E/M code, the E/M visit is included in the payment of 69210. Unless the visit is reported as a separately identifiable service, above and beyond the usual preoperative visit, the E/M visit will not be reimbursed.

CLAIM AUDITING RULES AND CLINICAL RATIONALE

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you can use the Clear Claim Connection™ (C3) tool. C3 is a free, online reference tool that mirrors the logic behind BCBSIL's code-auditing software, ClaimsXten®. Refer to the Education and Reference/Provider Tools section of our Provider website for additional information on C3 and ClaimsXten.

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New and Established Patients – Understanding When to Use Patient E/M Codes

According to the CPT codebook, there are two subcategories of office visits: new patient and established patient. Recently, BCBSIL has received a number of claims where new patient codes are billed repeatedly for the same patient.

- A *new* patient is defined as one who **has not received** any professional services from the physician or qualified health care professional or another physician of the same specialty and subspecialty who belongs to the same group practice, within the past three years.
- An *established* patient is defined as one who **has received** professional services from the physician or qualified health care professional of the same specialty and sub-specialty who belongs to the same group practice, within the past three years.

It is important to note that selecting the appropriate level of E/M codes when rendering services for new and established patients also requires key components, such as an expanded or problem-focused history or examination and medical decision-making. For more information to help ensure you are reporting correctly, such as details on E/M service guidelines and clarification, refer to the AMA CPT codebook.

FRAUD AWARENESS

As a reminder, BCBSIL has the right to conduct audits or reviews of claims submitted by health care providers, which may include, but is not limited to requesting medical records and refunds as the result of inappropriate payments made on behalf of our members. If you suspect or need to report any form of medical identify theft or fraud, you may contact BCBSIL, 24 hours a day, seven days a week by calling the Fraud Hotline at 877-272-9741. You may remain anonymous, as all calls and online reports are confidential.

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Provider Learning Opportunities

BCBSIL WEBINARS

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*.

Introducing Remittance Viewer

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.

Dec. 10, 2014
11 a.m. to noon

Jan. 14, 2015
11 a.m. to noon

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.

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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. 7 - 13, 2014. Vaccinate Illinois Week is a statewide effort to promote influenza vaccinations throughout the influenza season.

National Influenza Vaccination Week (NIVW) also runs Dec. 7 - 13, 2014. 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.

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.

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*.

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BLUE REVIEW
Blue Cross and Blue Shield of Illinois
300 E. Randolph Street – 24th Floor
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Email: *bluereview@bcbsil.com*
Website: *bcbsil.com/provider*

Publisher:
Stephen Hamman, Vice President, Network Management

Managing Editor:
Jeanne Trumbo, Senior Manager, Provider Communications

Editorial Staff:
Margaret O'Toole, Marsha Tallerico, Edna Johnson