Integrated Palliative Care in Action: What does it look like?

Because patients and providers will often mistakenly equate palliative care with hospice care, there is confusion as to what role palliative care may play for the patient who is still receiving or who desires disease-focused therapies. In the November 2013 Blue Review, the optimal model of palliative care was depicted as a simple graph.

The model above illustrates the integration between attempts to modify disease trajectory and assessments for unmet palliative needs, which span physical, emotional, social and spiritual realms. This model is designed to allow medical teams to provide complete care of the patient and improve overall quality of life. The following patient examples demonstrate this model working at its highest level, where conversations start early and guide the later transitions in care planning.

Since 2011, Blue Cross and Blue Shield of Illinois (BCBSIL), the Illinois Hospital Association and the Northwestern University Feinberg School of Medicine have worked together to help implement PREP, Preventing Readmissions through Effective Partnerships. The PREP program assists hospitals in addressing issues that may lead to readmissions. Twenty-four Illinois hospitals have participated in the PREP Communication and Palliative Care program, which provides training and a physician mentor to assist hospitals in addressing palliative care needs. Dr. Jessica Montalvo, Assistant Professor in the Section of Palliative Care at Feinberg and a faculty member and mentor for the PREP Communication and Palliative Care Program, has provided this information for Blue Review readers for the final article in a three-part series about palliative care.

When Renee* was diagnosed with an aggressive lymphoma in early 2013, like many patients, she was focused on a cure. Her disease showed some response to the first-line chemotherapy regimens. By June, unfortunately, her cancer was growing despite those therapies. Renee made the decision to transition her care to a specialized cancer center.

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Integrated Palliative Care in Action: What does it look like?

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During her first hospital stay for a new chemotherapy regimen, she requested a palliative care consultation. Her oncologist and hospital physician were surprised, but consulted the palliative care team nonetheless. Renee spoke of her desire to continue pursuing disease-modifying therapies, while planning for the possibility that her cancer might not get better. She discussed her work in patient relations at a nearby hospital, and how often she observed people growing more and more ill without open conversations about what was really happening to them. Renee spoke of hip pain that was worsening and making it difficult for her to be as active as she wanted to be.

The team examined her medications and recommended adjustments during her hospital stay, which improved her walking significantly. Renee expressed the desire to follow up in the outpatient palliative clinic, and she has done so for the past six months. The physicians and nurses have supported Renee through subsequent chemotherapy and radiation treatments by addressing ongoing pain and nausea, listening to her concerns about how her husband is coping with her illness and discussing when, in her view, the burdens of further treatment will outweigh possible benefits. She hopes to have the social worker speak with her husband about the questions that he has regarding what her path looks like if the cancer can be controlled, and if it can’t.

In general, palliative care has had a more natural relationship with oncology than with other medical disciplines, but this is changing. Consider the story of Betty,* an elderly female with severe COPD and heart failure. Her pulmonologist employed excellent primary palliative care practice by focusing on maximizing her physical function and initiating conversations about the progressive debility Betty would experience as a result of her illness. Eventually, the pulmonologist reached out to the palliative care clinic for assistance with managing her severe shortness of breath. Betty and her children developed a relationship with both teams that lasted for two years. When an interventional procedure led to difficulty with her breathing, Betty’s family faced the decision of whether or not to place her on a ventilator. As a result of the previous conversations with the pulmonary and palliative teams, the family understood the ramifications of intubation and did not believe that this would be consistent with Betty’s goals or wishes. With noninvasive breathing support, Betty’s breathing improved, and she was able to pursue acute inpatient rehabilitation to become stronger. The palliative care team remained involved in her care, helping to manage opioid medications that she used to ease her breathlessness. When Betty and her family needed more support at home, the palliative care team helped arrange for home hospice care. She spent most of the last 18 months of her life at home, with her family, and occasionally traveling to family reunions.

Renee and Betty benefitted tremendously from early palliative care practice. Both pursued curative, disease-modifying therapies in conjunction with aggressive symptom management and future care planning. Both felt stronger and more active because the physical manifestations of their two diseases were addressed. For Renee, facing the uncertain outcome of her illness has been simpler because of conversations that are allowing her to plan how she would want to spend her final days if her cancer proves unresponsive. For Betty, when the ultimate path of her illnesses was clear, she and her family were empowered by the previous conversations with their providers to set limits on the type of interventions she wanted to receive.

This model of health care, which integrates palliative care principles into patient evaluation earlier, is the goal.

*The names of the patients have been changed to protect their privacy and comply with privacy laws.
Update on Confirming Eligibility of New BCBSIL Members

With the new federal requirement for individuals to have insurance coverage beginning Jan. 1, 2014, along with new commercial groups with coverage starting Jan. 1, 2014, BCBSIL is pleased to be serving many new members. There are some important things to be aware of when verifying eligibility:

**Member ID information:** Members should receive their member ID card within days of completing their enrollment. However, some of your patients may not have received their member ID card at the time of their appointment. If they have their member identification number and group number from another source, such as their new member welcome letter or phone confirmation, we can verify eligibility and benefits. For patients who do not have this information, you should direct them to contact our Member Customer Service Center at 800-538-8833 to obtain their information, or reschedule their appointment to a later date.

If the member is exhibiting an urgent need for inpatient services or admission and you are unable to verify their information, please contact the preauthorization department at 855-462-1786.

**Confirming coverage:** As usual, coverage cannot be used until the member’s first month premium payment has been applied to effectuate coverage. Also, benefits may vary depending on the coverage purchased by the member. It is important to check for eligibility and benefits each time you see a patient. We are experiencing high call volumes and increased hold times due to 2014 updates. At this time, please wait until patients have scheduled appointments before making eligibility and benefit inquiries.

**Network terms:** We want to stress the importance of confirming your network status for the member’s plan before services are provided. As a reminder, the terms of your network contract prevent you from refusing to provide services to a BCBSIL member, irrespective of where they purchased their coverage. Care provided for emergency conditions will follow our standard authorization process.

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**Reminder: CMS-1500 Paper Claim Form (Version 02/12) Available January 2014**

As reported in previous issues, the National Uniform Claim Committee (NUCC) recently announced that in early January 2014, the health care industry will transition to a revised version of the CMS-1500 paper claim form: OMB-0938-1197 FORM 1500 (02-12).

The tentative 2014 transition timeline, which aligns with Medicare's timeline, includes:

- Jan. 6, 2014 – Payer begins receiving and processing paper claims on the revised CMS-1500 claim form (version 02/12).
- Jan. 6, 2014 through March 31, 2014 – Dual-use period during which payer continues to receive and process paper claims submitted on the old CMS-1500 claim form (version 08/05), as well as on the revised CMS-1500 claim form (version 02/12).
- April 1, 2014 – Payer receives and processes paper claims submitted only on the revised CMS-1500 claim form (version 02/12). As mandated by CMS, claims submitted after this date using the old form will be rejected.

This revised paper claim form also aligns with HIPAA-standard electronic claim submission requirements. For more information on the CMS-1500 claim form and technical specifications, visit the NUCC website at nucc.org.

Please note: If you use a practice management system, billing service or clearinghouse, it’s important to check with your vendor(s) to ensure they are aware and can accommodate any changes.

**Tip:** Electronic claim submission can help streamline your administrative processes, help protect your patients’ information and may result in faster claim processing and payment. To learn more about these electronic benefits, visit the Claims and Eligibility/Electronic Commerce section on our website at bcbsil.com/provider.
In an effort to comply with fairness in contracting legislation and keep our independently contracted providers informed, BCBSIL has designated a column in the Blue Review to notify you of any significant changes to the physician fee schedules. Be sure to review this section each month.

**Effective Jan. 1, 2014, code range 96401-96425 will be updated.**

**Effective Jan. 1, 2014, the following codes will be updated: 90649, 90710 and 90732.**

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

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**A Closer Look: Documentation and Coding for Pulmonary Diagnoses**

On Oct. 1, 2014, all HIPAA-covered entities must transition from ICD-9-CM to the ICD-10-CM/PCS code sets. At that time, claims with ICD-9-CM codes will not be accepted unless they are for service dates or discharge dates prior to Oct. 1, 2014.

As we draw closer to the 2014 ICD-10 implementation date, it is essential to take note of the key differences to coding in the ICD-10-CM code set. The goal of this article is to take a closer look at documentation and diagnosis coding for certain chronic pulmonary conditions to successfully achieve accurate and compliant practices.

### ASTHMA

The ICD-9-CM code structure classifies asthma into a single code category, 493. Accurate code assignment involves determination of specific fourth- and fifth-digit subclassifications. The fourth digit identifies the asthma type, while the fifth digit identifies the presence of an acute exacerbation, status asthmaticus or an unspecified episode as follows:

#### Fourth-digit subclassification:

- **0** = Extrinsic Asthma
- **1** = Intrinsic Asthma
- **2** = Chronic Obstructive Asthma

#### Fifth-digit subclassification:

- **0** = Unspecified
- **1** = with status asthmaticus
- **2** = with (acute) exacerbation

When selecting the appropriate ICD-9-CM fifth-digit subclassification, an important consideration is to distinguish between an acute asthma exacerbation versus a status asthmaticus episode. The ICD-9-CM coding guidelines define status asthmaticus as a “severe, intractable episode of asthma unresponsive to normal therapeutic measures.” An acute asthma exacerbation, on the other hand, is an increase in severity of asthma symptoms such as shortness of breath, wheezing, coughing and chest tightness. When a status asthmaticus episode occurs, documentation should be concise and include specific terms such as intractable asthma attack; severe, intractable wheezing; and severe prolonged asthma attack. Concise documentation will allow for unambiguous interpretation and code assignment.

### CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AND CHRONIC BRONCHITIS

Over time, asthma may develop into COPD and one diagnosis may exacerbate the other. As such, clinical documentation for these pulmonary diagnoses is key to accurate code assignment. The ICD-9-CM code structure represents a relationship between COPD and chronic bronchitis. When both of these conditions occur together, the two diagnoses are grouped into a single code category, 491.3 These conditions represent instances when an individual may have a combination of pulmonary disorders that fall within the COPD category. For example, the fifth-digit assignment identifies obstructive chronic bronchitis with the presence of an acute exacerbation, acute bronchitis or obstructive chronic bronchitis with no exacerbation as follows:

#### Fifth-digit subclassification:

- **0** = without exacerbation
- **1** = with (acute) exacerbation
- **2** = with (acute) bronchitis

Code 491.20, obstructive chronic bronchitis without exacerbation, is reported for a diagnosis of COPD with bronchitis, without acute bronchitis or an acute exacerbation. This is commonly documented as chronic obstructive bronchitis. Conversely, code 491.21, obstructive chronic bronchitis with (acute) exacerbation is reported to capture a diagnosis of acute bronchitis with chronic obstructive bronchitis. From an ICD-9-CM coding perspective, this is considered an acute exacerbation and is often documented as COPD with acute exacerbation.

Over the coming months, BCBSIL will be providing more information about impacts of coding and documentation that may help your practice with the transition to ICD-10, Risk Adjustment and more.

Self-Administered Specialty Drug Claim Processing Reminder

Beginning Jan. 1, 2014, BCBSIL expanded its claims processing system edit to redirect professional electronic (837P) and paper (CMS-1500) claims for fertility, oral oncology and various other select self-administered specialty drugs.* Specialty drugs approved by the U.S. Food and Drug Administration (FDA) for self-administration must be billed under the member’s pharmacy benefit for members to receive benefit coverage consideration.

Members impacted by the recent claim system edit expansion were advised through letters sent in late October 2013. These member letters included a sample list of self-administered specialty medications, along with instructions on how to obtain these specialty medications and whom to call for assistance, if needed.

To help providers determine the correct path for medication fulfillment and ensure that the correct benefit is applied, a Specialty Pharmacy Program Drug List is available in the Pharmacy Program/ Specialty Pharmacy section of our Provider website at bcbsil.com/provider.

- This list identifies medications that require administration by a health care professional, and are often covered under a member’s medical benefit.
- This list also identifies specialty drugs that are approved by the U.S. FDA for self-administration, and are usually covered under the member’s pharmacy benefit. For these self-administered drugs, the member’s physician must write or call in the prescription to a pharmacy provider that is contracted to provide specialty services.

A specialty pharmacy program drug list is also available as a reference for your patients on our Member website, at bcbsil.com/member. In accordance with their benefits, members may be required to use a preferred specialty pharmacy. Providers and members may call the number on the member’s ID card to verify coverage or obtain clarification on the member’s benefits.

*The various other select specialty drugs of this system edit expansion include: Actimmune, Apokyn, Firazyr, Fuzeon, Leuprolide Acetate, Octreotide Acetate and Stelara.

**Third party brand names are the property of their respective owners.**

Pharmacy benefits and limits are subject to the terms set forth in the member’s certificate of coverage which may vary from the limits set for the above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions.

New Providers: Confirm PPO Network Status Before Rendering or Submitting Claims

Credentialing by BCBSIL is a prerequisite to be considered an in-network independently contracted PPO provider. This would include a provider who is being added to an existing PPO group contract with BCBSIL.

While the credentialing process can take time to complete, it is imperative to wait for the appointment letter from BCBSIL. This letter signals completion of the credentialing process and confirms the effective date for new providers joining the PPO network. It is only after receiving this appointment letter that providers may begin rendering services to BCBSIL members and submitting claims for payment as an in-network provider.

For additional information, visit the Network Participation/ Credentialing section of our website at bcbsil.com/provider.

Online Resources Available for Physical Utilization Management

The BCBSIL PPO Physical Medicine Utilization Management program became effective on Jan. 1, 2014. For program reference guides and preauthorization forms, please visit the Forms section located under the Education and Reference Center tab of the BCBSIL Provider website at bcbsil.com/provider.

If you have any questions, please contact your Provider Network Consultant (PNC). The name and contact information for your assigned PNC may also be found under the Education and Reference Center tab of the website address listed above.
The BCBSIL Special Investigations Department (SID) occasionally reviews claims for possible upcoding. Upcoding occurs when a provider submits a claim for payment to the insurance company for a higher paying service than is supported by the medical records documentation. Intentional upcoding is illegal and fraudulent. The SID has identified that a small percentage of providers may be billing high complexity Current Procedural Terminology (CPT)® Evaluation and Management (E/M) codes solely based upon the amount of time spent with a patient. Per CPT coding guidelines, selecting a level of E/M service based upon time is only appropriate when counseling and/or coordination of care dominates (greater than 50 percent) the encounter with the patient and/or family. This includes face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility. The extent of counseling and/or coordination of care must be documented in the medical record when time is considered as the key or controlling factor in determining a particular level of E/M service. It is important to note that selecting the appropriate level of E/M service in any other instance is based upon meeting the required key component criteria including history, examination and medical decision-making for each respective E/M category and subcategory. Appropriate clinical documentation must be present in the medical record to support code assignment.

Anyone who is aware of a provider or organization that may be defrauding insurance companies by committing upcoding offenses, or any other alleged fraudulent practice, may contact the BCBSIL Fraud Hotline at 800-543-0867.

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Avoid the ICD-10 coding pitfalls!

BCBSIL conducted preliminary ICD-10 testing with a subset of providers in 2012 and 2013. Although we are planning a larger scale testing phase in second quarter 2014, we wanted to share some of the common issues identified in our initial testing. Submitting claims with the following errors after Oct. 1, 2014, may delay or negatively impact reimbursement.

**USE OF INVALID DIAGNOSIS CODES**
Invalid diagnosis codes were common for three reasons, all of which would cause a claim to be rejected. Providers who use billing services or practice management systems that have claims scrubbers may avoid these problems; however, they should serve as test conditions for any provider.

1. **Confusion between letters and numbers.** We saw several examples where numbers were used in place of letters or vice versa. This confusion happened most frequently with the following commonly used numbers and letters in ICD-10:

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<thead>
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<th>Letter</th>
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<tr>
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<tr>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>1</td>
<td>I</td>
</tr>
<tr>
<td>2</td>
<td>Z</td>
</tr>
</tbody>
</table>

Examples:

- A pediatrician used diagnosis code 301.80XA – *Unspecified open wound of other part of head, initial encounter*, and should have used diagnosis code S01.80XA. The “S” was incorrectly sent as a “3.”
- A hospital trying to send a procedure code for a C-section – *Extraction of products of conception, low cervical, open approach conception, low cervical, open approach*, sent a procedure code of I0D0021 when they were trying to send I0D00Z1. The letter “I” was used in place of the number “1,” the letter “O” was used twice rather than the number “0” and the number “2” was used in place of the letter “Z.”

2. **Transposed digits and typographical errors.**
- For example, a hospital used diagnosis code K45.909 when they should have used diagnosis code J45.909 for *Unspecified asthma, uncomplicated*. A “K” was used in place of a “J” in error.

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3. Truncated and incomplete diagnosis codes.

These types of errors are primarily received from physicians’ offices. They are not as common with submissions from hospitals.

- For example, a physician’s office used diagnosis code R50 – Fever, when only diagnosis codes R50.2, R50.81-R50.84 and R50.9 are valid for that use.

**INAPPROPRIATE USE OF ICD-10 DIAGNOSIS CODES**

Many providers struggled with the combination diagnosis codes available in ICD-10 and continued to bill conditions separately in error. In some cases, they used two diagnosis codes that are mutually exclusive, as in this example:

- A hospital sent a claim with diagnosis code I25.10 – Atherosclerotic heart disease of native coronary artery without angina pectoris, along with a second diagnosis of I20.9 – Angina pectoris, unspecified. However, they should have used a single diagnosis code of I25.119 – Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris.

**LACK OF TRIMESTER OR ENCOUNTER SEQUENCE WHEN NEEDED**

Some ICD-10 diagnosis codes require identification of the encounter or trimester sequence. There were numerous claims received that did not specify or provided incorrect trimester/encounter information. Consider the following two examples:

**Trimesters:** A hospital sent a series of obstetrical claims that involved the treatment of a patient who had low weight gain during her pregnancy. The diagnosis codes for the trimesters were submitted out of sequence. The hospital used a diagnosis code of O26.12 – Low weight gain in pregnancy, second trimester, then on a later date of service used a diagnosis code of O26.11 – Low weight gain in pregnancy, first trimester.

**Encounters:** The injuries section (S00.00XA-S99.929S) in ICD-10-CM and poisonings/external causes section (T07-T88.9XXS) is full of diagnosis codes that contain encounter sequence information. We saw many of these miscoded, such as billing the subsequent encounter diagnosis code T23.161D – Burn of first degree of back of right hand, subsequent encounter without billing the initial encounter with diagnosis code T23.161A – Burn of first degree of back of right hand, initial encounter.

**USE OF “UNSPECIFIED” DIAGNOSIS CODES**

Some providers were using unspecified diagnosis codes when a more specific diagnosis was available.

For example, a general practitioner billed diagnosis code J20.9 – Acute bronchitis, when a more specific diagnosis code J21.0 – Acute bronchiolitis due to respiratory syncytial virus, was available. The practitioner coded the same claim in ICD-9 with the additional diagnosis of respiratory syncytial virus, so the underlying virus was most likely documented in the patient’s chart. Coding guidelines dictate that diagnosis code assignment should fully identify the diagnostic condition including specificity in describing causal conditions, secondary processes, manifestations and complications.

Whether you are conducting testing with BCBSIL or other payers/clearinghouses, the ICD-10 coding issues identified above are good teaching examples. Good documentation practices and accurately coding with ICD-10 upon the Oct. 1, 2014 transition date will help avoid incorrect, delayed and rejected claims.
### New Account Groups Table

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**NEW ACCOUNT GROUPS (continued)**

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<td>PPO (Portable), BlueEdge HSA (Portable)</td>
<td>Jan. 1, 2014</td>
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NOTE: Some of the accounts listed above may be new additions to BCBSIL; some accounts may already be established, but may be adding member groups or products. The information noted above is current as of the date of publication; however, BCBSIL reserves the right to amend this information at any time without notice. The fact that a group is included on this list is not a guarantee of payment or that any individuals employed by any of the listed groups, or their dependents, will be eligible for benefits. Benefit coverage is subject to the terms and conditions set forth in the member’s certificate of coverage.

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**Learn What’s New on iEXCHANGE for 2014**

Beginning Jan. 1, 2014, BCBSIL is enhancing iEXCHANGE, our Web-based preauthorization tool, to support requests for additional Behavioral Health, Pharmacy and Medical/Surgical Treatment services.

With iEXCHANGE, you can submit initial and extension requests for approval prior to services being rendered, once eligibility, benefits and preauthorization requirements have been confirmed through your current process. This flexible tool provides you with real-time responses for direct submission of inpatient admissions and select outpatient medical services, and enables you to send preauthorization submissions after hours and on weekends.

We have scheduled 90-minute webinars throughout the month of January to provide iEXCHANGE users with an overview of what’s new and improved for 2014. See page 8 for dates and times. To register, visit the Workshops/Webinar page in the Education and Reference Center section of our website at bcsbsil.com/provider.

For more information about iEXCHANGE, including how to register if you are not a current user, visit the Provider Tools page on our Provider website.

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

**Changes Effective Jan. 1, 2014**

This is a summary of an article titled *Pharmacy Program Changes, Effective Jan. 1, 2014*, posted in the News and Updates section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

**Standard Formulary Additions and Deletions, Effective Jan. 1, 2014**

Based on the Prime National Pharmacy and Therapeutics Committee review of changes in the pharmaceuticals market, some revisions were made to the standard BCBSIL formulary effective Jan. 1, 2014. Refer to the article in the News and Updates section of our Provider website for specific brand medications that were added to the formulary. The Standard Formulary Updates List is also posted in the Pharmacy Program section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

**Dispensing Limit Changes, Effective Jan. 1, 2014**

BCBSIL’s standard prescription drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. FDA dosage regimens and product labeling. Refer to the News and Updates section of our Provider website to view the listing of drugs for which dispensing limits were added effective Jan. 1, 2014. For the most up-to-date list of drug dispensing limits, visit the Pharmacy Program/Dispensing Limits section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

**Utilization Management Program Package Changes, Effective Jan. 1, 2014**

Effective Jan. 1, 2014, several drug categories were added to the Prior Authorization program for all standard benefit plans as those plans are renewed. Additional information, including the Prior Authorization/Step Therapy program drug list, can be found in the Pharmacy Program/Prior Authorization and Step Therapy Programs section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

Targeted mailings were sent to members affected by the formulary, dispensing limit and utilization management program changes, per our usual process of notifying members at least 60 days prior to implementation.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSIL contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Pharmacy benefits and limits are subject to the terms set forth in the member’s certificate of coverage. 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.
GuidedHealth® Helps Identify Drug Therapy Opportunities

At BCBSIL, we understand that medication therapy can be an essential part of a member’s overall treatment plan. That’s why we use the GuidedHealth clinical rules platform to conduct periodic reviews to help to identify opportunities that may positively impact members’ medication therapy. This platform drives our Retrospective Drug Utilization Review (RDUR) program, which integrates medical and pharmacy claims data for generating evidence-based, medication-related recommendations for physicians and members.

The GuidedHealth program targets drug therapy issues in modules such as overutilization, safety and cost. The table below lists the programs that were implemented during the fourth quarter of 2013. If your patient is identified in one or more of these categories, you may receive a letter from BCBSIL that references GuidedHealth.

WE INVITE YOUR COMMENTS

In support of your treatment plan for your patient and our member, a drug therapy opportunity summary will be included with your letter for your consideration, along with a medication claims profile for the identified member. We hope you find this information helpful and we want to thank you in advance for taking the time to review all medication-related recommendations. If you receive a letter, we would appreciate your taking the time to fill out the enclosed feedback survey so we can continue to improve the service we provide.

FOURTH QUARTER 2013 PROGRAMS

<table>
<thead>
<tr>
<th>Module</th>
<th>Objective</th>
<th>Program Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overutilization</td>
<td>Identify potential misuse and/or abuse, as well as drug conflict and off-label use</td>
<td>• Off-Label Use (requires medical claim)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trinity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stimulant Polypharmacy</td>
</tr>
<tr>
<td>Safety</td>
<td>Identify and recommend discontinuation of potentially unsafe medication use</td>
<td>• High Dose Acetaminophen</td>
</tr>
<tr>
<td>Cost Savings</td>
<td>Promote the awareness of generic drug alternatives in place of non-formulary brand products.</td>
<td>• Generic Opportunity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proton Pump Inhibitors</td>
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<tr>
<td></td>
<td></td>
<td>• Statins</td>
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</tbody>
</table>

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.

GuidedHealth is a registered trademark of Prime Therapeutics LLC (Prime), a pharmacy benefit management company. BCBSIL contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime. BCBSIL makes no endorsement, representations or warranties regarding GuidedHealth. If you have any questions about this product or services, you should contact Prime Therapeutics LLC directly.

Check Your Records for Outdated Drug Codes

When billing with National Drug Codes (NDCs) on medical professional/ancillary electronic (837P) or paper (CMS-1500) claims, it is important to ensure that the NDC used is valid for the date of service. This is because NDCs can expire or change. An NDC’s inactive status is determined based on a drug’s market availability in nationally recognized drug information databases. Additionally, an NDC is considered to be obsolete two years after its inactive date. It is a good idea to conduct a periodic check of records or automated systems where NDCs may be stored in your office for billing purposes. To help ensure that correct reimbursement is applied, the NDC on your claim should match the active NDC on the medication’s current label or packaging. Inactive products will continue to be reimbursed until they become obsolete.

For more quick tips to assist you with billing for drugs on medical claims, view the NDC Billing Guidelines and answers to Frequently Asked Questions in the Claims and Eligibility/Claim Submission section of our website at bcbsil.com/provider.
From the Medical Director’s Library

David W. Stein, M.D., offers the following message and reading selection for January:

The article selected to start the New Year is an optimistic one and certainly worth perusing. Taylor Eagle et al. A Middle School Intervention to Improve Health Behaviors and Reduce Cardiac Risk Factors, published in the American Journal of Medicine 2013; 126:903-908.

Project Healthy Schools is a middle school intervention designed to improve childhood risk factors. The study showed significant improvement in risk factors which are associated with early atherosclerosis. They looked at total and LDL cholesterol, triglycerides and both systolic and diastolic blood pressure. The study began in one school seven years ago and now involves 33 schools around Michigan. Students not only learned heart healthy behaviors together, but were shown to have changed their habits in a positive way.

Wishing you all a happy and healthy New Year.

David W. Stein, M.D.
FACC FACP FSCP FSCAI

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