



# Blue REVIEW<sup>SM</sup>

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS

JANUARY 2015

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## Understanding Tiered Products: Are you an in-network provider?

Our November 2014 *Blue Review* included an article titled, *New Products Offer More Choices and Potential Savings for Our Members*. This article focused on two new PPO products – Blue Options PPO<sup>SM</sup> and Blue Choice Options PPO<sup>SM</sup> – which became effective Jan. 1, 2015. These tiered products are designed to give the employer and the member the opportunity to help them self-manage their health care spending.

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

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

Using the example of the Blue Choice Options PPO tiered product, which currently is offered by the City of Chicago (group numbers 195500, 195501, 195502 and alpha prefix CTY) and Rivers Casino (group number 154061 and alpha prefix XOX) members, the tier 1 contracted provider network is Blue Choice OPT PPO<sup>SM</sup>. This network is identified on our Provider Finder<sup>®</sup> as follows: Blue Options or Blue Choice Options (BCO). The tier 2 contracted provider network for Blue Choice Options members includes participating providers in the broader PPO network. Tier 3 benefits, when available, give these members the option to use out-of-network providers, but with the largest responsibility for the cost of care.

**All PPO participating providers and Blue Choice PPO<sup>SM</sup> participating providers are considered to be in-network for Blue Choice Options members.**

### From the Blue Choice Options member perspective, here's how it works:

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

*(continued on p. 2)*



## What's new on iExchange®?

Blue Cross and Blue Shield of Illinois (BCBSIL) continues to enhance iExchange, our online tool that supports direct submission and provides online approval of benefits for inpatient admissions, as well as select outpatient, pharmacy and behavioral health services.

Webinars have been scheduled through January and February 2015 to present information on recent enhancements, such as the capability to add on services to an open request. We will also provide an overview of some of the most important and commonly used features, along with user-friendly tips, such as how to gain access to iExchange through a convenient single sign-on process.

**Refer to the Provider Learning Opportunities on page 4 for dates and times of upcoming webinars, along with registration information.** If you are a current iExchange user, please provide your iExchange ID and office or group name in the Company Name field when registering.

### Not enrolled for iExchange?

Additional information on iExchange, including our online enrollment form, is available in the Education and Reference Center/Provider Tools section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

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.



## Understanding Tiered Products: Are you an in-network provider?

(continued from p. 1)

### HOW TO IDENTIFY BLUE CHOICE OPTIONS MEMBERS

It has come to our attention that members may be mistakenly denied services by contracted PPO providers. We understand and recognize that this is a new product for you and our members. Here are some tips to assist your staff when scheduling appointments for these members:

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

Our growing portfolio of product offerings is part of BCBSIL's efforts to meet its goal of increasing access and affordability of health care products to our members and the community that we serve. Making it easier for you and your staff to conduct business with us is equally important. We appreciate your patience, cooperation and support as we all work to adapt to new product options.

## UNITE HERE HEALTH Offers Tiered Benefit Plan

Effective Nov. 1, 2014, members enrolled through the group plan of UNITE HERE HEALTH moved to a multi-tiered benefit plan. **Updated ID cards issued to these UNITE HERE HEALTH members include a new group number – 0M7506. The alpha prefix is EIU.** There were no changes to the customer service number, which appears on the back of the card.

The UNITE HERE HEALTH member's use of the independently contracted provider network for each tier, or not using any contracted provider, will determine the level of the member's financial liability as outlined below. Members that receive covered services from a Tier 1 provider will have the highest benefit levels with the lowest copay under the benefit plan.

- **Tier 1** – Members will receive the highest level of benefits for covered services with the lowest out-of-pocket expense when they utilize contracted providers in a network defined by this employer as Tier 1. The following three facilities and their respective physician groups are considered in-network for Tier 1: Presence Health System, St. Joseph Hospital and Little Company of Mary. **Members can find out which health care providers are affiliated with these institutions by calling the UNITE HERE HEALTH office at the number listed on their ID card.**
- **Tier 2** – A member may choose to use any contracted provider from the broader Blue Choice PPO network. However, at this level, the member's out-of-pocket expense will be slightly higher. **If you are a Blue Choice PPO provider you are considered as in-network for UNITE HERE HEALTH members, but at the Tier 2 level.**
- **Tier 3** – Members who decide to receive health care services from a provider other than those defined above for Tiers 1 and 2 have been advised by UNITE HERE HEALTH that there are no benefits and the member is responsible for the entire cost of care, except in emergency situations.

While informational materials are typically provided by employer groups to their members, some members may not be aware of higher out-of-pocket costs that may be incurred for tiered product options. As always, if members have any questions or concerns, they should contact the number on the back of their member ID card.

### NETWORK STATUS CHECK

As a reminder, it is important to confirm your network status for each member's plan in addition to checking eligibility and benefits for each patient prior to rendering services. **UNITE HERE HEALTH** member ID cards indicate **Blue Choice PPO** on the front of the card. The **BCS** network code will appear in our online Provider Finder to help when members are searching for independently contracted network providers.

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, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

# Controlled Substance Program Reports Positive Outcomes

In the July 2014 issue of the *Blue Review* newsletter, BCBSIL announced enhancements to the Controlled Substance Program to help identify members with controlled substance utilization patterns that may indicate potential abuse, misuse and/or opportunities for coordination of care.

In addition to the enhanced program criteria, an integrated team was established to review and track potential cases. This review team includes BCBSIL care management and clinical staff, as well as our Special Investigations Department. The team investigates the member's circumstances and works with the member's prescribing physician(s) to help coordinate care, determine interventions as appropriate and assist with the development of action plans.

Since the launch of our enhanced Controlled Substance Program, our review team has reported some positive outcomes. Below is an example of how the program worked for one of our members.

## IDENTIFYING THE CASE

A routine review of medical and pharmacy claims revealed a pattern of frequent visits to urgent care with prescriptions for controlled substance medications for a particular member.

## INITIAL EVALUATION

The claims history for the member was forwarded to the Controlled Substance Program review team for further investigation. The review team learned that the member did not have a primary care physician. The team also learned that the member was struggling with the challenges of a domestic violence situation and caring for children with special needs.

## ACTION PLAN AND FOLLOW-UP

The review team recommended that BCBSIL Behavioral Health Case Management contact the member to conduct an assessment and discuss possible options for care and outreach services.

- First, our Behavioral Health team helped the member establish a relationship with a primary physician.
- Next, the team collaborated with the physician to develop an overall treatment plan that included monitoring the use of prescribed controlled substance medications and help educate the member about the importance of taking these medications only as prescribed to help reduce future urgent care visits.
- Finally, our Behavioral Health team connected the member with community resources to help with finding safe housing, filing a domestic complaint with the proper authorities and locating information about programs for special needs children.

Our Controlled Substance Program offers a multi-faceted approach to help identify possible cases and researching potential underlying causes of potential abuse, misuse or improper utilization of controlled substances. We look forward to sharing more stories of members who have achieved successful outcomes.

Sometimes members may not know where to turn when faced with complex life situations. They may seek your guidance as their trusted health care provider. BCBSIL offers a variety of pharmacy-related and other resources on Blue Access for Members<sup>SM</sup>. Additionally, we encourage you to direct your patients to our public Be Smart. Be Well.<sup>®</sup> website, at [besmartbewell.com](http://besmartbewell.com), where they can obtain information on topics such as Addiction, Domestic Violence/Dating Abuse, Mental Health and more.

The Controlled Substance Program is not a substitute for the independent medical judgment of doctors and other health care providers. Providers are instructed to exercise their own independent medical judgment, based upon the patient's documented medical history and prescription drug use.

### Pharmacy Disclaimer

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

## Pharmacy Program Changes, Effective Jan. 1, 2015

BCBSIL Pharmacy Program Updates are typically published on a quarterly basis in the *Blue Review* and/or on our Provider website to help keep you informed of standard drug list additions/deletions, dispensing limit changes and utilization management program enhancements. Most recently, we posted a document titled, *Pharmacy Program Changes, Effective Jan. 1, 2015*, which is available in the Pharmacy Program/Related Resources section of our website at [bcbsil.com/provider](http://bcbsil.com/provider). This document includes:

- A listing of brand medications that have been added to the BCBSIL standard drug list, as well as information on brand medications on the standard drug list that have moved to a higher out-of-pocket payment level, effective Jan. 1, 2015.
- Information on dispensing limits that have been added for certain drugs, effective Jan. 1, 2015. BCBSIL's standard prescription drug benefit program includes coverage limits on certain medications and drug categories.
- A listing of drug categories added to the BCBSIL Pharmacy Prior Authorization (PA) program effective Jan. 1, 2015, as part of our utilization management program for standard pharmacy benefit plans upon renewal.
- A listing of specialty medications that, while they may have processed under the member's pharmacy benefit prior to Jan. 1, 2015, will now be considered for coverage under the member's medical benefit when billed on professional/ancillary electronic (837P) and paper (CMS-1500) claims, as these medications require administration by a health care professional.

For details, please refer to the complete article in the Pharmacy Program/Related Resources section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

## Provider Learning Opportunities

### BCBSIL WEBINARS

Below is a list of complimentary training sessions sponsored by BCBSIL. For details and online registration, visit the Workshops/ Webinars page in the Education and Reference Center of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

#### Introducing Remittance Viewer

*The remittance viewer is an online tool that offers providers and billing services a convenient way to retrieve, view, save or print claim detail information.*

Feb. 18, 2015 – 11 a.m. to noon

#### iExchange Training

*Join us for an overview of this online benefit preauthorization tool. See page 2 for a webinar description and other details.*

Jan. 28, 2015 – 2 to 3 p.m.

Feb. 4, 2015 – 10 to 11 a.m.

Feb. 11, 2015 – 2 to 3 p.m.

Feb. 18, 2015 – 10 to 11 a.m.

Feb. 25, 2015 – 2 to 3 p.m.

### AVAILITY™ WEBINARS

Availity also offers free webinars for their registered users. For a current listing of webinar topics, dates and times, registered Availity users may log on to the secure Availity provider portal – the Live Webinar Schedule is located under the **Free Training** tab. Not yet registered with Availity? Visit their website at [availity.com](http://availity.com) for details, or call Availity Client Services at 800-AVAILITY (282-4548) for assistance.

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## Affordable Care Act in Action: Grace Periods

The second open enrollment period for consumers shopping on Get Covered Illinois, the official health marketplace (“Marketplace”) began Nov. 15, 2014, and enrollment for 2015 will remain open through Feb. 15, 2015. The Affordable Care Act (ACA) has opened the door for many Americans to obtain health insurance coverage, even if they have been unable to secure coverage in the past due to pre-existing conditions or financial constraints.

Under ACA, members who purchase coverage on the Marketplace and receive the advance premium tax credit (APTC) are allowed a 90-day grace period for payment of their health care insurance premiums, as long as they have already paid one month’s premium in full within the benefit year. It is important to note that **not all members who purchase coverage on the Marketplace will receive the APTC.**

The information below provides guidelines to assist you with identifying when a BCBSIL member is in a grace period, along with important reminders on claim processing, supporting patient awareness and maintaining compliance with your provider contract.

### ELIGIBILITY AND BENEFITS

As always, it is important to check eligibility and benefits for every patient at the start of every visit. When a BCBSIL member is in the second or third month of a grace period, we will provide notification of the member’s status during electronic response or telephone verification to indicate the member’s grace period status, including the date the grace period began.

### CLAIMS PROCESSING

- **Medical Claims** – All allowable services provided during the first month of the grace period will be the responsibility of BCBSIL, subject to the terms of the member’s benefit plan, including cost sharing, deductibles and out-of-pocket costs. BCBSIL will pend claims for covered services rendered during the second and third months of the grace period. However, if the member has not paid premiums in full by the end of the grace period, BCBSIL will deny claims for services provided during the second or third months of the grace period. In this case, the patient is responsible for paying the entire bill for services rendered during the second and third months.
- **Pharmacy Claims** – A member’s pharmacy claims will be denied during months two and three. If the member retroactively pays the premium in full, they may submit claims for prescriptions dispensed during this time to BCBSIL. If a member elects to receive a 90-day supply of a prescription during month one of the grace period, the member will receive the full 90-day prescription and BCBSIL will pay this claim.

### PATIENT AWARENESS

You may notify your patients that they will be responsible for payment for the full cost of provided services, up to billed charges, if their health care coverage terminates at the end of the grace period. You may encourage your patients to make their premium payments to avoid termination of their health insurance policies.

### PROVIDER RESPONSIBILITY

As a reminder, the terms of your network contract prevent you from refusing to provide services to a BCBSIL member, regardless of where they purchased their coverage. Your contract with BCBSIL requires the provision of services to members and prohibits advance payment for such covered services except for the member’s required cost sharing, if any.

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, any claims received during the interim period and the terms of the member’s certificate of coverage applicable on the date services were rendered.



# New in 2015: Blue Cross Medicare Advantage (PPO)<sup>SM</sup> Plans

Beginning January 2015, BCBSIL is offering two Blue Cross Medicare Advantage (PPO) plans: Blue Cross Medicare Advantage Choice Plus (PPO)<sup>SM</sup> and Blue Cross Medicare Advantage Choice Premier (PPO)<sup>SM</sup>. These plans include the same benefits as original Medicare Part A and Part B, with a built-in prescription drug benefit. The Blue Cross Medicare Advantage (PPO) independently contracted provider network includes select IPAs and PHOs and is available to Medicare eligible BCBSIL members residing in the following counties: Cook, DuPage, Kane and Will.

Here are some of the details that will appear on front of the Blue Cross Medicare Advantage Choice Plus (PPO) and Blue Cross Medicare Advantage Choice Premier (PPO) member ID cards:

- Plan name: Blue Cross Medicare Advantage (PPO)
- Alpha prefix: **XOD**
- Copay/coinsurance information (office visit, specialist and ER charges, and out-of-network percent coverage)

To help maximize their benefits, members must use providers from among the Blue Cross Medicare Advantage (PPO) contracted network of IPAs and PHOs. Members may self-refer to providers within the designated network, with the exception of services that require preauthorization. Not all physicians and other health care providers within each IPA and PHO are Blue Cross Medicare Advantage (PPO) providers.

Members may use out-of-network providers at a reduced level of benefits and higher out-of-pocket cost. Emergency care services will be covered at the in-network benefit level. For the most up-to-date Blue Cross Medicare Advantage (PPO) contracted provider network information, members are instructed to use the appropriate online Provider Finder at [bcbsil.com/medicare/mapd\\_provider.html](http://bcbsil.com/medicare/mapd_provider.html).

## IMPORTANT EXCEPTION: CHICAGO TEACHERS' PENSION FUND (CTPF)

In the December 2014 *Blue Review*, we announced enrollment of Medicare eligible CTPF members in the Blue Cross Medicare Advantage (PPO) plan, effective Jan. 1, 2015, **with group number 80840**. Please note that, while the alpha prefix for these members is the same (XOD), benefits for CTPF members differ significantly from the Blue Cross Medicare Advantage (PPO) plans described above.

Key differences include, but are not limited to:

- CTPF members may obtain medical care from **any provider that accepts Medicare assignment**.
- If a CTPF member obtains services from a provider that does not accept Medicare assignment, no benefits will be available and the member will be responsible for all charges.
- There are no copayments, although CTPF members typically pay a 4% coinsurance for services after the plan deductible is satisfied.
- While Part D prescription drug benefits are not offered as part of the Blue Cross Medicare Advantage (PPO) plan for CTPF members, coverage for Medicare Part B drugs is offered under the medical benefit.

Additional information, such as the appropriate customer service phone number(s) to contact for assistance, is included on the back of all Blue Cross Medicare Advantage (PPO) member ID cards.

PPO plan provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.

This is only a brief description of some of the plan benefits. For more complete details, including benefits, limitations and exclusions, members should refer to their certificate of coverage. Pharmacy benefits, limitations and exclusions are subject to the terms set forth in the member's certificate of coverage. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

## Caterpillar Offers New Health Care Benefit Option, Effective Jan. 1, 2015

Effective Jan. 1, 2015, Caterpillar is offering the Blue Cross Blue Shield Exclusive Provider Organization (BCBS EPO) as a new health care benefit plan option for its employees.

The Caterpillar EPO administered by BCBSIL will utilize the independently contracted BCBSIL PPO network. If a Caterpillar BCBS EPO member chooses to use an out-of-network provider, the entire cost of care will be the member's responsibility.

### NETWORK STATUS CHECK

As a reminder, it is important to confirm your network status for each member's plan in addition to checking eligibility and benefits for each patient prior to rendering services.

**Caterpillar** member ID cards will indicate **Use PPO network for EPO Plan**. The PPO network code will appear in our online Provider Finder<sup>®</sup> to help when members are searching for independently contracted network providers.

If you have questions, contact the appropriate number on the back of the member's ID card.

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, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.



## 2014 Blue Star Hospital Report<sup>SM</sup>

BCBSIL is committed to helping members make informed health care decisions. As part of BCBSIL's transparency initiative, the 2014 Blue Star Hospital Report is now available on the BCBSIL Provider website.

The purpose of the Blue Star Hospital Report is to provide employers and members with information about indicators for which hospitals have demonstrated high levels of performance.

The 2014 Blue Star Hospital Report, based on the 2014 Annual BCBSIL Hospital Profile, summarizes the results related to quality, patient safety and efficiency measures for 100 Illinois hospitals.

Hospital profiles are compiled using data collected from multiple sources, including BCBSIL claims data, information provided by the hospitals and publicly available information from entities such as the Centers for Medicare & Medicaid Services (CMS). BCBSIL uses the most current data available at the time the hospital profiles are prepared. However, there may be more current information for the Experience, Outcome and Process measures available at [medicare.gov/hospitalcompare/](http://medicare.gov/hospitalcompare/) and [healthcarereportcard.illinois.gov/](http://healthcarereportcard.illinois.gov/).

For the 2014 Blue Star Hospital Report, each hospital's performance is reported for indicators in six categories: Structure, Process, Outcome, Patient Experience, Efficiency and Informed Decision-Making. One blue star can be earned for each indicator, for a maximum of six blue stars.

The 2014 Blue Star Hospital Report can be found in the Clinical Resources/Quality Improvement section of our website at [bcbsil.com/provider](http://bcbsil.com/provider).

The Blue Star Hospital Report is not a guarantee of a particular outcome or the quality of care rendered by any hospital. Individual results may vary.

## Payer ID and Mailing Address Reminders for Blue Cross Community Options<sup>SM</sup> Claims

Our Blue Cross Community Options plans include Blue Cross Community MMAI (Medicare-Medicaid Plan)<sup>SM</sup>, Blue Cross Community ICP<sup>SM</sup>, or Integrated Care Plan, and the Blue Cross Community Family Health Plan<sup>SM</sup> (FHP). BCBSIL maintains a network of independently contracted providers including physicians, hospitals, skilled nursing facilities, ancillary providers, Long-term Services and Support (LTSS) and other health care providers through which MMAI, ICP and FHP members may obtain benefits for covered services.

If you submit professional or institutional claims for services rendered to MMAI, ICP and/or FHP members, please take note of the important changes and related reminders below.

### ELECTRONIC CLAIM SUBMISSIONS – NEW PAYER ID

Effective Dec. 9, 2014, BCBSIL has assigned a new Payer ID – MCDIL – for electronic Blue Cross Community Options (MMAI, ICP or FHP) claims.

- MCDIL should be used instead of 00621 as the Payer ID for Blue Cross Community Options member claims **only**. (This Payer ID change does not affect any other line of business.)
- Blue Cross Community Options claims will continue to be accepted with the 00621 Payer ID, if the appropriate alpha prefix is included (see Alpha Prefix Reminders below). However, we encourage you to use the new MCDIL Payer ID to help expedite processing of MMAI, ICP and FHP member claims.
- If you use a billing service or clearinghouse other than Availity or Passport/Nebo Systems, please contact your vendor to ensure they are aware of the above information.

Please note that the new Payer ID does not affect other transactions, such as claim status requests. If you have questions on how to check claim status, or if you need assistance with navigating the Availity Web portal, please contact our Provider Education Consultant team at [PECS@bcbsil.com](mailto:PECS@bcbsil.com).

### PAPER CLAIM SUBMISSIONS – NEW MAILING ADDRESS

Electronic submission of claims is preferred. However, effective Dec. 9, 2014, if you need to submit paper claims for Blue Cross Community Options members, please use the new mailing address below. This new address has been established to help ensure proper routing of these claims.

Blue Cross Community Options  
P.O. Box 804433  
Chicago, IL 60680-4105

This address should be used **only** for professional and institutional paper claims submitted for Blue Cross Community Options (MMAI, ICP or FHP) members. (**This address change does not apply to any other line of business.**)

### ALPHA PREFIX REMINDER FOR ALL CLAIMS

Blue Cross Community Options claim submissions should include the member ID number exactly as it appears on the member's BCBSIL ID card, including the alpha prefix (**XOG**). If the member ID card is not available at the time of service, you may submit a claim using the member's Medicaid or Recipient Identification Number (RIN), preceded by the **XOG** alpha prefix.

If you have any questions regarding this notification, contact our Blue Cross Community Options Provider Network team at [govproviders@bcbsil.com](mailto:govproviders@bcbsil.com) or 855-653-8126 and your inquiry will be routed to the appropriate area for assistance.

For additional information, such as availability of related resources, please watch the News and Updates on our website at [bcbsil.com/provider](http://bcbsil.com/provider), as well as upcoming issues of the *Blue Review*.

Nebo Systems, a division of Passport Health Communications, Inc., is an independent third party vendor that is solely responsible for its products and services. BCBSIL makes no endorsement, representations or warranties regarding independent third party vendors such as Availity and Passport/Nebo Systems. If you have any questions or concerns about the products or services offered by such vendors, you should contact the vendor(s) directly.

# Digital Breast Tomosynthesis (3D Mammography) Medical Policy Reminder



Digital breast tomosynthesis, commonly known as 3D mammography, uses modified digital mammography equipment to obtain additional radiographic data to reconstruct cross-sectional images, “slices” of breast tissue, for diagnostic evaluation. The BCBSIL Medical Policy for Digital Breast Tomosynthesis (RAD601.055) specifies that 3D mammography is considered experimental, investigational and/or unproven for the screening or diagnosis of breast cancer, and as such is considered a non-covered service.

BCBSIL has identified that Current Procedural Terminology (CPT®) code 76499 (Unlisted diagnostic radiographic procedure) has been used by some providers to report this non-covered service on claims. The American Medical Association (AMA) has created new CPT codes effective Jan. 1, 2015, that better describe this non-covered service, as follows: 77061 (Digital Breast Tomosynthesis/unilateral), 77062 (Digital Breast Tomosynthesis/bilateral) and 77063 [Screening Digital Breast Tomosynthesis, bilateral (*listed separately in addition to code for primary procedure*)].

As a reminder, per the BCBSIL Provider Agreement, if a contracted provider is aware that a service is not covered, the provider must notify the BCBSIL member in writing prior to the service being rendered, informing the member that they will be financially responsible for the non-covered service.

To view the full medical policy for Digital Breast Tomosynthesis (RAD601.055) and access the most up-to-date BCBSIL Medical Policy information, visit the Standards and Requirements/Medical Policy section of our website at [bcbsil.com/provider](http://bcbsil.com/provider). Although medical policies can be used as a guide, HMO providers should refer to the HMO Scope of Benefits in the BCBSIL Provider Manual, which is located in the Standards and Requirements section of our Provider website.

The BCBSIL Medical Policies are for informational purposes only and are not a substitute for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient’s health care needs. Some benefit plans administered by BCBSIL, such as some self-funded employer plans or governmental plans, may not utilize BCBSIL Medical Policy. Members should contact their local customer services representative for specific coverage information.

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## Diagnosis and Medical Management of Sleep Related Breathing Disorders

The purpose of this article is to provide you with a brief overview of recent updates to the BCBSIL Medical Policy for Diagnosis and Medical Management of Sleep Related Breathing Disorders (MED205.001). The changes below will be effective for dates of service beginning April 15, 2015.

The policy coverage was revised to indicate that for adult patients with symptoms suggestive of Obstructive Sleep Apnea (OSA) and without significant co-morbidities, home sleep studies may be considered medically necessary.

Facility/laboratory polysomnography (PSG) is considered **not medically necessary** when the criteria for unattended home sleep studies are met. The use of an abbreviated daytime sleep study as a supplement to standard sleep studies, Positive Airway Pressure-Negative Airway Pressure (PAP-NAP), is considered **experimental, investigational and/or unproven**.

Additional information on these changes will be included in an upcoming issue of the *Blue Review*.

**The above article does not apply to HMO members.**

The BCBSIL Medical Policies are for informational purposes only and are not a substitute for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient’s health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Members should refer to their certificate of coverage or summary plan description for more complete details regarding what services are covered including, benefits, limitations and exclusions. Some benefit plans administered by BCBSIL, such as some self-funded employer plans or governmental plans, may not utilize BCBSIL Medical Policy.





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# Blue REVIEW

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS



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## ClaimsXten™ to Add Correct Coding Initiative Rule

Beginning on or after March 23, 2015, BCBSIL will enhance the ClaimsXten code auditing tool by adding the CMS Correct Coding Initiative Rule into our claim processing system. The purpose of this new rule is to identify claims containing code pairs found to be unbundled according to the CMS National Correct Coding Initiative (NCCI). The CMS NCCI coding policies are based on coding conventions defined in the American Medical Association's (AMA) CPT manual; national and local Medicare policies and edits; coding guidelines developed by national societies; and standard medical and surgical practice and/or current coding practice.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSIL's code-auditing software.

For additional information on gaining access to C3 along with details on the ClaimsXten tool – including answers to frequently asked questions – refer to the Education and Reference Center/Provider Tools/Clear Claim Connection page on our Provider website.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third party vendor that is solely responsible for its products and services.

*Blue Review* is a monthly newsletter published for institutional and professional providers contracting with Blue Cross and Blue Shield of Illinois. We encourage you to share the content of this newsletter with your staff. *Blue Review* is located on our website at [bcbsil.com/provider](http://bcbsil.com/provider).

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

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