BlueCross BlueShield of Illinois

BLUE REVIEW℠

A newsletter for contracting institutional and professional providers

March 2021

Wellness and Member Education

Free Minority Health Programs Next Month at Blue Door Neighborhood Center℠

Encourage your patients to check out the **free National Minority Health Month** events hosted by our Blue Door Neighborhood Center (BDNC℠). Since programming is virtual due to COVID-19, all your patients can take advantage of these activities no matter where they live.

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Clinical Updates, Resources and Reminders

Telehealth Services for Our Government Programs Members

This article includes general information on telehealth services during the COVID-19 Public Health Emergency (PHE) to help with claims coding and documentation for our government programs members.

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What’s New

DME Benefit Limits Verification Request Form

As of **Feb. 1, 2021**, if you provide Durable Medical Equipment (DME) services to our BCCHP and/or MMAI members, you may use our new DME Benefit Limits Verification Request Form.

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Pharmacy Program

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective April 1, 2021 – 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 on or after **April 1, 2021**, are outlined here.

Claims and Coding

CPT® Category II Codes Can Help Close Care Gaps

Using the proper Current Procedural Terminology (CPT) Category II codes when filing claims may help you streamline your administrative processes and close gaps in care.

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Health Care Fraud is Not a Victimless Crime

Most health care fraud in the U.S. is committed by a small minority of health care providers and/or organized crime syndicates posing as legitimate health care professionals. At BCBSIL, we actively participate in inquiries and investigations to accurately identify and appropriately address potentially fraudulent activities.

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Notification and Disclosure

Important Dates and Reminders

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

Procedure Code and Fee Schedule Updates

As part of our commitment to informing our independently contracted providers of certain developments, BCBSIL has designated a specific section in the *Blue Review* to notify you of any significant changes to the physician fee schedules.

Read More

ClaimsXten™ Quarterly Updates

New and revised 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.

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Quick Reminders

Stay informed!

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

Update Your Information

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

Provider Training

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

Contact Us

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

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Free Minority Health Programs Next Month at Blue Door Neighborhood Center℠

Encourage your patients to check out the **free National Minority Health Month** events hosted by our Blue Door Neighborhood Center (BDNC℠). Since programming is virtual due to COVID-19, all of your patients can take advantage of these activities no matter where they live.

According to the National Institute of Minority Health and Health Disparities, National Minority Health Month is an effort to build awareness about the disproportionate burden of premature death and illness in minority populations and to encourage action through health education, early detection, and control of disease complications. Our BDNC staff created programming to help support this mission.

In April, we'll welcome Blue Cross and Blue Shield of Illinois (BCBSIL) members and non-members to our free **Ask A Doctor** events to discuss health and COVID-19 vaccine concerns.

According to Kaiser Family Foundation research, **35% of Black adults** (a group that has borne a disproportionate burden of the pandemic) say they **definitely or probably would not get vaccinated**. Throughout April, BDNC will provide collateral, webinars and education campaigns to help inform and educate the community about COVID-19 and vaccinations.

These are just a few of the programs we'll offer at BDNC on multiple dates and times during National Minority Health Month. Encourage your patients to check the calendars at BDNC at Morgan Park, BDNC at Pullman and BDNC at South Lawndale for details and to register. They can also visit the BDNC Facebook page for other events and happenings at all three BDNC locations.

Supporting our members on their health education journeys and increasing access to health care where our members live, work and play is an ongoing priority at BCBSIL. We're also committed to strengthening the health of communities across the state. BDNC gives BCBSIL the opportunity to partner with you to help make a difference in the lives of residents in our communities. Once we open our doors to in-person guests, please encourage your patients to stop by. If you or your patients have questions, email the BDNC or call 773-253-0900.

We'd love to hear from you! Would you like more information about BDNC? Are there courses/activities you'd like to see

offered at BDNC? Will you encourage your patients to visit BDNC? Would you like to get more involved at BDNC? Take our short survey and let us know what you think.

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Telehealth Services for Our Government Programs Members

Below is general information on telehealth services during the COVID-19 Public Health Emergency (PHE) to help with claims coding and documentation for our government programs members. This includes our members with any of the following health benefit plans: **Blue Cross Medicare Advantage℠, Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ and Blue Cross Community Health Plans℠ (BCCHP℠) members**. This is consistent with information from the Centers for Medicare & Medicaid Services (CMS) and Illinois Department of Healthcare and Family Services (HFS).

Members' telehealth benefits depend on the terms of their benefit plan. To verify telehealth coverage for our government programs members, call the appropriate Provider Services number to speak to a Customer Advocate: Medicare Advantage – 877-774-8592; MMAI – 877-723-7702; BCCHP – 877-860-2837. See the Additional Information for Government Programs section of our COVID-19 Preparedness FAQs for more details.

Topic	For Medicare Advantage and MMAI members:	For BCCHP members:
Audio-Plus-Visual Telehealth Services	Services may include: • Office or other outpatient visits • Annual Wellness Visits • Telehealth consultations (emergency department, initial inpatient, skilled nursing facilities)	Services may include Medicaid-covered medically necessary and clinically appropriate telehealth and virtual care services.
Audio-Only Telehealth Services	Audio-only services don't satisfy CMS' face-to-face criteria for risk adjustment. CMS permits them during the PHE only in limited circumstances	Audio-only (telephone) evaluation and management (E/M) services to new or existing patients are permitted. • Bill as a distant site telehealth visit if the care given meets the key components of a face-to-face visit

		• Otherwise, bill using CPT code **G2012** for virtual check-in services
Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) Codes	CMS List of Telehealth Services	Illinois Medicaid COVID-19 Fee Schedule
Modifier/Place of Service (POS)	Report the POS code that would have been reported had the service been provided in person. • Include CPT telehealth **modifier 95** • You can also report **POS 02** with no modifier	All virtual health care/telehealth codes must be billed with **POS 02 and GT modifier**.
Documentation	During the PHE, CMS has revised its policy[1]: • To specify the office/outpatient E/M level selection for these services when furnished via telehealth can be based on medical decision making or time, with time defined as all of the time associated with the E/M on the day of the member visit; and • To remove any requirements regarding documentation of history and/or physical exam in the medical record	The distant site provider and originating site provider eligible for a facility fee must maintain adequate documentation of the telehealth services provided.[2]
Technology*	Interactive audio and video telecommunications system that permits two-way, real-time communication,[3] including: • HIPAA-approved telehealth platforms • Non-HIPAA-approved applications for the duration of the PHE	A brief communication technology-based service that uses audio-only real-time telephone interactions or synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission.

*This information regards HIPAA-compliant remote technologies to meet risk adjustment criteria. Providers can find the latest guidance on acceptable HIPAA-compliant remote technologies issued by the U.S. Department of Health and Human Services' Office for Civil Rights in Action. Also see BCBSIL's COVID-19 Preparedness FAQs for more information.

[1] CMS interim final rule and comment period (IFC), 136, https://www.cms.gov/files/document/covid-final-ifc.pdf

[2] Illinois General Assembly, Joint Committee on Administrative Rules, http://www.ilga.gov/commission/jcar/admincode/089/089001400D04030R.html

[3] CMS IFC, 49, https://www.cms.gov/files/document/covid-final-ifc.pdf

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. If you have any questions, call the number on the member's ID card.

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Blue Cross Community Health Plans℠ (BCCHP℠) and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ Appointment Availability Timeframes

To ensure that BCCHP and MMAI members have timely access to care, the following appointment standards are specified in your provider agreements:

- **Routine preventive care appointments** – Available within five weeks of the request and within two weeks from the date of the request for infants under 6 months.
- **Serious problem but not an emergency medical condition** – Within one business day of the request.
- **Non-urgent/needs attention** – Within three weeks of the date of the request.
- **Initial prenatal visits without problems** – Within two weeks of the date of request for a member within the first trimester, within one week in the second trimester and within three days in the third trimester.
- **Behavioral health emergency care** – Within six hours of the request.
- **Behavioral health initial visit for routine care** – Within two weeks of the date of the request.
- **Behavioral health routine follow-up care** – Within three months of the request.
- **Behavioral health urgent/non-emergent** – Within 48 hours of the request.

In addition to the above appointment timeframes, providers are contractually required to ensure that provider coverage is available for members 24 hours a day, seven days a week. In addition, providers must maintain a 24-hour answering service and ensure that each primary care physician (PCP) provides a 24-hour answering arrangement, including a 24-hour on-call PCP arrangement for all members. An answering machine doesn't meet the requirements for a 24-hour answering service arrangement. Hospital emergency rooms or urgent care centers aren't substitutes for covering providers.

We routinely monitor for compliance with the above standards. Compliance monitoring includes, but is not limited to, conversations with your Provider Network Consultant (PNC), site visits and "Secret Shop" calls. Lack of compliance may lead to corrective actions, which may include corrective action plans or termination.

If you have questions about these requirements, contact your assigned PNC or email our Government Programs Provider Relations team.

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Medicaid Providers: Updated Prior Authorization Tips and Peer-to-Peer Discussion Process (One Change Effective May 1, 2021)

Blue Cross and Blue Shield of Illinois (BCBSIL) would like to outline some important updates, tips and reminders on prior authorization processes for independently contracted providers treating our Blue Cross Community Health Plans℠ (BCCHP℠) and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ members. For some services/members, prior authorization may be required through BCBSIL. For other services/members, BCBSIL has contracted with eviCore healthcare (eviCore) for utilization management and related services. ***Please note that, effective May 1, 2021, there will be a change to the BCCHP peer-to-peer discussion process, as specified below.***

It's important to check eligibility and benefits first for each patient at every visit to confirm coverage details. This step also helps you identify prior authorization requirements and utilization management vendors, if applicable. For more information, refer to the 2021 Medicaid Prior Authorization Requirements Summary and 2021 Medicaid Prior Authorization Code List available in the Medicaid section on the Support Materials (Government Programs) page.

BCBSIL adheres to the standards for addressing all urgent concurrent requests, meeting or exceeding National Committee for Quality Assurance (NCQA) standards. These requests must be decided within 48 hours for BCCHP members, and 72 hours for MMAI members. Clear and timely submission of prior authorization requests and clinical documentation is very important to process requests within the required timeframes.

To help ensure turnaround times are met and decisions are provided to requesting providers as quickly as possible, BCCHP and MMAI utilization management (UM) reviewers and medical directors are available seven days a week, excluding BCBSIL identified holidays. During weekend hours, UM reviewers and medical directors continue to review requests and make decisions.

When faxing prior authorization requests, you must use the Medicaid Prior Authorization Request Form. If we do not receive adequate clinical documentation, BCBSIL will reach out to your facility UM department and provide a date and time in which clinical documentation is required to be received. If a request does not meet medical necessity criteria for approval, the request will be assigned to a BCBSIL medical director for determination.

To support the decision process, BCBSIL gives providers the opportunity to discuss UM determinations with a peer physician. Providers are allowed the opportunity to schedule one peer-to-peer discussion per adverse determination. A provider may initiate a peer-to-peer discussion by calling 800-981-2795. The peer-to-peer discussion process is as follows:

- **MMAI providers** will be notified by phone of potential adverse determinations and offered a date and time in which a pre-service, peer-to-peer discussion is available. Once the offered date and time has passed and if adequate information still has not been received, the request will be sent to a BCBSIL medical director for review and final decision. Please be advised that in compliance with the Centers for Medicare & Medicaid Services (CMS), BCBSIL is not allowed to change a denial decision once it has been finalized by the BCBSIL medical director and the determination has been issued to the member. An appeal or grievance may be filed regarding the denial decision. For more information about appeals and grievances, refer to the MMAI provider manual or call 877-723-7702.
- **Updated: Effective May 1, 2021,* BCCHP providers** will be notified by phone or fax of potential adverse determinations and given a date and time in which a pre-service peer-to-peer discussion is available. Once the date given has passed and if adequate information still has not been received, the request will be sent to a BCBSIL medical director for review and final decision. If the decision rendered by the BCBSIL medical director is an adverse determination, providers are allotted an additional seven calendar days from the notification of the adverse determination to schedule and complete a peer-to-peer discussion. If the provider wishes to forego the peer-to-peer discussion and wishes to submit an updated clinical packet for review, the BCBSIL Utilization Management team will review one packet of additional supporting documentation after the adverse determination. The clinical packet must be submitted within seven days of the adverse determination and the fax cover sheet must be clearly identified as the wish for a clinical re-review in lieu of a peer-to-peer discussion. If an appeal has been filed during this period, the peer-to-peer discussion and clinical review is no longer available. An appeal or grievance may be filed regarding the denial decision. For more information about appeals and grievances, refer to the BCCHP provider manual or call 877-860-2837.

Effective May 1, 2021, the only change is that providers can no longer submit clinicals for BCCHP members IN ADDITION TO doing a peer-to-peer call after the adverse determination. As of this date, providers may submit a new packet for clinical re-review OR do a peer-to-peer discussion.

For BCCHP and MMAI: Peer-to-peer discussions are allowed for requests where clinical information was submitted with the original request. If no clinical information was submitted with a request, a peer-to-peer discussion is not permitted. It is the responsibility of the requesting provider to submit clinical documentation to substantiate a request for services at the time of the service authorization request. Additional clinical information will not be reviewed by the utilization management team if the initial determination was an adverse determination due to failure to submit clinical information with the original request.

The peer-to-peer discussion is available as a courtesy to providers. The peer-to-peer discussion is not required, nor does it affect the providers' right to an appeal on behalf of a member. If an appeal has been filed, the peer-to-peer discussion is no longer available. Additionally, the Provider Service Authorization Dispute process is available when an adverse service authorization has been rendered and the UM process has been followed. Failing to provide clinical information or timely notification of prior authorization requests may affect the outcome of a Service Authorization Dispute. Information on Service Authorization Disputes can be found on the Provider Service Authorization Dispute Resolution Request Form.

BCBSIL makes no endorsement, representations or warranties regarding third-party vendors. Members should contact the vendor(s) directly with questions about the products or services offered by third parties.

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Check Eligibility and Benefits: Don’t skip this important first step!

Is your patient’s membership with Blue Cross and Blue Shield of Illinois (BCBSIL) still active? Are you or your practice/medical group in- or out-of-network for a specific patient? Is prior authorization required for a particular member/service?

Get Answers Up Front

Benefits will vary based on the service being rendered and individual and group policy elections. It’s critical to check eligibility and benefits for each patient before every scheduled appointment. Eligibility and benefit quotes include important information about the patients’ benefits, such as membership verification, coverage status and applicable copayment, coinsurance and deductible amounts. Also, the benefit quote may include information on applicable prior authorization or pre-notification requirements. When services may not be covered, you should notify members that they may be billed directly.

Don’t Take Chances

Ask to see the member’s BCBSIL ID card for current information. Also ask for a driver’s license or other photo ID to help guard against medical identity theft. Remind your patients to call the number on their BCBSIL card if they have questions about their benefits.

Use Online Options

We encourage you to check eligibility and benefits via an electronic 270 transaction through the Availity® Provider Portal or your preferred vendor portal. You may conduct electronic eligibility and benefits inquiries for local BCBSIL members, and out-of-area Blue Plan and Federal Employee Program® (FEP®) members.

Learn More

For more information, such as an Availity user guide, refer to the Eligibility and Benefits section of our Provider website. BCBSIL also offers educational webinars with an emphasis on electronic transactions, including eligibility and benefits inquiries. Refer to the Webinars and Workshops page for upcoming dates, times and registration links to sign up now.

Checking eligibility and benefits and/or obtaining preauthorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any preauthorization or benefit determination, the final decision regarding any treatment or service is between the patient and their health care provider.

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Provider Learning Opportunities

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

BCBSIL WEBINARS

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

Descriptions:	Dates:	Session Times:
Availity® Authorizations Tool *We are hosting one-hour webinar sessions for providers to learn how to electronically submit inpatient and outpatient benefit preauthorization requests handled by BCBSIL using Availity's Authorizations tool*.	Mar. 10, 2021 Mar. 17, 2021 Mar. 24, 2021 Mar. 31, 2021	11 a.m. to noon
Availity Claim Status *We are hosting complimentary webinars for providers to learn how to verify detailed claim status online using Availity's Claim Status tool.*	Mar. 4, 2021 Mar. 11, 2021 Mar. 18, 2021 Mar. 25, 2021	11 to 11:30 a.m.
Availity Remittance Viewer and Reporting On-Demand *These online tools give providers and billing services a convenient way to view claim detail information from the 835 Electronic Remittance Advice (835 ERA) and the Provider Claim Summary (PCS). Attend a webinar to learn how to gain or grant access, conduct a search, view general and payer-specific information and save or print results.*	Mar. 18, 2021	1 to 2 p.m.

BCBSIL Back to Basics: 'Availity 101' *Join us for a review of electronic transactions, provider tools and helpful online resources.*	Mar. 9, 2021 Mar. 16, 2021 Mar. 23, 2021 Mar. 30, 2021	11 a.m. to noon
BCCHP[SM] and MMAI Required Provider Training Webinars *If you provide care and services to our Blue Cross Community MMAI (Medicare-Medicaid Plan)[SM] and/or Blue Cross Community Health Plans[SM] (BCCHP) members, please join us for guided webinars that will review all the provider trainings required by the Centers for Medicare & Medicaid Service (CMS) and/or Illinois Department of Healthcare and Family Services (HFS).*	Mar. 17, 2021	1 to 3 p.m.
Monthly Provider Hot Topics Webinar *These monthly webinars will be held through December 2020. 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*	Mar. 10, 2021	10 to 11 a.m.
Single Access Point for 835 EFT and ERA Enrollments *We are hosting complimentary webinars for providers to learn how to enroll online via Availity*	Mar. 15, 2021 Mar. 16, 2021 Mar. 17, 2021 Mar. 18, 2021 Mar. 19, 2021	1 to 2 p.m. 10 to 11 a.m. 2 to 3 p.m. 9 to 10 a.m. 3 to 4 p.m.

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Overpayment Recovery for Multiple Surgical Procedures

On **June 1, 2021**, Blue Cross and Blue Shield of Illinois (BCBSIL) will begin additional reviews of claims after payment to make sure they adhere to our reimbursement policy for multiple surgical procedures.

Key Point: Our payment policy states that when multiple procedures are performed by the same physician or physician group on the same patient in the same operative session, only the **primary procedure** will **pay 100%** of the allowed amount. **Secondary or subsequent procedures** will **pay at 50%.**

If you submit claims with multiple billable units of the **same procedure**, for the **same member**, on the **same date of service**, at the **same location**, you may be paid 100% for each procedure, despite our current payment policy. However, claims with dates of service on and after **June 1, 2021**, will be processed consistent with our payment policy. Some procedures may be exempt from this policy and pay 100% of the allowed amount.

What this means: If we overpay you, we'll **recoup** the amount overpaid against future claims. This could also **impact member cost-share**, so you may need to reimburse members.

Multiple Surgical Procedure Guidelines

- **Primary procedure:** The surgical procedure with the highest allowed amount is the primary procedure. If two procedures have the same allowed amount, only one will be considered primary. Other procedures are secondary or subsequent. The primary procedure will be reimbursed 100% of the allowed amount.
- **Secondary procedures:** Secondary procedures will be reimbursed 50% of the allowed amount.
- **Bilateral procedures:** If the surgical procedure for either side is the highest allowed amount, then one procedure will pay at 100% and the second at 50%, all other secondary procedures will also be reimbursed at 50%. If at least one other surgical procedure is the highest allowed amount, then the bilateral procedure (both sides combined) will be reimbursed at 75% and all other secondary procedures will be reimbursed at 50%.

Exclusions: Claims for members with the following benefit plans are excluded from this policy:

- BCBSIL is the secondary payer
- Medicare Supplement
- Medicaid

- HMO plans: Blue Advantage HMO℠, Blue Cross Medicare Advantage (HMO)℠, Blue FocusCare℠, Blue Precision HMO℠, BlueCare Direct℠, HMO Illinois®

More information: If you have any questions, please call the number on the member's ID card or contact your BCBSIL Provider Network Consultant (PNC).

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DME Benefit Limits Verification Request Form

As of Feb. 1, 2021, providers who provide Durable Medical Equipment (DME) services to our Blue Cross Community Health Plans℠ (BCCHP℠) and/or Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ members, now have the ability to verify DME Benefit Limits information by completing the DME Benefit Limits Verification Request Form.

Complete section one of this form and email to BCCHP Benefit Limit Verification. Blue Cross and Blue Shield of Illinois (BCBSIL) will complete section two. Providers will receive the requested benefit limit verification information within two business days.

If you have any questions, call your Provider Network Consultant (PNC) at 855-653-8126 or email our Government Providers team.

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CPT® Category II Codes Can Help Close Care Gaps

Using the proper **Current Procedural Terminology (CPT) Category II codes** when filing claims may help you streamline your administrative processes and close gaps in care.

CPT II codes are tracked for certain performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA). We use these measures to help monitor and improve the quality of care our members receive.

CPT II codes are more specific than CPT I codes. When submitted for services performed during office, lab or facility visits, CPT II codes can help:

- Provide more accurate medical data and decrease requests for members' records for review
- Identify and close gaps in care more accurately and quickly – this drives HEDIS measures and quality improvement initiatives
- Track member screenings to help you monitor care and avoid sending unnecessary reminders

CPT II codes may be submitted on claims with other applicable codes. The list of CPT II codes is updated annually according to HEDIS specifications published by NCQA.

CPT II Coding – Examples for Quick Reference Purposes
Listed below are examples of 2021 measurement year HEDIS measures and applicable codes.

HEDIS Measure	Description	Applicable Codes
Controlling High Blood Pressure (CBP)	Members ages 18-85 with a diagnosis of hypertension (HTN) and BP adequately controlled at 139/89 mmHg or less during the measurement year *A diagnosis of Essential Hypertension and*	**Hypertension diagnosis:** • **ICD-10-CM** – I10, I11.9, I12.9, I13.10 (Essential Hypertension) • **CPT II** – 3074F (systolic < 130 mmHg)

	last blood pressure reading in 2021 should be documented in the medical record.	3075F (systolic = 130-139 mmHg) 3077F (systolic > 140 mmHg) 3078F (diastolic < 80 mmHg) 3079F (diastolic = 80-89 mmHg) 3080F (diastolic > 90 mmHg)
		Remote BP monitoring: **CPT** – 93784, 93788, 93790, 99091
Comprehensive Diabetes Care (CDC)	Members ages 18-75 diagnosed with diabetes who have documentation in their medical record indicating the date and result of a Hemoglobin A1c test in the measurement year. *Last A1c result in 2021 should be documented in the medical record.*	**HbA1c level less than 7.0:** • **ICD-10-CM** – E10.10-E13.9, O24.011-O24.33, O24.811-O24.83 • **CPT II** – 3044F
		HbA1c level between 7.0 and 7.9: • **ICD-10-CM** – E10.9, E10.10-E13.9, O24.011-O24.33, O24.811-O24.83 • **CPT II** – 3051F
Prenatal and Postpartum Care (PPC)	Pregnant members who delivered live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year and received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the health plan.	**Prenatal visits:** • **ICD-10-CM** – Use appropriate code from "O" family; Z03.71-Z03.75, Z03.79, Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93, Z36 • **CPT II** – 0500F, 0501F, 0502F

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Health Care Fraud is Not a Victimless Crime

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

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

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

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

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

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

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

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

[2,3] NHCAA, The Problem of Health Care Fraud, Feb. 9, 2011, http://web.archive.org/web/20110209140325/http:/www.nhcaa.org:80/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud

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. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

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bcbsil.com/provider

BlueCross BlueShield of Illinois

BLUE REVIEW℠

A newsletter for contracting institutional and professional providers

March 2021

Procedure Code and Fee Schedule Updates

As part of our commitment to help inform our independently contracted providers of certain developments, Blue Cross and Blue Shield of Illinois (BCBSIL) has designated a specific section in the *Blue Review* to notify you of any significant changes to the physician fee schedules. It's important to review this area in our provider newsletter each month.

Effective March 1, 2021, we will update select immunizations, vaccines and toxoids in the 90281-90396 and 90476-90756 Current Procedural Terminology (CPT®) code ranges. Please note that not all CPT codes in this range will be affected.

FEE SCHEDULE UPDATE:
Effective June 1, 2021, BCBSIL will implement its annual update of the Schedule of Maximum Allowances (SMA) including Durable Medical Equipment (DME) supplies, prosthetics, orthotics and clinical laboratory codes. This fee schedule update takes into consideration the revisions made by the Centers for Medicare & Medicaid Services (CMS) to the resource based relative value scale. Reimbursement for services provided on or after June 1, 2021, will be based on the updated fee schedule. This update affects PPO and Blue Choice PPO℠ fee schedules for professional providers. Providers may request fee schedules for this update starting May 26, 2021.

The information above is not intended to be an exhaustive listing of all the changes. Annual and quarterly fee schedule updates may also be requested by using the Fee Schedule Request Form. Specific code changes that are listed above may 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 on the Forms page on our Provider website.

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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. When applicable, advance notice of significant changes may be posted in the News and Updates section of our Provider 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 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*. 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.

BlueCross BlueShield of Illinois

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective April 1, 2021 – Part 1

Posted February 9, 2021

DRUG LIST CHANGES

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 revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) will be made to the Blue Cross and Blue Shield of Illinois (BCBSIL) drug lists. Your patient(s) may ask you about therapeutic or lower cost alternatives if their medication is affected by one of these changes. **Changes effective April 1, 2021 are outlined below.**

The Quarterly Pharmacy Changes Part 2 article with more recent coverage additions will also be published closer to the April 1 effective date.

Please note: The drug list changes below do not apply to BCBSIL members on the Basic Annual, Multi-Tier Basic Annual, Enhanced Annual, Multi-Tier Enhanced Annual or Performance Annual Drug Lists. These drug lists will have the revisions and/or exclusions applied on or after Jan. 1, 2022.

If you have patients with an HMO Illinois® or Blue Advantage HMO℠ plan, these drug list revisions/exclusions may not apply to their pharmacy benefits, administered through Prime Therapeutics, until on or after Jan. 1, 2022.

Drug List Updates (Revisions/Exclusions) – As of April 1, 2021

Non-Preferred Brand[1]	Drug Class/ Condition Used For	Preferred Generic Alternative(s)[2]	Preferred Brand Alternative(s)[1, 2]
Basic, Multi-Tier Basic, Enhanced and Multi-Tier Enhanced Drug List Revisions			
COPAXONE (glatiramer acetate soln prefilled syringe 20 mg/ml, 40 mg/ml)	Relapsing Multiple Sclerosis	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
SYMFI (efavirenz-lamivudine-tenofovir df tab 600-300-300 mg)	HIV	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
SYMFI LO (efavirenz-lamivudine-tenofovir df tab 400-300-300 mg)	HIV	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
Basic and Multi-Tier Basic Drug List Revisions			
CIPRODEX (ciprofloxacin-dexamethasone otic susp 0.3-0.1%)	Otic Infections	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	

Drug[1]	Drug Class/Condition Used For	Generic Alternatives[1,2]	Brand Alternatives[1,2]
Balanced, Performance and Performance Select Drug List Revisions			
ISONIAZID (isoniazid tab 100 mg)	Infections	*Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	

Balanced and Performance Select Drug List Revisions			
NIZATIDINE (nizatidine cap 300 mg)	Gastroesophageal Reflux Disease (GERD), Ulcers	*Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
Balanced Drug List Revisions			
DAPSONE (dapsone gel 7.5%)	Acne, Skin infections	clindamycin phosphate 1% gel or topical solution, tretinoin cream	
DEXAMETHASONE 10-DAY DOSE PACK (dexamethasone tab therapy pack 1.5 mg (35))	Inflammatory Conditions	dexamethasone tablet	
DEXAMETHASONE 13-DAY DOSE PACK (dexamethasone tab therapy pack 1.5 mg (51))	Inflammatory Conditions	dexamethasone tablet	
Balanced, Performance and Performance Select Drug List Exclusions			
CIPRODEX (ciprofloxacin-dexamethasone otic susp 0.3-0.1%)	Otic Infections	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
COPAXONE (glatiramer acetate soln prefilled syringe 20 mg/ml, 40 mg/ml)	Relapsing Multiple Sclerosis	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
EMTRIVA (emtricitabine cap 200 mg)	HIV	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
JADENU SPRINKLE (deferasirox granules packet 90 mg, 180 mg, 360 mg)	Chronic Iron Overload	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
LAMICTAL ODT (lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit)	Seizures	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
SYMFI (efavirenz-lamivudine-tenofovir df tab 600-300-300 mg)	HIV	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
SYMFI LO (efavirenz-lamivudine-tenofovir df tab 400-300-300 mg)	HIV	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
Performance and Performance Select Drug List Exclusions			
CONDYLOX (podofilox gel 0.5%)	Warts	imiquimod 5% cream, podofilox 0.5% solution	

TIMOPTIC-XE (timolol maleate ophth gel forming soln 0.25%, 0.5%)	Glaucoma, Ocular Hypertension	timolol solution	
VEREGEN (sinecatechins oint 15%)	Warts	imiquimod 5% cream, podofilox 0.5% solution	
Performance Select Drug List Exclusions			
butalbital-acetaminophen-caffeine cap 50-300-40 mg	Pain	butalbital-acetaminophen-caffeine 50-325-40 mg tablet	
Balanced and Performance Select Drug List Exclusions			
PROTONIX (pantoprazole sodium for delayed release susp packet 40 mg)	Gastroesophageal Reflux Disease (GERD)	esomeprazole powder packet, omeprazole capsule, pantoprazole tablet	
Balanced Drug List Exclusions			
DEMSER (metyrosine cap 250 mg)	Hypertension	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
DESONATE (desonide gel 0.05%)	Atopic Dermatitis	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	
NORGESIC FORTE (orphenadrine w/ aspirin & caffeine tab 50-770-60 mg)	Pain/Muscle Spasm	*Generic equivalent available. Members should talk to their doctor or pharmacist about other medication(s) available for their condition.*	

[1]Third-party brand names are the property of their respective owner.
[2]This list is not all inclusive. Other medicines may be available in this drug class.

DISPENSING LIMIT CHANGES

The BCBSIL prescription drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. Food and Drug Administration (FDA) approved dosage regimens and product labeling. **Changes by drug list are listed on the charts below. Note:** The dispensing limits listed below do not apply to BCBSIL members on the Basic Annual or Enhanced Annual Drug Lists. Dispensing limits will be applied to these drug lists on or after Jan. 1, 2022.

BCBSIL letters all members with a claim for a drug included in the Dispensing Limit Program, regardless of the prescribed dosage. This means members may receive a letter even though their prescribed dosage doesn't meet or exceed the dispensing limit.

Effective April 1, 2021:

Drug Class and Medication(s)[1]	Dispensing Limit(s)
Basic, Enhanced, Balanced, Performance, Performance Annual and Performance Select Drug Lists	
SA Oncology	
Alunbrig 30 mg	120 tablets per 30 days
Bosulif 100 mg	90 tablets per 30 days
Lonsurf 15-6.14 mg	60 tablets per 28 days
Therapeutic Alternatives	
Doral (quazepam) tablet 15 mg	30 tablets per 30 days
Extina (ketoconazole) 2% aerosolized foam*	100 grams per 30 days
Migranal (dihydroergotamine) 4 mg/mL nasal spray*	8 mL per 30 days
Sorilux (calcipotriene) foam 0.005%	120 grams per 30 days
Xolegel (ketoconazole) 2% gel*	45 grams per 30 days
Basic and Enhanced Drug Lists	
Fintepla	
Fintepla 2.2 mg/mL	360 mL per 30 days
Balanced and Performance Select Drug Lists	
Therapeutic Alternatives	
Allzital 25 mg/ 325 mg tablet	360 tablets per 30 days
Alphagan-P 0.15% ophthalmic solution	5 mL per 20 days
Amrix 15 mg capsule	30 capsules per 30 days
Amrix 30 mg capsule	30 capsules per 30 days
Ativan 0.5 mg tablet	150 tablets per 30 days
Ativan 1 mg tablet	150 tablets per 30 days
Ativan 2 mg tablet	150 tablets per 30 days
Azelex 20% cream	30 grams per 30 days
Bethkis (tobramycin) 300 mg/4 mL*	224 mL per 56 days
Bupap 50-300 mg tablet	180 tablets per 30 days
Butalbital-acetaminophen-caffeine solution 50-325-40 mg/15 mL	1000 mL per 30 days
Carospir 25 mg/ 5 mL oral suspension	450 mL per 30 days
Chlorzoxazone 250 mg tablet	120 tablets per 30 days
Cuprimine (penicillamine) 250 mg capsule	480 capsules per 30 days
Dexpak 6 Day 1.5 mg tablet, therapy pack	1 pack per 90 days
Dexpak 10 Day 1.5 mg tablet, therapy pack	1 pack per 90 days
Dexpak 13 Day 1.5 mg tablet, therapy pack	1 pack per 90 days
Diflorasone/ Psorcon 0.05% cream*	180 grams per 90 days
Diflorasone 0.05% ointment*	180 grams per 90 days
Durlaza 162.5 mg capsule	30 capsules per 30 days
Dxevo 1.5 mg tablet, therapy pack	39 tablets per 90 days
Fenoprofen 200 mg capsule	180 capsules per 30 days
Fenoprofen 400 mg capsule	120 capsules per 30 days
Fexmid 7.5 mg tablet	90 tablets per 30 days
Kenalog 0.147 mg/ gram spray	189 grams per 90 days
Ketoprofen ER 200 mg capsule	30 capsules per 30 days
Levorphanol 2 mg tablet	120 tablets per 30 days
Levorphanol 3 mg tablet	120 tablets per 30 days
Librax 5 mg/ 2.5 mg capsule	240 capsules per 30 days
Lorzone 375 mg tablet	120 tablets per 30 days

Lorzone 750 mg tablet	120 tablets per 30 days
Mupirocin 2% cream*	120 grams per 90 days
Nalfon (fenoprofen) 600 mg tablet	150 tablets per 30 days
Naprelan 375 mg tablet	60 tablets per 30 days
Naprelan 500 mg tablet	60 tablets per 30 days
Naprelan 750 mg tablet	60 tablets per 30 days
Noritate 1% cream	60 grams per 30 days
Oxistat 1% cream	180 grams per 30 days
Pandel 0.1% cream	80 grams per 90 days
Sitavig 50 mg tablet	2 tablets per 180 days
Sorilux (calcipotriene) foam 0.005%	120 grams per 30 days
Spritam 250 mg tablet	60 tablets per 30 days
Spritam 500 mg tablet	60 tablets per 30 days
Spritam 750 mg tablet	120 tablets per 30 days
Spritam 1000 mg tablet	60 tablets per 30 days
Taperdex 6-day 1.5 mg tablet, therapy pack	1 pack per 90 days
Taperdex 7-day 1.5 mg tablet, therapy pack	1 pack per 90 days
Taperdex 12-day 1.5 mg tablet, therapy pack	1 pack per 90 days
Tivorbex 20 mg capsule	90 capsules per 30 days
Tivorbex 40 mg capsule	90 capsules per 30 days
TOBI/ Kitabis (tobramycin) 300 mg/5 mL inhalation solution*	280 mL per 56 days
Vanos 0.1% cream	60 grams per Rx 120 grams per 180 days
Vivlodex 5 mg capsule	30 capsules per 30 days
Vivlodex 10 mg capsule	30 capsules per 30 days
Zcort 7-day 1.5 mg tablet, therapy pack	1 pack per 90 days
Zegerid (omeprazole/ sodium bicarbonate) 20/1100 mg capsule*	60 capsules per 90 days
Zegerid (omeprazole/ sodium bicarbonate) 20/1680 mg packets*	60 packets per 30 days
Zegerid (omeprazole/ sodium bicarbonate) 40/1100 mg capsule*	60 capsules per 30 days
Zegerid (omeprazole/ sodium bicarbonate) 40/1680 mg packets*	60 packets per 30 days
Zipsor 25 mg capsule	120 capsules per 30 days
Zorvolex 18 mg capsule	90 capsules per 30 days
Zorvolex 35 mg capsule	90 capsules per 30 days
Zyflo 600 mg tablet	120 tablets per 30 days
Zyflo CR 600 mg tablet	120 tablets per 30 days

[1]Third-party brand names are the property of their respective owner.
** Not all members may have been notified due to limited utilization.*

UTILIZATION MANAGEMENT PROGRAM CHANGES

- Effective **Feb. 1, 2021**, the Enspryng Specialty Prior Authorization (PA) program was added for standard pharmacy benefit plans on the Basic, Basic Annual, Enhanced and Enhanced Annual Drug Lists. This program includes the newly FDA-approved target drug Enspryng.
    - Effective **April 1, 2021**, this Specialty PA program will be added for standard pharmacy benefit plans on the Balanced, Performance, Performance Annual and Performance Select Drug Lists.

- Effective **April 1, 2021**, the following changes will be applied:
    - The Multiple Sclerosis Specialty Step Therapy (ST) program is moving to a standard Specialty PA program effective April 1, 2021. Note: Continuation of Therapy (or grandfathering) will apply. Members who may have had a prior authorization approval currently in place from the ST program will not be impacted until their current PA approval expires in 2021.
        - *Please note:* Only members on the Basic and Enhanced Drug Lists with recent prescription history for the target drugs Copaxone and Tecfidera will be notified of the change. However, Continuation of Therapy (or grandfathering) will not apply to these two program targets only, and members on all drug lists (Basic, Enhanced, Balanced, Performance, Performance Annual and Performance Select Drug Lists) will need a prior authorization approval for coverage consideration.
            - Impacted members on the Basic Annual and Enhanced Annual Drug Lists will be notified on or after Jan. 1, 2022, upon renewal.
        - The new Multiple Sclerosis Specialty PA program also applies to the Balanced, Performance, Performance Annual and Performance Select Drug Lists.
        - The Preferred target drugs in this Specialty PA program are: Aubagio, Avonex, Betaseron, Gilenya, Mavenclad, Mayzent, Plegridy, Rebif and Zeposia.
        - The Non-Preferred target drugs in this Specialty PA program are: Bafiertam, Copaxone, Extavia, Glatopa, Kesimpta, Tecfidera and Vumerity.

    - The Supplemental Therapeutic Alternatives PA program will be added to the Basic, Basic Annual, Enhanced, Enhanced Annual, Performance and Performance Annual Drug Lists. This program includes the following target drugs: Absorica, Absorica LD, Cambia, Daraprim and Rytary. Members were not notified of this change because these drugs were targeted in the Therapeutic Alternatives PA program prior to April 1, 2021.

    - Targretin Gel will be added as a target to the Self-Administered Oncology Specialty PA program, which applies to the Basic, Enhanced, Balanced, Performance, Performance Annual and Performance Select Drug Lists. Auto – Continuation of Therapy (or auto – grandfathering) is in place.

Members were notified about the PA standard program changes listed in the tables below.

Drug categories added to current pharmacy PA standard programs, effective April 1, 2021

Drug Category	Targeted Medication(s)[1]
Basic and Enhanced Drug Lists	
Dojolvi	Dojolvi*
Fintepla	Fintepla*
Multiple Sclerosis	Copaxone, Tecfidera
Balanced and Performance Select Drug Lists	
Therapeutic Alternatives	Allzital (butalbital/acetaminophen) 25 mg/ 325 mg, Alphagan-P 0.15% sol, Amrix (cyclobenzaprine SR) 15 mg capsule, Amrix (cyclobenzaprine SR) 30 mg capsule, Aplenzin 174 mg, Aplenzin 348 mg, Aplenzin 522 mg, Ativan 0.5 mg tablet, Ativan 1 mg tablet, Ativan 2 mg tablet, Auvi-Q, Azelex 20% cream, Bethkis neb 300 mg/4 mL, Bupap 50-300 mg tablet, Butalbital-acetaminophen-caffeine

	solution 50-325-40 mg/15 mL, Cardizem CD 120 mg capsule, Cardizem CD 180 mg capsule, Cardizem CD 240 mg capsule, Cardizem CD 300 mg capsule, Cardizem CD 360 mg capsule, Carospir 25 mg/ 5 mL oral suspension, Chlorzoxazone 250 mg tablet, Cuprimine (penicillamine) 250 mg capsule, Dexpak 6 Day 1.5 mg tablet, therapy pack, Dexpak 10 Day 1.5 mg tablet, therapy pack, Dexpak 13 Day 1.5 mg tablet, therapy pack, diflorasone 0.05% cream, diflorasone 0.05% ointment, Doral (quazepam) tablet 15 mg, Durlaza 162.5 mg capsule, Dutoprol 25 mg /12.5 mg tablet, Dutoprol 50 mg /12.5 mg tablet, Dutoprol 100 mg /12.5 mg tablet, Dxevo 1.5 mg tablet, therapy pack, Extina (ketoconazole) 2% foam, Fexmid 7.5 mg tablet, Kenalog 0.147 mg/ gram spray, Ketoprofen capsule 200 mg ER, Kitabis pak neb 300 mg/5 mL, Levorphanol 2 mg tablet, Levorphanol 3 mg tablet, Librax 5 mg/ 2.5 mg capsule, Lorzone 375 mg tablet, Lorzone 750 mg tablet, Migranal (dihydroergotamine) spr 4 mg/mL, mupirocin 2% cream, Nalfon/fenoprofen 200 mg capsule, Nalfon/fenoprofen 400 mg capsule, Nalfon/fenoprofen 600 mg tablet, Naprelan 375 mg tablet, Naprelan 500 mg tablet, Naprelan 750 mg tablet, Noritate 1% cream, Oxiconazole cream 1%, Oxistat lotion 1%, Pandel 0.1% cream, Sitavig 50 mg tablet, Sorilux (calcipotriene) aer 0.005% foam, Spritam 250 mg tablet, Spritam 500 mg tablet, Spritam 750 mg tablet, Spritam 1000 mg tablet, Taperdex 6-day 1.5 mg tablet, therapy pack, Taperdex 7-day 1.5 mg tablet, therapy pack, Taperdex 12-day 1.5 mg tablet, therapy pack, Tivorbex 20 mg capsule, Tivorbex 40 mg capsule, Tobi neb 300 mg/5 mL, Vanos 0.1% cream, Vivlodex 5 mg capsule, Vivlodex 10 mg capsule, Wellbutrin XL 150 mg tablet, Wellbutrin XL 300 mg tablet, Xolegel (ketoconazole) 2% gel, Zcort 7-day 1.5 mg tablet, therapy pack, Zegerid 20/1100 mg capsule, Zegerid 20/1680 mg packet, Zegerid 40/1100 mg capsule, Zegerid 40/1680 mg packet, Zipsor 25 mg capsule, Zorvolex 18 mg capsule, Zorvolex 35 mg capsule, Zyflo 600 mg tablet, Zyflo CR 600 mg tablet

[1]Third-party brand names are the property of their respective owner.
** Not all members may have been notified due to limited utilization.*

Targeted drugs added to current pharmacy PA standard programs, effective April 1, 2021

Drug Category	Targeted Medication(s)[1]
Basic, Enhanced, Performance and Performance Annual Drug Lists	
Actinic Keratosis	fluorouracil cream 0.5%
Therapeutic Alternatives	Doral (quazepam) tablet 15 mg, Extina 2% foam, Migranal (dihydroergotamine) spr 4 mg/mL, Sorilux (calcipotriene) aer 0.005% foam, Xolegel (ketoconazole) 2% gel

Basic, Enhanced, Balanced, Performance, Performance Annual and Performance Select Drug Lists	
Alternative Dosage Form	Sprix
Basic and Enhanced Drug Lists	
Elagolix	Oriahnn

[1]Third-party brand names are the property of their respective owner.

Weight Loss PA Program Available as a Non-Standard PA Program for Select Plans
The Weight Loss PA program will be available for select benefit plans only. Effective April 1, 2021, and upon renewal, this program may apply for members whose benefit plan includes coverage of these weight loss products and has this program added to their benefit design.

Medications included in the program are listed in the table below. Impacted members were notified of this change.

Drug Category	Targeted Medication(s)[1]
Weight Loss	Adipex-P (phentermine) 37.5 mg capsule, Adipex-P (phentermine) 37.5 mg tablet, Belviq (lorcaserin) 10 mg tablet, Belviq XR (lorcaserin) 20 mg tablet, Contrave (naltrexone/bupropion) 8 mg / 90 mg tablet, Didrex (benzphetamine) 50 mg tablet, Diethylpropion 25 mg tablet, Diethylpropion 75 mg extended-release tablet, Lomaira (phentermine) 8 mg tablet, phendimetrazine 35 mg tablet, phendimetrazine 105 mg extended-release capsule, phentermine 15 mg capsule, phentermine 30 mg capsule, Qsymia (phentermine/topiramate) 3.75 mg / 23 mg capsule, Qsymia (phentermine/topiramate) 7.5 mg / 46 mg capsule, Qsymia (phentermine/topiramate) 11.25 mg / 69 mg capsule, Qsymia (phentermine/topiramate) 15 mg / 92 mg capsule, Regimex (benzphetamine) 25 mg tablet, Saxenda (liraglutide) 6 mg / mL, Xenical (orlistat) 120 mg capsule

[1]Third-party brand names are the property of their respective owner.

Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.

Per our usual process of member notification prior to implementation, targeted mailings were sent to members affected by drug list revisions and/or exclusions, dispensing limit and prior authorization program changes. For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of our Provider website.

If your patients have any questions about their pharmacy benefits, please advise them to contact the number on their member ID card. Members may also visit *bcbsil.com* and log in to Blue Access for Members℠ (BAM℠) or MyPrime.com for a variety of online resources.

Reminder: Split Fill Program Available to Select Members
BCBSIL offers its members and groups a Split Fill program to reduce waste and help avoid costs of select specialty medications that may go unused. Members new to therapy (or have not had claims history within the past 120 days for the drug) are provided partial, or "split," prescription fills for up to three months.

The Split Fill Program applies to a specific list of drugs known to have early discontinuation or dose modification. The specific list of drugs is subject to change at any time. You can view the current list of drugs in the *Split Fill Program* on the Specialty Program section of our Provider website.

Members must use an in-network specialty pharmacy. Members will pay a prorated cost share (if applicable) for the duration of the program. Once the member can tolerate the medication, the member will pay the applicable cost share amount for a full supply. All member share costs are determined by the member's pharmacy benefit plan.

Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.

Change in Benefit Coverage for Select High Cost Products
Starting Jan. 1, 2021, several high cost products with lower cost alternatives will be excluded on the pharmacy benefit for select drug lists. This change impacts BCBSIL members who have prescription drug benefits administered by Prime Therapeutics.

Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.

Members will be notified about these excluded high cost products with lower cost alternatives listed in the table below. Please talk to your patient about other products that may be available.

Product(s) No Longer Covered[1*]	Condition Used For	Covered Alternative(s)[1,2]
DEXCHLORPHENIRAMINE SOLN 2 MG/5 ML	ALLERGIES	RYCLORA
ESOMEPRAZOLE CAP 49.3 MG	ACID REFLUX	ESOMEPRAZOLE 40 MG
FENOPROFEN CAP 400 MG	INFLAMMATION AND PAIN	OTHER MANUFACTURERS
GLYCOPYRROLATE TAB 1.5 MG	PEPTIC ULCER DISEASE	OTHER MANUFACTURERS
JENLIVA CAP[†]	PREGNANCY	PRENATAL 19, PRENATAL+FE TAB 29-1, SE-NATAL 19, TRINATE, VINATE M
PRENATRYL TAB[†]	PREGNANCY	PRENATAL 19, PRENATAL+FE TAB 29-1, SE-NATAL 19, TRINATE, VINATE M

1 All brand names are the property of their respective owners.
2 This list is not all-inclusive. Other products may be available.
* This chart applies to members on the Basic, Basic Annual, Multi-Tier Basic, Multi-Tier Basic Annual, Enhanced, Enhanced Annual, Multi- Tier Enhanced and Multi-Tier Enhanced Annual Drug Lists.
† The prenatal products also apply to members on the Balanced, Performance, Performance Annual and Performance Select Drug Lists.

Additional Single-Agent Statin Coverage Without Cost-Sharing
Starting April 1, 2021, BCBSIL will be offering additional single-agent statin coverage for members with an ACA-compliant plan. The generic Atorvastatin tablets (10 mg and 20 mg) will be available at $0 if members meet the conditions set under ACA. This addition is based on the United States Preventive Services Task Force recommendation.

Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.