Structured for Success, Focused on Our Members

By Sherman Wolff
Executive Vice President and Chief Operating Officer
Health Care Service Corporation, a Mutual Legal Reserve Company

You might have seen the name Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), on letterhead or on the back page of this newsletter, but do you know what HCSC really is? Although, as a provider, you know HCSC as Blue Cross and Blue Shield of Illinois, we think that it’s important for you to know that standing behind the Illinois Plan is a company with a corporate structure that aligns us with the interests of our members.

Background

Blue Cross and Blue Shield of Illinois is one of three Blues Plans operated by HCSC. We also operate the Plans in Texas and New Mexico. In addition, pending regulatory approvals, Blue Cross and Blue Shield of Oklahoma is scheduled to join HCSC by the end of the year, bringing our medical membership to more than 10 million.

While HCSC is certainly a large company, we still believe that health care delivery is a local issue. Some of our operating functions are managed centrally to achieve maximum cost-effectiveness, but the business of these functions, like provider relations, is conducted locally.

Non-investor Owned

In addition, to our status among the top five health insurers, HCSC is the largest non-investor-owned health insurer in the nation. What is a non-investor-owned company? Fundamentally, it means that we are “owned” by our members, our policyholders, and not by stockholders. HCSC is not publicly traded on Wall Street, which allows us to do some things differently than a stock company. First of all, it allows us to take a longer view of health care issues without the pressure of meeting the quarterly expectations of analysts. Whenever we are faced with a difficult decision at HCSC, we only have to ask one basic question: What’s best for our members?

In addition to being non-investor owned, HCSC also is a not-for-profit mutual legal reserve company. It’s important to note, however, that HCSC is not a charity. We can and we do earn money. It’s what we do with those earnings and our motivation for earning money that makes us different. We do not pay dividends to Wall Street. We do not focus on shareholder value. I often note that an investor-owned company provides a service to earn money, while a non-investor-owned company, like HCSC, earns money to provide a service.

Success is Focused on Policyholders

Since 1990, HCSC has been a successful company. We steadily have grown our membership and we have had positive earnings. Those earnings have gone right back into the company for the benefit of all of our members, not to pay dividends to shareholders. Our sustained success has allowed us to develop one of the best customer service operations in the industry. We also have built state-of-the-art claims processing systems that allow faster and more accurate resolution of claims than ever before. We have designed industry-leading health plans that have helped employers hold down costs, while providing significant benefits to employees.

While we are not scrutinized by Wall Street analysts, we still are accountable to our policyholders, our independent board of directors and the rating agencies, which review us at least annually. By the way, those agencies like what they see in HCSC’s operation. HCSC has a Standard and Poor’s “A+” rating, a Moody’s “A1” rating and a rating of “A” from A.M. Best Company. Those are very high ratings, but not the absolute highest, validating that HCSC has appropriate financial strength to back the claims of its policyholders.

Aligned Interests

While HCSC’s corporate structure has promoted success in the marketplace, it more importantly has allowed us to focus on our members, who are also your patients. In other words, HCSC’s interests are aligned with its members’ interests and with the interests of providers.

As a non-investor owned company we are able to concentrate 100 percent on our mission, which is to promote accessible, cost-effective, quality health care for our customers. Meeting that mission is how we and you should ultimately judge our success.
As a participating provider in the BlueCard Program (out-of-area claims), your satisfaction is a top priority for Blue Cross and Blue Shield of Illinois (BCBSIL). We value the care that you provide to all Blues plan members, and with your feedback we can continue to identify ways to serve you more effectively.

Based on input from last year’s survey, providers noted significant service delivery improvements with the BlueCard Program, including claims accuracy and resolution:

- Claims accuracy improved 6 percent
- Satisfaction with resolving problem claims increased 8 percent
- The number of claims requiring follow-up decreased 10 percent

Throughout the year we have implemented the following initiatives to improve your satisfaction.

- Conducted focus trainings to strengthen provider knowledge of the BlueCard program
- Featured monthly articles and updates on BlueCard in our Blue Review provider newsletter
- Broadened the scope of training for our provider relations and customer service staff

To help evaluate our performance and track the progress we have made since the last survey, The Response Center, an independent research company, will conduct telephone interviews on behalf of BCBSIL using a randomly-selected sample of providers who have serviced BlueCard members within the past year. This year’s survey is being administered from September through early November.

The Response Center will ask to speak with the person who is most knowledgeable about filing Blue Cross and Blue Shield claims and/or the billing department. Please share this information with the appropriate staff in your office. If you receive a call, please take a moment to participate, as your feedback is important to us.

If you need more information, have questions, or want to make suggestions for improving the BlueCard Program, please let us know by:

- Contacting Customer Service Representatives at our Provider Telecommunications Center at (800) 972-8088
- Visiting us online at: www.bcbsil.com/provider, and viewing the BlueCard Program Manual and Reference Guide

We thank you in advance for taking the time to provide us with your feedback.
APN/DME/HIT Specialty Update

In the September 2005 Blue Review, we announced that Durable Medical Equipment (DME), Home Infusion Therapy (HIT) and Advanced Practice Nurses (APN) - Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP) - provider specialties have been added to our PPO Network. These provider specialties will be added to the PPO Network, upon group renewal, starting November 1, 2005.

Please note: DME, HIT and APN’s are not required to go through the credentialing process at BCBSIL, but are required to meet the necessary criteria in order to be eligible to participate in the PPO network (valid license, contract, application, accreditation, as applicable). These providers may request a PPO contract and application by submitting an email to network_development@bcbsil.com.

Those APNs that are currently employed by a physician or physicians’ group and do not intend to bill on their own should not apply to participate in the PPO network. Please reference upcoming editions of the Blue Review for further information regarding group renewal and reimbursement.

Forms

NEW! Provider Voluntary Refund Form

Blue Cross and Blue Shield of Illinois (BCBSIL) strives to pay claims accurately the first time; however, when payment errors occur, we need your cooperation in correcting the error and recovering the overpayment.

A Voluntary Refund Form is now available for use by all Non-UPP individual providers and facilities. You should use this form when sending in a check. The form, along with instructions for completion, is located on our BCBSIL Web site in the Provider Library Section at www.bcbsil.com/provider, under Payment Recovery Program.

UPP providers/facilities will soon have access to an updated BC370 to expedite the processing of their refunds.

In all cases, if you have questions regarding the new or revised form please contact your BCBSIL Provider Network Consultant for further information.

Now Accepting Predeterminations by FAX

We have recently updated our Provider Review Form to easily identify predetermination requests. Located on the top right side of the form you will find a check box for requests for determination/review of medical necessity prior to services being rendered.

Predeterminations can be expedited by faxing them to the following number: (217) 698-2144.

This fax line is a dedicated number for predeterminations only. It is not necessary to refax or mail in predeterminations that have already been submitted. Our goal is to have all requests completed within 72 hours.

Provider Review Forms can be found on the BCBSIL Web site at: www.bcbsil.com/provider/forms.htm.

Please note: Only predeterminations will be accepted at this fax number. All other requests, reviews and standard written inquiries must be mailed to:

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
P O Box 805107
Chicago IL 60680-4112
A recent article in *Medical Economics* suggested that medical group practices could positively affect their bottom line by tracking all denials on the computer and learning from them. According to the article, this process could help physicians avoid working more hours or increasing their patient load in order to achieve their targeted income. By not tracking the types of denials, learning why the errors are happening and then fixing the root of the problem, practices are losing money through both reduced cash flow and operational inefficiencies. For these practices, RealMed could provide a simple solution and save them money.

**What is RealMed?**

- It is a web-based service that allows you to eliminate most claim errors before the claim is sent to the payer—and, in the case of registration errors, before the patient is even seen.

- It tracks all errors, categorizes them, analyzes why the errors happened and allows you to fix most problems systematically, so they won’t happen again.

- It can assign work to staff members and monitor their productivity—maximizing your revenue.

**The RealMed Process**

The process starts by allowing you to check registration information either by batch or one-at-a-time. Eligibility check allows you to ensure a patient’s eligibility information is correct and even brings back demographic and some deductible level information depending on the payer. RealMed also rechecks eligibility during claim submission and immediately notifies you if an error is encountered. Since about 60% of all errors are eligibility related, you could save time and money by catching these errors upfront versus waiting for the claim to get denied.

For coding errors, RealMed instantly applies all appropriate edits to claims before they go to the payer, including basic content validation, correct coding initiative (CCI), HIPAA, clearinghouse, payer-specific, custom-edits and (upon request) Medicare-LMRP edits. You can choose the type of edits you want to turn on or off, so that you remain in control of the process.

**Claim Submission Edits**

When you submit a batch of claims and RealMed finds a claim with an error, it is sent to the Edit/Error Management section, while the clean claims are sent directly to the payer. You can then fix the claim by going to the Edit/Error Management screen. RealMed makes editing claims simple by showing you the claim and highlighting what is wrong in an easy-to-understand message. It takes seconds to correct and resubmit the clean claim. RealMed then provides you with a daily electronic file of all claims that have been corrected, so that you can post them back to your practice management system.

The process is so easy that you can generally work claims in just one to two hours each day, submit clean claims, and get paid more quickly. Consequently, there are no complicated processes, no huge training commitments for your staff, and no waiting for things to “slow down” so that you can work that stack of denials.

RealMed could be a solution for your claim denials. To learn more, please contact Teresa Luciano at (773) 867-8304.


**Coming Soon...**

**Ability to Verify Out-of-Area Membership, Eligibility and Claim Status**

Coming this fall, providers utilizing THIN Online will be able to verify membership, eligibility and claim status for non-local or out-of-area Blue Cross and Blue Shield (BCBS) members. This new functionality will be available to providers currently checking membership, eligibility and claim status for local Blue Cross and Blue Shield of Illinois (BCBSIL) members. Providers will access THIN Online the same as today. For example, if a Blue Cross and Blue Shield of Florida member seeks services from your facility, you can log on to THIN Online and check the Florida member’s membership and eligibility status. The input screens for non-local membership, eligibility, and claim status look up will slightly differ from the current lookup screens. Next month’s *Blue Review* will highlight the new input screen changes that will allow non-local BCBS members’ membership, eligibility, and claim status to be checked. To sign up for THIN Online, please contact our EDI Hotline at (312) 653-7954.
Electronic Solutions

Update—Medicare Crossover

Medicare Primary, Blue Cross and Blue Shield Secondary Paper Claims

Advantages to Crossover
There are some very good reasons for you to wait for the electronic Crossover arrangement with Medicare:

- Eliminates submission of supplemental claims as well as EOMB attachments (the electronic crossover claim has the EOMB information (claim and remittance data) that we need to process supplemental claims).
- Reduces the administrative cost incurred when claims are submitted by paper.
- Eliminates the 688 rejections and B5 rejections.

Do All Claims Crossover?
A claim does not crossover because the member’s Health Insurance Claim Number (HICN) does not match our membership file. We have worked to minimize mismatched files. As a result, you should see fewer claims that do not crossover. It is only when a claim does not crossover that you need to file an electronic claim to BCBSIL.

Follow These Steps before Submitting a Supplemental Claim to Us
1. Check to see if the claim automatically crossed over:
   - The Medicare Remittance Advice will contain a message that the claim was forwarded through the Cross-over process.
   - Crossover claim payments are highlighted with the message, “Medicare Crossover Claim” on the Provider Claim Summary (PCS) and on the Electronic Remittance Advice (ERA)
2. If the claim did not crossover, you may submit it electronically.
   - For professional claims you may access the “Medicare B Supplemental Claim Submission Reference Guide” located at www.bcbsil.com/provider/referenceguide.htm. This guide provides the requirements for submitting electronically.
   - For facility claims you may access the “Medicare Supplemental UB-92 Claims Reference Guide” located at www.bcbsil.com/provider/referenceguide.htm. This guide provides information on submitting claims that did not crossover.
3. You must submit the rejected claim for review. Do not resubmit a rejected claim by paper; it will deny as a duplicate. Please follow the usual review process, either call the Provider Telecommunications Center at (800) 972-8088 or send in a Provider Review Form located on the BCBSIL Provider Web site at www.bcbsil.com/provider/forms.htm.

Attention...
Direct Data Entry (DDE)/Provider Terminal System (PTS) Users

Effective October 10, 2005, providers/users who dial into the Blue Cross and Blue Shield’s mainframe computer system CICS applications to submit professional claims via SSCE and BCBS applications will be issued instructions to begin using a new application Provider Claim Entry System (PCES) for the submission of professional claims. To receive the new DDE/PTS User Guide, please complete the attached DDE/PTS USER Form. More information on PCES is located on our BCBSIL Web site under What’s New at www.bcbsil.com.

Professional Reimbursement—Fairness In Contracting

Fairness & Contracting
In order to comply with the Fairness In Contracting Legislation, and in an effort to inform our contracting providers, BCBSIL has designated a column in the Blue Review to notify you of any changes to the physician fee schedules. Be sure to review this new area each month.

Effective August 17, 2005, reimbursement for 0073T has changed.
Codes that are part of the Specialty Pharmacy Programs will be updated effective October 1, 2005. You may request fees by downloading the Fee Schedule Request Form at www.bcbsil.com/provider/forms.htm.
New Account Groups

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<th>Group Name</th>
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Key:

- BA HMO = BlueAdvantage HMO
- BlueEdgeSM Participating Provider Option (PPO) = Consumer Driven Healthcare Product (CDHP)
- BlueChoice Select = Point of Service
- CMM = Comprehensive Major Medical
- POS = Point of Service (BlueChoice)
- PPO = Participating Provider Option (Hospital and Physician Network)
- PPO Hospital Network = Participating Provider Option (Hospital Network Only)
- PPO(Portable) = BlueCard PPO
- HMOI = Health Maintenance Organization of Illinois
- HMOI AFHC = HMOI Away From Home Care

Provider Telecommunications Center

New Hours of Availability for the Provider Telecommunications Center (PTC)

In an effort to better service our customers, the Provider Telecommunications Center is expanding its hours of Customer Service Representative availability. Effective September 26, 2005, Customer Service Representatives are available in the PTC from 7:30 a.m. to 5:30 p.m., Central Standard Time. The office will no longer be closed from 12:30 to 1 p.m.

Our Automated Information System can also handle eligibility, benefits, and claim status inquiries for providers and is available from 6 a.m. to 11:30 p.m. Monday through Friday Central Standard Time.
**Pharmacy**

**Synagis™ (Palivizumab) Intramuscular (IM) Injections**

**Change in Pharmacy Provider of Synagis™**

**Coverage**

BCBSIL’s PPO, BlueChoice POS, BlueChoice Select and indemnity plans cover Synagis™ IM injections for the prevention of serious lower respiratory tract infection caused by Respiratory Syncytial Virus (RSV). Coverage is limited to members who meet the BCBSIL Medical Policy criteria. Please refer to our Web site at www.bcbsil.com for further details on this Medical Policy.

**Pre-Authorization**

We encourage providers to confirm member eligibility. However, a predetermination is required for Synagis™ IM injections administered in a physician’s office based on the above referenced Medical Policy. Once an approval is given, it will be approved for the entire RSV season.

**Reimbursement**

Reimbursement for Synagis™ (Palivizumab) IM injections is set at 81% of the Average Wholesale Price (AWP). Synagis™ (Palivizumab) can be ordered through Accredo Health Group Pharmacy. Accredo Pharmacy will arrange shipment to your office and bill BCBSIL directly for the cost of the drug. You can order forms by calling Accredo Pharmacy at (877) 482-5927 or go online to www.bcbsil.com/provider/index and download the Accredo form located under Pharmacy Management. You can fax the completed form to (877) 369-3447.

**Billing Guidelines**

For providers who do not use Accredo Pharmacy, you may bill BCBSIL directly using CPT code 90378, “Respiratory syncytial virus immune globulin (RSV-IgM) for intramuscular use, 50 mg. each”. Please note that the vial size in the CPT code description is 50 mg. If more than 50 mg. is administered, increase the units billed to reflect the dosage administered. For example, when administering 100 mg, indicate 2 units on the CMS-1500 form.

If you have any questions regarding Synagis™ (Palivizumab) IM injections, please contact the Provider Telecommunications Center (PTC) at (800) 972-8088.

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**Provider Workshops**

**Fourth Quarter Workshop Schedule**

Don’t delay! Sign-up now for one of our free workshops and begin to grow. You’ll be glad you did! Go to www.bcbsil.com/provider/training.htm for workshop times, agendas, and to register online. A confirmation or “Request to Reschedule” form will be e-mailed to you.

**New Contracting Provider**

In-House Workshop—Full Day

October 19, 2005

**Vendor Workshop**

In-House Workshop—Half Day

October 20, 2005

**Managed Care Roundtable**

In-House Workshop—Half Day

October 26, 2005

**Experienced Contracting Provider**

In-House Workshop—Half Day

November 2, 2005

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**Medical Policy Disclosure Statement**

When approved, new or revised Medical Policies will be posted in the “Pending Policies” section of the Medical Policy site on the Blue Cross and Blue Shield of Illinois Web site. The new or revised policies will be available on the first day of each month. The specific effective or implementation date will be noted for each policy that is posted.

To review these policies, view the Web site at www.bcbsil.com/provider. Click on “Medical Policies.” After reading the Medical Policies Disclaimer, click on “I Agree.” The policies that are awaiting implementation can be found at the “Pending Policies” selection of the Medical Policy site.
Beginning September 1, 2005, BCBSIL began offering you the option of receiving duplicate copies of your Provider Claim Summary (PCS) on a CD Rom. This offer is being made available until November 1st, after which time we will transition to paperless vouchers, making all requested PCS duplicates available on CD-ROM only.

**Benefits**

The PCS on CD Rom is very user friendly and:
- Offers a quicker turn around time
- Gives you the option of searching by individual patients
- Requires less storage space
- Allows you to receive multiple vouchers on one disk

Please contact our Provider Telecommunications Center (PTC) at (800) 972-8088 to request your vouchers today.

If you currently receive an Electronic Remittance Advice (ERA) and an Electronic Payment Summary (EPS), please contact the EDI Hotline at (312) 653-7954.

**Want to learn more about the ERA and EPS?**

The ERA explains benefit payments for Blue Cross and Blue Shield showing how claims are paid and processed. The EPS provides the same payment information you currently receive on your paper PCS. The advantage is that the payment information is received in your office the same day your ERA is delivered, the day after the claims have been finalized.

- The EPS provides you the same search and print advantages once you download the file.
- The EPS cannot be a stand alone document but can be delivered with the ERA or directly to your own Receiver ID.

Visit our Web site at www.bcbsil.com/provider/eft_qa.htm or contact the EDI Hotline at (312) 653-7954.