December 2019

What’s New

New Health Equity and Social Determinants of Health (SDoH) Page on Provider Website
In our continuous effort to partner with the provider community to help improve member and community health outcomes, we’ve created a page on the Provider website to centralize resources and tools to help you learn and be engaged.

Read More

CMO Perspective

Rural Health Priorities: Assessing Disparities Outside of Chicago
Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to addressing health equity and identifying which, and to what extent, SDoH contribute to the health of our members. In this month’s CMO Perspective, our Vice President and Chief Medical Officer, Dr. Derek J. Robinson, M.D., MBA, FACEP, CHCQM, introduces a new clinical initiative to help further address the health and wellbeing of our members in non-metropolitan counties.

Read More

Network Updates/Product Innovation

Adding Value: Addressing Health Equity in the HMO
It’s important to have a cohesive plan of action for addressing member needs across the continuum of care. For BCBSIL’s HMO plans, an annual population assessment is conducted to help ensure that the member population and subpopulations have access to all needed services and community resources. This assessment also looks at the impact of SDoH.

Read More
Electronic Options

**Government Programs: New Claim Status Tool via Availity® Provider Portal**

As of **Oct. 31, 2019**, a new and improved Availity Claim Status tool is available for you to check status online for claims submitted to BCBSIL for our Medicare Advantage and Illinois Medicaid members.

**New Online Enrollment Process for 835 EFT/ERA through the Availity Provider Portal**

A new online 835 Electronic Funds Transfer (EFT) and 835 Electronic Remittance Advice (ERA) setup tool is coming soon to BCBSIL. Registered Availity users will be able to use Availity’s Transaction Enrollment tool to submit EFT and ERA enrollments electronically to multiple payers at the same time.

**Government Programs: Interpreting the ‘PLB’ Segment on the 835 ERA**

Reversals and corrections may occur when claim adjudication results have been modified from a previous claim report. The method for revision is to reverse the entire claim and resend with modified data. Provider level adjustments are reported in the Provider Level Balance (PLB) segment within the 835 ERA from BCBSIL. As of **Dec. 5, 2019**, some information will change in the 835 ERA PLB segment for claims submitted for Medicare Advantage and Illinois Medicaid members.

**Government Programs: Electronic Payment Summary Now Available for 835 ERA Receivers**

As of **Nov. 18, 2019**, for Medicare Advantage and **Dec. 13, 2019**, for Medicaid, providers enrolled to receive the ERA from BCBSIL for government programs claims will begin receiving electronic provider claim summary (PCS) files, the electronic version of the remittance advice (RA), in conjunction with the ERA. With this transition, ERA receivers will no longer receive paper remittance advices delivered by mail.

**Availity Remittance Viewer Tool Upgrade**

The Availity Remittance Viewer tool has been upgraded to better assist you with viewing, searching and reconciling the 835 ERA. Remittance Viewer is available to providers who are enrolled to receive ERA files from BCBSIL.
Clinical Updates, Reminders and Resources

**Verify Benefit Preauthorization Requirements by Procedure Code via IVR Phone System**
If you need to use the Interactive Voice Response (IVR) phone system, as of **Oct. 21, 2019**, you can now verify procedure code benefit preauthorization requirements for outpatient, office and home services when calling the IVR phone system for most BCBSIL members.

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Provider Education

**New Health Equity Resources: Toolkits for Hypertension and Diabetes**
There are significant disparities between different U.S. population groups when it comes to hypertension and diabetes incidence, prevalence and sequelae. We are committed to collaborating with you to help support improved health outcomes for your patients, our members and their communities. We’ve gathered resources from well-known websites to create two provider toolkits – one for hypertension, and one for diabetes. The toolkits focus on addressing social determinants of health to achieve health equity for all Illinois populations, regardless of ZIP code.

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Provider Learning Opportunities

BCBSIL offers free webinars and workshops for the independently contracted providers who work with us. A preview of upcoming training sessions is included in this month’s issue.

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Wellness and Member Education

**Osteoporosis Management in Women Who Had a Fracture Remains Low**
Osteoporotic fractures can reduce patient quality of life, increase morbidity and mortality and lead to higher health care costs.

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**New Programs Help Members Lead Healthier Lives**
Our Wellbeing Management and Health Advocacy Solutions programs help empower our members to improve their own health and wellness.
Pharmacy Program

**New Program Notification for Blue Cross Community Health PlansSM (BCCHP®SM)**

*Members: Opioid Diagnosis Code Required at Pharmacy*

BCBSIL has launched a new program to help prevent diversion and inappropriate use of opioids while still providing access for medically necessary purposes.

**Inappropriate Antibiotic Use in Outpatient Settings**

Overprescription of antibiotics has increased antibiotic resistance. We can work together to combat antibiotic resistance and appropriately prescribe these important medications.

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

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](#).

**Claims and Coding**

**Recommendations and Reminders for Eye Care Professionals**

Many primary care providers (PCPs) refer our diabetic Federal Employee Program® (FEP®) and other members to eye care specialists for annual eye examinations. PCPs need to know details about the care their patients receive and to receive communications from their patients’ eye care specialists.

**2019 Updates in Pre- and Post-Natal Care Information to Support Effective Coordination and Continuity of Care**

This article includes important information to help you when providing pre- and post-natal care and services to FEP and other BCBSIL members.

**Quality Improvement and Reporting**

**Hospital Discharge Summaries Contain Important Information for Primary Care Providers**
We want to remind you about some important information to help you when discharging FEP and other BCBSIL members after inpatient hospital stays.

**CMS Star Ratings Matter: CAHPS Survey Begins First Quarter of 2020**
The Centers for Medicare & Medicaid Services (CMS) uses Star measures to rate Medicare Advantage and Part D programs.

**Notification and Disclosure**

**Provider Credentialing Rights and Responsibilities**
Applicants applying or reapplying for participation or continued participation in BCBSIL networks have the right to review information submitted to support their credentialing applications and receive the status of their credentialing or recredentialing applications, upon request.

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

**Has your information changed? Let us know!**
When seeking health care services, our members often rely upon the information in our online Provider Finder®. In particular, potential patients may use this online tool to confirm if you or your practice is a contracted in-network provider for their health care benefit plan. Other providers may use the Provider Finder when referring their patients to your practice.

**ClaimsXten™ Quarterly Updates**
New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes are periodically added to, or deleted from, the ClaimsXten code auditing tool software by the software vendor.
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.
New Health Equity and Social Determinants of Health Page on Provider Website

Throughout 2019, you’ve read multiple CMO Perspectives on health equity (HE) and social determinants of health (SDoH), including:

- Let’s Work Together in 2019 to Help Reduce Health Care Disparities
- Health Equity: Bold Strategies, Unique Solutions
- BCBSIL Hosts Its Inaugural Physician Diversity Summit
- Addressing the Maternal and Infant Health Crisis Through A Health Equity Lens
- Housing as a Health Strategy: Removing Barriers to Improved Health Outcomes

In our continuous effort to partner with you and help improve member and community health outcomes, we’ve created a page on the Provider website to centralize resources and tools to help you learn more about HE and SDoH and to be engaged.

The new HE and SDoH page includes three sections:

- What You Can Do Now
- What BCBSIL is Doing to Address Health Equity and SDoH
- Reference Library

We encourage you to check this page often as strategies for achieving health equity continue to gain momentum. And, we’ll be seeking your input to make sure the content is useful and relevant, so we can add more resources based on your feedback.

bcbsil.com/provider
Rural Health Priorities: Assessing Disparities Outside of Chicago

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

The Illinois Rural Health Summit Planning Committee published key findings in October 2018 that demonstrate disparities in access to health care services and disease incidence. The report found that there are primary care physician shortages in 30.3% of Illinois small and rural hospitals. This climbs to shortages of 93.7% in small and rural hospitals for behavioral health services. Whereas there are 87.1 primary care physicians per 100,000 individuals in large urban counties, this number drops to 45.5 per 100,000 in rural counties. Psychiatrists number 12.6 per 100,000 and 1.6 per 100,000 in urban and rural counties, respectively. This report also found higher numbers of opioid prescriptions and overdose deaths, greater readmission rates for the elderly, and less nutrition and physical fitness opportunities for youth in rural areas.¹ This report demonstrates that a person’s ZIP code is an important factor when it comes to overall health and wellbeing.

BCBSIL is committed to addressing health equity and identifying which, and to what extent, social determinants of health (SDoH) contribute to the health of our members. Though headquartered in Chicago, we realize that not all 8.1 million members reside in Chicago, but throughout Illinois. We’re proud of the fact that we offer coverage in all 102 Illinois counties, of which 62 are considered non-metropolitan counties. To help further address the health and wellbeing of our members in these non-metropolitan counties, we’ve begun a clinical initiative titled “Rural Health Priorities.”

While developing our clinical Rural Health Priorities initiative, we felt early on it was important to partner with providers to help assess needs and focus our efforts on enhancing care for our members in rural locations. In other words, we wanted to determine if our perspectives, programs, goals and perceived needs aligned with the network of clinicians delivering care. We distributed a survey to participating Value Based Care (VBC) groups, including providers who are more likely to render care and interact with this membership. VBC Medical Directors and Administrators were invited to rank issues as high, moderate or low priority. The top three issues ranked high priority by survey participants were Behavioral Health Access, Health Equity (HE)/SDoH and the Opioid Epidemic. And these are some of BCBSIL’s top priorities, too.

The statistics mentioned above reflect the disparity in numbers of psychiatrists available in urban versus rural Illinois counties. Rural provider recruitment challenges may include lack of familiarity with rural life as most medical students come from urban areas. The decision to work or live in a rural location instead of an urban one may depend on many
factors, including social program opportunities or the preferences of providers and their families. We are actively engaged in finding alternative solutions. Leveraging technology is one method that may help improve access to behavioral health services in rural areas. For example, starting in 2020, we are looking to partner with our VBC groups to provide telepsychiatry services to our retail HMO membership. We hope this strategy will create an opportunity to not only increase much-needed access and care but also serve as a means to broaden how we use technology for other members in the years to come.

Our programs and initiatives to address HE and SDoH go hand in hand with our Rural Health Priorities initiative. We must emphasize that in no way is it meant to be inferred that one place is better to live than another. Rather, these initiatives signify that we must all be cognizant that where people live or work contributes to their health and develop strategies to incorporate these components into an individual's care. We have included a HE/SDoH continuing medical education (CME) component as a quality metric for participating HMO medical groups in 2019 and are expanding this to Accountable Care Organization (ACO) contracts in 2020. We are also looking to our VBC groups to determine and use an SDoH screening tool that is best suited to their member and provider communities and report their findings and how this helps them to address improving care and outcomes. For more information, refer to the related article in this month's issue titled, Adding Value: Addressing Health Equity in the HMO.

The opioid epidemic cannot be addressed without collaboration. As an example, we've partnered with our pharmacy colleagues at Prime Therapeutics. In August 2018 Prime began by allowing only a seven-day supply of opioids for members who were considered opioid-naïve (with exceptions being allowed in some cases based upon diagnosis or discussions with a member’s provider). Since that time, we have conducted claims analyses and other initial research and our findings for BCBSIL members agree with the state of Illinois that opioid prescription rates are higher in rural settings. Along with this challenge, there are fewer physicians in rural areas who can provide medication assisted therapy (MAT). This gap in care is something we are hoping to help address through outreach to providers in the months to come.

Other areas on our VBC survey that were identified as moderate priorities included Diabetes/Diabetic Complications, Maternal/Child Health and Colon Cancer Screening. These areas are concerning to BCBSIL, too. Participating VBC groups have diabetic measures as part of their quality metrics. We are looking into ways we can help increase awareness and availability of important services such as prenatal care opportunities and colorectal cancer testing options for our members outside of Chicago and the collar counties.

We don’t expect changes overnight and we know everything can’t be addressed all at once. What we do see is the need to augment SDoH screening and analysis of results to continue to help find ways to support enhancements that factor a patient’s ZIP code into the care they receive. What’s more important and positive is that the goals and programs at BCBSIL are in alignment with the needs and priorities identified by providers such as VBC network participants. By working together, we can rely on one another’s strengths to address shared priorities concerning the health and wellbeing of your patients and our members in all the Illinois communities we serve.

I have enjoyed reaching out through the CMO Perspective this year and look forward to continuing it in 2020. If you’d like to offer feedback, ideas or input, please email the Blue Review editor.

Learn more about Dr. Derek J. Robinson


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
Prime Therapeutics LLC (Prime) is a separate pharmacy benefit management company contracted by BCBSIL to provide pharmacy benefit management and other related services. BCBSIL, as well as several Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.
December 2019

Adding Value: Addressing Health Equity in the HMO

Research has shown that ZIP code has a greater impact than genetic code on health outcomes. Many people across the country are affected by health inequities. Health inequity is identified as differences in health status or in the distribution of health resources between population groups. Such disparities can be traced to social determinants of health (SDoH), which are the circumstances in which people are born and live that have an impact on their health. Blue Cross and Blue Shield of Illinois (BCBSIL) is taking aim at these factors by looking at member data at the local level, then tailoring programs and partnerships to help meet communities’ needs.

Providing resources to help reverse health inequities can improve clinical outcomes while also having a positive impact on member experience with Population Health Management (PHM) programs. It’s important to have a cohesive plan of action for addressing member needs across the continuum of care. For BCBSIL’s HMO plans,* an annual population assessment is conducted to help ensure that the member population and subpopulations have access to all needed services and community resources. This assessment also looks at the impact of SDoH. It focuses on members who have lower incomes, coverage under federal and state programs, multiple chronic conditions or severe injuries, as well as those who may be at-risk from being in potentially under-served ethnic, linguistic or racial groups.

Beginning in 2017, BCBSIL initiated discussions on SDoH and in 2018 addressed health inequity with HMO providers within the structured annual Utilization Management (UM) and PHM plan. Medical groups were tasked with collecting and analyzing data that adequately describe the member populations they serve. They were also asked to establish community resources and help improve member engagement by informing members about available PHM programs. BCBSIL incentivizes medical groups in recognition of assessing SDoH in members enrolled in Case Management programs.

In 2019 we now see medical groups addressing SDoH in their PHM programs through initial assessments and discharge planning. BCBSIL’s Quality Department provided free access to two 60-minute online training modules for primary care providers (PCPs) on the subject of physician bias through the HMO 2019 Health Equity Continuing Medical Education (CME) Project. In addition, the BCBSIL HMO Population Health Academy Day and Administrative Forum provided useful tools and information to reinforce core population health principles and highlight ways to help advance health equity. Presenters emphasized that all BCBSIL plans offer opportunities to help our members live healthier lives. These opportunities may include no-cost education, discount nutrition and fitness programs, and discounted health and wellness...
merchandise (including items like fitness equipment and activity tracking devices). Members can learn more via Blue Access for MembersSM.

Looking to 2020, we remain steadfast in our goal to help improve our members’ lives by continuing to address health equity through our work with providers. We will be asking medical groups to set disparity reduction goals for clinical programs for all members, and we’ll be asking that medical groups educate their staff on potential biases and stigma related to SDoH and health equity. We are adding new initiatives to our PHM program and plan to continue to prioritize member needs by providing formal and informal educational opportunities related to those needs. These initiatives will focus on helping to identify and address some of the root causes of rising health care costs that may be associated with SDoH.

For more information, HMO medical groups may refer to the newly released 2020 UM/PHM Plan, participate in educational webinars and workshops, or reach out to their designated HMO Nurse Liaison for assistance. Also, be sure to visit our new Health Equity and SDoH page for helpful links and related resources, such as hypertension and diabetes toolkits.

Would you like to share the ways you are advancing health equity in your PHM programs? You’re welcome to email our Blue Review editor with feedback.


*Refers to: HMO Illinois®, Blue Advantage HMOSM, Blue Precision HMOSM, BlueCare Direct HMOSM and Blue Focus Care HMO™.

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December 2019

Government Programs: New Claim Status Tool via Availity® Provider Portal

This notice applies to providers rendering services for the following Blue Cross and Blue Shield of Illinois (BCBSIL) government programs members:

- Blue Cross Community Health PlansSM (BCCHPSM) and Blue Cross Community MMAI (Medicare-Medicaid Plan)SM
- Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM

As of Oct. 31, 2019, a new and improved Availity Claim Status tool is available for you to check status online for claims submitted to BCBSIL for the above-referenced members. Registered Availity users may access the Claim Status tool via the Claims & Payment menu in the Availity portal. This tool allows you to search for claims by member ID or specific claim number.

Availity Claim Status results are returned in real-time, with more detailed information than the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard 277 claim status transaction. This new claim status option provides you with the following details:

- Patient and provider data submitted on claims
- In-network and out-of-network patient liability breakdown
- Billing and rendering provider name and National Provider Identifier (NPI)
- Check number, check date and payee name
- Other carrier payment amount
- Ineligible reason codes and associated descriptions

For More Information
Refer to our new Government Programs: Claim Status Tool tip sheet, available in the Provider Tools section of our website. As a reminder, you must be registered with Availity to use the Claim Status tool. To register, visit Availity, or contact Availity Client Services at 800-282-4548.

Questions? Contact our Provider Education Consultants.
New Online Enrollment Process for 835 EFT/ERA through the Availity® Provider Portal

A new online 835 Electronic Funds Transfer (EFT) and 835 Electronic Remittance Advice (ERA) setup tool is coming soon to Blue Cross and Blue Shield of Illinois (BCBSIL). This new capability will be available in the Availity Provider Engagement Portal using the multi-payer Transaction Enrollment tool. BCBSIL’s current online 835 EFT and 835 ERA enrollment option available in our Availity Payer Spaces section will be removed once the transition to the new tool is complete.

This new enrollment capability allows you to submit EFT and ERA enrollments electronically to multiple payers at the same time. You can also use Availity’s Transaction Enrollment option to monitor enrollment status.

EFT and ERA enrollment via Availity is easy to complete, without the inconvenience of downloading and faxing or mailing paper enrollment forms. Once the enrollment is processed, you will receive a confirmation letter acknowledging the enrollment effective date along with other important details.

Advantages of enrolling for EFT:
- Quicker receipt of payments
- Greater security – no more risk of lost or stolen paper checks
- Direct deposit into the bank account of your choice

Advantages of enrolling for ERA:
- Faster remittance delivery
- Automatic posting capabilities
- Designate delivery to a specific clearinghouse or vendor

How to access Availity’s Transaction Enrollment option:
1. Log in to Availity
2. Select My Account Dashboard on the Availity homepage
3. Select Enrollments Center
4. Select Transaction Enrollment*
5. Complete and submit
Online EFT and ERA enrollment is available to registered Availity users. To register for Availity, go to Availity's website and sign up today, at no cost. We are updating our Availity EFT Tip Sheet and Availity ERA Tip Sheet this month to reflect the new enrollment process.

**Have questions or need additional education?**
Email Electronic Commerce Services. Be sure to include your name, direct contact information and Tax ID or Billing National Provider Identifier (NPI).

*The EFT Transaction Enrollment option is only available to the Availity administrator and/or users who have been granted access.*

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.

**bcbsil.com/provider**

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Government Programs: Interpreting the ‘PLB’ Segment on the 835 Electronic Remittance Advice (ERA)

The below announcement applies to providers submitting claims for the following Blue Cross and Blue Shield of Illinois (BCBSIL) government programs members:

- Blue Cross Community Health Plans℠ (BCCHP℠)
- Blue Cross Community MMAI (Medicare-Medicaid Plan)℠
- Blue Cross Medicare Advantage (HMO)℠
- Blue Cross Medicare Advantage (PPO)℠

Reversals and corrections may occur when claim adjudication results have been modified from a previous claim report. The method for revision is to reverse the entire claim and resend with modified data. Provider level adjustments are reported in the Provider Level Balance (PLB) segment within the 835 ERA from BCBSIL.

As of **Dec. 5, 2019**, the following information will change in the 835 ERA PLB segment for the above-referenced members’ claims:

- Adjustment Reason Code (PLB03-1) – qualifier FB (Forward Balance) will be replaced with qualifier WO (Overpayment Recovery – negative amount).
- Provider Adjustment Identifier (PLB03-2) – this field currently contains check number and will be replaced with patient control number and payer document control number (DCN) of the overpaid claim.
  - Example: PLB*15483NN082*20191231*WO:JONES001 181580099999*-1156

We encourage you to refer to our Government Programs: Interpreting the PLB Segment on the 835 ERA resource document. This document provides details about adjustment codes that may appear in the PLB segment, in accordance with the requirements as specified within the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated Technical Report Type 3 (TR3).* The document also includes information on PLB segment definitions and examples, as well as how to locate overpaid claims on the ERA and paper Provider Claim Summary (PCS).
Please share this document with your practice management/hospital information system software vendor, and/or your billing service or clearinghouse, if applicable.

*The HIPAA mandated ASC X12 Health Care Claim/Payment Advice (835) TR3 is available for purchase on the [X12 website](http://x12website.com).

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- Blue Cross Community MMAI (Medicare-Medicaid Plan)SM
- Blue Cross Medicare Advantage (HMO)SM
- Blue Cross Medicare Advantage (PPO)SM

As of Nov. 18, 2019, for Medicare Advantage and Dec. 13, 2019, for Medicaid, if you are enrolled to receive the 835 Electronic Remittance Advice (ERA) from BCBSIL for the above-referenced government programs members, you will also receive an electronic provider claim summary (PCS), the electronic version of the remittance advice (RA), in conjunction with your 835 ERA. The ERA and electronic PCS/RA files are delivered to your designated clearinghouse or vendor. With this transition, ERA receivers will no longer receive paper remittance advices delivered by mail.

As an additional option, provider claim summary and/or remittance advice details are available online in the Reporting On-Demand application via the Availity® Provider Portal. This application allows you to view, download, save and/or print claim remittances for claims processed on or after April 12, 2019. For instructions on how to use this application, refer to the Reporting On-Demand tip sheet in the Provider Tools section of our website.

Not yet enrolled for ERA?
Online ERA enrollment is available to registered Availity users. If you need to register, visit Availity and complete the online guided process – at no charge. To learn more about ERA enrollment through Availity, refer to the Availity ERA tip sheet. For more information, refer to the Claim Payment and Remittance section of our Provider website.

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**Availity® Remittance Viewer Tool Upgrade**

The Availity Remittance Viewer tool has been upgraded to better assist you with viewing, searching and reconciling 835 Electronic Remittance Advices (ERA). Remittance Viewer is available to providers who are enrolled to receive 835 ERA files from Blue Cross and Blue Shield of Illinois (BCBSIL). If you have not yet enrolled with BCBSIL, you can register online via the Availity Portal. Refer to the [Availity ERA tip sheet](#) for enrollment instructions.

**Remittance Viewer upgraded features:**

- Improved data response – Remittance Viewer now displays the provider organization’s last 48 hours of remittances upon opening the tool.
- More search options – New search technology is available for providers to locate specific information with advanced filtering.

Providers can search by check number, 835 Electronic Funds Transfer (EFT) trace number or BCBSIL claim number. When a check number, claim number or patient/member ID is entered, this intuitive tool presents applicable options as the user enters characters. Also, the claim search option now offers additional filter fields, allowing users to specify exceptions and adjustment code(s), as needed.

**How to access Remittance Viewer via Availity Portal:**

- Log in to [Availity](#)
- Select Claims & Payment from the navigation menu
- Select Remittance Viewer

Contact your Availity Administrator if Remittance Viewer is not available in your Claims & Payments menu. As a reminder, you must be registered with Availity to use Remittance Viewer. If you are not yet registered, visit [Availity](#) and complete the online guided process to register – at no charge.

**Additional Support**

Learn how to use this improved Availity offering by attending a Remittance Viewer training webinar hosted monthly by BCBSIL. To register for an upcoming session, refer to the [Webinars and Workshops page](#). Also, see the updated [Remittance Viewer tip sheet](#) for navigational assistance.
If you have questions or would like customized training, email the Provider Education Consultant team.

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Verify Benefit Preauthorization Requirements by Procedure Code via IVR Phone System

As a reminder, checking eligibility and benefits electronically through the Availity® Provider Portal or your preferred web vendor is the quickest way to access coverage and benefit preauthorization information for Blue Cross and Blue Shield of Illinois (BCBSIL) members.

However, if you need to use the Interactive Voice Response (IVR) phone system, as of Oct. 21, 2019, you can now verify procedure code benefit preauthorization requirements for outpatient, office and home services when calling the IVR phone system for most BCBSIL members.* This IVR enhancement will improve provider administrative efficiencies and ultimately reduce call and/or hold time with BCBSIL. Checking procedure code(s) in the IVR is for benefit preauthorization determination only and is not a code-specific quote of benefits.

How to determine procedure code benefit preauthorization requirements via IVR phone system:

- If calling BCBSIL (800-972-8088) to verify eligibility and benefits for outpatient, office or home services, the IVR provides an optional prompt to “check preauthorization by procedure code” after eligibility and benefits are quoted.
- If calling BCBSIL (800-572-3089) to initiate and submit an outpatient, office or home benefit preauthorization request, the IVR will request a procedure code to determine if the specific code(s) requires preauthorization before initiating the request.
- IVR quotes benefit preauthorization requirements based on the code(s) entered.
- Confirmation number for the quote is provided to the caller.
- Callers can request a faxed response of the IVR quote once completed.

Important Notes:

- You may verify up to five procedure codes during the IVR quote.
- If you do not have a procedure code when the IVR prompts for it, say “I don’t have one” and the system will quote benefit preauthorization requirements based on the benefit category instead (i.e., physical therapy, surgical, etc.).
- If no benefit preauthorization is required, you will be returned to the main menu in the IVR.

For step-by-step IVR navigational assistance, refer to the Eligibility and Benefits Caller Guide or Outpatient
Preauthorization Caller Guide located on our Provider website.

*Checking code-specific benefit preauthorization in the IVR is not available for the following members:

- Federal Employee Program® (FEP®)
- Blue Cross Medicare Advantage (HMO)SM and Blue Cross Medicare Advantage (PPO)SM
- Blue Cross Community MMAI (Medicare-Medicaid Plan)SM and Blue Cross Community Health PlansSM (BCCHPSM)

If you need additional support or have any questions, contact our Provider Education Consultant team.

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.

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 independent 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.
December 2019

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.*

<table>
<thead>
<tr>
<th>Descriptions</th>
<th>Dates:</th>
<th>Session Times:</th>
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</table>
| BCBSIL Back to Basics: ‘Availity® 101’ Join us for a review of electronic transactions, provider tools and helpful online resources. | Dec. 10, 2019  
Dec. 17, 2019 | 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. | Dec. 12, 2019 | 11 a.m. to noon |
| Blue Cross Community Health Plans℠ (BCCHP℠) for Behavioral Health/Medical Providers This webinar is intended for the following provider types: Long Term Care Facilities (LTC), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Specialized Mental Health Rehab Facility (SMHRF), Supportive Living Facilities (SLF), Home Health, Hospice, Durable Medical Equipment (DME), Home Infusion, | Dec. 17, 2019 | 10 to 11 a.m. |
Managed Long Term Services and Supports (MLTSS) Orientation
Dec. 10, 2019 10 to 11 a.m.

This webinar offers LTSS providers more information about the MLTSS program as it relates to our BCCHP product and how to navigate BCBSIL requirements, electronic options and online provider resources.

Monthly Provider Hot Topics Webinar
Dec. 4, 2019 10 to 11 a.m.

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.

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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Osteoporosis Management in Women Who Had a Fracture Remains Low

Osteoporotic fractures can reduce patient quality of life, increase morbidity and mortality and lead to higher health care costs. Women 65-85 years of age who have suffered a fracture are at a significantly higher risk for developing additional fractures. Therefore, osteoporosis management in these women is critical to prevent future fractures.

The recommended treatment is for women to have a bone mineral density test or osteoporosis treatment within six months after a fracture.

According to the National Committee for Quality Assurance (NCQA), osteoporosis testing and treatment among patients who are at risk and those who have already suffered a fracture remains low despite the availability of effective treatments.

What can you do to help ensure optimal management of these patients?

- Schedule fracture patients for a bone mineral density test or prescribe an osteoporosis medication within 180 days of the fracture.
- Annually test women age 65 to 85 that are at risk with a bone mineral density test to prevent fractures and the development of osteoporosis.
- Promote and ensure patient compliance with osteoporosis medications by ensuring patients are filling their prescriptions.
- Talk to patients about eating a healthy diet that includes adequate calcium and vitamin D, smoking cessation, limiting alcohol use and performing regular weight-bearing exercises if appropriate.

Below is the list of medications provided on the Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications for the measure Osteoporosis Management in Women with Fracture:

<table>
<thead>
<tr>
<th>Bisphosphates</th>
<th>Other Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alendronate</td>
<td>Abaloparatide</td>
</tr>
<tr>
<td>Alendronate-cholecalciferol</td>
<td>Denosumab</td>
</tr>
<tr>
<td>Ibandronate</td>
<td>Raloxifene</td>
</tr>
</tbody>
</table>
Remember to check formularies for drugs covered by the member's plan. Also ask to see the member's ID card for current information and a photo ID to help guard against medical identity theft.


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, or the listing of any particular drug or classification of drugs, 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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December 2019

New Programs Help Members Lead Healthier Lives

A complex combination of factors affects each person’s health journey. Some of our members are navigating critical health concerns. They may be struggling to combat chronic conditions such as diabetes, obesity, substance abuse disorder or depression. Our Wellbeing Management and Health Advocacy Solutions programs help empower our members to improve their own health and wellness.

Wellbeing Management and Health Advocacy Solutions
Employers can offer Wellbeing Management and Health Advocacy Solutions to their employees, our members. Members have access to components of these programs depending on their benefit plans. We have relationships with several companies to increase member participation in programs that target critical health issues. We’ve seen positive results.

Options for Member Engagement
Some of your patients with Wellbeing Management or Health Advocacy Solutions may mention Well onTarget®, Livongo®, Omada® and Naturally Slim®. These programs combine data sciences with cognitive behavioral therapy coaching techniques. They often use internet-connected biometric devices to help our members achieve health improvement goals.

Well onTarget
Our Well onTarget Wellness Portal gives eligible members an online platform to find support for chronic conditions. They can also use the portal to help establish lifelong wellness goals.

Livongo
Livongo is an end-to-end diabetes management solution. It combines the use of a connected glucose meter with personal support by Certified Diabetes Educators.

Omada
Omada is an obesity-related prevention program. It uses remote monitoring tools, education and social community support to improve health and reduce chronic disease risk.

Naturally Slim
Naturally Slim is an online weight loss and metabolic syndrome management solution and coaching program. It teaches
healthy eating behaviors via a behavior modification structure.

**New for 2020 – Hinge Health**

Hinge Health provides a musculoskeletal program that takes proven nonsurgical care guidelines and turns them into a coach-led program. It is delivered remotely using mobile and wearable technology.

We encourage you to talk with your patients about available programs and resources, when appropriate. Members with questions can call the number on their Blue Cross and Blue Shield of Illinois (BCBSIL) ID card or log into their Blue Access for Members℠ (BAM℠) account for more information.

This material is meant for informational purposes only. It includes only a brief description of some plan benefits. Not all benefits are offered by all plans. For details, including benefits, limitations and exclusions, refer patients to their certificate of coverage.

Livongo is an independent company that has contracted directly with BCBSIL to provide a diabetes management program that is covered under some of the health benefit plans. Naturally Slim is an independent company that has contracted directly with BCBSIL to provide a weight loss and metabolic syndrome reduction program that is covered under some of the health benefit plans. Omada is an independent company that has contracted directly with BCBSIL to provide an obesity-related chronic conditions (type 2 diabetes and heart disease) risk reduction program that is covered under some of the health benefit plans. Hinge Health offers digital care programs for people with chronic musculoskeletal conditions, such as back or joint pain, using technology to create a delightful participant experience by combining sensor-guided exercise therapy with health coaching and education. This material is meant for informational purposes only. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by independent companies such as Livongo, Naturally Slim, Omada, and Hinge Health. These companies are solely responsible for the products or services they provide. If you have any questions regarding the services described here, you should contact Livongo, Naturally Slim, Omada, or Hinge Health directly.

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December 2019

New Program Notification for Blue Cross Community Health PlansSM (BCCHPSM) Members: Opioid Diagnosis Code Required at Pharmacy

Blue Cross and Blue Shield of Illinois (BCBSIL) has launched a new program to help prevent diversion and inappropriate use of opioids while still providing access for medically necessary purposes.

To further ensure proper use of opioids, we have worked closely with our Pharmacy Benefit Manager (PBM), Prime Therapeutics, to build and implement a Diagnosis (Dx) code requirement at the dispensing pharmacy, which may improve care and disease management engagement with our members. This new process helps ensure that opioid prescriptions covered for our members are appropriate and the dispensing pharmacists are aware of the member’s pain treatment needs.

Effective Nov. 1, 2019: BCBSIL requires each opioid prescription to have a valid and appropriate diagnosis code (defined below). Excluded from this requirement will be buprenorphine products used for treating opioid addiction.

- **Appropriate Code**: A valid ICD-10 Dx code that is an appropriate indication for the use of opioids (i.e., G89.3 Neoplasm related pain).

If you are a provider that is a Part 2 Program under the Substance Abuse and Mental Health Services Administration (SAMHSA) 42 CFR Part 2 Rules, you may have obligations to obtain a patient consent and provide notices related to the use or redisclosure of the diagnosis information to the dispensing pharmacy.

For questions about drug coverage, members can call the Customer Service number on their member ID card.

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

Prime Therapeutics LLC (Prime) is a separate pharmacy benefit management company contracted by BCBSIL to provide pharmacy benefit management and other related services. BCBSIL, as well as several Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.
Inappropriate Antibiotic Use in Outpatient Settings

Overprescription of antibiotics has increased antibiotic resistance. We can work together to combat antibiotic resistance and appropriately prescribe these important medications. According to a Pew Charitable Trust report regarding Antibiotic Use in Outpatient Settings, 30% of antibiotics prescribed are found to be unneeded for treating conditions like viral illnesses and asthma exacerbation.¹

Common Conditions That Don’t Need Antibiotics

The Centers for Disease Control and Prevention (CDC) suggests that antibiotics are most often inappropriately prescribed for conditions like:²

- Common cold
- Bronchitis
- Viral sore throats
- Sinus and ear infections

Using antibiotics when they are not needed can do more harm than good.

Alternatives to Antibiotics

You may consider other remedies when treating conditions that don’t need antibiotics, like:

- Getting adequate rest
- Increasing oral fluids
- Using a humidifier or cool mist vaporizer and ensuring they have been properly cleaned
- Inhaling hot shower steam or other sources of hot vapor
- Taking throat lozenges for adults and children, ages 5 years and older
- Considering over-the-counter medications to treat symptoms

The CDC has a poster you can download and display in the exam room to inform patients of your commitment to their health.

If you have any questions about the appropriate use of antibiotics for Federal Employee Program® (FEP®) members,
please email the Quality Improvement Department at Blue Cross and Blue Shield of Illinois.


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.
December 2019

**Recommendations and Reminders for Eye Care Professionals**

This article pertains to care/services provided to our Federal Employee Program® (FEP®) members.

Many primary care providers (PCPs) refer our diabetic FEP and other members to eye care specialists for annual eye examinations. PCPs need to know details about the care their patients receive and to receive communications from their patients’ eye care specialists. We want to encourage providers who do not routinely share results to consider doing so.

For quick reference purposes, a recommendation summary and additional information are included below to assist you when you are providing annual eye exams to our diabetic FEP members.

In 2017, the American Diabetes Association (ADA) updated its position statement on diabetic retinopathy and screening recommendations.¹ A summary of ADA recommendations is included here for your reference purposes.

<table>
<thead>
<tr>
<th>Screening:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Comprehensive evaluation by an eye care specialist should not be substituted by retinal photography. However, retinal photography with remote reading by retinal specialist is acceptable where eye care professionals are not readily available.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Exam:</th>
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<tbody>
<tr>
<td>• Within five years of diagnosis for adults who have Type 1 diabetes</td>
</tr>
<tr>
<td>• At the time of diagnosis for adults with Type 2 diabetes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine Exams:</th>
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</thead>
<tbody>
<tr>
<td>• Every two years in the absence of retinopathy</td>
</tr>
<tr>
<td>• Annually in the presence of retinopathy</td>
</tr>
<tr>
<td>• At more frequent intervals in the presence of progressive retinopathy and/or deterioration of vision due to disease progression</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancy:</th>
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<tbody>
<tr>
<td>• Educate women who are planning to be or are pregnant and who also have diabetes about</td>
</tr>
</tbody>
</table>
the risk of diabetic retinopathy developing or progressing

- Perform an eye exam prior to or at the time of diagnosis of pregnancy, during every trimester, and one year after delivery in the presence of pre-existing Type 1 or Type 2 diabetes

To help improve patient outcomes, please consider the following practices:

- **Incorporate ADA recommendations into practice.** Following the above recommendations can help ensure best practice for patients.
- **Gather patient information.** Ask the patient about their diabetes history, medications they are taking, symptoms they are experiencing and if they have any questions.
- **Educate your patients.** Help them understand why a retinal exam for patients with diabetes is different than an eye exam for glasses and why it is essential to help prevent future problems.
- **Remind your diabetic patients to contact the number on their member ID card if they have any questions about their health care coverage details.** A yearly retinal exam may be a covered benefit for patients with diabetes.
- **Submit claims accurately.** When submitting a claim for a diabetic patient eye exam, be sure to include “diabetes” as a diagnosis to help ensure proper application of benefits.

Thank you for collaborating with us to support the health and wellness of our FEP members. Working together, we can help support improved outcomes for people with diabetes.

1 ADA, Diabetic Retinopathy: A Position Statement by the American Diabetes Association, March 2017, [http://care.diabetesjournals.org/content/40/3/412](http://care.diabetesjournals.org/content/40/3/412)

The information in this article is being provided for educational purposes only and is not the provision of medical care or advice. Physicians and other health care providers are 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. 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.
December 2019

2019 Updates in Pre- and Post-Natal Care Information to Support Effective Coordination and Continuity of Care

This article includes important information to help you when providing pre- and post-natal care and services to Federal Employee Program® (FEP®) members.

Communication between health care professionals during the course of a patient’s pre-pregnancy, pregnancy and postpartum medical journey is important. When you are providing care, you may want to include the following information in the patient’s chart to help ensure effective coordination and continuity of care:

Prenatal Visit in First Trimester
- Prenatal risk assessment may include the complete medical and obstetrical history, physical exam [e.g., American College of Obstetrics and Gynecology (ACOG) Form] and patient education/counseling
- Prenatal lab reports [e.g., obstetric (OB) panel/toxoplasmosis, rubella, cytomegalovirus, herpes simplex, and HIV antibody (TORCH) panel/Rubella antibody test/ABO (O, A, B, or AB blood group testing)/Rh factor testing]
- Ultrasound, estimated due date (EDD)

Duration of Prenatal Visits
- Prenatal flow sheet [e.g., ACOG, Electronic Health Record (EHR), or other]
- All progress/visit notes for duration of pregnancy
- Ultrasound reports and all consult reports

Delivery
- Documents, such as hospital delivery records, verifying the member had a live birth; or,
- If the member had a non-live birth, records that document the non-live birth

Postpartum
- Documentation of a postpartum visit on or between seven to 84 days after delivery
- Postpartum office visit progress notation that documents an evaluation of weight, blood pressure, breast exam, abdominal exam and pelvic exam
Hospital Discharge Summaries Contain Important Information for Primary Care Providers

It is important for primary care providers (PCPs) to know details about the care their patients receive during inpatient hospital stays. The hospital discharge summary is the key source for this information and is used to improve coordination and quality of care.

Here’s some useful information you may want to use to help when discharging Federal Employee Program® (FEP®) members after inpatient hospital stays.

Studies have shown that providing timely, structured discharge summaries to PCPs helps reduce readmission rates, improves patient satisfaction and supports continuity of care. One study found that at discharge, around 40% of patients typically have test results pending and 10% of those results require action. PCPs and patients may be unaware of these results.1,3

A prospective cohort study found that one in five patients discharged from the hospital to their homes experienced an adverse event (defined as an injury resulting from medical management rather than from the underlying disease) within three weeks of discharge. This study found 66% of these were drug-related adverse events.2,3

The following key information is important to include in every discharge summary:

- Course of treatment
- Diagnostic test results
- Follow-up plans
- Diagnostic test results pending at discharge
- Discharge medications with reasons for changes/medication reconciliation

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exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.
December 2019

**CMS Star Ratings Matter: CAHPS Survey Begins First Quarter of 2020**

The Centers for Medicare & Medicaid Services (CMS) uses Star measures to rate Medicare Advantage and Part D programs. Star ratings are determined by several different measures, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey evaluates how satisfied members are with their health plans and prescription drug services. Member satisfaction is impacted by experiences and interactions the member has with every part of their health plan, including you, the provider community. That's why it's so important for all of us to be focused on member satisfaction throughout the year.

Some of the important questions members are asked on the survey include:

- **Have you had a flu shot since July 1 of the previous year?**
- **How often did you get an appointment to see a specialist as soon as you needed?**
- **How often did you see the person you came to see within 15 minutes of your appointment time?**
- **How often did you and your personal doctor talk about all the prescription medicines you are taking?**
- **How often did your personal doctor seem informed and up-to-date about the care you received from specialists?**

The CAHPS survey is administered to a random sample of Blue Cross and Blue Shield of Illinois members from March through June 2020. Members will begin receiving their survey in just a few months, so you may want to encourage your patients to respond to the CAHPS survey if they are selected to participate.

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.
December 2019

Provider Credentialing Rights and Responsibilities

Applicants applying or reapplying for participation or continued participation in Blue Cross and Blue Shield of Illinois (BCBSIL) networks* have the right to review information submitted to support their credentialing application and receive the status of their credentialing or recredentialing applications, upon request.

Applicants should direct all requests to NetOps Provider Updates. The Enterprise Credentialing Department will notify the applicant in writing if we discover wrong information during the verification process from any primary source. We will give applicants 30 calendar days to correct wrong and/or conflicting information and resubmit to the Enterprise Credentialing Department, your assigned Provider Network Consultant or the Medical Director. It will be the applicant’s responsibility to work with the reporting entity to correct the wrong and/or conflicting information.

Please note: Credentialing decisions will not be made until the applicant has responded or if the response has exceeded the 30 calendar days allocated.

Applicants who only see patients in an office setting and do not have hospital admitting privileges at a network hospital may attest to having coverage for hospital admissions by submitting a signed Hospital Coverage Letter.

*This article applies to BCBSIL HMO, PPO, Blue Choice PPOSM, Blue Cross Medicare Advantage (PPO)SM, Blue Cross Medicare Advantage (HMO)SM and Blue Cross Community MMAI (Medicare-Medicaid Plan)SM. Effective Jan. 1, 2019, the State of Illinois is responsible for credentialing and recredentialing of physicians and certain other providers that participate in the Blue Cross Community Health PlansSM (BCCHPSM) Medicaid plan.
Has your information changed? Let us know!

When seeking health care services, our members often rely upon the information in our online Provider Finder®. In particular, potential patients may use this online tool to confirm if you or your practice is a contracted in-network provider for their health care benefit plan. Other providers may use the Provider Finder when referring their patients to your practice.

We encourage you to check your information in our Provider Finder. Is your online information accurate? If changes are needed, please let us know as soon as possible.

Types of Information Updates

- **Demographic Changes**
  Use the [Demographic Change form](#) to change existing demographic information, such as address, email, National Provider Identifier (NPI)/Tax ID or to remove a provider. You may specify more than one change within your request as long as all changes relate to the same billing (Type 2) NPI. As a participating provider, your NPI(s) should already be on file with BCBSIL. You may use this online form to request changes, such as deactivation of an existing NPI.

- **Request Addition of Provider to Group**
  If you need to add a provider to your current contracted group, complete the [Provider Onboarding Form](#). Due to the credentialing requirements, changes are not immediate upon submission of this form. The provider being added to the group will not be considered in network until they are appointed into the network.

Other Information Changes

The following types of changes are more complex and require special handling:

- **Legal Name Change for Existing Contract**
  If you are an existing provider who needs to report a legal name change, [complete a new contract application](#) to initiate the update process.

- **Medical Group Change for Multiple Providers**
  If you are a group (Billing NPI Type 2) and have more than five changes, please email a request to [Illinois Provider Roster Requests](#) to obtain a current copy of your roster to initiate your multiple-change request.
Changes are not immediate upon request submission.

For status of your professional contract application, or if you have questions or need to make changes to an existing contract, email NetOps Provider Update.
December 2019

**ClaimsXten™ Quarterly Updates**

New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes are periodically added to, or deleted from, the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and aren’t considered changes to the software version. Blue Cross and Blue Shield of Illinois (BCBSIL) will normally load this data to the BCBSIL claim processing system after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSIL Provider website. We will also post advance notice of ClaimsXten software updates on our website.

To help determine how some coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to use Clear Claim Connection™ (C3). C3 is a free, online reference tool. Refer to the [Clear Claim Connection](http://example.com) page on our website for more information about C3, including frequently asked questions about ClaimsXten. Updates may be included in future issues of the [Blue Review](http://example.com). Please note that C3 doesn’t contain all of the claim edits and processes used by BCBSIL in adjudicating claims, and results from use of the C3 tool aren’t a guarantee of the final claim determination.

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