Introducing Blue Cross Community MMAI (Medicare-Medicaid Plan)SM and Blue Cross Community ICPSM

We would like to take this opportunity to thank all MMAI and ICP independently contracted providers for their cooperation and support of the March 1, 2014, implementation of MMAI and ICP.

MMAI

The Centers for Medicare & Medicaid Services (CMS) and the State of Illinois have contracted with Blue Cross and Blue Shield of Illinois (BCBSIL) to implement MMAI – a three-year demonstration program developed to better serve individuals who are eligible for both Medicare and Medicaid. The plan will combine Medicare and Medicaid funding under a blended payment agreement to provide benefits for integrated, comprehensive care for dual-eligible members. BCBSIL will arrange for the provision of services, through the network of contracted providers, to MMAI members in six counties: Lake, DuPage, Kane, Cook, Will and Kankakee.

With this implementation, providers and members will no longer need to navigate two distinct plans with two sets of benefits and three separate member ID cards for Medicare, Part D and Medicaid. Providers can now manage one set of policies, procedures and reimbursement rules. MMAI should also help resolve fragmentation of care with better coordination for members accessing care from multiple providers.

ICP

The Illinois 2011 Medicaid Reform Law requires the Medicaid plan to enroll at least 50 percent of Medicaid members into coordinated care/managed care by Jan. 1, 2015. The Integrated Care Plan (ICP) is for seniors and adults, 19 or older with disabilities and Medicaid only (no Medicare). BCBSIL will arrange for the provision of services, through the network of contracted providers, to ICP members who live in Cook County.

GOALS AND OBJECTIVES

Together, MMAI and ICP are designed to improve accessibility and availability of health care with a focus on helping to maintain the independence of each individual member. Objectives also include improving transitions between care settings, while establishing a single point of accountability for the delivery and coordination of medical and surgical services, behavioral health services, prescription drugs and other social support services, as well as Medicaid-funded Long Term Services and Support (LTSS).

REQUIRED TRAINING FOR PROVIDERS

The MMAI and ICP contract with BCBSIL requires that providers for MMAI and ICP members must participate in specific training. BCBSIL is required by CMS and the State of Illinois to offer members this training.

The training includes the following topics:

• Person Centered Practice, Care Coordination and the Interdisciplinary Care Team
• Fraud, Waste and Abuse
• Critical Incidents – Health, Safety and Welfare
• Cultural Competency
• Disability Literacy
• Independent Living and Recovery
• Mental Health Crisis Intervention

If you were unable to attend one of the hospital-based trainings conducted by BCBSIL last fall, please refer to the new Blue Cross Community OptionsSM page, located in the Network Participation section of our website at bcbil.com/provider. This page includes links to our online training modules for MMAI and ICP. In addition to training on the required topics, you may also complete an MMAI and ICP Overview module.
New 2014 prescription drug benefits for Blue Cross Medicare AdvantageSM HMO members have been designed to help create savings on medications that treat conditions such as diabetes, high blood pressure, high cholesterol, depression, osteoporosis and many others.

Plans are currently available for individuals residing in Cook, DuPage, Kane and Will counties.

Most generics are available for copays of $0 and $2 at preferred pharmacies.

Participants in our new Preferred Pharmacy Network include:

- Nationwide: CVS/Pharmacy and Walmart
- Grocer: Jewel Osco Pharmacy
- Independents: AccessHealth Pharmacies and Good Neighbor Pharmacies

<table>
<thead>
<tr>
<th>Category</th>
<th>Stars/HEDIS/NCQA</th>
<th>Drugs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Stars: Medication Compliance</td>
<td>Glimepiride, Glipizide, Glipizide 24-hour, Metformin</td>
</tr>
<tr>
<td>ACE Inhibitors and ARBs</td>
<td>Stars: ACE/ARB use in Diabetes with HTN Medication Compliance</td>
<td>Benazepril, Captopril, Enalapril, Lisinopril, Irbesartan, Losartan (related combination products)</td>
</tr>
<tr>
<td>Statins</td>
<td>Stars: Medication Compliance</td>
<td>Lovastatin, Pravastatin, Simvastatin</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Stars/HEDIS: Osteoporosis Management in Women who had a Fracture</td>
<td>Alendronate</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>HEDIS: Anti-depressant Medication Management (six months)</td>
<td>Citalopram, Sertraline</td>
</tr>
<tr>
<td>Beta Blocker</td>
<td>HEDIS: Beta Blocker use post MI</td>
<td>Atenolol, Metoprolol Tartrate</td>
</tr>
</tbody>
</table>

*Additional generics available for $2 member copays at preferred pharmacies.

Providers and payers must wait for the primary insurer to adjudicate the claim first. When a Medicare claim has crossed-over, providers are to wait 30 calendar days from the Medicare remittance date before submitting the claim to BCBSIL.

For additional information, including answers to frequently asked questions (FAQs), look for the article in the News and Updates section of our website at bcbsil.com/provider.

Stars/HEDIS® Focused 2014 Medicare Advantage Formulary

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

Note: 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 terms set forth in the member’s certificate of coverage will govern.

The listing of any particular drug or classification of drugs is not a representation or warranty about the suitability of a drug for any particular condition nor is it a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. The final decision about what medication should be prescribed is between the member and their health care provider.

HEDIS is a registered trademark of NCQA.
Not Enrolled for Electronic Funds Transfer (EFT)?

EFT is a convenient, confidential and secure method of payment. Using EFT means your payments are delivered directly to the financial institution of your choice. This alternative to receiving paper checks can help save you time while reducing the risk of lost or misrouted payments. In general, funds will be transferred to the provider’s bank in two banking days, after the claim is finalized depending on your payment schedule.*

There’s no cost to enroll, and the enrollment process is easier than ever. BCBSIL independently contracted providers who are registered with Availity may complete the EFT and Electronic Remittance Advice (ERA) electronic enrollment process online via the secure Availity provider portal. Please note that you must be a registered Availity user to complete the online enrollment process – visit availity.com for more information. Or, to enroll by submitting a paper form, complete the Electronic Funds Transfer (EFT) Authorization Agreement, which is available in the Claims and Eligibility/Claim Payment and Remittance section of our website at bcbsil.com/provider.

*Add one day if the normal day falls on a banking holiday. EFT payment dates also may be affected by our corporate holiday schedule. Visit the Claims and Eligibility/Electronic Commerce section of our website at bcbsil.com/provider for details. Uniform Payment Program (UPP) providers, please note: The timeline referenced in the above article does not apply to the UPP payment schedule.

Billing for Medically Unnecessary and/or Medically Unproven Services

Under the terms of the health benefit plans that are offered or administered by BCBSIL, benefits for health care services will be denied if it is determined that such items are deemed “medically unnecessary” or which are medically unproven, often referred to as “experimental and/or investigational.” Effective on or after May 19, 2014, claims submitted to BCBSIL for services that are deemed to be medically unnecessary and/or medically unproven (experimental and investigational) will be denied with a message specifying that the member will not be financially responsible for charges associated with an inpatient hospital stay or any outpatient procedure or other service that is determined by utilization management to be medically unnecessary and/or medically unproven.

If you and your patient are aware that a proposed service will be deemed medically unnecessary and/or medically unproven and you decide to proceed, you must obtain a written disclosure/authorization signed by the member informing the member that services are not covered by BCBSIL and the patient is assuming all financial responsibility. The disclosure/authorization must state that the member has been informed prior to services being rendered that the services are not covered; the date, or dates of such service; the cost of the services and confirmation that the member accepts all financial responsibility.

You may view the BCBSIL Medical Policies in the Standards and Requirements section of our website at bcbsil.com/provider to help determine when services may be considered medically unproven.
**NEW FAX PROCESS FOR LENGTH OF STAY BENEFIT EXTENSION REQUESTS**

Effective March 3, 2014, BCBSIL implemented a new fax process for receipt of clinical information from hospitals to support length of stay benefit extension requests for BCBSIL PPO members. As we reported previously, results of a recent pilot to test the effectiveness of the new fax process showed improved response times to benefit requests with a decrease in phone calls by providers and BCBSIL. The new fax process replaces the previous method of submitting clinical information to BCBSIL via voicemail. See below for recommended information to include when utilizing the new fax process; we’ve also included some notification and approval reminders for your convenience.

**NOTIFICATION OF ADMISSION**

As a reminder, benefit preauthorization (also referred to as pre-certification or pre-notification) for an inpatient acute hospital admission may be completed in one of two ways:

- The preferred and more efficient method is electronic submission via iEXCHANGE®, our automated online tool that supports quick, direct submission and processing of benefit preauthorization for inpatient admissions 24 hours a day, seven days a week; or
- By phone, using the appropriate number on the back of the member’s ID card.

**LENGTH OF STAY BENEFIT EXTENSION REQUESTS**

Requests for length of stay benefit extensions may now be initiated by faxing clinical information prior to the last approved day. See below for a recommended list of information to include.

Please submit typed information and limit your fax to 10 pages or less. The information may be transmitted via your electronic medical record system, if applicable.

The centralized fax number for BCBSIL Utilization Management is 312-946-3985.

**APPROVAL STATUS AND FOLLOW-UP**

Approval information for preauthorization and length of stay benefit extension requests will be available through iEXCHANGE and/or by mailed letter. In addition, hospital personnel can check approval status by calling the number on the back of the member’s ID card. If the member’s ID card is unavailable, contact Medical Management Customer Service at 800-572-3089. BCBSIL will continue to make outbound notification calls to facilities in order to expedite transition of members who are moving from the hospital to a less intensive treatment setting. In the event of an adverse benefit determination, notification will be made by phone within one business day of determination.

(continued on p.5)
New Fax Process for Length of Stay Extension Requests

We encourage you to share this information with your Care Management department to ensure they are aware of the new fax process. To learn more about iEXCHANGE, visit the Education and Reference/Provider Tools section of our website at bcbsil.com/provider, or contact your assigned BCBSIL Provider Network Consultant for assistance.

This article is specific to BCBSIL PPO members only. For out-of-area members, please use the Pre-cert/Pre-auth Router (Out-of-area members) located in the Claims and Eligibility/Pre Authorization section of our website at bcbsil.com/provider. Pre-certification also may be required for outpatient services for some employer groups.

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.

Reminder: CMS-1500 Paper Claim Form (Version 02/12)

Previous articles have referenced the transition from the previous version of the paper CMS-1500 claim form (08/05) to the revised version (02/12). As a reminder, the transition timeline, which aligns with Medicare’s timeline, is as follows:

• Jan. 6, 2014 through March 31, 2014 – Dual-use period during which payers continue to receive and process paper claims submitted on the old CMS-1500 claim form (version 08/05), as well as claims submitted on the revised CMS-1500 claim form (version 02/12).

• April 1, 2014 – Payers receive and process only those claims that are submitted on the revised CMS-1500 claim form (version 02/12). As mandated by the Centers for Medicare & Medicaid Services (CMS), claims submitted on the old form (version 08/05) will no longer be accepted.

WHAT’S DIFFERENT?

If you’ve submitted claims on the revised form (version 02/12) during the dual-use period, you may have noticed that Field 21 now requires users to specify whether they are using ICD-9 or ICD-10 diagnoses codes. Additionally, eight diagnosis codes have been added on the revised form. There are other minor changes as well. If you use a practice management system, billing service or clearinghouse, it’s important to check with your vendor(s) to ensure they are aware and can accommodate any changes.

DON’T FORGET TO RECYCLE!

As noted above, the previous version of the CMS-1500 claim form (08/05) will be discontinued as of April 1, 2014. This means you should discard or recycle any unused forms as of this date. For more information on the revised CMS-1500 claim form (version 02/12) such as specific changes, technical specifications and how to order a new supply of printed forms, visit the National Uniform Claim Committee (NUCC) website at nucc.org.

Why not take this opportunity to make the switch to paperless transactions?

Electronic claim submission can help streamline your administrative processes, help protect your patients’ information and may result in faster claims processing and payment. To learn more, visit the Claims and Eligibility/Claim Submission section of our website at bcbsil.com/provider.

Introducing Our New Genetic Testing Form

A new form is available now on our Provider website to help facilitate processing of claims for Tier 2 CPT Molecular Pathology codes for genetic testing.

Tier 2 codes are used to report genetic testing procedures that are not listed as Tier 1 genetic testing procedures. According to the CPT codebook, the Tier 2 codes denote procedures that are generally performed in lower volumes than Tier 1 procedures and the incidence of the disease being tested is rare. Please refer to the most current CPT codebook for a complete set of guidelines for Tier 1 and Tier 2 CPT codes.

Our new genetic testing form enables providers to include the exact gene that is being tested under a Tier 2 code and to describe the rationale for performing the test. Additionally, the form can be used as a supplement to a benefit predetermination or medical record request. When use of this form is necessary, you will receive instructions from BCBSIL for submitting information.

The new genetic testing form is available in the Education and Reference/Provider Tools section of our website at bcbsil.com/provider.
2013 HMO Member Survey Results

The 2013 HMO Member Survey was conducted in July and August of 2013. The primary purpose of this survey was to assess member satisfaction in a variety of areas at the Medical Group/Independent Practice Association (MG/IPA) site level, including medical care and services rendered by Primary Care Physicians (PCPs) and Specialists, access to care and overall MG/IPA service. Survey recipients included a random sampling of adult patients who have been BCBSIL HMO members for at least one year. The overall response rate for this year was 22 percent.

"Top 2 Box" scores (Excellent and Very Good) were counted as positive responses in the HMO Member Survey analysis. The 2013 HMO Member Survey results are listed below.

### 2013 ACCOLADES

Many items in the 2013 survey received a score of **80 percent or better**, including the following:

<table>
<thead>
<tr>
<th>PCP Management/Coordination of the Member’s Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall member rating of PCP (percent of “Excellent,” or “Very Good” responses)</td>
<td>81%</td>
</tr>
<tr>
<td>Members’ rating of PCP for thoroughness of examinations (percent of “Excellent,” or “Very Good” responses)</td>
<td>81%</td>
</tr>
<tr>
<td>Members’ rating of PCP for respect shown and attention to privacy (percent of “Excellent” or “Very Good” responses)</td>
<td>86%</td>
</tr>
<tr>
<td>Members’ rating of PCP for medical care received (percent of “Excellent,” or “Very Good” responses)</td>
<td>82%</td>
</tr>
<tr>
<td>Length of time waited for a routine appointment (within two weeks) Results are based on respondents who had appointments</td>
<td>82%</td>
</tr>
<tr>
<td>Length of time waited for an urgent appointment (within 24 hours)</td>
<td>86%</td>
</tr>
<tr>
<td>PCP’s office contacted the member about test results (percent of “Yes” responses) Results are based on respondents who had tests performed</td>
<td>84%</td>
</tr>
<tr>
<td>PCP gave the member clear instructions on health problems or symptoms bothering the member (percent of “Always” and “Usually” responses)</td>
<td>89%</td>
</tr>
<tr>
<td>PCP’s office reminded the member about getting preventive care (percent of “Yes” responses)</td>
<td>85%</td>
</tr>
<tr>
<td>PCP talked with the member about different medicines he or she is using, including ones prescribed by a specialist (percent of “Yes” responses)</td>
<td>84%</td>
</tr>
<tr>
<td>PCP gave the member easy-to-understand instructions about taking his or her medicines (percent of “Always” and “Usually” responses)</td>
<td>88%</td>
</tr>
</tbody>
</table>

From the Medical Director’s Library

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

The article recommended this month is a fascinating one to ponder and is reminiscent of reading some of the works of the great philosophers. It is by Amol Verna et al. ‘Understanding Choice: Why Physicians Should Learn Prospect Theory’, JAMA Feb. 12, 2014, Vol 311, Number 6 571-572.

It is a compact two page article that addresses our need to understand the behavioral components of choice and how one makes a choice in the face of uncertainty. It reinforces the importance of logic and the impact of how delivered information is framed. It addresses what constitutes a good medical decision.

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

The above article is for informational purposes only. The views and opinions expressed in this article are solely those of the authors, and do not represent the views or opinions of BCBSIL, Health Care Service Corporation, its medical directors or Dr. Stein.

(continued on p. 7)
### Referral Process

| Satisfaction with MG’s/IPA’s referral process (percent of “Yes” responses) | 88% |

### Specialist-related Questions

| Members’ rating of Specialist for thoroughness of examinations (percent of “Excellent,” or “Very Good” responses) | 81% |
| Members’ rating of Specialist for respect shown and attention to privacy (percent of “Excellent,” or “Very Good” responses) | 83% |
| Members’ rating of Specialist for medical care received (percent of “Excellent,” or “Very Good” responses) | 81% |

### Reports

| Usefulness of information contained in the Blue Star MG/IPA Report (percent of “Yes” responses) | 91% |

### OPPORTUNITIES FOR IMPROVEMENT

Select items that received a score of less than 80 percent including the following:

- PCP and Specialist availability during office and after hours
- PCP and Specialist response time to an emergency phone call (within 30 minutes)
- Length of time spent in the waiting room for PCP and Specialist
- Length of time between making an appointment and the day of the appointment for PCP and Specialist
- PCP talking with member about eating habits, and exercise or physical activity (percent of “Yes” responses)
- PCP explaining possible side effects or medicine in an easy-to-understand way (percent of “Always” and “Usually” responses)
- PCP talking with member about the cost of their medication
- PCP suggesting ways to help member remember to take medicines (percent of “Always” and “Usually” responses)
- Length of time waited for a routine (less than two weeks) or urgent (less than 24 hours) exam appointment from a Specialist

### BLUE RIBBON℠ STATUS

The Blue Ribbon designation (ribbon) recognizes MGs/IPAs that received a Top 2 Box score of at least 75 percent for 21 specified survey questions. Of the 92 MGs/IPAs analyzed in 2013 for a Blue Ribbon Directory Indicator:

- Forty-five MG/IPA sites received a Blue Ribbon
- Thirty-eight MG/IPA sites did not receive Blue Ribbon status
- Nine MG/IPA sites received an “Insufficient Responses” designation

---

### Medical Policy Updates

Approved, new or revised BCBSIL Medical Policies and their effective dates are usually posted on our website the first day of each month. Medical policies, both new and revised, are used as guidelines for benefit determinations in health care benefit programs for most BCBSIL members, unless otherwise indicated. These policies may impact your reimbursement and your patients’ benefits.

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 website at [bcbsil.com/provider](http://bcbsil.com/provider).

You may view active, new and revised policies, along with policies pending implementation, by visiting the Standards and Requirements/Medical Policy section of our website at [bcbsil.com/provider](http://bcbsil.com/provider). Select “View all Active and Pending Medical Policies.” After confirming your agreement with the Medical Policies disclaimer, you will be directed to the Medical Policies Home page.

You may also view draft medical policies that are under development, or are in the process of being revised, by selecting “View and comment on Draft Medical Policies.” After confirming your agreement with the Medical Policies disclaimer, you will be directed to the Draft Medical Policies page. Just click on the title of the draft policy you wish to review, and then select “Comments” to submit your feedback to us.

Please visit the Standards and Requirements/Medical Policy section of our website at [bcbsil.com/provider](http://bcbsil.com/provider) for access to the most complete and up-to-date medical policy information.

The BCBSIL Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are instructed 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.
The Importance of Accurate Coding

Submitting claims with accurate coding is more important than ever with the increased documentation needs of modern health care. Accurate coding also helps providers and payers reduce waste due to rejected claims or possible fraud.

For example, telemedicine services do not qualify for benefit reimbursement and are subject to the terms and conditions listed in a member’s benefit plan. The same is true for the costs of telecommunications equipment or line charges, as they do not qualify as medical expenses. Recent BCBSIL claims data indicates that some claims are being submitted using incorrect CPT codes to possibly mask telemedicine services.

When submitting a claim, you are required to accurately reflect the location where services or supplies were rendered or provided along with accurate CPT codes. Your claim should indicate the services rendered in terms of the procedure codes listed in the most recent version of the CPT.

To learn more about submitting claims, refer to the Billing and Reimbursement section of the Provider Manual located under the Standards and Requirements tab on our Provider website at bcbsil.com/provider. To report a concern, contact the Fraud Hotline at 877-272-9741. All calls are confidential, and you may remain anonymous.

A Closer Look: Documentation and Coding for Chronic Kidney Disease

This month’s Blue Review highlights documentation and coding for Chronic Kidney Disease (CKD) under the ICD-9-CM and ICD-10-CM code sets.

The National Kidney Foundation defines CKD as a "condition characterized by a gradual loss of kidney function over time." CKD is classified to category 585–Chronic Kidney Disease, in ICD-9-CM. Fourth-digit assignment indicates the stage of the disease which is based on severity. The stage is determined by the degree of kidney damage and the Glomerular filtration rate (GFR), an indicator of how well the kidneys are functioning. The severity is designated by Stages I–V. CKD can progress to End Stage Renal Disease (ESRD), which is also reported using a code from the 585 category. The code for end stage renal disease (585.6) cannot be assigned without supporting documentation from the provider.

In ICD-10-CM, CKD is reported under category N18, with fourth-digit assignment indicating the stage of the disease. The code for ESRD is found in the same category as the codes for CKD In both ICD-9-CM and ICD-10-CM.

When coding CKD in ICD-9-CM or ICD-10-CM, coding guidelines provide instruction to also assign diagnosis codes for any associated conditions.

**HYPERTENSIVE CHRONIC KIDNEY DISEASE**

Hypertension is one of the leading causes of CKD and, together with diabetes, is responsible for nearly two-thirds of CKD cases. ICD-9-CM presumes a cause-and-effect relationship and classifies CKD with hypertension as hypertensive CKD. The Official ICD-9-CM Guidelines for Coding and Reporting provide guidance related to hypertensive CKD coding. Assign codes from category 403-Hypertensive CKD, when conditions classified to category 585-CKD are present with hypertension.

To accurately report a diagnosis of hypertensive CKD using diagnosis code 403, it is important to select the appropriate fourth digit to indicate whether the hypertension is classified as malignant (0), benign (1) or unspecified (9). Fifth-digit assignment identifies the stage of the kidney disease. CKD stage I-IV or unspecified is indicated by a fifth-digit assignment of (0), while CKD stage V or ESRD is indicated by a fifth-digit assignment of (1).

The appropriate code from category 585-CKD, should be reported as discussed above, to identify the stage of CKD.

Similar to the current ICD-9-CM coding system, ICD-10-CM requires two codes to accurately report a diagnosis of hypertensive CKD. The first code indicates the presence of both hypertension and CKD, the second code identifies the stage of CKD. Under the ICD-10-CM coding system, there is no distinction between benign, malignant or unspecified hypertension as is under the ICD-9-CM code set.

**DIABETIC CHRONIC KIDNEY DISEASE**

February’s Blue Review highlighted documentation and coding for diabetes and related diabetic diagnoses. As previously mentioned, diabetes is responsible for nearly two-thirds of CKD cases. Recall that under category 250 Diabetes mellitus, ICD-9-CM requires a fourth digit to identify associated conditions and a fifth digit to identify the type of diabetes mellitus, and whether the diabetes is controlled or uncontrolled.

In ICD-9-CM, when CKD is due to diabetes, it is reported with code 250.4X and the documented stage of CKD is reported with code 585.X.

Under ICD-10, CKD due to diabetes has a fourth- and fifth-digit designation. The fourth digit “2” indicates the underlying condition is a kidney complication. The fifth digit, also a “2”, indicates the complication is associated with chronic kidney disease. Additionally, assign a code from category N18 to identify the stage of the CKD.
END STAGE RENAL DISEASE (ESRD)

In the U.S., ESRD is an administrative term based on conditions for health care payment by the Medicare ESRD Program for patients treated with dialysis or transplantation due to permanent kidney failure. ESRD is the most severe form of CKD and should only be assigned when the provider documents ESRD. If both a stage of CKD and ESRD are documented, ESRD is the only code that should be assigned per ICD-9-CM and ICD-10-CM guidelines. ESRD is reported as 585.6 in ICD-9-CM and N18.6 in ICD-10-CM. Additional guidance is provided in ICD-10-CM under N18.6 to use additional code to identify dialysis status (Z99.2).

HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE

When both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis, ICD-9-CM guidelines require assignment of codes from category 404-Hypertensive heart and CKD. With hypertensive CKD, ICD-9-CM and ICD-10-CM assumes a relationship between the hypertension and the CKD, whether or not the condition is so designated. This assumption is the same under ICD-10-CM. Assign an additional code from category 428-Heart failure, to identify the type of heart failure. If a causal relationship is not documented, the heart condition and hypertension are coded separately and sequenced according to the circumstances of the admission/encounter.

ICD-10-CM guidelines for reporting hypertensive heart and CKD are very similar to ICD-9-CM. ICD-10-CM instructs the user to assign codes from category I13-Hypertensive heart and CKD, when both conditions are stated in the diagnosis. Category I13 represents combination codes that include hypertension, heart disease and CKD. Therefore, if a patient has each of these conditions, a code from I13 should be assigned. Additionally, the appropriate code to identify the stage of the CKD is assigned in both ICD-9-CM and ICD-10-CM.

This material is for educational purposes only and is not intended to dictate what codes should be used in submitting claims. Health care providers are instructed to use the most appropriate codes based upon the medical record documentation and coding guidelines.

References:
1. The National Kidney Foundation: About Chronic Kidney Disease
2. Optum ICD-9-CM for Hospitals-Volumes 1, 2 & 3 2014 Professional
4. KDIGO 2012 Clinical Practice Guidelines for CKD Evaluation and Management

Fairness in Contracting

In an effort to comply with fairness in contracting legislation and keep our independently contracted providers informed, BCBSIL has designated a column in the Blue Review to notify you of any significant changes to the physician fee schedules. Be sure to review this area each month.

Effective June 1, 2014, BCBSIL will implement its annual update of the Schedule of Maximum Allowances (SMA) in relation to the CMS Resource Based Relative Value Scale (RBRVS) revisions and CMS fees for DME Supplies, Prosthetics, Orthotics and clinical laboratory codes. Reimbursement for services provided on or after June 1, 2014, will be based on the updated fee schedule. This update affects PPO and BlueChoice Select fee schedules for professional providers. Providers may request fee schedules for this update starting May 27, 2014.

A Reminder to Providers: Please do not contact the Provider Telecommunications Center (PTC) for National Drug Code (NDC) Fee Schedules. You can locate your NDC fee schedule by registering for Blue Access for ProvidersSM, BCBSIL's secure provider portal. To log in or register, look for the National Drug Codes (NDCs): Billing Resources box on our Provider Home page at bcbsil.com/provider.

Note: First time registration must be completed by someone of authority at your practice, such as the Office Administrator. Completion of the registration process will designate you as the “Super User.” The Super User will be responsible for adding users and delegating roles.

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

BCBSIL reminds you to encourage your patients to get their annual flu shot. In the U.S., the flu season can start as early as October and last as late as May.

The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months of age and older receive an annual influenza vaccination. The CDC specifically encourages vaccination for all health care providers, as well as individuals at higher risk for influenza complications. Additional information and resources on influenza are available on the CDC website at cdc.gov/flu.

Please note that, while many BCBSIL members’ health benefit plans include influenza vaccination coverage with no member cost sharing, there are some exceptions. It is important to check eligibility and benefits information to confirm details regarding copays, coinsurance and deductibles before administering the influenza vaccine to BCBSIL members.

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

Electronic Options for Prescription Drug Benefit Prior Authorization (PA) Requests

BCBSIL continues to enhance the process for submitting PA benefit requests for drugs that are a part of our Pharmacy PA program. In our November 2013 Blue Review, we announced the availability of CoverMyMeds® for electronic completion and submission of PA requests for drugs that may be considered eligible for benefits under the member’s pharmacy benefit. A link to CoverMyMeds is available in the Pharmacy Program section of our website at bcbsil.com/provider; a link is also available to registered users on the Availity portal. CoverMyMeds is available for PA requests for members who have their pharmacy benefit administered by Prime Therapeutics; exclusions may apply.

Now, you can also submit medical pharmacy PA requests online using iEXCHANGE, our Web-based tool that accepts benefit prior authorization requests, 24 hours a day, seven days a week.* In addition to PA requests for medical/surgical and behavioral health services, iEXCHANGE supports outpatient PA requests for the following specialty drugs, which may be considered eligible for benefits under the member’s medical benefit: Avastin, Mybloc, Reclast, Botox and Remicade.

Using online options for specialty drug PA requests replaces the need to fax paper forms to BCBSIL. It provides immediate confirmation upon receipt, without the need to resubmit requests or call to check status.

LEARN MORE ABOUT iEXCHANGE

To get started using iEXCHANGE, new users can register by completing the online enrollment form found on the Provider Tools page in the Education and Reference Center section of our Provider website. Upon completion, users will receive login information to access iEXCHANGE via the Provider login page. iEXCHANGE is also accessible to registered users via a “single sign-on” feature at availity.com.

For reference, a new Submitting an Outpatient Pharmacy Preauthorization Tip Sheet is available on the Provider Tools page in the Education and Reference Center section of our Provider website. This tip sheet offers step-by-step instructions for submitting a medical pharmacy PA request using the iEXCHANGE tool.

Additional training for iEXCHANGE is available upon request by contacting the iEXCHANGE training team at ProviderOutreachEducation@bcbsil.com.

LEARN MORE ABOUT OUR PHARMACY PA PROGRAM

Please be sure to visit the Prior Authorization and Step Therapy Programs page in the Pharmacy Program section of our website at bcbsil.com/provider for details and helpful resources. Also continue to check the News and Updates on our Provider website, as well as upcoming issues of the Blue Review for announcements on program enhancements related to pharmacy optimization and other important initiatives.

Please note that the listing of any particular drug or classification of drugs and/or 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. 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.

CoverMyMeds is a registered trademark of CoverMyMeds LLC, an independent third party vendor that is solely responsible for its products and services.

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

*With the exception of the third Sunday of every month when the system will be unavailable from 11 a.m. to 2 p.m.

Third party brand names are the property of their respective owners.
ICD-10 Testing with BCBSIL to Begin April 1, 2014

The Oct. 1, 2014, federally mandated transition to ICD-10 is only months away. Providers, payers and all other HIPAA-covered entities should be preparing for the transition.

BCBSIL is beginning ICD-10 provider testing – an important readiness activity recommended by the U.S. Department of Health and Human Services (HHS) and other industry organizations. We will be testing electronic professional and institutional claim submissions (837P and 837I transactions) and Electronic Remittance Advice (835 ERA) transactions with a cross-section of providers.

BCBSIL has scheduled ICD-10 provider testing to begin in April 2014, and continue through Sept. 15, 2014. We will continue to share our findings, suggestions and recommendations – along with the results revealed during this six-month testing program – with all BCBSIL independently contracted providers.

Our provider testing will allow both providers and us to:

• Confirm BCBSIL’s ability to accept and process ICD-10 codes submitted on electronic claims (837 transactions.)

• Understand the possible operational impact of electronically submitted claims with provider-generated ICD-10 codes prior to the Oct. 1, 2014, implementation.

• Confirm BCBSIL’s ability to return an 835 ERA transaction on claims submitted with ICD-10 codes.

• Increase mutual confidence in the ICD-10 readiness capabilities.

BCBSIL is currently contacting providers for testing. Providers who are not part of the initial testing phase may have the opportunity to test with BCBSIL in subsequent phases.

Visit the ICD-10 page in the Standards and Requirements section of our website at bcbsil.com/provider for more information about ICD-10 preparation, implementation, training, technology planning and more.

1Mandated by the Department of Health and Human Services through the CMS Office of E-Health Standards and Services (OESS)

New Account Groups

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Group Number</th>
<th>Product Type</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keystone Capital Inc.</td>
<td>PA0092</td>
<td>PPO (Portable)</td>
<td></td>
</tr>
<tr>
<td>LTX Credence Corporation</td>
<td>827892-93</td>
<td>PPO (Portable)</td>
<td>March 1, 2014</td>
</tr>
<tr>
<td>McLeod Express, LLC</td>
<td>PA0211</td>
<td>PPO (Portable)</td>
<td>Feb. 1, 2014</td>
</tr>
<tr>
<td>Roseland Community Hospital</td>
<td>PA0418</td>
<td>PPO (Portable)</td>
<td>Feb. 1, 2014</td>
</tr>
<tr>
<td>Unidine</td>
<td>B04611</td>
<td>BlueAdvantage HMO™</td>
<td></td>
</tr>
<tr>
<td>Prairie Management &amp; Development, Inc.</td>
<td>PA0471</td>
<td>PPO (Portable)</td>
<td>Feb. 1, 2014</td>
</tr>
<tr>
<td>McLeod Express, LLC</td>
<td>PA0211</td>
<td>PPO (Portable)</td>
<td></td>
</tr>
<tr>
<td>Roseland Community Hospital</td>
<td>PA0418</td>
<td>PPO (Portable)</td>
<td></td>
</tr>
<tr>
<td>Unidine</td>
<td>B04611</td>
<td>BlueAdvantage HMO™</td>
<td></td>
</tr>
<tr>
<td>Roseland Community Hospital</td>
<td>PA0418</td>
<td>PPO (Portable)</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Some of the accounts listed above may be new additions to BCBSIL; some accounts may already be established, but may be adding member groups or products. The information noted above is current as of the date of publication; however, BCBSIL reserves the right to amend this information at any time without notice. The fact that a group is included on this list is not a guarantee of payment or that any individuals employed by any of the listed groups, or their dependents, will be eligible for benefits. Benefit coverage is subject to the terms and conditions set forth in the member’s certificate of coverage.
BlueCard® Program Reminder: Claim Filing Tips for Out-of-area Members

Our BlueCard program is designed to help our members take their coverage with them when they travel. It also offers providers access to an electronic network for claim submission and reimbursement. As a result, while you may see multiple patients from out-of-area Blues Plans, you still have one source for claim filing in most instances: your local Blue plan. For Illinois providers, that’s BCBSIL.

Here’s a checklist of BlueCard claim filing tips:

☑ Ask members for their current ID card. Photocopy both the front and back. BlueCard members have a suitcase logo on their ID card. Having the current ID information available enables you to submit claims with the correct member information and avoid unnecessary delays in payment.

☑ Verify the member’s eligibility, benefits and copayments. For fastest processing, verify coverage electronically through your preferred vendor portal. To verify by phone, call BlueCard Eligibility at 800-676-BLUE (2583).

☑ When recording the member ID number, be sure to include the three-digit alpha prefix. This indicates the member’s group.

☑ Submit BlueCard claims to BCBSIL electronically.

☑ Do not submit duplicate claims. Duplicate claims often result in a denial and may delay payment.

☑ Check claim status online. Check the status of the original claim online by submitting an electronic claim status request to BCBSIL via your preferred vendor. If you do not have online access, contact BCBSIL at 800-972-8088 to use our automated phone system.

For additional information on our BlueCard program, refer to the BlueCard Program Manual in the Standards and Requirements section of our website at bcbsil.com/provider.

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.

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

BLUE REVIEW
Blue Cross and Blue Shield of Illinois
300 E. Randolph Street – 24th Floor
Chicago, Illinois 60601-5099
Email: bluereview@bcbsil.com
Website: bcbsil.com/provider

Publisher:
Stephen Hamman, Vice President, Network Management

Editor:
Wes Chick, Divisional Vice President, Provider Relations

Managing Editor:
Jeanne Trumbo, Senior Manager, Provider Communications

Editorial Staff:
Margaret O’Toole, Marsha Tallerico, Michael Chaney, Edna Johnson

BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors mentioned in this newsletter. The vendors are solely responsible for the products or services offered by them. If you have any questions regarding any of the products or services mentioned in this periodical, you should contact the vendor directly.