



BLUE REVIEWSM

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS

MARCH 2016

A Review of Tiered Products

Blue Cross and Blue Shield of Illinois (BCBSIL) introduced a number of new products last year, with an emphasis on giving employers and members more options to help them manage their health care spending. While tiered products offer greater flexibility and potential savings for our members, making it easier for you and your staff to conduct business with us is equally important. This article offers a review of tiered product offerings, using our Blue OptionsSM and Blue Choice OptionsSM PPO products as examples.

HOW IS A TIERED PRODUCT STRUCTURED?

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

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

Using the example of the Blue Choice Options tiered product, which is offered by groups such as the City of Chicago (group numbers 195500, 195501, 195502 and alpha prefix CTY) and Rivers Casino (group number 154061 and alpha prefix XOX), the tier 1 contracted network is Blue Choice OPT PPOSM (BCO). This network is identified on our Provider Finder[®] as *Blue Options/Blue Choice Options (BCO)*.

The tier 2 contracted provider network for Blue Choice Options members includes participating providers in the broader PPO network. Tier 3 benefits, when available give these members the option to use out-of-network providers, but the member has a much higher out-of-pocket cost responsibility for the cost of care.

ARE YOU AN IN-NETWORK PROVIDER?

While network details are defined in each provider's contractual agreement with BCBSIL, it has come to our attention that some contracted PPO providers have mistakenly denied services to Blue Choice Options members. **Please note that all PPO participating providers and Blue Choice PPOSM participating providers are considered to be in-network for Blue Choice Options members.**

(Continued on next page)

How to Join a BCBSIL Network



BCBSIL continues to add new products and networks in order to serve a broader range of members. As a contracted provider, you are already part of at least one BCBSIL network. You may be eligible to join additional networks.

There are four easy steps to join a BCBSIL network:

1. **Select your new network**
2. **Request an application**
3. **Become credentialed**
4. **Get connected**

To get started or to view more information, refer to the Network Participation/Join Our Network section of our website at bcbsil.com/provider, or contact your Provider Network Consultant (PNC).

Participation in a new network is subject to the terms of the agreement for such network, completion of any credentialing requirements applicable to the network and the provider's current good standing with BCBSIL.

Outpatient Behavioral Health Clinical Documentation

BCBSIL requires that all independently contracted BCBSIL providers maintain adequate medical and administrative records consistent with the standards of the medical community and major federal and state accrediting and professional organizations. In particular, we ask **behavioral health providers** to maintain records that accurately document all aspects of the care rendered to members including such necessary details as:

- Who provided the service;
- Who received the service;
- Whether counseling was individual, family, or group; and
- Additional extenuating circumstances to support the necessity for services, if any crisis, extended session, or other non-standard codes are billed.

For more information about general medical record procedures, you may wish to refer to the “Documentation Guidelines for Evaluation and Management (E/M) Services” on the Centers for Medicare & Medicaid Services (CMS) website at [cms.gov](https://www.cms.gov), in the Outreach and Education section. Also consult your local licensing or accreditation body for specific documentation elements that may be required for your license type.

This article may not apply to HMO members.



(A Review of Tiered Products, continued from page 1)

THE MEMBER PERSPECTIVE

Members receive information from the sponsor of the health benefit plan to help them understand how to maximize their benefits. From the Blue Choice Options member perspective, here’s how it works:

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

HOW TO IDENTIFY BLUE CHOICE OPTIONS MEMBERS

Here are some tips to assist your staff when scheduling appointments for Blue Choice Options members:

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

CHECK ELIGIBILITY AND BENEFITS

As always, before providing care and services, it is important to check eligibility and benefits to determine membership and coverage information. We encourage you and your staff to view our online Provider Finder to review and confirm the health care benefit plans for which you may be considered an in-network provider. Also use the Provider Finder to confirm network status of other providers before directing your patients to those providers.

Checking eligibility and/or benefits 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, conditions, limitations and exclusions of the member’s certificate of coverage.

Has your information changed? Let us know!

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

We encourage you to check your own information in the Provider Finder – look for the link on our Provider website Home page at bcbsil.com/provider. Is your online information accurate? If changes are needed, it's important that you inform BCBSIL as soon as possible.

USE OUR ONLINE CHANGE REQUEST FORMS

You can request most changes online by using one of our electronic change request forms. Visit the Network Participation/Update Your Information section of our Provider website to access instructions along with links to each type of form. There are three different change request forms to help you organize your information, as follows:

1. Request Demographic Information Changes

Use this form to request changes to your practice information currently on file with BCBSIL (such as address, email or NPI). You may specify more than one change within your request as long as all changes relate to the same billing (Type 2) NPI. As a participating provider, your NPI(s) should already be on file with BCBSIL. You may use this online form to request changes, such as deactivation of an existing NPI.

2. Request Addition of Provider to Group

Use this form to notify BCBSIL when a new individual provider joins your practice. Please remember that new providers are subject to credentialing review and will not be effective until the process is completed.

3. Request Removal of Provider from Group

Use this form to notify BCBSIL when an individual provider is leaving any or all of your practice locations.

Please note that changes are not immediate upon submission of an online change request form. Processing can take a minimum of 30 business days. If you would prefer to mail or fax your changes to BCBSIL, there is a downloadable Provider Information Change Request Form in the Education and Reference/Forms section of our Provider website. If you have any questions or need assistance, contact Provider Network Operations at netops_provider_update@bcbsil.com.

EXCEPTIONS TO THE ONLINE REQUEST PROCESS

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

- **Multiple changes, especially changes involving more than one billing (Type 2) NPI** – These should be submitted via email to netops_provider_update@bcbsil.com.
- **Tax ID changes that involve Legal Business Name changes** – This type of change often requires a new contract. To request a contract application, visit the Network Participation/Contracting section of our Provider website.
- **Ancillary provider changes** – Skilled nursing facilities, home health agencies, hospice, home infusion therapy, durable medical equipment (DME) suppliers, orthotics and prosthetics, dialysis centers, private duty nursing agencies and other ancillary providers may request changes by sending details to ancillarynetworks@bcbsil.com, or by calling 312-653-4820.

Fighting Health Care Fraud, One Phone Call at a Time

Each year, our Fraud Hotline receives thousands of calls reporting possible health care fraud and abuse. The BCBSIL Special Investigations Department (SID) actively reviews every call to determine if the call provides sufficient information to investigate suspected fraud and abuse.

If there is a question of fraud, preliminary interviews and field audits may be conducted to determine if fraud was intentionally committed. If the SID concludes that there was no act of fraud, the case may be referred to the appropriate business area, which may offer guidance to resolve the issue.

There are cases in which hotline reports have led to recovery efforts for inappropriate payment of claims and reimbursements or to law enforcement for criminal prosecution. Some of the most egregious cases leading to criminal prosecutions have stemmed from hotline calls.

Members and providers are encouraged to call the **BCBSIL Fraud Hotline at 800-543-0867*** to report suspicions of potential health care fraud and abuse. The Fraud Hotline is available 24 hours a day, seven days a week. All calls are confidential and may be made anonymously.

*In previous communications you may have seen a separate Provider Fraud Hotline number. That number has been replaced with the centralized toll-free number, as noted above.



Chief Medical Officer's Huffington Post Article – 'Beyond the ACO: Building a Better Health Care Reimbursement Model'

The health care industry is at a crossroads in terms of how care is delivered. In his latest Huffington Post column, Chief Medical Officer Dr. Stephen Ondra talks about a variety of approaches to "fee-for-value" provider reimbursement. Accountable Care Organizations, or ACOs, are just one model of reimbursement.

Dr. Ondra is senior vice president and enterprise chief medical officer for the operating company of our health insurance Plans in Illinois, Montana, New Mexico, Oklahoma and Texas. He said, "We need to change the economics of the health care delivery system to incentivize more efficient, higher quality, and more easily accessible care. In short, we want a system that delivers high-value care." How we reach that goal matters, but it won't happen overnight.

Find out more in Dr. Ondra's latest article, "Beyond the ACO: Building a Better Health Care Reimbursement Model" at huffingtonpost.com/dr-stephen-ondra. Watch for future HuffPost articles from Dr. Ondra in this newsletter, and follow him on Twitter at @StephenOndra where he tweets about his work and the future of health care.



Benefit Preauthorization and Predetermination Guidelines

In addition to checking eligibility and benefits, there may be other steps you need to take to help our members maximize their benefits before treatment begins. A quick review of benefit preauthorization and predetermination guidelines is included below as a reminder of definitions and important details. Special processes for out-of-area Blue Plan and Federal Employee Program (FEP) members are included on the next page. For more information, refer to the Claims and Eligibility/Prior Authorization section of our website at bcbsil.com/provider.

BENEFIT PREAUTHORIZATION

Benefit preauthorization, also known as benefit pre-certification or pre-notification, is a review to determine if the proposed service or treatment meets the definition of medical necessity as set forth in the member's certificate of coverage and as a required part of the Utilization Management process for certain covered services. Failure to obtain preauthorization if required may affect claim payment, subject to the terms and conditions of the member's health benefit plan. A benefit preauthorization is not a guarantee of payment.

When is benefit preauthorization required?

Most PPO contracts require the member or provider to contact BCBSIL to receive prior benefit approval for inpatient hospital admissions, including acute, inpatient rehab, skilled nursing, long-term acute care, inpatient hospice (some groups) and coordinated health care (most groups) such as skilled nursing visits, IV medication, etc. Preauthorization also may be required for outpatient services for some employer groups.

How do I complete the benefit preauthorization process?

We encourage you to use iExchange®, our online benefit preauthorization tool. iExchange supports online benefit preauthorization requests for inpatient admissions, as well as select outpatient, pharmacy and behavioral health services. iExchange is accessible to physicians, professional providers and facilities contracted with BCBSIL. For details and to sign up for iExchange, visit the Education and Reference Center/Provider Tools section of our Provider website. Also join us for an iExchange webinar – see the Provider Learning Opportunities on page 6 for upcoming session dates and times.

What about behavioral health services?

For PPO members, benefit preauthorization is required for all inpatient hospital admissions, inpatient residential treatment center (RTC) admissions and partial hospital program (PHP) admissions for behavioral health and chemical dependency services. Some outpatient behavioral health services also may require benefit preauthorization. Members are advised to contact the appropriate number on their ID card for assistance. Providers and/or authorized caregivers may request benefit preauthorization on the member's behalf. For details, refer to the Clinical Resources/Behavioral Health Care Management Program section of our Provider website.

PREDETERMINATION OF BENEFITS

Predetermination of benefits is a voluntary, written request for review of treatment or services and includes services that may be considered not medically necessary; investigational, experimental or unproven; or cosmetic. Predetermination of benefits approvals and denials are usually based on provisions in medical policies. A predetermination of benefits is not a substitute for a preauthorization.

(continued on page 5)

How do I submit a Predetermination of Benefits request?

Requests for review of services must be made using the Predetermination Request Form, available in the Education and Reference Center/Forms section of our Provider website. This form also may be used to appeal a previously denied Predetermination of Benefits. The completed form must be faxed to BCBSIL, as indicated on the form. BCBSIL will notify the provider when the final outcome has been reached.

BLUECARD® OUT-OF-AREA MEMBERS

An online “router” tool is available to help you locate Plan-specific preauthorization/pre-certification and medical policy information for out-of-area Blue Plan members. Look for the Medical Policy/Pre-cert (Out-of-area members) link under the Claims and Eligibility tab on our website at bcbsil.com/provider. When you enter the alpha prefix from the member’s ID card, you will be redirected to the appropriate Blue Plan’s website for more information. Predetermination requests for members with Blue Plan benefits in another state should be sent to the Plan indicated on the member’s ID card.

FEDERAL EMPLOYEE PROGRAM (FEP) MEMBERS

For FEP members, you must call the local Blue Plan where services are being rendered for preauthorization, regardless of the state in which the member is insured. A Predetermination of Benefits review is required for the following services: Outpatient/Inpatient surgery for Morbid Obesity; Outpatient/Inpatient surgical correction of Congenital Anomalies; and Outpatient/Inpatient Oral/Maxillofacial surgical procedures needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

Please note that the fact that a service or treatment has been preauthorized or predetermined for benefits 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.

Refer to our Website for the Updated Blue Cross Community OptionsSM Benefit Preauthorization List

In our January 2016 *Blue Review*, we published an article on pages 4 and 5 titled, *Blue Cross Community Options Benefit Preauthorization List, Effective Jan. 1, 2016*. This article included information on benefit preauthorization requirements for non-emergency services provided to Blue Cross Community MMAI (Medicare-Medicaid Plan)SM, Blue Cross Community ICPSM or Integrated Care Plan, and Blue Cross Family Health PlanSM (FHP) members.

Please note that several of the HCPCS codes listed in the January 2016 *Blue Review* have been updated. For the most updated information, refer to the updated Benefit Preauthorization List available under the Related Resources of the Network Participation/Blue Cross Community Options section of our website at bcbsil.com/provider. Also refer to the Standards and Requirements/BCBSIL Provider Manual section of our Provider website.

Please note that the fact that a service has been preauthorized 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.

Utilization Management Decision-making Guidelines

BCBSIL confirms that there is no conflict of interest between BCBSIL contracted HMO Medical Group/Independent Practice Associations (MG/IPAs) and the MG/IPA employees regarding Utilization Management (UM) issues. To help ensure we adhere to this requirement, BCBSIL and independently contracted HMO MG/IPAs must affirm that their employees and contracting physicians abide by certain UM decision-making guidelines.

BCBSIL HMO employees affirm that:

- UM benefit decisions are based on medical necessity criteria, as set forth in the member’s certificate of coverage, which include appropriateness of care and services, and the existence of available benefits;
- The organization does not specifically reward health plan staff, providers or other individuals for issuing benefit denials for any health care service or products; and
- Incentive programs are not utilized to encourage decisions that result in underutilization.

HMO MG/IPAs that contract with BCBSIL to participate in our HMO products must also affirm that their employees and contracted physicians follow established UM decision-making guidelines.

HMO MG/IPAs must meet the following UM access standards:

- Calls regarding UM decisions after normal business hours must be answered or taken via a voicemail system, answering machine or answering service;
- Calls regarding UM decisions must be returned within one business day of receipt; and
- Collect calls must be accepted **only** in regard to UM decisions.

Annual statements regarding these guidelines are distributed to BCBSIL HMO product staff, MG/IPA physicians and staff, and BCBSIL HMO members.

Provider Learning Opportunities

Midwest Operating Engineers Local 150 Offers New Health Care Benefit Options, Effective April 1, 2016

BCBSIL offers complimentary educational webinars with an emphasis on electronic options that can help create administrative efficiencies for providers who conduct business with us. A snapshot of upcoming training sessions is included below. To register online, visit the Workshops and Webinars page in the Education and Reference Center on our website at bcsil.com/provider.



BCBSIL WEBINARS

BCBSIL Back to Basics: Availity™ 101

This training reviews electronic transactions, provider tools and online resources.

March 15, 2016

March 22, 2016

March 29, 2016

April 5, 2016

April 12, 2016

April 19, 2016

April 26, 2016

All sessions: 11 a.m. to noon

Introducing Remittance Viewer

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

March 16, 2016

April 20, 2016

All sessions: 11 a.m. to noon

iExchange Training: 2016 System Enhancements

Join us for a review of how to use our online benefit preauthorization tool, including an overview of new features.

March 9, 2016

All sessions: 11 a.m. to noon

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Effective April 1, 2016, Midwest Operating Engineers Local 150 will see some important changes, as noted below.

NEW ID CARDS

BCBSIL will produce new member ID cards for this group, replacing the paper ID cards issued previously by the Labor group.

BLUE CHOICE PPO OPTION

A new narrow network health care benefit option will be available under group number OMB858, alpha prefix MHE. Members selecting this option must use Blue Choice PPO (BCS) contracted network providers to receive the highest level of benefits. If members choose out-of-network providers, they could pay substantially more and may be responsible for up to the entire amount of billed charges.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) OPTION

A new EPO health care benefit plan option will be offered under group number PB7125, with alpha prefix MUS. The EPO will utilize the independently contracted BCBSIL PPO network. When members use the BCBSIL independently contracted network of PPO professional providers, PPO hospitals and PPO ancillary providers, they can help maximize their benefits and reduce the amount they may have to pay for covered medical services. EPO members will have no benefit coverage if they choose non-contracted PPO providers, with the exception of emergencies. If an EPO member chooses to use an out-of-network provider, the entire cost of care will be the member's responsibility.

As a reminder, it is important to confirm your network status for each member's plan in addition to checking eligibility and benefits for each patient prior to rendering services. If you have questions, contact the appropriate number on the member's ID card.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

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 March 1, 2016, select immunizations, vaccines and toxoids in the 90281-90396 and 90476-90748 Current Procedural Terminology (CPT®) code ranges were updated. Please note that not all CPT codes in this range were affected.

Effective March 1, 2016, radiopharmaceutical codes A9500-A9700 were updated.

FEE SCHEDULE UPDATE:

Effective June 1, 2016, BCBSIL will implement its annual update of the Schedule of Maximum Allowances (SMA) for 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 to the resource based relative value scale. Reimbursement for services provided on or after June 1, 2016, 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 25, 2016.

Specifically, the June 1, 2016, update will include:

- **Updates to the National Drug Code (NDC) fee schedule, including NDCs in the following categories:**

Antibiotic, antiviral, antifungal therapies	Antiemetic therapies
Anticoagulation therapies	Anti-hemophilic therapies
Chelation (iron binding) therapies	Enzyme replacement therapies
Immunoglobulin therapies	Immunosuppressive therapies
Inotropic therapies	Monoclonal antibody therapies
Pulmonary arterial hypertension (PAH) therapies	

- **Updates to home infusion administration codes in ranges S5501-S5523 and S9061-S9542.**
- **A change to the multiple procedure pricing of the professional component (PC) for select diagnostic imaging procedures. This payment methodology change applies to PC-only services (including modifier 26) and the PC portion of global services (including modifier 26) for select procedures. In most cases, BCBSIL will allow 100% of the SMA for the highest priced procedure, and 75% of the SMA will be allowed for each additional procedure when performed during the same session.**
- **Updates to reimbursement for surgical tray code A4550.**
- **Updates to reimbursement for office and inpatient consultation codes in ranges 99241-99245 and 99251-99255.**

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 website at bcbsil.com/provider.

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Annual HEDIS® Medical Record Data Collection for 2016

As previously communicated in the January 2016 and February 2016 issues of *Blue Review*, BCBSIL is collecting data to meet the requirements of the National Committee for Quality Assurance (NCQA) for the Healthcare Effectiveness Data and Information Set (HEDIS) and by the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS). You may receive a request for medical records for one or more of your patients as a part of this process. The request will specify the timeframe and data elements required. It is important that the data collection instructions are followed for each patient and measure.

BCBSIL has contracted with Enterprise Consulting Solutions, Inc. (ECS), HealthPort Technologies, LLC and IOD Incorporated to collect medical records on our behalf. If contacted by ECS, or any of the other named vendors, a key contact in your office will be asked to determine the preferred data collection method (fax, secure mail, email or onsite visit). Appointments for onsite visits will be scheduled with your staff, if applicable. You will then receive a letter outlining the information that is being requested, the medical record request list with members' names and the identified measures that will be reviewed.

If you have any questions about medical record requests, please contact BCBSIL at 312-653-5005. We at BCBSIL thank you for your assistance with this very important health plan quality improvement initiative.

HEDIS is a registered trademark of NCQA.

ECS, HealthPort Technologies, LLC and IOD Incorporated are independent third party vendors that are solely responsible for the products or services they offer. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions regarding the services they offer, you should contact the vendor(s) directly.



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WHAT'S INSIDE?

- A Review of Tiered Products..... 1, 2
- Has your information changed? Let us know!..... 3
- Fighting Health Care Fraud,
One Phone Call at a Time..... 3
- Benefit Preauthorization and
Predetermination Guidelines 4, 5
- Provider Learning Opportunities..... 6
- Fairness in Contracting..... 7

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:

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