BlueCross BlueShield of Illinois

BLUE REVIEW℠

A newsletter for contracting institutional and professional providers

November 2017

New Online Magazine Spotlights Emerging Episodes of Care Payment Model

At Blue Cross and Blue Shield of Illinois (BCBSIL), we believe that having access to affordable, quality coverage can make a positive, and often profound, difference in our members' lives. We want to be part of the solution.

This is one of the reasons we've launched Making the Health Care System Work, our new online magazine, to help tell our story and explore ways we can all work together to make the health care system work better for everyone. Insurers, providers, employers and members all have a vital role to play in finding bold solutions for the future.

In our recent online article – Should health care be a package deal? – we explore how the health care industry is moving toward viewing and paying for all of the care associated with a single condition or procedure, such as knee replacement surgery and rehabilitation, as one reimbursable product. This new payment model has all parties focused on cost and quality, something that has been a challenge in the current fee-for-service models.

Join the Conversation

Subscribe to get updates from Making the Health Care System Work delivered right to your inbox. We will let you know when new stories are published and share featured stories that explore how we can help expand access to quality coverage and care, reduce costs and improve health.

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Colorectal Cancer Screenings Goal: 80% Participation by 2018 – Pulling It All Together

The final article in a 4-part series on Colorectal Cancer Screenings

In collaboration with the American Cancer Society and the National Colorectal Cancer Roundtable, Blue Cross and Blue Shield of Illinois (BCBSIL) endeavors to have 80 percent of our members, ages 50-75, screened for colorectal cancer (CRC) by 2018.

How far away are we from reaching this goal?
We believe our goal is within reach, and would like to improve our 2016 Healthcare Effectiveness Data and Information Set (HEDIS®) BCBSIL Commercial PPO result of 55.94 percent to 80 percent. As a benchmark, 57.1 percent is the National Committee for Quality Assurance (NCQA) Quality Compass National PPO Average.

We need your help to reach this goal!
Although some CRC screening methods are not appropriate or feasible for all patients, having a conversation with your patients to encourage CRC screenings is most likely to result in your patients getting screened regardless of the method chosen. CRC screenings are recommended for adults ages 50-75 who are at average risk for CRC and who are asymptomatic. Some patients may need to be screened for CRC at an earlier age. It is also important to be aware that certain screening methods may not be covered and an out-of-pocket cost may result.

What actions can you take to make a difference?
Have the conversation with your patients about CRC risks and the best screening method for them. You are the biggest influence on whether your patients receive CRC screenings.

CRC Screening Intervals

Screening	Recommended Intervals[1]
Colonoscopy	Every 10 years
Flexible Sigmoidoscopy	Every 5 years
CT Colonography	Every 5 years
Stool-based Test (including): • FIT or immunologic Fecal Occult Blood Test (iFOBT). FIT tests may be one or two sample tests. • Guaiac based stool tests or gFOBT • Stool DNA with FIT testing, also known as Cologuard®	 Every year Every year Every 3 years

Consider using a system within your practice to identify your patients ages 50-75 who need CRC screenings and start the conversation.

With your influence, we can raise the CRC screening rate, and meet our 2018 goal of 80 percent.

Click the links below to read parts 1, 2 and 3 of this 4-part CRC screening article series:

- Colorectal Cancer Screening: 80% Participation by 2018 – Will You Commit?
- Colorectal Cancer Screening Options and Statistics – Get the Conversation Started
- Overcoming Barriers to Colorectal Cancer Screenings

[1] Final Recommendation Statement: Colorectal Cancer: Screening. U.S. Preventive Services Task Force (USPSTF). June 2017. Retrieved Dec. 6, 2016.

The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

References to other third party sources or organizations are not a representation, warranty or endorsement of such organizations. Any questions regarding those organizations should be addressed to them directly.

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Government Programs: Benefit Preauthorization Requirements, Effective Jan. 1, 2018

Blue Cross and Blue Shield of Illinois (BCBSIL) has contracted with eviCore healthcare (eviCore) to manage benefit preauthorization requests for select care categories for certain government program members. For these services, providers must obtain benefit preauthorization through eviCore. Benefit preauthorization for all other care categories is managed by BCBSIL; providers may continue to use iExchange® for these benefit preauthorization requests.

Medicare Advantage
In early October 2017, an overview of Medicare Advantage PPO Benefit Preauthorization Requirements (Effective Jan. 1, 2018) was posted in the News and Updates section of our website at bcbsil.com/provider. This information is also available in the Standards and Requirements/Provider Manual section, under Blue Cross Medicare Advantage (PPO)℠ Manual/Resources.

Medicaid
Also in early October 2017, a summary list of Illinois Medicaid Benefit Preauthorization Requirements (Effective Jan. 1, 2018) was posted in the News and Updates section of our Provider website. Medicaid includes Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ and Blue Cross Community Health Plans℠ members. This summary list also may be found in the Network Participation section of our Provider website, in the Related Resources section.

As a reminder, it is important to check member eligibility and benefits through Availity™ or your preferred vendor Web portal prior to every scheduled appointment, as this step will help you determine if benefit preauthorization is required for a particular member. Obtaining benefit preauthorization is not a substitute for checking eligibility and benefits. If benefit preauthorization is required, services performed without benefit preauthorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Our goal is to support access to quality, affordable health care for our members. Additional information on benefit preauthorization requirements will be published in the News and Updates, as well as the *Blue Review*, in the coming months. If you have any questions, contact your assigned Provider Network Consultant (PNC) for assistance.

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.

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for BCBSIL.

iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. Availity is a trademark of Availity, LLC, 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 provided by third party vendors such as Medecision and Availity. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

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Benefit Preauthorization Requirements for PPO Members with Health Advocacy Solutions

Beginning Jan. 1, 2018, Blue Cross and Blue Shield of Illinois (BCBSIL) will provide Health Advocacy Solutions (HAS) for some PPO members. Members who **may** have HAS available to them include PPO (PPO network), Blue Choice PPO℠ (BCS network), Blue Choice Preferred PPO℠ (BCE network), Blue Options℠/Blue Choice Options℠ (BCO network). There are dedicated HAS Health Advocates who will help deliver personalized communication and educational resources, such as cutting-edge cost transparency tools, to help members make better-informed decisions concerning their health care.

As part of HAS, there are additional care categories that will require benefit preauthorization. Information regarding HAS will appear on BCBSIL member ID cards. However, it is always important to check eligibility and benefits through Availity™ or your preferred Web vendor prior to rendering services, as this step will also help you determine if benefit preauthorization is required for a particular member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits and Prior Authorization pages in the Claims and Eligibility section of our website at *bcbsil.com/provider*.

The additional care categories for HAS that will require benefit preauthorization are listed below. Please note that some benefit preauthorizations must be requested through BCBSIL (these are marked with an asterisk in the list below); others must be obtained through eviCore.

- Advanced Radiology Imaging (eviCore) *(**Note:** For some members, pre-service notification, rather than benefit preauthorization, may be required.)*
- Cardiology*
- Ear, Nose and Throat*
- Fertility *(**Note:** Pre-service notification, rather than benefit preauthorization, may be required.)*
- Gastroenterology*
- Molecular and Genomic Testing (eviCore)
- Musculoskeletal*
- Radiation Therapy (eviCore)
- Sleep Studies and Sleep Durable Medical Equipment (DME) (eviCore)
- Neurology*
- Non-Emergent Air Ambulance*
- Outpatient Surgery (Orthognathic Surgery, Mastopexy, Reduction Mammaplasty, Bunionectomy, Cardiac Catheterization, Carpal Tunnel Repair, Inguinal Hernia Repair, Lithotripsy)*
- Specialty Pharmacy (Administration)*
- Wound Care*

*To obtain benefit preauthorization through BCBSIL (such as for the services marked with an asterisk above), you will continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSIL. For more information or to set up a new account, refer to the iExchange page in the Provider Tools section of our Provider website.

To obtain benefit preauthorization through eviCore, go to evicore.com or call 855-252-1117. **See below for information on upcoming training sessions, hosted by eviCore.**

As a reminder, it is important to check member eligibility and benefits through Availity or your preferred vendor Web portal prior to every scheduled appointment, as this step will help you determine if benefit preauthorization is required for a particular member. Obtaining benefit preauthorization is not a substitute for checking eligibility and benefits. If benefit preauthorization is required, services performed without benefit preauthorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

For any service where benefits are not available or not approved, BCBSIL will provide, subject to the member or provider (as applicable) making an appeal, all appropriate rights for review or appeal. Please note that a member penalty may also apply based on the terms of the member's particular benefit plan.

eviCore Web Orientation Schedule
eviCore will be hosting complimentary orientation sessions on how to obtain benefit preauthorization for the care categories listed below. During these training sessions, BCBSIL presenters will also provide a brief overview of Health Advocacy Solutions (HAS) and Availity's role. Each training session will last approximately one hour. Advance registration is required. See information below on how to register.

Upcoming Training Sessions:
Please note that training session times on the eviCore site may be listed according to Eastern Time.

- **Radiation Therapy** – Tues., Dec. 5, 2017, 11 a.m., CT (noon, ET)
- **Molecular and Genomic Testing** – Tues., Dec. 5, 2017, 1 p.m., CT (2 p.m., ET)
- **Advanced Radiology Imaging (CT/MR/PET)** – Wed., Dec. 6, 2017, 1 p.m., CT (2 p.m., ET)
- **Sleep Studies** – Thurs., Dec. 7, 2017, 10 a.m., CT (11 a.m., ET)
- **Sleep DME** – Thurs., Dec. 7, 2017, 1 p.m., CT (2 p.m., ET)

How to Register:
Please read the following instructions carefully to register for and participate in a session:

1. Once you have chosen a date and time, go to http://evicore.webex.com.
2. Click on the "Training Center" tab at the top of the page.
3. Find the date and time of the orientation session you wish to attend by clicking the "Upcoming" tab. All of the orientation sessions will be named "BCBSIL Provider [Program Name] Orientation Session."
4. Click "Register."
5. Enter the registration information.

After you have registered, you will receive an email containing the following information:

- The toll-free phone number and pass code you will need for the audio portion of the training.
- A link to the online portion of the session.
- The conference password.

Keep the registration email so you will have the audio and online information for the session in which you will be participating. If you are unable to participate in a session at any of the times listed, a copy of the presentation will be available on the implementation site at https://www.evicore.com/healthplan/bcbsil_c.

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.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. iExchange is a trademark of Medecision, Inc., a separate company that provides collaborative health care management solutions for payers and providers. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity and Medecision. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

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Additional Benefit Preauthorization Requirements for 2018

Beginning Jan.1, 2018, benefit preauthorization **through Blue Cross and Blue Shield of Illinois (BCBSIL)** will be required for certain additional care categories, as outlined below. These new benefit preauthorization requirements will apply for some PPO members with the following plans: PPO (PPO network), Blue Choice PPO℠ (BCS network), Blue Choice Preferred PPO℠ (BCE network), Blue Options℠/Blue Choice Options℠ (BCO network). Additional requirements may apply, such as for PPO members with Health Advocacy Solutions (HAS). Benefit preauthorization through eviCore for additional care categories may be required as well.

For some PPO members, here is a summary listing of additional care categories that will require benefit preauthorization through BCBSIL, effective Jan. 1, 2018:

- Cardiology (Cardiac Services – Lipid Apheresis)
- Ear, Nose and Throat
- Facility-based Sleep Studies
- Gastroenterology
- Musculoskeletal (Interventional Pain Management, Orthopedic)
- Neurology
- Non-emergent Air Ambulance
- Outpatient Surgery (Orthognathic Surgery, Mastopexy, Reduction Mammaplasty)
- Wound Care

To obtain benefit preauthorization through BCBSIL for the care categories noted above, you may continue to use iExchange®. This online tool is accessible to physicians, professional providers and facilities contracted with BCBSIL. For more information or to set up a new account, refer to the iExchange page in the Education and Reference Center/Provider Tools section of our website at *bcbsil.com/provider*.

Services performed without benefit preauthorization may be denied for payment in whole or in part, and you may **not** seek reimbursement from members. Please note that a member penalty may also apply based on the benefit plan.

As a reminder, it is important to check member eligibility and benefits through Availity™ or your preferred vendor Web portal prior to every scheduled appointment. Eligibility and benefit quotes include membership status, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. Providers must also ask to see the member's ID card for current information and a photo ID to help guard against medical identity theft. When services may not be covered, members should be notified that they may be billed directly. **Obtaining benefit preauthorization is not a substitute for checking member eligibility and benefits.**

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.

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New Applied Behavior Analysis (ABA) Service Request Forms

There are updated forms on the Blue Cross and Blue Shield of Illinois (BCBSIL) provider website for use when requesting ABA services. BCBSIL continually looks for ways to help enhance operational and clinical efficiencies that add value while not sacrificing quality. The ABA service request forms were updated to capture sufficient data needed by the Clinical Reviewer and reduce additional clinical requests of the provider. The ABA initial treatment request forms can be found in the Education and Reference Center/Forms section, under **Behavioral Health**. The three updated ABA forms are:

- ABA Treatment Request – Member Schedule
- Initial Treatment Request
- Managed Care/Concurrent Review Form

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Important Information on ABA Authorizations and Payment

Blue Cross and Blue Shield of Illinois (BCBSIL) aligned its Applied Behavior Analysis (ABA) authorizations and payments of Current Procedural Terminology (CPT®) codes with the Centers for Medicare & Medicaid Services (CMS) recommended edits on Oct. 1, 2017. For more information, search for “Practitioner Services MUE Table-Effective 10/1/17” on cms.gov. The CPT codes are listed with the units per day that may be billed.

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This article does not apply to HMO.

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2017-2018 Flu Season: Flucelvax Quadrivalent Billing Update

The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months of age and older get a flu shot. Again for the 2017-2018 flu season, the nasal spray flu vaccine, also known as the live attenuated influenza vaccine (LAIV), should not be used, according to the CDC.*

The American Medical Association (AMA) has released Current Procedural Terminology (CPT®) code 90756 effective for claims processed with dates of service on or after Jan. 1, 2018. According to the AMA, CPT code 90756 – Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use – may be used to best describe preservative-containing Flucelvax Quadrivalent vials, which received U.S. Food and Drug Administration (FDA) approval as of July 7, 2017, for the 2017-2018 flu season.

CPT code 90756 will not be effective until Jan. 1, 2018. For claims with dates of service prior to Jan. 1, 2018, National Drug Codes (NDCs) for doses using preservative-containing Flucelvax Quadrivalent 2017-2018 may be submitted with 90749 – Unlisted vaccine/toxoid or Q2039 – Influenza virus vaccine, not otherwise specified.

CPT code 90674 – Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative- and antibiotic-free, 0.5 mL dosage, for intramuscular use – may continue to be used to best describe ***preservative-and antibiotic-free*** Flucelvax Quadrivalent pre-filled syringes.

When billing flu vaccines, please note that code descriptions may be specific to dosage, formulations such as trivalent vs. quadrivalent, preservative vs. preservative-free, or other distinctive features (i.e., split virus, recombinant DNA, cell cultures, intradermal, or intramuscular).

As a reminder, while many Blue Cross and Blue Shield of Illinois (BCBSIL) members' health benefit plans include influenza vaccination coverage with no member cost sharing when using a participating provider, 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.

Note: This flu vaccine billing process does not apply to HMO members. Refer to the HMO Scope of Benefits guidelines.

*https://www.cdc.gov/flu/about/season/flu-season-2017-2018.htm

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This material is for informational purposes only and is not intended to be a definitive source for what codes should be used for any particular health care claim. Providers are instructed to submit claims using the most appropriate code based upon medical record documentation, coding guidelines and reference materials.

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.

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Reminder: Improper Documentation of Laboratory Services Could Result in Denial of Payment for Services

The Blue Cross and Blue Shield of Illinois (BCBSIL) Special Investigations Department (SID) would like to remind independently contracted providers that in order to assist in prompt payment of claims and to help ensure payment integrity, BCBSIL requires laboratory services to be properly documented. Incomplete or illegible medical records may result in a reduction in or no payment for services. In order for BCBSIL to process a claim and for BCBSIL benefits to be applied, there must be sufficient documentation in the provider's or hospital's records to verify the services performed were medically necessary and required the level of care billed. Request for payment for the services may be denied if there is insufficient documentation. Additionally, if there is insufficient documentation for the claims that have already been adjudicated by BCBSIL, reimbursement may be considered an overpayment and the funds may be recovered.

Laboratory claims for BCBSIL members should be submitted through the Blue Plan where any samples were obtained, usually where the testing facility is situated. Each laboratory claim should have valid laboratory medical records documenting the services ordered and the results of the services performed. Laboratory medical records consist of a signed valid requisition and complete results of the tests performed. A valid requisition is one received from the patient's treating physician or qualified health care provider (i.e., the provider treating the patient and who will use the test results in the management of the patient's specific medical problem). Records should be complete, legible and include the following:

Requisition

- Complete patient identification
- Complete ordering provider identification [at a minimum, full name and National Provider Identifier (NPI)]
- Signature of ordering physician (must be legible; "Signature on File," signature stamp or photocopies of signature are not acceptable)
- Facility and location where sample was collected is relevant [e.g., office, home, hospital, Residential Treatment Center (RTC); also include state (such as Illinois)]
- Type of sample (e.g., blood, serum, urine, oral swab)
- Date and time collected
- Date and time received in the lab
- Identity of individual who collected sample
- For urine testing, a temperature at time of collection may be relevant and aid in validity
- ICD-10-CM diagnosis codes received from ordering provider (specificity required)
- Identify specific tests ordered (avoid "Custom" panels)
- For drug testing, a current medication list may be relevant and aid in supporting medical necessity
- For drug testing Point of Care (POC) test results may be relevant and aid in supporting medical necessity

Providers are reminded to refer to BCBSIL's Urine Drug Testing Policy MED207.154. In addition, it is useful to recall that Medicare will only pay for tests that are medically reasonable and necessary based on the clinical condition of each individual patient. Confirmation of drug screening is only indicated when the result of the drug screen is different than suggested by the patient's medical history, clinical presentation, or the patient's own statement. Medicare makes this statement to reinforce that the ordering provider is cautioned that the justification for the need for testing is required.

Laboratory Results Documentation

- Complete identification of performing entity (name, address, Clinical Laboratory Improvement Amendments (CLIA) number)
- Identity of patient (full name, date of birth)
- Identity of ordering provider (name, NPI number)
- Identity of facility, if applicable
- Date sample was collected
- Date sample was received in lab
- Date test results were reported
- Complete test results including validity testing if performed

Although BCBSIL does not require a laboratory provider to recover and submit medical records from an ordering provider, it should be noted that **it is the billing provider's responsibility to be able to substantiate the medical necessity of the laboratory services billed.** If necessary, BCBSIL will request records from an ordering provider to substantiate and provide supporting information during a laboratory claim audit/review. Insufficient or a lack of supporting information may result in denial of the laboratory claim. For more information, see the BCBSIL's Urine Drug Testing Policy MED207.154 by visiting the Standards and Requirements/Medical Policy section of our website at *bcbsil.com/provider* for the most up-to-date medical policy information.

Medicare auditors similarly require a billing provider to assume responsibility for obtaining supporting documentation as needed from a referring physician's office. For more information, see the Medicare Program Integrity Manual on the Centers for Medicare & Medicaid Services (CMS) website.

It is the responsibility of the ordering provider to document in a patient's medical record the support required to determine the medical necessity for each service ordered so as to allow BCBSIL to determine if the services are eligible for coverage. The record must be specific to an individual patient and not consist of "standing," "routine" or "orders per protocol." Such "one size fits all" ordering will not support the necessity for testing and may result in a payment denial for the laboratory service.

Familiarity with health care plan medical policies regarding laboratory testing may help prevent unexpected claim denials. Orders alone do not ensure reimbursement. Medical policies, benefits, eligibility, and medical record documentation are the determining factors for reimbursement.

Laboratories also should be mindful of requests for testing received from inpatient and intensive outpatient behavioral health facilities as laboratory services are included in per diem rates paid to the entities and should not be "unbundled" and submitted for separate claim reimbursement. In those instances, separate reimbursement for laboratory services may be denied or disallowed as payment is included in the ordering provider's per diem payment.

BCBSIL's Medical Policies may be found by visiting the Standards and Requirements/Medical Policy section of our website at *bcbsil.com/provider*. Medicare Local and National coverage documents may be found online by searching Medicare's public website. Individual benefit/coverage information may be found by calling the Customer Service number on the member's BCBSIL ID card.

For additional information related to HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠, BlueCare Direct℠ and Blue FocusCare℠, the provider should refer to the BCBSIL HMO Provider Manual, located in the Standards and Requirements section of our website at bcbsil.com/provider.

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New Medical Record Retrieval Vendor for Out-of-area Blue Plan Member Records

The “risk adjustment” requirement under the Affordable Care Act (ACA) requires Blue Cross and Blue Shield of Illinois (BCBSIL) to meet data submission and coding accuracy standards. Member medical records are necessary to help ensure that these requirements are satisfied.

Currently, BCBSIL works with Verscend to retrieve medical records for all out-of-area Blue Plan members to support Healthcare Effective Data and Information Set (HEDIS®), the risk adjustment requirement under ACA and government programs.

Effective Jan. 1, 2018, Inovalon will replace Verscend as the new medical records retrieval vendor. Between now and Jan. 1, 2018, you may see requests from both Verscend and Inovalon as the transition is completed on Jan. 1, 2018.

Both Verscend and Inovalon are independent companies and contractually bound to preserve the confidentiality of members’ protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Please note that patient authorized forms are not required for disclosures of members’ medical records to Verscend or Inovalon.

As set forth in your Agreement with BCBSIL, you are required to respond to requests for medical records from BCBSIL. Such compliance is also required for requests for medical records from BCBSIL’s designees, such as Verscend and Inovalon, in support of risk adjustment, HEDIS, and government programs, within the requested timeframe. BCBSIL is working diligently to ensure this process is followed.

For your convenience medical records may be submitted in the following ways:

Inovalon

- Fax: 877-221-0604
- Email: EMRService@inovalon.com (send secure)
- Mail: Inovalon Document Processing, 7777 Market Center Ave, Suite E, El Paso, TX 79912

Verscend

- Upload the record image to Verscend’s secure portal and enter your password that is included with your Verscend request. Select the files to be uploaded.
- Fax: 888-231-9601
- Mail: Verscend, 66 E. Wadsworth Park Dr., Draper, UT 84020

Providers are permitted to disclose PHI to BCBSIL without authorization from the member when both the provider and BCBSIL have or had a relationship with the member and the information relates to the relationship. See 45 CFR 164.506(c)(4) for additional details. For more information regarding the HIPAA Privacy Rule, visit hhs.gov/ocr/privacy.

If you have any questions about sending medical records to Verscend or Inovalon, contact your assigned Provider Network Consultant (PNC).

Inovalon and Verscend are independent companies that have been contracted to provide medical record collection retrieval services for BCBSIL. Inovalon and Verscend are wholly responsible for their own products and services. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by Inovalon or Verscend.

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BCBSIL Celebrates LGBTQ Inclusion

Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to supporting initiatives that promote the health and wellness of our members and communities. Our commitment guides us in fostering greater access to affordable, quality care for all of our members.

Our responsibility to our diverse member base led us to work with our lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) employees here at BCBSIL to begin to understand some of the unique health care needs of the LGBTQ population. We are proud to inform you that this partnership resulted in the creation of the BCBSIL Values LGBTQ Inclusion resource webpage. This webpage underlines the importance of this dynamic community and supports our purpose.

To do everything in our power to stand with our members in sickness and in health®

We invite you to visit our new webpage and learn how you can join us in supporting the LGBTQ community. You will find examples of our internal and external commitments, as well as information on GLMA: Health Professionals Advancing LGBT Equality (formerly known as the Gay & Lesbian Medical Association). GLMA offers an online provider directory where patients can search for primary care providers, specialists, therapists, dentists, and other health care professionals who welcome LGBTQ individuals and their families. We hope you find this information helpful.

BCBSIL stands by the core values of integrity, respect, commitment, caring, and excellence. We recognize the diverse views that drive many health care choices. To that end, we are committed to providing a variety of products and services that address the unique needs of our members by meeting them where they are and hope that you will join us in this effort.

GLMA: Health Professionals Advancing LGBT Equality (GLMA) is a separate and independent company that is the world's largest and oldest association of healthcare professionals committed to providing individuals with health care services regardless of sexual orientation, gender identity or marital status. GLMA is wholly responsible for its own products and services. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by GLMA. Learn more about GLMA.

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Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois (BCBSIL) provides complimentary educational workshops and webinars with an emphasis on electronic options that can help create administrative efficiencies for the independently contracted providers who conduct business with us. A snapshot of upcoming training sessions is included below. For additional information, refer to the Workshops/Webinars page in the Education and Reference Center on our website at *bcbsil.com/provider*.

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

Descriptions:	Dates:	Session Times:
BCBSIL Back to Basics: 'Availity™ 101' *Join us for a review of electronic transactions, provider tools and helpful online resources.*	Nov. 21, 2017	11 a.m. to noon
Introducing Remittance Viewer Have you heard? This online tool gives providers and billing services a convenient way to retrieve, view, save or print claim detail information.	Nov. 16, 2017	10 to 11 a.m.
iExchange®: New Enrollee Training *Learn how to gain access to and begin using our online benefit preauthorization/predetermination of benefits tool.*	Nov. 9, 2017	11 a.m. to 12:15 p.m.

AVAILITY WEBINARS

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

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Operational Effectiveness: Better and Faster Ways to Do Business Together

How can we help providers so that they can effectively drive operational and clinical efficiencies while continuing to deliver quality care? Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to making system and process improvements and innovations to better support and collaborate with providers. Now more than ever, collaboration is essential to help control rising health care costs, avoid redundant or unnecessary care, identify opportunities for members to get the right care at the right time and in the right place, and streamline administrative work. We want to make it easier for providers to do business with us, and we want to continue to earn their satisfaction.

In the months ahead, we are rolling out new ways to work together, created with efficiency and effectiveness in mind. As we systematically deploy new processes and programs, we are helping providers realize the ability to integrate these new efficiencies into existing workflows with relative ease.

We are introducing more ways to transact provider-payer business electronically, with an increased emphasis on online forms, tools, and other resources. The increased focus on electronic tools will help improve data accuracy – which in turn helps ensure claims process accurately. These tools will also help to ensure provider directories are up-to-date.

Another way we are building efficiencies into the provider-payer relationship is through various data solutions designed to offer providers greater insight into our members' health status and the quality, and cost, of care they deliver. New Clinical Data Exchange (CDE) tool capabilities will help to streamline and speed the online exchange of member clinical data between providers and BCBSIL in a scalable and secure platform. This technology will help enable connected providers to access a member's medical record and the health summary at the site of service. We anticipate this will help providers identify unmet care needs and avoid unnecessary or redundant services. We also anticipate that clinical data exchange will help reduce claims processing and payment time as a likely result of fewer pended, denied and appealed claims.

Care quality and cost analytics and reporting augment our clinical data exchange efforts. We are working to make the health care system work better through the controlled deployment of a single, online platform for a suite of quality and efficiency analytics and reporting. Our new Provider Performance Analytics and Reporting tool is accessible in the BCBSIL-branded Payer Spaces section to registered Availity™ Web portal administrators and assigned users. This tool offers a robust suite of data dashboards that display valuable information about providers' overall BCBSIL member population and allows users to filter quality data in a variety of ways, such as age range, diagnosis type, and contract type. Providers can view emergency room and pharmacy risk adjustment and incentive data, among other details. Our reporting tools can help illuminate the services that may help providers maximize reimbursement.

In addition, provider performance efficiency analytics offer insight into the cost of care by type of care episode and how it compares to care delivered by peer providers in the same market, specialty or network for similar BCBSIL members. This new platform will allow us to deliver reports faster, and with dynamic reporting capability.

As Executive Director of Quality and Accreditation, Terri Kitchen shares, "With so many different types of performance management metrics available through the dashboards, depending on what the end user needs, there's probably a dashboard for that." We believe that the quality and efficiency data will help providers identify and prioritize practice enhancement opportunities.

To prepare for the use of these new data solutions, we encourage you to become a registered Availity user – visit availity.com today to register online at no charge. Becoming a registered Availity user will give you immediate access to many tools and resources that are available now, while also ensuring you will be first in line to begin using new data solutions when they launch.

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How to Find BCBSIL Resources in Availity™ Payer Spaces

Have you recently been searching in the Availity Web Portal to locate a specific Blue Cross and Blue Shield of Illinois (BCBSIL) tool or enrollment option? Some of our electronic resources offered through Availity have moved to the BCBSIL-branded Payer Spaces section in Availity.

The BCBSIL Payer Spaces section contains payer-specific in-house applications, resources, and links to the BCBSIL Provider website for quick access to pertinent information. You can also view the latest Availity News and Announcements for various payer-specific articles, newsletters, and reference documents. Providers may access BCBSIL Payer Spaces by selecting the Payer Spaces drop-down option from the Availity navigation menu.

The following online tools and resources are now available via the **Resource** tab within the BCBSIL Payer Spaces section:

- Electronic Fund Transfer (EFT) online enrollment
- Electronic Remittance Advice (ERA) online enrollment
- iExchange® online benefit preauthorization tool
- National Drug Code (NDC) Units Calculator
- Electronic Refund Management (eRM) tool
- and more…

Note: *The Claim Research Tool remains available in the* ***Claims & Payments*** *tab on the Availity navigation menu.*

To learn more about BCBSIL's electronic offerings, visit the Provider Tools page in the Education and Reference Center of our website at *bcbsil.com/provider*. For assistance or customized training, contact a BCBSIL Provider Education Consultant at *PECS@bcbsil.com*.

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Member Rights and Responsibilities Notification

Blue Cross and Blue Shield of Illinois (BCBSIL) will provide members* with a written statement of the Member Rights and Responsibilities. Members will receive the document through the Member Handbook and via hard copy upon request. This information is also found on the BCBSIL website. Providers can review the Member Rights and Responsibilities policy listed under BCBSIL Provider Manual, located in the Standards and Requirements section of our website at *bcbsil.com/provider*.

Note: Information contained in the BCBSIL Provider Manual section is password protected. Please follow the instructions given on our Provider website to gain access to this secure information, then review the policy under the Policy and Procedures/Health Care Delivery Policy and Procedures section.

*This includes members with HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠, Blue Choice Preferred PPO℠, BlueCare Direct℠ and Blue FocusCare℠ products.

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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 are not considered changes to the software version. Blue Cross and Blue Shield of Illinois (BCBSIL) will normally load this additional data to the BCBSIL claim processing system after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSIL Provider website at *bcbsil.com/provider*. Advance notification of updates to the ClaimsXten software version also will be posted on the BCBSIL 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 utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool. Refer to the Clear Claim Connection page in the Education and Reference Center/Provider Tools section of our Provider website for additional information on gaining access to C3, as well as answers to frequently asked questions about ClaimsXten. Updates may be included in future issues of the *Blue Review*. It is important to note that C3 does not contain all of the claim edits and processes used by BCBSIL in adjudicating claims, and the results from use of the C3 tool are not a guarantee of the final claim determination.

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

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Medical Policy Updates

Approved, new, or revised Blue Cross and Blue Shield of Illinois (BCBSIL) Medical Policies and their effective dates are usually posted on our website at *bcbsil.com/provider* 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, providers serving HMO members should refer to the HMO Scope of Benefits in the BCBSIL Provider Manual, which is located in the Standards and Requirements section of our Provider website.

You may view active, new, and revised policies, along with policies pending implementation, by visiting the Standards and Requirements/Medical Policy section of our Provider website. 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 Provider website 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 substitute for the independent medical judgment of health care providers. Providers are instructed to exercise their own clinical judgment based on each individual patient's health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Some benefit plans administered by BCBSIL, such as some self-funded employer plans or governmental plans, may not utilize BCBSIL Medical Policies. Members should contact the customer service number on their member ID card for more specific coverage information.

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