



BLUE REVIEWSM

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS

OCTOBER 2016

A Review of PPO Tiered Products

Blue Cross and Blue Shield of Illinois (BCBSIL) introduced a number of new products last year, with an emphasis on giving employers and members more options to help them manage their health care spending. While PPO tiered products offer greater flexibility and potential savings for our members, making it easier for you and your staff to conduct business with us is equally important. This article offers a review of tiered product offerings, using our Blue OptionsSM and Blue Choice OptionsSM PPO products as examples.

HOW IS A TIERED PRODUCT STRUCTURED?

With a tiered product, the member's benefit level and cost-sharing are determined by the network of the independently contracted provider that renders the service to the member. Keep in mind that an employer can customize the benefit levels for each tier. Here is the basic benefit structure of a tiered product:

- **Tier 1** is the highest benefit level and the lowest out-of-pocket level for the member, and is tied to a narrow network of designated providers.
- **Tier 2** benefits offer members the option to select a provider from the broader network of contracted PPO providers, but at a higher out-of-pocket expense.
- **Tier 3** benefits, if offered, typically address the use of out-of-network providers as the highest cost option for members for covered services.

Using the example of the Blue Choice Options tiered product, the tier 1 contracted network is Blue Choice OPT PPOSM (BCO). This network is identified on our Provider Finder[®] as *Blue OptionsSM/Blue Choice OptionsSM (BCO)*. The tier 2 contracted provider network for Blue Choice Options members includes participating providers in the broader PPO network. Tier 3 benefits, when available, give these members the option to use out-of-network providers, but the member has a much higher out-of-pocket cost responsibility for the cost of care.

ARE YOU AN IN-NETWORK PROVIDER?

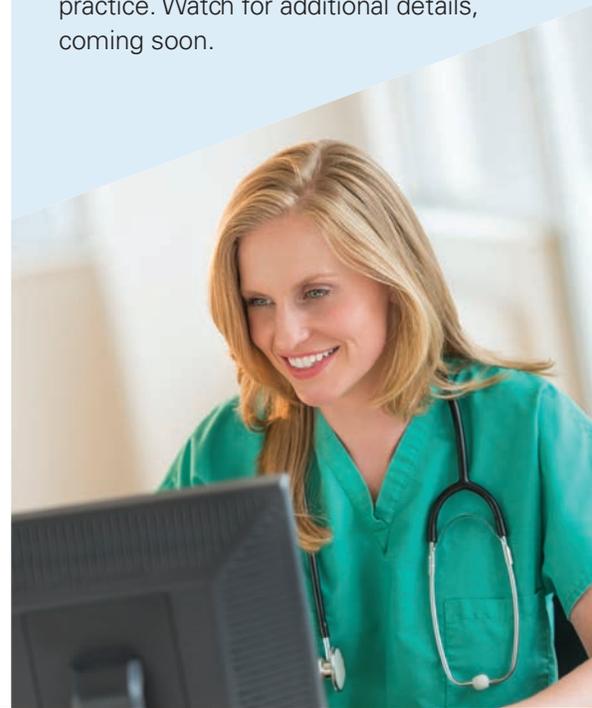
While network details are defined in each provider's contractual agreement with BCBSIL, it has come to our attention that some contracted PPO providers have mistakenly denied services to Blue Choice Options members. **Please note that all PPO participating providers and Blue Choice PPOSM participating providers are considered to be in-network for Blue Choice Options members.**

(continued on page 3)

Blue Review – New format coming in 2017!

As part of an effort to improve timeliness and accessibility of our monthly provider newsletter, we are transitioning to an electronic format as of Jan. 1, 2017. While the *Blue Review* will no longer be printed and mailed, it will remain available in the Education and Reference Center/*Blue Review* section of our website at bcbsil.com/provider for your convenience.

The *Blue Review* will continue to be one of our primary communication channels to help keep you aware of BCBSIL programs, products, educational opportunities, network news, process/administrative reminders, important dates, key changes and major initiatives. We look forward to launching this new format to better convey information that may be relevant to your practice. Watch for additional details, coming soon.



BCBSIL Launches 'Taking On Asthma' Site

As part of a five-year collaboration with the American Lung Association of Illinois to help enhance care for children with asthma, BCBSIL has launched a Taking on Asthma microsite to help spread the word about pediatric asthma. The site shares information about our Enhancing Care for Children with Asthma project that aims to help improve pediatric asthma care for high-risk patients through community-based interventions at primary health centers, including physician offices, federally qualified community health centers and school-based clinics.

The Taking on Asthma site includes a variety of educational tools and information for kids, parents and schools, such as asthma history, myths and facts, how asthma is diagnosed and treated and tips on living with asthma. Your patients can view a video, take an asthma quiz or share their experiences with other families.

The site also offers information and tools for health professionals, including training resources to help you help your patients learn to self-manage symptoms and minimize flare-ups. We encourage you and your patients to learn more about the Enhancing Care for Children with Asthma project and to access the library of resources available at bcbsil.com/taking-on-asthma.

The information referenced above is for educational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Members are advised to discuss diagnosis and treatment options with their physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.



New Health of America Report Links Cesarean Section Rates to Where Members Live



According to the newest Health of America Report by the Blue Cross and Blue Shield Association (BCBSA), the rates of babies delivered by cesarean section (C-section) varies widely by geographic location, indicating that where a mother lives has a significant impact on how she will give birth. The study, "Cesarean Birth Trends: Where You Live Significantly Impacts How You Give Birth,"¹ represents a comprehensive analysis of medical claims from 3 million commercially-insured Blue Cross and Blue Shield members across the U.S.

Results of the study show that in a five-year span from 2010 to 2015, certain parts of the country – primarily the West South Central divisions of the U.S. (Texas, Oklahoma, Arkansas, Louisiana) – had the highest C-section rate of 39.4 percent, while the lowest rate of 29.3 percent was found in the Mountain division (Montana, Idaho, Wyoming, Nevada, Utah, Colorado, Arizona, New Mexico). In fact, the rate of C-section deliveries was more than twice as high in some parts of the country than in others, after adjusting for factors such as age, breech birth and multiple births.

The study looked at cities that had at least 5,000 births from 2010 to 2015. Among cities served by BCBSIL, only the City of Chicago made the list, with a 32.1 percent rate of C-sections.

While the reasons for the variations were not included in the study, the report indicated that factors such as local and regional practice patterns and malpractice laws may play a role.

The data also pointed to a consistent decline in the national rate of C-section births, reversing a 20-year trend of increasing rates. Given the increased medical complications and extended recovery time associated with C-sections, this reversal is promising. The report does not examine the cause or factors that affect the rate decrease. It notes that general awareness by women and the medical community as well as trends toward healthy living could be contributing to the decline.

Besides the higher likelihood of complications for mothers and babies, C-section deliveries that are not medically necessary add cost to the health care system. For commercially-insured BCBS members the average cost difference between cesarean and vaginal deliveries, adjusted for risk, currently exceeds \$4,000 – \$17,482 for C-section compared to \$13,320 for natural birth.¹

¹ Cesarean Birth Trends: Where You Live Significantly Impacts How You Give Birth, published Aug. 25, 2016, at bcbs.com/healthofamerica.

THE MEMBER PERSPECTIVE

Members receive information from the sponsor of the health benefit plan to help them understand how to maximize their benefits. From the Blue Choice Options member perspective, here's how it works:

In-network	Tier 1 (BCO)	<p>If the member wants to select a Tier 1 contracted provider and pay the least out-of-pocket costs:</p> <ul style="list-style-type: none"> • The member will select the network code of BCO when conducting a search on our Provider Finder • The search will return a list of participating providers in the BCO network • Tier 1: Blue Choice OPT will appear under participating providers' names
	Tier 2 (PPO)	<p>If the member wants to select a Tier 2 contracted provider knowing they will incur higher out-of-pocket costs:</p> <ul style="list-style-type: none"> • The member will select the network code of PPO when conducting a search on our Provider Finder • The search will return a list of participating providers in the PPO network • When the member clicks on the provider's name, applicable networks will be displayed
Out-of-network	Tier 3 (when available)	<p>The member may select a non-participating provider knowing this option will result in incurring the highest out-of-pocket costs for covered services.</p>

HOW TO IDENTIFY BLUE CHOICE OPTIONS MEMBERS

Here are some tips to assist your staff when scheduling appointments for Blue Choice Options members:

- **Ask for the name of the product.** The product name, Blue Choice Options, appears on the front of the ID card in the lower left corner. This will help you and your staff identify that this is a tiered benefit product. As indicated in the chart on page 1, you are considered an in-network provider for this patient if you are either a PPO participating provider or a Blue Choice PPO participating provider.
- **Ask for the three-letter network code.** This is in red in the lower left on the front of the ID card. The network code for Blue Choice Options is BCO – another indicator that this is a tiered benefit product.
- **Ask for the statement on the back of the ID card.** For Blue Choice Options members this statement will read: *This plan uses the Blue Choice OPT (BCO) network with tiered benefits.*

As always, before providing care and services, it is important to check eligibility and benefits to determine membership and coverage information. We encourage you and your staff to view our online Provider Finder to review and confirm the health care benefit plans for which you may be considered a contracted in-network provider. Also use the Provider Finder to confirm network status of other providers before directing your patients to those providers.

Checking eligibility and/or benefits information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms, conditions, limitations and exclusions of the member's certificate of coverage.

2017 Open Enrollment Dates

During open enrollment, a shopper on the Illinois marketplace exchange has the opportunity to select a new individual or family health insurance plan or renew their current policy for 2017.

Here are some important dates for the marketplace exchange:

- **Nov. 1, 2016** – Open Enrollment begins
- **Dec. 15, 2016** – Deadline in order to have coverage that begins on Jan. 1, 2017. If application is filed on Dec. 16, 2016 – the coverage will most likely not start until Feb. 1, 2017.
- **Dec. 31, 2016** – Coverage ends for 2016 plans.
- **Jan. 31, 2017** – Last day to apply for 2017 coverage before the end of Open Enrollment.

BCBSIL members who keep their same plan will retain their member ID card. New enrollees and BCBSIL members who change their plan selection for 2017 will receive new member ID cards.

As a reminder, it is important to check eligibility and benefits prior to rendering services for BCBSIL members. This step will help you identify the member's product/plan, network, benefit preauthorization requirements and other important details.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member's ID card.



Flucelvax Quadrivalent Billing Update

The American Medical Association (AMA) has released Current Procedural Terminology (CPT®) code 90674 for implementation effective Jan. 1, 2017. According to the AMA, CPT code 90674 – Influenza virus vaccine, quadrivalent (ccIIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage for intramuscular use – may be used to best describe Flucelvax Quadrivalent, a new flu vaccine for the 2016-2017 flu season. Please note that CPT code 90674 will not be effective until Jan. 1, 2017. Until the effective date, BCBSIL believes Flucelvax Quadrivalent may be appropriately billed with CPT code 90749.

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This material is for informational purposes only and is not intended to be a definitive source for what codes should be used for any particular health care claim. Providers are instructed to submit claims using the most appropriate code based upon medical record documentation, coding guidelines and reference materials.

Updates to the Diabetes Blood Glucose Meter Program for BCBSIL Members

BCBSIL offers certain blood glucose meters to members with diabetes at no additional charge to help them manage their condition. (Note: Members are limited to one glucose meter per year.) Effective Oct. 1, 2016, changes were made to the program including the types of products offered, as well as how members can obtain one of these meters. You are encouraged to share this updated program information with your patients. Members can access this updated program information from the member website at bcbsil.com. Or, view the member flyer at bcbsil.com/PDF/rx/glucose-meter-offer-il.pdf.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Health care providers are instructed to exercise their own independent medical judgment based upon the patient's medical condition and history. Regardless of benefits, the final decision about any treatment is between the member and their health care provider.

Pharmacy Updates

Program Changes, Effective Oct. 1, 2016

DRUG LIST (FORMULARY) CHANGES

Based on the availability of new prescription medications and the Prime National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some revisions were made to the BCBSIL standard drug list and generics plus drug list, effective Oct. 1, 2016.

Brand Medications Added to the Standard and Generics Plus Drug Lists, Effective Oct. 1, 2016

Preferred Brand ¹	Drug Class/Condition Used For
Afstyla	Hemophilia

Brand Medications Added to the Standard Drug List, Effective Oct. 1, 2016

Preferred Brand ¹	Drug Class/Condition Used For
Impavido	Leishmaniasis
Velphoro	Anemia

Brand Medications Moved to a Higher Out-of-Pocket Payment Level on the Standard Drug List, Effective Oct. 1, 2016

Non-Preferred Brand ¹	Drug Class/Condition Used For	Generic Preferred Alternative(s) ²	Preferred Brand Alternative(s) ^{1,2}
Cuprimine	Wilson's Disease, Cystinuria	N/A	Depen
Roche Accu-Chek Active, Aviva, Aviva Plus, Compact, Smartview, Roche Accutrend	Diabetic Supplies	N/A	Bayer Ascensia Autodisc, Breeze2, Contour, ContourNext

DISPENSING LIMIT CHANGES

The BCBSIL standard and generics plus prescription drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. FDA-approved dosage regimens and product labeling.

Effective Oct. 1, 2016, dispensing limits for the following drugs were added to the standard list:

Drug Class and Medication ¹	Dispensing Limit
Atypical Antipsychotics	
Abilify Oral Solution	900 mLs per 30 days
Fanapt Titration Pack	8 tablets per 180 days
Anticoagulant	
Pradaxa 110 mg	71 capsules per 180 days
Fibromyalgia	
Savella Titration Pack	55 tablets per 180 days

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Drug Class and Medication ¹	Dispensing Limit
Gabapentin ER	
Gralise Starter Pack	78 tablets per 180 days
Therapeutic Alternatives	
Lidocaine patch	120 patches per 30 days
Lidocaine ointment	120 grams per 30 days
Sitavig	2 tablets per 180 days
Solaraze Gel	100 grams per 30 days
Topical NSAIDs	
Flector patches	150 patches per 30 days
Voltaren Gel	150 grams per 30 days

UTILIZATION MANAGEMENT PROGRAM CHANGES

Effective July 1, 2016, the Hetlioz Prior Authorization (PA) program changed its name to: Circadian Rhythm Disorders. All targeted medications and program criteria remained the same. Also, the Kalydeco (Cystic Fibrosis) specialty PA program officially changed its name to: Cystic Fibrosis.

Effective Oct. 1, 2016, several targeted medications were added to the current PA and Step Therapy (ST) programs for standard pharmacy benefit plans, upon renewal for most members.

Targeted drugs added to current pharmacy PA standard programs, Effective Oct. 1, 2016

Drug Category	Targeted Medication(s) ^{1,2}
Therapeutic Alternatives	Cardizem CD, Evzio, Kazano, Lidocaine patch/ointment, Nesina, Oseni, Sitavig

Targeted drugs added to current pharmacy ST standard programs, Effective Oct. 1, 2016³

Drug Category	Targeted Medication(s) ^{1,2}
Glucose Test Strips	All non-preferred brand test strips, such as Roche Accu-Chek Active, Aviva, Aviva Plus, Compact, Smartview and Roche Accutrend

Targeted mailings were sent to members affected by standard drug list deletions, dispensing limit and prior authorization program changes per our usual process of member notification prior to implementation. **Please note:** For members affected by the diabetic test strip formulary change, a letter was sent that also included information on obtaining a new blood glucose meter at no additional charge. For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of our website at bcbsil.com/provider.

¹ Third party brand names are the property of their respective owners

² These lists are not all inclusive. Other medications may be available in this drug class.

³ Members on a current drug regimen will be grandfathered from participation in the ST program.

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 independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Pharmacy Disclaimer

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

Medical Identity Theft: A Growing Problem

According to the Federal Trade Commission, medical identity theft occurs when someone uses another person's name or insurance information to obtain medical treatment, prescription drugs or surgery.¹ It would also be considered medical identity theft if a provider were to knowingly bill for services provided to one member if they were actually rendered for another. Not only could medical identity theft have a potentially negative impact on the victim's financial credit, but possible patient harm could occur if incorrect information is added to a patient's medical records.

The *Fifth Annual Benchmark Study on Privacy & Security of Healthcare Data* reveals medical identity theft nearly doubled in five years, from 1.4 million adult victims to over 2.3 million in 2014.² With identity theft on the rise, reviewing a patient's government-issued photo ID card, such as a driver's license or passport, is an increasingly important step. Independently contracted BCBSIL providers are required to verify the identities of our members each and every time services are provided, as stated in the BCBSIL Provider Manual.

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

¹ <https://www.ftc.gov/tips-advice/business-center/guidance/medical-identity-theft-faqs-health-care-providers-health-plans>

² Ponemon/MIFA 2014 Fifth Annual Study on Medical Identity Theft.

Benefit Preauthorization: Laying the Groundwork for Positive Outcomes

At BCBSIL, we use benefit preauthorization requirements to help make sure that the service or drug being requested is medically necessary, as defined in the member's certificate of coverage.

Benefit preauthorization is one of the many things we are doing to help make the health care system work better, by focusing on improving health care delivery. We want our members to receive the best health outcomes for all of the dollars spent on their care.

This month's *Blue Review* includes a preview of some of the benefit preauthorization and related changes to be implemented as of Jan. 1, 2017. Also watch the News and Updates section of our website at bcbsil.com/provider for additional announcements.

Applied Behavioral Analysis Benefit Preauthorization Requirement for PPO Members



Effective Jan. 1, 2017, benefit preauthorization will be required for BCBSIL PPO members before Applied Behavioral Analysis (ABA) services may be scheduled for the treatment of Autism Spectrum Disorder. As always, checking eligibility and benefits is an important first step. Providers may obtain benefit preauthorization on behalf of members by calling the number on the member ID card at least one business day prior to the scheduling of the planned outpatient service.*

To initiate the ABA benefit preauthorization process for eligible members, submission of three forms will be required. These forms will be available on our website at bcbsil.com/provider.

- **Diagnostic Physician/Specialist Evaluation** – *The member must have a diagnosis of Autism Spectrum Disorder from a qualified diagnostician.*
- **Provider Credentials Verification** – *The ABA service provider must have the credentials necessary to conduct ABA services.*
- **Assessment Information and Initial Treatment Plan** – *An initial functional assessment, including a treatment plan that identifies any deficient skills and the appropriate interventions, must be completed by the servicing provider.*

After the first benefit preauthorization for ABA services, additional benefit preauthorization requests may require concurrent review to help ensure the services continue to meet the medical necessity criteria set forth in the member's benefit plan. **Additional information will be provided in upcoming issues of the *Blue Review*, as well as the News and Updates section of our Provider website.** If you have questions, contact your assigned Provider Network Consultant for assistance.

**Our online benefit preauthorization tool iExchange is not available for ABA preauthorization at this time.*

Please note that verification of eligibility and benefits, and the fact that a service or treatment has been preauthorized or predetermined for benefits, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. Regardless of any benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.



Blue Cross Medicare AdvantageSM PPO Pre-service Requirement Reminders

There are many steps you can take to help ensure your claims are accepted for processing by BCBSIL. For example, it is important to be aware of pre-service requirements that may apply, prior to providing care and services to BCBSIL members. Listed below are pre-service reminders specific to Blue Cross Medicare Advantage PPO ("MA PPO") members.

ELIGIBILITY & BENEFITS

Checking eligibility and benefits for every member before rendering care and services is an important first step. When you check eligibility and benefits for a particular member, you will be alerted if benefit preauthorization is required. As a reminder, in addition to checking the member's BCBSIL ID card, independently contracted BCBSIL providers also are required to check each patient's government-issued photo ID card, such as a driver's license or passport, to verify identity.

BENEFIT PREAUTHORIZATION

Benefit preauthorization is required for certain services, drugs, devices and equipment for MA PPO members. Benefit preauthorization requests may be submitted electronically through iExchange®, our online benefit preauthorization tool. If you do not have online access, you may call the Customer Service number on the member's ID card.

FOR MORE INFORMATION

The following resources are available on our website at bcbsil.com/provider:

- **Prior Authorization Required List** – The current list is available in the Standards and Requirements/Provider Manual section of our Provider website, under the Blue Cross Medicare Advantage PPO Manual/Resources menu. The 2017 list, effective Jan. 1, 2017, also is posted for your reference.
- **iExchange Enrollment and Webinars** – To learn more, enroll to gain access or sign up for a webinar on how to navigate our online benefit preauthorization tool, visit the Provider Tools and Workshops/Webinars pages in the Education and Reference Center of our Provider website.

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



Reminder: Outpatient Molecular and Genetic Tests and Radiation Oncology Benefit Preauthorization Requirements through eviCore

As previously mentioned on June 28, 2016, effective immediately, BCBSIL has contracted with eviCore healthcare (eviCore) to provide benefit preauthorization services for Blue Choice PPO, Blue Choice Preferred PPOSM and PPO for select services.

As of Oct. 3, 2016, eviCore now manages benefit preauthorization for **outpatient molecular and genetic tests and radiation oncology**. Services performed without benefit preauthorization may be denied.

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

For more information on the new prior authorization process (for medical necessity under the applicable benefit plan), accessing information from the evicore.com website or a review of the Quick Reference Guides, view a recorded presentation on the implementation site at <https://www.carecorenational.com/page/bcbs-implementations.aspx>. Or call eviCore's Provider Relations department at 800-646-0418, option 4.

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

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.

Online Portal Applications Help Expedite Administrative Workflow

Does your office or organization ever ask ...

“Is this patient eligible for Blue Cross and Blue Shield Illinois (BCBSIL) benefits?”, “Does this service require preauthorization?”, or “How did my claim process?” If so, these questions

and so many more can be answered with a few key strokes, often in just a matter of seconds, using an online portal application, such as Availity™.

Electronic options deliver near real-time resolutions in many instances, helping you avoid disapproved services and optimizing your payment. You can confirm patient coverage, preauthorize services and post payments with a few simple clicks.

Not only can you conduct HIPAA-compliant transactions online, using Availity, you can also:

- Submit pre- and post-exam transactions
- Conduct pre-service requests
- Complete post-service reconciliation
- Update provider demographics
- Enroll for electronic remittance and fund transfer

If you have not registered and would like to learn more about Availity and our online benefit preauthorization tool iExchange®, we invite you to sign up now for a BCBSIL Back to Basics: ‘Availity 101’ Webinar. For upcoming webinar dates and times, see the Provider Learning Opportunities on page 9. For more advanced training about online tools, email a Provider Education Consultant at PECS@bcbsil.com.

Please note that the fact that a service has been preauthorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

2016-2017 CDC Flu Season Recommendation

The Centers for Disease Control and Prevention (CDC) recommends a flu vaccine injection for everyone 6 months and older by the end of October, if possible. The nasal spray flu vaccine is not recommended this year as it has not provided the same protection as the injection has over the last three influenza seasons. Flu vaccination may reduce flu illnesses and prevent flu-related hospitalizations.¹

A flu vaccine is the first and best way to help prevent seasonal influenza. Antiviral drugs are a second line of defense to treat the flu. In accordance with our government program contract, BCBSIL has sent each member of Blue Cross Community MMAI (Medicare-Medicaid Plan)SM, Blue Cross Community Integrated Care Plan (ICP)SM, Blue Cross Community Family Health PlanSM (FHP) and Blue Cross Community Managed Long Term Supports and ServicesSM (MLTSS), influenza vaccine reminder postcards in the month of September 2016. Please educate your patients on the importance of vaccinating all family members 6 months or older.

ANTIVIRAL DRUGS ARE NOT A SUBSTITUTE FOR FLU SHOTS

Between October 2015 and April 2016, BCBSIL received over 2,300 claims for Tamiflu® (generic name oseltamivir) for our members enrolled in MMAI, ICP, FHP and MLTSS programs. While Tamiflu is a U.S. Food and Drug Administration (FDA) approved antiviral drug to treat influenza within two days of getting sick, it is not a substitute for getting a flu vaccine. Over 57 percent of claims received by BCBSIL for Tamiflu were for our members under 18 years of age, making it a top drug in terms of ingredient cost for our FHP plan. Tamiflu is also FDA-approved for the prophylaxis of influenza for persons aged 3 months and older who have been exposed to infected individuals or during a community outbreak. There is no evidence for efficacy of Tamiflu in any illness caused by agents other than influenza viruses Type A and B.

¹ <http://www.cdc.gov/flu/antivirals/whatyoushould.htm>

Tamiflu is a registered trademark of Hoffmann-la Roche

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Provider Learning Opportunities

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



BCBSIL WEBINARS

<p>BCBSIL Back to Basics: 'Availity 101'</p> <p><i>A review electronic transactions, provider tools and online resources.</i></p>	<p>Oct. 25, 2016 Nov. 8, 2016</p>	<p>All sessions: 11 a.m. to noon</p>
<p>BCBSIL Professional PPO Provider Webinar</p> <p><i>Learn about products, benefit preauthorization updates and new PPO credentialing guidelines.</i></p>	<p>Nov. 2, 2016</p>	<p>9:30 a.m. to noon</p>
<p>Introducing Remittance Viewer</p> <p><i>This online tool offers providers and billing services a convenient way to retrieve, view, save or print claim detail information.</i></p>	<p>Oct. 19, 2016 Oct. 26, 2016 Nov. 1, 2016</p>	<p>October sessions: 11 a.m. to noon November session: 10 to 11 a.m.</p>
<p>iExchange® Training:</p> <p>New Enrollee Training</p> <p><i>Learn how to gain access to and begin using our online benefit preauthorization/predetermination of benefits tool.</i></p>	<p>Oct. 25, 2016 Nov. 8, 2016</p>	<p>11 a.m. to 12:15 p.m.</p>
<p>Predetermination of Benefits Requests</p>	<p>Nov. 3, 2016</p>	<p>11 a.m. to 12:15 p.m.</p>
<p>2016 System Enhancements</p>	<p>Oct. 20, 2016</p>	<p>11 a.m. to noon</p>

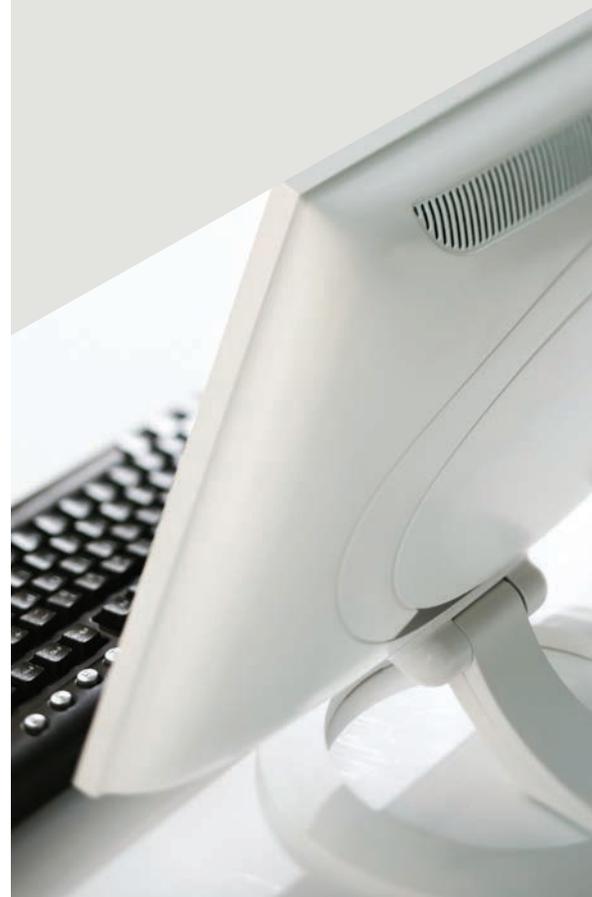
Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendors directly.

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 Jan. 1, 2017, code J7330 will be updated.

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



Member Rights and Responsibilities Notification

BCBSIL will provide members of HMO Illinois®, Blue Advantage HMOSM, Blue Precision HMOSM and Blue Choice Preferred PPO 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, located in the Standards and Requirements section of our website at bcbsil.com/provider.

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



Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Alcohol and other drug (AOD) dependence significantly increases the risk of serious health issues, accidents, communicable diseases, suicide and family, legal or financial issues.¹ Although it is often the primary care providers (PCPs), pediatricians or obstetricians who assign a patient an initial AOD dependence diagnosis, any provider (PCP, pediatrician, obstetrician, urgent care, ER, acute inpatient, partial hospitalization and all specialties) can diagnosis a member by using an AOD dependence diagnosis code.

The Healthcare Effectiveness Data and Information Set (HEDIS®) measure for IET requires a member diagnosed with AOD, Adolescents and adult members (13 years and older) to receive:

- **Initiation of AOD dependence treatment:** Through an outpatient visit, intensive outpatient encounter, partial hospitalization or AOD dependence inpatient admission within 14 days of the diagnosis.
- **Engagement of AOD dependence treatment:** Following the initiation phase, the member received two or more additional services with a diagnosis of AOD dependence within 30 days of the initiation visit.

Providers can improve their IET HEDIS quality score by:

- Scheduling a visit at your practice within 14 days of the AOD dependence diagnosis date to initiate AOD dependence treatment for the patient. Have a frank discussion and provide education and counseling to adolescents and their parents, pregnant women and all adult members on the risks and health outcomes associated with alcohol and drug addiction and dependence.
- Scheduling at least two additional follow up visits for the patient, at your practice, within 30 days of the initiation of treatment visit.

Providers can improve their IET HEDIS quality score by referral:

- If you choose to refer the patient to a behavioral health practitioner such as a Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), Licensed Marriage and Family Therapist (LMFT), to start treatment within 14 days of diagnosis. If provider referral assistance is needed, use the Mental Health phone number on the back of the member card.
- Notify the referral provider of the appropriate AOD dependence code to be used for all follow up member visits. This will ensure that the visits are counted for the measure. For example, use of the code for anxiety does not meet the measure for AOD dependence treatment.

¹ www.mayoclinic.org/diseases-conditions/drug-addiction/basics/complications/con-20020970 (accessed August 2015)

HEDIS is a registered trademark of the NCQA.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Health care providers are instructed to exercise their own independent medical judgment based upon the patient's medical condition and history. Regardless of benefits, the final decision about any treatment is between the member and their health care provider.

Coordination of Care between Behavioral Health Specialists and Medical Providers



To help ensure that members who are newly diagnosed with Major Depressive Disorder (MDD) receive quality care, BCBSIL performs annual assessments, through claims filed with BCBSIL, as part of our goal to help improve continuity and coordination of care.

Through an annual HEDIS audit measuring Antidepressant Medication Management (AMM), it has come to our attention that approximately half of the members who are newly diagnosed with MDD are not remaining on antidepressant medications for the recommended period of time (at least 12 weeks for the acute phase and 6 months for the continuation phase).

There are several factors that can hinder a member from continuing to take antidepressant medications which may include:

- A lack of adequate knowledge on the importance of proper continuation of all antidepressant medications to help prevent relapse. Members may mistakenly discontinue taking the medication when they feel better. Additionally, they may not be aware of the potentially transient nature of some side effects.
- Not discussing their current medications with all providers or specialist involved in their care.
- Personal or financial reasons that are not discussed with providers that may impact medication compliance.

BCBSIL needs your assistance to help improve compliance by educating those newly diagnosed members with MDD on the importance of continuing with their antidepressant medications. This quality improvement initiative depends largely upon communication between medical and behavioral health care providers. With your help, we look forward to improving the coordination of care for our members who have MDD.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Health care providers are instructed to exercise their own independent medical judgment based upon the patient's medical condition and history. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Improving Coordination of Care for HMO Members with an Inpatient Stay

To help ensure that HMO members who are seen by a hospitalist during an inpatient stay receive quality care, BCBSIL performs annual assessments through the BCBSIL HMO Primary Care Physician (PCP) Survey and review of medical records data, as part of our goal to help improve continuity and coordination of care.

Through a recent analysis, it has come to our attention that some members' inpatient plan of care, including medications, are not being reported back to the members' regular providers to be included in the members' medical records. BCBSIL needs your assistance to help ensure that our members' inpatient results are properly documented in the referring practitioners' records. This quality improvement initiative depends largely upon communication between hospitalists and referring providers. With your help, we look forward to improving the coordination of care for our members who have been seen by a hospitalist during an inpatient stay.





BLUE REVIEW

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS



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

BLUE REVIEW

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