BlueCross BlueShield of Illinois

BLUE REVIEW℠

A newsletter for contracting institutional and professional providers

January 2020

CMO Perspective

Blue University℠ and Blue Review: Connecting with Providers on Topics that Matter

We're pleased to launch another year of CMO Perspective articles. This month, our Vice President and Chief Medical Officer, Dr. Derek J. Robinson, M.D., MBA, FACEP, CHCQM, recaps the November 2019 Blue University event: Addressing the Maternal and Infant Health Crisis Through A Health Equity Lens. Dr. Robinson also offers a preview of additional events to come.

Read More

Wellness and Member Education

Explanation for Gaps in Long Term Supports and Services (LTSS) Form

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Provider Education

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Our Provider Network Consultants (PNCs) serve as liaisons, developing and maintaining working relationships with providers. To follow up on questions and feedback they've received, our PNCs have compiled a list of helpful tips and reminders for quick reference purposes.

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Clinical Updates, Reminders and Resources

Notification of Annual Benefit Updates

As a reminder, BCBSIL will be updating member files with annual benefit changes over the next few weeks. We encourage you to verify your patients' coverage first, using the Availity® Provider Portal or your preferred vendor portal.

Read More

2020 Benefit Preauthorization Requirements, Reminders and Resources (PPO – Commercial and Government Programs)

This article includes some general reminders, with links to recent communications and related resources to help you navigate 2020 changes.

Read More

Reminder: City of Chicago Discontinuing Second Surgical Opinion Requirement Jan. 1, 2020

Beginning **Jan. 1, 2020**, the City of Chicago will no longer require their employees with BCBSIL insurance to get a second surgical opinion from Best Doctors or benefit preauthorization from Telligen before having scheduled surgeries in certain areas.

Read More

Claims and Coding

Reminder: Laboratory Benefit Level Change for Some Commercial Members Takes Effect this Month

Beginning **Jan. 1, 2020**, or upon a member's renewal date, non-preventive labs will no longer be covered at the no member cost-share level for some of our commercial PPO and HMO members.

Read More

Focus on Behavioral Health

Coordinating Care Between Behavioral Health and Medical Providers

Coordinating care between behavioral health and medical providers helps deliver quality care for our members. We've prepared a simple form to help providers request information from each other.

Read More

Electronic Options

2020 Holiday Schedule Reminders

These reminders are intended to assist providers in planning ahead for scheduling variances that may affect electronic claims (837) and/or claims payment and remittance (835) transactions in 2020.

Pharmacy Program

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Jan. 1, 2020 – Part 2

Based on the availability of new prescription medications and Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some additions, revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) were made to the BCBSIL drug lists. Changes effective **Jan. 1, 2020**, are outlined here.

New Formulary Notification for Blue Cross Community Health Plans℠ (BCCHP℠): Uniform Preferred Drug List

Illinois Healthcare and Family Services (HFS) has mandated that, effective **Jan. 1, 2020**, all Illinois Managed Care Organizations (MCOs) adopt the HFS Preferred Drug List (PDL).

Read More

Quality Improvement and Reporting

CAHPS® Survey's Importance to CMS Star Ratings: Measures for Blue Cross Medicare Advantage℠ Members

BCBSIL strives to achieve the highest possible Centers for Medicare & Medicaid Services (CMS) Star rating for the Blue Cross Medicare Advantage plans (HMO and PPO) we offer.

Read More

2019 HEDIS® Results for Medicaid Children and Adolescent Immunization

Healthcare Effectiveness Data and Information Set (HEDIS) is a nationally standardized set of measures related to important areas of care and service in the health care field.

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Quality of Care Complaints

Quality of Care (QOC) complaints submitted by our members most commonly express dissatisfaction with one or more of the following circumstances regarding their medical care: clinical issues, access to care issues, interpersonal issues and/or service issues.

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Notification and Disclosure

Annual Reminder: Medicare Outpatient Observation Notice Required

Hospitals and Critical Access Hospitals (CAH) must give the standardized Medicare Outpatient Observation Notice (MOON) to people who receive Medicare benefits and are observed as outpatients for more than 24 hours.

Read More

Reminder: Medicare Providers May Not Bill Members in the Qualified Medicare Beneficiary Program

As a provider treating Medicare members, you may not bill beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) Program, a federal Medicare Savings Program.

Read More

Important Dates and Reminders

Check here each month for a quick snapshot of recent implementations, upcoming changes, special events, important deadlines and other reminders.

Quick Reminders

Stay informed!

Watch the News and Updates on our Provider website for important announcements.

Update Your Information

Do you need to update your location, phone number, email or other important details on file with BCBSIL? Use our online forms to request an information change.

Provider Training

For dates, times and online registration, visit the Webinars and Workshops page.

Contact Us

Questions? Comments? Send an email to our editorial staff.

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Blue University℠ and *Blue Review*: Connecting with Providers on Topics that Matter

By: Dr. Derek J. Robinson, M.D., MBA, FACEP, CHCQM, Vice President and Chief Medical Officer (CMO), Blue Cross and Blue Shield of Illinois (BCBSIL)

I'm pleased to launch another year of CMO Perspective articles in the *Blue Review.* This forum presents an opportunity to connect with providers peer-to-peer on a regular basis. I believe this connection is vital as it opens a door for increased awareness, communication and collaboration. I'm also pleased to announce that, due to the success of our 2019 Blue University events, we'll be continuing this provider education initiative by hosting more Blue University events in 2020.

Fall 2019 Blue University Recap: Maternal Health Equity
BCBSIL is deeply committed to finding solutions to help reduce health care disparities and partner with providers to help reduce adverse birth outcomes, eliminate maternal disparities, and combat the rising maternal mortality rates for our members in the communities we serve. The topic of our most recent Blue University event on Nov. 22, 2019, was Addressing the Maternal and Infant Health Crisis Through A Health Equity Lens. BCBSIL's Director of Quality and Health Equity, Jenné Johns, set the stage by comparing the day's agenda to embarking on a journey toward the following destination: **"To equip and empower us to operate with a sense of urgency for collectively eliminating inequity in outcomes that are avoidable, preventable and costly, particularly for women who are disproportionately impacted by these issues at alarming rates."**

Why do maternal mortality and morbidity rates continue rising in the U.S., and why are those rates magnified even more for women of color? Our keynote speaker, Joia Adele Crear-Perry, M.D., FACOG, founder and president of the National Birth Equity Collaborative, noted that "the reason health inequities exist is not because black people are broken." Rather, as Dr. Crear-Perry pointed out, social determinants of health – the circumstances or conditions in which people live and work – are shaped by imbalances in power and wealth. Add to that a long history of reproductive injustice, and we begin to see the why. But there's hope. Implicit or unconscious bias can be reframed through education to help ensure black women are seen, heard and treated with compassion. In defining birth equity and the mission of her organization, Dr. Crear-Perry said, **"We don't just want folks to survive. We want them to thrive."**

Our next speaker was Robin Jones M.D., assistant professor of Obstetrics and Gynecology at Rush University Medical Center, Chair of the Illinois Department of Public Health (IDPH) Maternal Mortality Review Committee (MMRC) and

Clinical Lead for the Birth Equity Initiative for the Illinois Perinatal Quality Collaborative (ILPQC). Dr. Jones gave a preview of data from the second edition of the IDPH Maternal Morbidity and Mortality Report (released in late 2019). The report confirms that, in Illinois, the mortality ratio is still highest for black women age 40 and older in Chicago. Nearly half of pregnancy-related deaths occurred during or within two weeks of pregnancy. Sadly, the majority of deaths were found to be potentially preventable. Dr. Jones noted that everyone has a role to play – providers, payers, patients, family members, caregivers – in improving post-delivery survival rates. As Dr. Jones noted, "**We want healthy babies, but we need to refocus our attention on healthy moms."**

Our last speaker was Patricia Lee King, Ph.D., MSW. Dr. King is the State Project Director and Quality Lead for the ILPQC. Dr. King noted that the ILPQC is a collaboration of physicians, nurses, hospital teams, patients, public health and other stakeholders who implement data-driven, evidence-based practices to help improve maternal and infant health outcomes. ILPQC initiatives are created in response to State mortality review. Dr. King gave an overview of the Maternal Hypertension Initiative conducted in 2016-2017 with 110 hospital teams. The initiative focused on using screening tools, protocols and safety checklists. Improvements were seen in early recognition of hypertension and correct diagnosis; reducing time to treatment; providing patient education and follow-up; and implementing protocols for treatment of complications. Dr. King touched on current initiatives, too (Mothers and Newborns Affected by Opioids and Improving Postpartum Access to Care). She also gave a preview of the 2021 Birth Equity initiative, which will focus on strategies such as improving race/ethnicity data reporting, engaging patients and facilitating feedback, and engaging/educating providers and birth partners, such as doulas. Why? Because, as Dr. King noted: **"These are women's lives. Families' lives. Patients' lives."**

A panel discussion with a question and answer session rounded out the event. A common theme that emerged was the need to take action now. BCBSIL agrees with that theme. We're leading educational efforts for increased awareness and empowerment, such as a maternal and health education series at our Blue Door Neighborhood Center℠ in the Pullman community. We also offer all our pregnant members case management services through our Special Beginnings® program. We're enhancing resources for providers, too. For more information, including links to helpful resources such as diabetes and hypertension toolkits, visit the new Health Equity and Social Determinants of Health (SDoH) section of our Provider website.

2020 Blue University Preview: Focus on Behavioral Health

We'll be focusing on behavioral health topics this year at upcoming Blue University events along with health equity as an ongoing underlying theme. Some providers have already suggested behavioral health-related topics through our 2019 *Blue Review* readership survey, conducted last year in October and November. If you missed the *Blue Review* survey and would like to suggest behavioral health-related topics – for newsletter articles or discussion at an upcoming Blue University event – please email the *Blue Review* editor. As always, we value your input.

Learn more about Dr. Derek J. Robinson

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To notify the Care Coordination team, providers must fill out this Gaps in LTSS Services form and email it to LTSS Support Center or fax it to 312-309-0468.

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Health Care Fraud is Not a Victimless Crime

Most health care fraud in the U.S. is committed by a small minority of health care providers and/or organized crime syndicates posing as legitimate health care professionals.[1] Sadly, the actions of these deceitful few ultimately sully the reputation of some of the most trusted and respected members of our society – our physicians.[1]

Although the exact amount is unknown, the National Health Care Anti-Fraud Association (NHCAA) estimates conservatively that 3% of all health care spending – or $68 billion – is lost to health care fraud annually.[2] Other estimates by government and law enforcement agencies place the loss due to health care fraud as high as 10% of our nation's annual health care expenditure – or a staggering $226 billion – each year.[2] And the cost of health care will only continue to rise, which means the price tag associated with health care fraud will rise too, unless we can work together to combat it.

If financial losses caused by health care fraud are only part of the story. Victims of health care fraud are easy to find. These are people who are exploited and subjected to unnecessary or unsafe medical procedures, whose medical records are compromised or whose legitimate insurance information is used to submit falsified claims. Other common nonfinancial negative consequences of health insurance fraud include, but are not limited to, the following:

- Inaccurate patient records resulting from the documenting of false diagnoses, treatments and medical conditions in legitimate medical histories
- Theft of patients' finite health insurance benefits
- Physical risk to patients by subjecting them to unnecessary and/or dangerous medical procedures because of greed
- Medical identify theft

At Blue Cross and Blue Shield of Illinois (BCBSIL), we actively participate in inquiries and investigations to accurately identify and appropriately address potential fraudulent activities. Our Special Investigations Department (SID) is committed to fighting fraud, reducing health care costs, and protecting the integrity of the BCBSIL provider network. The SID offers two ways to take action, 24 hours a day, seven days a week:

- File a report online, or
- Call the Fraud Hotline at **800-543-0867**. All calls are confidential, and you may remain anonymous.

Always ask to see the member's ID card for current information and a photo ID to help guard against medical identity theft.

[1] National Health Care Anti-Fraud Association, The Challenge of Health Care Fraud, https://www.nhcaa.org/resources/health-care-anti-fraud-resources/the-challenge-of-health-care-fraud.aspx

[2] NHCAA, The Problem of Health Care Fraud, Feb. 9, 2011, http://web.archive.org/web/20110209140325/http:/www.nhcaa.org:80/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud

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Our Provider Network Consultants (PNCs) serve as the liaison between Blue Cross and Blue Shield of Illinois (BCBSIL) and the independently contracted providers who work with us, developing and maintaining working relationships with providers. Based on feedback from providers, our PNCs would like to share some quick tips and reminders for you and your staff.

New Groups/Providers: Prior to billing for services you are rendering to our members, please ensure your contract has been successfully completed and you have received network effective dates. If you have already completed a Provider Onboarding Form, you can check the status of your application by entering the case number you received in your confirmation email in our Case Status Checker.

- All providers who require credentialing must complete an Illinois Council for Affordable Quality Healthcare (CAQH®) File. Make sure your CAQH is up-to-date prior to submitting your application. This will lessen outstanding billing issues. If your CAQH profile is not complete, your onboarding form will be rejected/returned to the submitter. To check the status of your credentialing process, enter your National Provider Identifier (NPI) or state license number in our Credentialing Status Checker.
- Once your contract has been completed, you will receive notification from our Network Operations team. If claims are received prior to the network effective dates and contract completion, your claims may deny or reject.

Updating Your Group/Provider File: We understand change is continual for contracted providers. To update demographic information – such as adding or removing an address, changing your Tax ID or NPI, removing a provider from the Group, or changing your Legal Name – you may use the online Demographic Change Form. If you have completed a Demographic Change Form, you can check the status of your application by entering the case number you received in your confirmation email in our Case Status Checker.

Direct Deposit: To ensure your reimbursements are properly received, we encourage providers to enroll for Electronic Funds Transfer (EFT).

Provider Claim Summary: The Electronic Remittance Advice (ERA) is equivalent to an Explanation of Benefits. The Explanation of Benefits provides detailed information concerning the medical insurance claim and the summary of

charges.

Don’t Miss Our Monthly ‘Hot Topics’ Webinars

Each month, our PNCs will be hosting a Hot Topics webinar to help keep you up-to-date on important information you need to know to do business with us. You’ll also get a chance to ask the PNCs questions. This month’s Hot Topics webinar will be on **Jan. 15, 2020**. Register today!

CAQH is an independent third party not-for-profit collaborative alliance of the nation’s leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH is solely responsible for its products and services, including the ProView database.

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Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois (BCBSIL) offers free workshops and webinars for the independently contracted providers who work with us. These trainings focus on electronic options and other helpful tools and resources. A preview of upcoming training sessions is included below. For more information, refer to our Webinars and Workshops page.

BCBSIL WEBINARS

To register now for a webinar on the list below, click on your preferred session date.

Descriptions:	Dates:	Session Times:
BCBSIL Back to Basics: 'Availity® 101' *Join us for a review of electronic transactions, provider tools and helpful online resources.*	Jan. 14, 2020 Jan. 21, 2020 Jan. 28, 2020	11 a.m. to noon
Introducing Availity Remittance Viewer *Have you heard? This online tool gives providers and billing services a convenient way to retrieve, view, save or print claim detail information. The Reporting On-Demand application allows users to readily view, download, save and/or print the Provider Claim Summary (PCS) and other reports online, at no additional cost.*	Jan. 16, 2020	11 a.m. to noon
Monthly Provider Hot Topics Webinar *These monthly webinars will be held through December 2019. They are customized for the BCBSIL contracted provider community. BCBSIL Provider Network Consultants (PNCs) will use this format to share upcoming initiatives, program changes and updates, as well as general network announcements.*	Jan. 15, 2020	10 to 11 a.m.

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

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Notification of Annual Benefit Updates

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In the event a call is necessary to contact BCBSIL Provider Customer Service, please know that hold times may be longer than normal.

- Customer Advocates will have extended hours for eligibility and benefit inquiries **Jan. 2 - 24, 2020**, Monday through Friday from 7:30 a.m. to 6 p.m., CST.
- Claims Customer Advocates hours will remain the same, Monday through Friday from 8:30 a.m. to 4:30 p.m., CST.

As a reminder, you may obtain routine eligibility and benefit information as well as claims status in seconds using Availity or the web vendor of your choice. For patients who are not scheduled for appointments, deferring eligibility and benefit information requests to a later date is appreciated.

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

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2020 Benefit Preauthorization Requirements, Reminders and Resources (PPO – Commercial and Government Programs)

Benefit preauthorization to confirm medical necessity is required for certain services and benefit plans as part of our commitment to help ensure all Blue Cross and Blue Shield of Illinois (BCBSIL) members get the right care, at the right time, in the right setting. It's important to remember that benefit plans differ in their benefits, and details such as benefit preauthorization requirements, are subject to change. This article includes some general reminders and links to recent communications to provide you with an overview of some of the changes to come in 2020 for PPO commercial and government programs.

OVERVIEW OF 2020 CHANGES

Commercial

- Specialty Pharmacy Benefit Preauthorization Requirement Changes for Some Commercial Members, Effective Jan. 1, 2020 – This News and Updates notice was posted on Oct. 1, 2019, to alert you that, for some of our members with Blue Choice Preferred PPO℠ and Blue Options℠/Blue Choice Options℠ benefit plans, some new benefit preauthorization requirements will be added, and some existing requirements will be expanded for select outpatient provider-administered drug therapies, such as cellular immunotherapy, gene therapy and other medical benefit drug therapies. An updated Specialty Pharmacy Select Infusion Drug List (Commercial) was posted on our website in December 2019.
- Benefit Preauthorization Changes for Some Custom Accounts Will Take Effect Jan. 1, 2020 – This News and Updates notice was posted on Oct. 2, 2019, to alert you of additional care categories for which benefit preauthorization through eviCore healthcare (eviCore) may be required for some members with group coverage; the notice includes a list of three-character member ID prefixes for members in three groups who may be affected by this change.
- Benefit Preauthorization for Fertility Services for Some Members Must Be Obtained Through WINFertility, Effective Jan. 1, 2020 – This News and Updates notice was posted on Oct. 2, 2019, to alert you that obtaining benefit preauthorization through WINFertility will be required prior to rendering fertility services for some BCBSIL members with group coverage; the notice includes a list of three-character member ID prefixes for members in two groups who may be affected by this change.
- Benefit Preauthorization Changes for Member ID Prefixes BBE, BHP, BNK, BRG and BYR Will Take Effect March 1, 2020 – This News and Updates notice was posted on Dec. 1, 2019, to alert you of additional care categories for which benefit preauthorization through eviCore may be required as of March 1, 2020, for some members with group coverage

and member ID prefixes BBE, BHP, BNK, BRG and BYR.

Government Programs

- 2020 Blue Cross Medicare Advantage (PPO)℠ (MA PPO) Prior Authorization Requirements Summary – A link to this summary listing was posted in the News and Updates on Oct. 1, 2019. Only one change has been made for 2020: The hyperbaric oxygen service category was removed, as benefit preauthorization through BCBSIL will no longer be required. (**Note:** The procedure codes within some other service categories may be changing; an updated 2020 MA PPO procedure code list was posted in December 2019 in the Prior Authorization section of our Provider website.)
- 2020 Medicaid Prior Authorization Requirements Summary – A link to this summary listing was posted in the News and Updates on Oct. 1, 2019. It includes information that applies to our Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ and Blue Cross Community Health Plans℠ (BCCHP℠) members. This summary list was last updated in September 2019; the categories will remain the same, with no additions or removals for January 2020. (**Note:** The procedure codes within some service categories may be changing; an updated 2020 Medicaid procedure code list was posted on our Provider website in December 2019.)

GENERAL REMINDERS

Check Eligibility and Benefits *First*

Benefit preauthorization requirements are specific to each patient's policy type and the procedure(s) being rendered. It's critical to check member eligibility and benefits through the Availity® Provider Portal or your preferred vendor portal prior to every scheduled appointment. This step will help you determine if benefit preauthorization is required for a particular member. Obtaining benefit preauthorization is not a substitute for checking eligibility and benefits. If benefit preauthorization is required, services performed without benefit preauthorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

How to Obtain Benefit Preauthorization

As always, we encourage you to use electronic options. If benefit preauthorization through eviCore is required, you may submit your request online via the eviCore Web Portal. If benefit preauthorization through BCBSIL is required, you may continue to submit requests using our online tool iExchange®. A new online application for submission of electronic benefit preauthorization requests (278 transactions) will soon be available. Watch the News and Updates for more information.

For More Information

We value your participation as an independently contracted network provider and we appreciate the quality care and services you provide to our members. We encourage you to visit us online often for the most up-to-date information.

- For links to helpful tip sheets, refer to the Eligibility and Benefits section of our Provider website.
- For summary and procedure code lists and other resources, go to the Prior Authorization section.
- Also continue to watch the News and Updates and upcoming issues of the *Blue Review*.

Questions? Contact your BCBSIL Provider Network Consultant (PNC) team.

This information does not apply to HMO members.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized/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. If you have any questions, call the number on the member's ID card.

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for BCBSIL. WINFertility is an independent company that provides fertility management solutions for BCBSIL. WINFertility is solely responsible for the products and services that it provides. iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. Availity is a trademark of Availity, LLC, 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 provided by third party vendors such as eviCore, WINFertility, Medecision or Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

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Reminder: City of Chicago Discontinuing Second Surgical Opinion Requirement Jan. 1, 2020

As stated in a November 2019 News and Updates, beginning **Jan. 1, 2020**, the City of Chicago will no longer require their employees with Blue Cross and Blue Shield of Illinois (BCBSIL) insurance to get a second surgical opinion from Best Doctors or benefit preauthorization from Telligen before having scheduled surgeries in the following areas:

- Hip/knee/shoulder
- Neck/back/spine
- Gallbladder
- Uterine/vagina/cervix

Providers will no longer be responsible for obtaining benefit preauthorization for surgical medical necessity by calling Telligen, and the additional Best Doctors mandatory second opinion won't be required. As a reminder, these procedures are still subject to BCBSIL medical necessity review. Check BCBSIL's Medical Policies for more information, if needed.

Telligen is an independent company that provides Utilization Review/Case Management/Disease Management/Maternity Management to BCBSIL. Best Doctors, an independent company owned and operated by Teladoc Health Inc., provides mandatory second surgical opinions for the City of Chicago. Telligen and Best Doctors are wholly responsible for its own products and services. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by Telligen and Best Doctors.

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.

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Reminder: Laboratory Benefit Level Change for Some Commercial Members Takes Effect this Month

As we shared in our October 2019 *Blue Review*, beginning **Jan. 1, 2020**, or upon a member's renewal date, non-preventive labs will no longer be covered at the no member cost-share level for some of our commercial PPO and HMO members. Non-preventive labs will be treated as a standard medical benefit regardless of diagnosis code. Any applicable cost sharing (copay, coinsurance and deductible) may apply based on the member's health plan.

What does this mean for you?

- You may have to seek payment from both Blue Cross and Blue Shield of Illinois (BCBSIL) and the member.
- You may want to alert members that they may have to pay any applicable cost share (copayment, coinsurance, deductible) for laboratory services.

For the list of lab procedures that are considered preventive, refer to the Preventive Services Clinical Payment and Coding Policy, available in the Standards and Requirements section of our Provider website. The listed preventive lab procedures will continue to process at the no cost-share benefit level when billed with a preventive diagnosis. To confirm how a lab will process if it's not identified on the Preventive Clinical Payment and Coding Policy, call the number on the member's ID card.

Note: The change referenced above does not apply to members who have Medicaid or Medicare benefit plans.

As a reminder, it's important to check eligibility and benefits for all of our members through the Availity® Provider Portal or your preferred vendor portal before every scheduled appointment. Eligibility and benefit quotes include membership/coverage status and other important details, such as applicable copayment, coinsurance and deductible amounts. Checking eligibility and benefits also may help you confirm benefit preauthorization/pre-notification requirements. Don't forget – you must ask to see the member's ID card for current information and a photo ID to help guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly.

Availity is a trademark of Availity, LLC, 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 provided by third party vendors such as Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized/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. If you have any questions, please call the number on the member's ID card.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. References to third party sources or organizations are not a representation, warranty or endorsement of such organizations. Any questions regarding those organizations should be addressed to them directly. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

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Coordinating Care Between Behavioral Health and Medical Providers

Coordinating care between behavioral health and medical providers helps deliver quality care for our members. Our surveys consistently show providers appreciate care coordination. Consulting and referring providers are encouraged to share information such as diagnoses, medications, treatment plans and recommendations to ensure care is appropriately coordinated. We've provided a simple form to help providers request information from each other.

Be sure members sign a release to allow you to share information with other providers before using this form.

Coordination of Care Form
The form is useful for both referring and consulting providers. To request patient visit information from a consulting provider, complete the Patient Information and Referring Provider sections before sending it to the consulting provider. The consulting provider can use the form to communicate information about the visit to the referring provider. Do not send this form to us. It is for your use with other providers only.

Need help finding a Behavioral Health provider?
Call the number on the member's ID card to find in-network outpatient providers or behavioral health facilities. You can also search for providers with our online Provider Finder®.

Have a member with complex health needs?
Additional support and resources from a behavioral health or medical clinician are available. Call the number on the member's ID card to refer members to Case Management and learn about other resources.

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New Formulary Notification for Blue Cross Community Health Plans℠ (BCCHP℠): Uniform Preferred Drug List

The update is to notify Blue Cross and Blue Shield of Illinois (BCBSIL) independently contracted providers about a change to the BCBSIL formulary **effective Jan. 1, 2020**.

Illinois Healthcare and Family Services (HFS) has mandated that effective Jan. 1, 2020, all Illinois Managed Care Organizations (MCO) adopt the HFS Preferred Drug List (PDL). Members that are currently taking medications that are not on the HFS PDL or that now require a prior authorization have been notified of this change and will be allowed a grandfather period of at least 90 days to transition to a preferred drug or request a prior authorization.

You may download the PDL or visit MyPrime.

To prevent member disruption, we suggest you access the BCBSIL formulary at the link above on or after Jan. 1, 2020, to determine if your patients will need to change medications to a preferred agent. You may also submit a prior authorization request to allow them to continue therapy with their current medications by faxing **877-480-8130** or calling **866-202-3474** (TTY/TDD 711).

To submit electronically, visit MyPrime and access the Coverage Exception Form. You can also visit CoverMyMeds®.

If you have any questions regarding processing claims, please call the Prime Contact Center at **800-821-4795.**

CoverMyMeds is a registered trademark of CoverMyMeds LLC, an independent third party vendor that is solely responsible for its products and services. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions regarding the products or services they offer, you should contact the vendor(s) directly.

BCBSIL contracts with Prime Therapeutics (Prime) to provide pharmacy benefit management and other related services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime. MyPrime.com is an online resource offered by Prime.

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CAHPS® Survey's Importance to CMS Star Ratings: Measures for Blue Cross Medicare Advantage℠ Members

Centers for Medicare & Medicaid Services (CMS) posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their areas. CMS rates Medicare Advantage plans on a scale of one to five stars, with five stars being the highest rating in terms of plan performance. Quality scores for Medicare Advantage plans are based on performance measures derived from sources such as Healthcare Effective Data and Information Set (HEDIS®) results, along with CMS administrative data (such as information on member satisfaction, appeal processes, audit results and customer service).

Blue Cross and Blue Shield of Illinois (BCBSIL) strives to achieve the highest possible CMS Star rating for the Blue Cross Medicare Advantage plans (HMO and PPO) we offer. These ratings reflect our performance as a health insurance carrier and serves as a testimony to the care and services you provide to our members. We appreciate your ongoing efforts and dedication in continuing to help improve your patients', and our members', experience.

One key factor in determining the CMS Star ratings is the results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. In early Spring 2020, a random sample of our Medicare Advantage and Prescription Drug Plan (PDP) members will respond to an annual CAHPS survey designed to determine how they experienced or perceived key aspects of their care. According to CMS, the CAHPS survey is one of the primary tools CMS uses to assess how your patients, and our members, experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions, and the coordination of their health care needs.[1]

This survey is an important measure of whether we're meeting our Medicare members' and your patients' expectations with each and every touchpoint. Touchpoints include how well their insurance plan meets their health needs, the quality of care they receive at your office or at the pharmacy counter, and how well customer service representatives address their concerns. These moments define their experience.

We encourage you to focus on the experience of your patients, our members, during the act of care management. Even minor acts may have significant impacts. For example, when a patient receives the flu vaccine, do you provide a certificate of completion? This small thing may help a patient remember they received the flu vaccine and if this member receives the

CAHPS survey, it increases the likelihood they will answer positively on the flu vaccine question.

It's important to monitor your own patient satisfaction surveys and, if possible, segment out Medicare Advantage patients from other patient pools. Each patient segment brings their own challenges and opportunities. Remember, the caregiver of a Medicare Advantage member is equally important because they may complete the CAHPS survey on behalf of the patient. Providing additional support for caregivers can increase the effectiveness of care for the patient and the experience of the caregiver.

The next several months are a perfect opportunity to increase your patient experience initiatives, which will hopefully drive improved CAHPS performance.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1]CMS, Consumer Assessment of Healthcare Providers & Systems (CAHPS), Nov. 13, 2019. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/index

This information is for informational purposes only and is not a substitute for the sound medical judgment of a doctor. Members are encouraged to talk to their doctor if they have any questions or concerns regarding their health.

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2019 HEDIS® Results for Medicaid Children and Adolescent Immunization

Healthcare Effectiveness Data and Information Set (HEDIS) is a nationally standardized set of measures related to important areas of care and service in the health care field. Developed by the National Committee for Quality Assurance (NCQA),[1] HEDIS is one of the most widely used set of health care performance measures in the U.S.

According to the 2019 HEDIS rates for Blue Cross Community Health Plans℠ (BCCHP℠) members, the childhood immunization measure, Combo 3 and Combo 10 are improving but fell short of the 75th percentile goal. The adolescent immunization measure, Combo 1 met the benchmark, however Combo 2 did not meet the benchmark.[2] **Proper documentation is crucial to ensure vaccinations are recorded correctly.**

Childhood Immunization Status (CIS)

- **Combo 3**: 2019 HEDIS Goal = 75.91%
  - 2019 HEDIS rate = 73.72%
  - 2018 HEDIS rate = 68.13%
  - 2017 HEDIS rate = 66.67%
- **Combo 10**: 2019 HEDIS Goal = 41.00%
  - 2019 HEDIS rate= 38.20%
  - 2018 HEDIS rate =36.01%
  - 2017 HEDIS rate=29.63%

Immunizations for Adolescents (IMA)

- **Combo 1**: 2019 HEDIS Goal = 83.89%
  - 2019 HEDIS rate = 85.40%
  - 2018 HEDIS rate = 80.78%
- **Combo 2**: 2019 HEDIS Goal = 38.00%
  - 2019 HEDIS rate = 37.23%
  - 2018 HEDIS rate = 33.82%

As part of the health care team, doctors, practitioners and nurses play a vital role in improving the HEDIS rates. You can

help by educating parents and encouraging them to vaccinate their children. Equally important is the proper documentation of the immunizations given, such as documenting all Combos correctly. Below are a few tips you may choose to apply:

- Communicate with parents regarding the benefits of age appropriate childhood immunization
- Explain the pros and cons of immunizations
- Allow the parents to express their concerns

To further your discussion, below are the HEDIS measures for CIS and IMA.

CIS: Combo 3 includes the below vaccinations. It is recommended children receive them by their second birthday.[2]

- Four diphtheria, tetanus and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps and rubella (MMR)
- Three haemophilus influenza type B (HiB)
- Three hepatitis B (HepB)
- One chicken pox (VZV)
- Four pneumococcal conjugate (PCV)

CIS: Combo 10 includes Combo 3 plus three additional vaccinations. It is recommended children receive them by their second birthday.[2]

- Four diphtheria, tetanus and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps and rubella (MMR)
- Three haemophilus influenza type B (HiB)
- Three hepatitis B (HepB)
- One chicken pox (VZV)
- Four pneumococcal conjugate (PCV)
- One hepatitis A (HepA)
- Two or three rotavirus (RV)
- Two influenza (Flu) vaccines

IMA: HEDIS measures assess adolescents 13 years of age who had the following immunizations by age 13:[3]
Combo 1

- One dose of meningococcal vaccine (between ages 11 to 13 years)
- One Tdap vaccine (between ages 10 to 13 years)

Combo 2

- One dose of meningococcal vaccine;
- One Tdap vaccine; **and**
- The complete human papillomavirus vaccine series between 9 to 13 years of age
  - Two-dose Series: must be at least 146 days between the first and second doses
  - Three-dose Series: If three vaccines with different date of service.

For additional information on recommended immunization schedule for children and adolescents aged 18 years or younger, review our Preventive Care Guidelines.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1] NCQA, HEDIS and performance measures, 2019. Retrieved from: https://www.ncqa.org/hedis/

[2]

NCQA, Childhood Immunization Status (CIS), 2019. Retrieved from https://www.ncqa.org/hedis/measures/childhood-immunization-status/

[3] CDC, Vaccines for Your Children, 2019. Retrieved from https://www.cdc.gov/vaccines/parents/index.html

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

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Quality of Care Complaints

Quality of Care (QOC) complaints submitted by our members most commonly express dissatisfaction with one or more of the following circumstances regarding their medical care: clinical issues, access to care issues, interpersonal issues and/or service issues.

When a QOC complaint is received from a member, Blue Cross and Blue Shield of Illinois (BCBSIL) reviews the complaint to determine next steps. QOC complaints may require follow-up with all involved parties to help support our members' safety and/or alert providers whose actions may have contributed in some way to our members' dissatisfaction.

If follow-up with the provider is deemed necessary, a letter is sent to the provider requesting a response, which may include a request from BCBSIL for medical records to aid in our investigation of the complaint. The member's Application for Coverage and Membership Certificate Agreement authorizes the release of required documents for this purpose. Therefore, a separate authorization for release of records is not necessary to ensure compliance with the request.

We seek to identify and evaluate individual instances of where there may be a potential QOC issue or concern. Quality review of individual cases may result in interventions such as corrective action, termination, or other action depending on case-specific details and findings of the review.

If you have questions about how member QOC complaints are handled and/or your responsibilities as a provider, please contact your Provider Network Consultant (PNC) team for help.

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Annual Reminder: Medicare Outpatient Observation Notice Required

As of March 8, 2017, hospitals and Critical Access Hospitals (CAH) must give the standardized Medicare Outpatient Observation Notice (MOON) to people who receive Medicare benefits and are observed as outpatients for more than 24 hours. This includes people with Blue Cross Medicare Advantage (PPO)℠, Blue Cross Medicare Advantage (HMO)℠, Blue Cross Community MMAI (Medicare-Medicaid Plan)℠, Blue Cross Group Medicare Advantage (HMO)℠, Blue Cross Group Medicare Advantage (PPO)℠ and Blue Cross Group Medicare Advantage Open Access (PPO)℠ health plans.

This notice lets people know why they are not considered to be inpatient and what their cost sharing and hospital coverage will be. It must be explained verbally and completed no later than 36 hours after observation begins or sooner if patients are admitted, transferred or released. Patients must sign to confirm they received and understand the notice. If they say no, the staff member who gave the patient the notice must certify that it was presented.

The MOON and what to do with it can be found here.

The information provided here is only intended to be a summary of the law that have been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here, you should consult with your legal advisor.

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Reminder: Medicare Providers May Not Bill Members in the Qualified Medicare Beneficiary Program

As a provider treating Medicare members, you may not bill beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) Program, a federal Medicare Savings Program.

Members enrolled in QMB are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a State Medicaid benefit, QMB covers these members' Medicare premiums, deductibles, coinsurance and copayments. QMB members are not responsible for Medicare cost-sharing, or out-of-pocket costs.

Your Responsibility

Providers participating in Blue Cross Medicare Advantage℠ plans may not bill their QMB patients for their services. This is regardless of whether the State reimburses the full Medicare cost-sharing amounts. You must accept Medicare payments and any Medicaid payments provided as payment in full.

Federal Law

Please ensure that you and your staff are aware of the federal billing law and policies regarding QMB. It is against federal law for any Medicare provider, not only those who also accept Medicaid, to bill QMB patients. Per your Medicare Provider Agreement, you may be sanctioned if you inappropriately bill QMB members for Medicare cost-sharing.

Helpful Tips

To avoid billing QMB members, please take these precautions:

- Understand the Medicare cost-sharing billing process
- Be sure your billing software and staff leave QMB members off Medicare cost-sharing billing and related collections efforts

More Information

Call Customer Service at 877-774-8592 to learn more about QMB procedures and ways to identify QMB patients. For more details about QMB, see the Centers for Medicare & Medicaid Services website.

This is a brief description of some of the terms of the Medicare Advantage plans. For more details, please refer to the applicable Medicare Advantage document. The information provided here is only intended to be a summary of the law that have been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here, you should consult with your legal advisor.

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