BlueCross BlueShield of Illinois

BLUE REVIEW℠

A newsletter for contracting institutional and professional providers

November 2019

What's New

Addressing the Maternal and Infant Health Crisis Through A Health Equity Lens Will Be the Fall Blue University℠ Topic

Register today for our free Illinois provider Blue University event taking place on **Nov. 22, 2019,** for a discussion with health care leaders to address the maternal and infant health crisis through a health equity lens.

Read More

Your Feedback is Important

With the *Blue Review,* we strive to provide important information each month to our growing readership of independently contracted providers. We need your feedback to assess the effectiveness of this newsletter in delivering timely content that's relevant to you and your staff. Please take a few minutes to complete our brief annual survey.

Focus on Behavioral Health

We're Collaborating with Members and Providers to Help Reduce Opioid Abuse

We've started a new program to help you when you're caring for your patients, our members, who may be at risk for an opioid-related adverse event. We hope that by collaborating with you and your patients, our members, we can find ways to help reduce risk and promote patient safety.

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Clinical Updates, Reminders and Resources

2020 Benefit Preauthorization Requirements, Reminders and Resources (PPO –

Commercial and Government Programs)

Benefit preauthorization to confirm medical necessity is required for certain services and benefit plans as part of our commitment to help ensure all Blue Cross and Blue Shield of Illinois (BCBSIL) members get the right care, at the right time, in the right setting. It's important to remember that benefit plans differ, and details such as benefit preauthorization requirements are subject to change.

Read More

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Electronic Options

eviCore Benefit Preauthorization Training for Advanced Imaging, Genomic Lab, Joint/Spine/Pain and Sleep Management Services

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CMO Perspective

Palliative Medicine and Hospice Care: Practical, Comforting Options to Help Empower Patients and their Families

In this month's CMO Perspective, our Vice President and Chief Medical Officer, Dr. Derek J. Robinson, M.D., MBA, FACEP, CHCQM, discusses palliative medicine and ways it can help ease physical, psychosocial and spiritual distress while also helping patients clarify their health care goals at various stages of illness.

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Wellness and Member Education

What You Need to Know About the 2019-2020 Flu Season

The Centers for Disease Control and Prevention (CDC) recommends yearly flu shots for all patients 6 months and older without vaccine contraindication. What's different this flu season and reminders, including coding, are discussed in this article.

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

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

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Claims and Coding

Changes to Medicare Advantage Payment Models for Skilled Nursing Facility and Home Health Care Claims

The Centers for Medicare & Medicaid Services (CMS) is launching new payment models for skilled nursing facilities and home health care. BCBSIL is aligning its payment models with CMS for claims you submit for services provided to our Blue Cross Medicare Advantage℠ and MMAI members.

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Itemized Bills Required for BlueCard® Claims Over $200K

Beginning **Jan. 1, 2020**, BCBSIL will require facilities to submit an itemized bill for any BlueCard member billed at or more than $200,000 for inpatient care.

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Time-Based Measurement Standard to Follow AMA: A Change in the Coding of Physical Medicine Service Units

On July 22, 2019, BCBSIL changed its time measurement standard for billing physical medicine services based on a regulation that was passed by the Illinois legislature.

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Provider Education

Provider Learning Opportunities

BCBSIL offers free webinars and workshops for the independently contracted providers who work with us. A preview of upcoming training sessions is included in this month's issue.

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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.

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Quality Improvement and Reporting

Information about BCBSIL's Quality Improvement Program

Our Quality Improvement (QI) Program addresses both care and services provided to BCBSIL members.

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HEDIS® Measure: Appropriate Testing for Children with Pharyngitis

Pharyngitis, or a sore throat, is one of the leading reasons for parents to bring their children to the doctor's office and may spread viral or bacterial sicknesses.

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Network Updates/Product Innovation

New Names and ID Cards for Some Medicare Plans

Beginning **Jan. 1, 2020**, you may notice new names and ID cards for some of our Medicare plans.

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Notification and Disclosure

Utilization Management Decisions Are Not Financially Influenced

We are committed to serving our members through the provision of health care coverage and related benefit services.

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Procedure Code and Fee Schedule Updates

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

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Important Dates and Reminders

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

Read More

Medical Policy Updates

Approved, new or revised BCBSIL Medical Policies and their effective dates are usually posted on our Provider website the first day of each month. These policies may impact your reimbursement and your patients' benefits.

Read More

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.

Read More

Quick Reminders

Stay informed!

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

Update Your Information

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

Provider Training

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

Contact Us

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

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Register today for our free Illinois provider Blue University event taking place on **Nov. 22, 2019,** for a discussion with health care leaders to address the maternal and infant health crisis through a health equity lens.

In a recent *Blue Review* article, Dr. Derek J. Robinson, Blue Cross and Blue Shield of Illinois (BCBSIL) vice president and chief medical officer, discussed that while pregnancy is a significant and happy life event for expecting parents, the risk some women face during pregnancy and after giving birth is magnified. Racial and ethnic disparities exist in both obstetric outcomes and health care quality. These disparities aren't simple differences but rather inequities that systematically and negatively impact less advantaged groups. Minority women suffer a disproportionate number of maternal deaths, pregnancy complications, comorbid illnesses, and adverse obstetric outcomes and have been shown to receive obstetric care that differs by race and ethnicity.

To further this discussion, we have invited **Joia Adele Crear-Perry**, M.D., FACOG, to be the keynote speaker at the fall Blue University event. Dr. Crear-Perry is the founder and president of the National Birth Equity Collaborative, whose mission is to create solutions that optimize Black maternal and infant health through training, policy advocacy, research and community-centered collaboration. Recently, Dr. Crear-Perry addressed the United Nations Office of the High Commissioner for Human Rights to urge a human rights framework to improve maternal mortality.

Additional speakers include **Patricia Lee King**, Ph.D., MSW, who will speak about the Illinois Perinatal Quality Collaborative (ILPQC) work on initiatives related to maternal and infant morbidity/mortality and looking ahead to the upcoming work on a statewide Birth Equity Initiative in 2021, and **Robin L. Jones**, M.D., to discuss Illinois' first Maternal Morbidity and Mortality Report from the Illinois Department of Health's Maternal Mortality Review Committee/Maternal Mortality Review Committee-Violent Deaths Committee.

Event Details
The workshop will be held on Friday, Nov. 22, 2019, at:
Blue Cross and Blue Shield of Illinois
300 E. Randolph St., Chicago, IL 60601
Registration Check-in: 8:30 to 9 a.m.

Forum: 9 a.m. to noon

Continental breakfast will be available.

Register today!

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We're Collaborating with Members and Providers to Help Reduce Opioid Abuse

At Blue Cross and Blue Shield of Illinois (BCBSIL), we pledge "to do everything in our power to stand with our members in sickness and health." We take that commitment seriously. That's why we've started a new program to help you when you're caring for your patients, our members, who may be at risk for an opioid-related adverse event. We hope that by collaborating with you and your patients, our members, we can find ways to help reduce risk and promote patient safety.

As part of our new program, we're now scanning pharmacy and medical claims that are submitted to BCBSIL to identify members with a combination of the following risk factors:

- High morphine equivalent daily dosing (MED)[1];
- Dangerous drug combinations (i.e., opioids, benzodiazepines, muscle relaxers); and/or
- Receiving controlled substance prescriptions from multiple providers.

When warranted, we may reach out to identified members and providers to inform them of potential risks. We also may provide support to help reduce that risk. Support may include helping to ensure that members have access to Narcan (naloxone) and are aware of how to use it. We also may suggest that providers and members consider non-opioid alternatives, such as physical therapy and cognitive behavioral therapy. This initiative is one of the enhancements BCBSIL made this summer to our Behavioral Health Program offerings.

"The number of opioid overdoses still occurring in this country requires a coordinated effort across the entire delivery system," said Ben Kurian, M.D., executive medical director of our Risk Identification and Outreach Program. "We hope to use our data to partner with providers for the benefit of patients and their families."

It is our hope that by identifying and sharing prescribing concerns, we can collaborate with members and providers to help promote positive changes. Thank you for everything you do to help ensure the safety and well-being of your patients/our members.

[1] Dowell D, Haegerich TM, Chou R. Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

benefits, limitations and exclusions, please refer patients to their certificate of coverage. If you have any questions, please call the number on the member's ID card.

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2020 Benefit Preauthorization Requirements, Reminders and Resources (PPO – Commercial and Government Programs)

Benefit preauthorization to confirm medical necessity is required for certain services and benefit plans as part of our commitment to help ensure all Blue Cross and Blue Shield of Illinois (BCBSIL) members get the right care, at the right time, in the right setting. It's important to remember that benefit plans differ in their benefits, and details such as benefit preauthorization requirements are subject to change. This article includes some general reminders and links to recent communications to provide you with an overview of some of the changes to come in 2020 for PPO commercial and government programs.

OVERVIEW OF 2020 CHANGES
Commercial

- Specialty Pharmacy Benefit Preauthorization Requirement Changes for Some Commercial Members, Effective Jan. 1, 2020 – This News and Updates notice was posted on Oct. 1, 2019, to alert you that, for some of our members with Blue Choice Preferred PPO℠ and Blue Options℠/Blue Choice Options℠ benefit plans, some new benefit preauthorization requirements will be added, and some existing requirements will be expanded for select outpatient provider-administered drug therapies, such as cellular immunotherapy, gene therapy and other medical benefit drug therapies.
- Benefit Preauthorization Changes for Some Custom Accounts Will Take Effect Jan. 1, 2020 – This News and Updates notice was posted on Oct. 2, 2019, to alert you of additional care categories for which benefit preauthorization through eviCore healthcare (eviCore) may be required for some members with group coverage; the notice includes a list of three-character member ID prefixes for members in three groups who may be affected by this change.
- Benefit Preauthorization for Fertility Services for Some Members Must Be Obtained Through WINFertility, Effective Jan. 1, 2020 – This News and Updates notice was posted on Oct. 2, 2019, to alert you that obtaining benefit preauthorization through WINFertility will be required prior to rendering fertility services for some BCBSIL members with group coverage; the notice includes a list of three-character member ID prefixes for members in two groups who may be affected by this change.

Government Programs

- 2020 Blue Cross Medicare Advantage (PPO)℠(MA PPO) Prior Authorization Requirements Summary – A link to this summary listing was posted in the News and Updates on Oct. 1, 2019. Only one change has been made for 2020: The hyperbaric oxygen service category was removed, as benefit preauthorization through BCBSIL will no longer be required. (**Note:** The procedure codes within some other service categories may be changing; an updated MA PPO procedure code list for 2020 will be published before Jan. 1, 2020, in the Prior Authorization section of our Provider website.)
- 2020 Medicaid Prior Authorization Requirements Summary – A link to this summary listing was posted in the News and Updates on Oct. 1, 2019. It includes information that applies to our Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ and Blue Cross Community Health Plans℠ (BCCHP℠) members. This summary list was last updated in September 2019; the categories will remain the same, with no additions or removals for January 2020. (**Note:** The procedure codes within some service categories may be changing; an updated Medicaid procedure code list for 2020 will be published before Jan. 1, 2020, in the Prior Authorization section.)

GENERAL REMINDERS

Check Eligibility and Benefits *First*

Benefit preauthorization requirements are specific to each patient's policy type and the procedure(s) being rendered. It's critical to check member eligibility and benefits through the Availity® Provider Portal or your preferred vendor portal prior to every scheduled appointment. 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.

How to Obtain Benefit Preauthorization

As always, we encourage you to use electronic options. If benefit preauthorization through eviCore is required, you may submit your request online via the eviCore Web Portal. If benefit preauthorization through BCBSIL is required, you may continue to submit requests using our online tool iExchange®. A new online application for submission of electronic benefit preauthorization requests (278 transactions) will soon be available. Continue to watch the News and Updates for more information.

FOR MORE INFORMATION

We value your participation as an independently contracted network provider and we appreciate the quality care and services you provide to our members. We encourage you to visit us online often for the most up-to-date information.

- For links to helpful tip sheets, refer to the Eligibility and Benefits section of our Provider website.
- For summary and procedure code lists and other resources, go to the Prior Authorization section.
- Also continue to watch the News and Updates and upcoming issues of the *Blue Review*.

Questions? Contact your assigned BCBSIL Provider Network Consultant (PNC). We're here to help!

This information does not apply to HMO members.

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City of Chicago Discontinuing Second Surgical Opinion Requirement Jan. 1, 2020

Beginning Jan. 1, 2020, the City of Chicago will no longer require their employees with Blue Cross and Blue Shield of Illinois (BCBSIL) insurance to get a second surgical opinion from Best Doctors before having scheduled surgeries in the following areas:

- Hip/knee/shoulder
- Neck/back/spine
- Gallbladder
- Uterine/vagina/cervix
- Gastric bypass

Providers will still be responsible for obtaining benefit preauthorization for surgical medical necessity by calling Telligen at 800-373-3727, but the additional Best Doctors mandatory second opinion won't be required.

Currently, BCBSIL members participating in the City of Chicago plan with the prefix CTY and the group numbers 195500, 195501 or 195502 on their member ID cards are required to call Telligen to initiate a second surgical opinion from Best Doctors before having any of the scheduled surgeries listed above.

If an above-listed surgery is scheduled through **Dec. 31, 2019**, it will continue to be the member's responsibility to obtain the Best Doctors second opinion, which can **take up to four weeks**. A provider may contact Telligen to start the second opinion process.

Association

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eviCore Benefit Preauthorization Training for Advanced Imaging, Genomic Lab, Joint/Spine/Pain and Sleep Management Services

eviCore healthcare (eviCore) is offering optional provider orientation sessions to review how to submit benefit preauthorization requests through eviCore. Sessions this month will cover benefit preauthorization requests for the following services:

- Advanced Imaging
- Genomic Lab
- Musculoskeletal (MSK) Joint/Spine/Pain Services
- Sleep Management and Related Equipment Services

These orientation sessions will review benefit preauthorization requirements and how to navigate the eviCore portal to submit benefit preauthorization requests online.

Each session will last about an hour, including a question and answer session. Registration is required. There is no cost for the training.

November Training Schedule

Course Topic	Date	Day of Week	Time*
Advanced Imaging	Nov. 5, 2019	Tuesday	11 a.m. – noon, CST*
Genomic Lab	Nov. 6, 2019	Wednesday	1 – 2 p.m., CST*
Joint/Spine/Pain	Nov. 5, 2019	Tuesday	2 – 3 p.m., CST*
Joint/Spine/Pain	Nov. 13, 2019	Wednesday	11 a.m. – noon, CST*

Sleep Management Services and Related Equipment	Nov. 4, 2019	Monday	9 – 10 a.m., CST*

***Note:** Sessions list the start time as Eastern Standard Time in the WebEx Video Conferencing application.

How to Register

- Go to evicore.webex.com.
- Click on the menu bar symbol located on the left-side of the webpage and select “Webex Training.” The “Live Sessions” page will display.
- Click the “Upcoming” tab and search by topic, course name or date. Look for **BCBSIL** before the course name.
- Click “Registration” next to the appropriate training session and enter all required information.

Confirmation Email

Following registration, you’ll receive a confirmation email containing the following information:

- Toll-free phone number
- Meeting number
- Conference password
- Link to the web portion of the training session

Please retain the confirmation email. Use the link and toll-free phone number to access your training session.

Training Documents

If you’re unable to attend a training session, go to the Provider Resources page on the eviCore portal to download a PDF copy of the presentation or related documents. If needed, download a copy of the Adobe Reader.

Questions?

For registration issues, contact eviCore at portal.support@evicore.com or call 800-646-0418. (Wait until prompted to enter “2.”) If you have other questions, email eviCore at clientservices@evicore.com.

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Palliative Medicine and Hospice Care: Practical, Comforting Options to Help Empower Patients and their Families

By: Dr. Derek J. Robinson, M.D., MBA, FACEP, CHCQM, Vice President and Chief Medical Officer, Blue Cross and Blue Shield of Illinois (BCBSIL)

We are committed to helping to promote the health and wellness of our members. To that end, we emphasize the importance of promoting quality of life for those with serious, chronic conditions such as multiple sclerosis or lupus, as well as illnesses that can be life-limiting, such as cancer or advanced cardiopulmonary diseases. Individuals with serious illnesses may have physical and emotional symptoms related to the illness itself, or the treatment of the illness, and they may need help clarifying their options and priorities as their illnesses progress. When faced with physically and emotionally challenging health conditions, your patients and their families may not be aware of health care options that may be available to provide support.

Palliative medicine can help ease physical, psychosocial and spiritual distress while also helping patients clarify their health care goals at various stages of illness. The basic goal of palliative medicine is to help people continue to lead their lives as fully as possible according to what is important to them in terms of comfort level and quality of life. Palliative medicine can be initiated anytime when someone is diagnosed with a serious illness, regardless of whether the illness is life-limiting. Palliative medicine is often associated with hospice care, but palliative medicine is broader. Hospice care focuses on maximizing comfort for a patient suffering from a life-limiting illness if comfort has emerged as the patient's primary goal of care. Palliative care is about emphasizing treatments and interventions focused on comfort and quality of life while still pursuing strategies focused on maximizing life.[1]

Both palliative medicine and hospice care involve specialized medical services offered by interdisciplinary teams of physicians, nurses, social workers and chaplains. The purpose of this health care team is to focus on the person as a whole – and not just their illness – to provide additional support to patients, caregivers and family members. Palliative medicine is often coordinated through the primary provider or specialist and can occur in the hospital, clinic or home setting. Hospice aims to provide services to where one chooses to live and therefore usually and preferably occurs in one's home, but depending on acute patient needs, also occurs in dedicated inpatient hospice facilities. Both palliative medicine and hospice involve aggressive management of symptoms, including but certainly not limited to controlling pain. Managing other troubling symptoms, such as nausea, constipation, shortness of breath, cough, fatigue, anxiety and

depression is often involved, too. Addressing the goals of care and the associated psychological and spiritual implications for patients with life-threatening illnesses and their loved ones is often a large component of both hospice care and palliative medicine.

Recognizing the value of offering early palliative care to patients with life-threatening illnesses is important. For example, for patients with cancer, palliative medicine may be offered to help improve symptom management and quality of life while still pursuing chemotherapy. In fact, studies have shown that patients with lung cancer who received palliative care had a higher quality of life in terms of physical, functional, emotional and social well-being, with less depressive symptoms compared to patients who did not receive focused symptom management.[2] Patients receiving early palliative care were also more likely to receive less aggressive end-of-life care when the benefits of continued life-sustaining treatments were more limited, since, despite receiving less aggressive care, median survival was longer among patients receiving early palliative care.[3] Clearly, early palliative care can be beneficial by empowering individuals with a practical approach to accepting and managing their conditions with a focus on living.

Access to palliative medicine continues to grow. For U.S. hospitals with 50 or more beds – hospitals that currently service 87% of all U.S. hospitalized patients – 72% have an inpatient palliative care team.[4] The growth of these programs has been dramatic: up from 67% in 2015, 53% in 2008, and just 7% in 2001.[5] This rapid development is even more impressive when considering that the American Board of Medical Specialties only recognized the field as an independent specialty in 2006 with the first certifications issued in 2008.[6]

It is not surprising that the growth of the field has centered around hospitals. These programs historically arose out of the need to assist primary care doctors, hospitalists and a range of specialists to manage complicated, end-of-life situations, particularly assisting medical teams with challenging shared decision-making involving the goals of care. However, these hospital-based palliative care programs are continuing to expand their range of services and increasingly offering outpatient availability in the clinic setting. Likewise, facilities that historically offered hospice services are also expanding their palliative care services beyond the hospice population to provide patients and their families with palliative care home nursing services using clinicians who are well-trained and comfortable managing symptoms in patients with serious illnesses.

We anticipate and hope that palliative care services will continue to grow in the outpatient setting. We look forward to working with palliative medicine clinicians throughout Illinois, including in rural areas, to continue to expand access to these vital services beyond the hospital to the outpatient setting, and, as much as possible, into patient homes where this care may have the greatest effect for our members and their families.

Do you have ideas or comments you'd like to share on this important topic? Please email our *Blue Review* editor with any thoughts or feedback. We value your input!

Learn more about Dr. Derek J. Robinson

[1] Kelley AS, Morrison RS. Palliative Care for the Seriously Ill. *N Engl J Med.* 2015 Aug 20;373(8):747-55. Available at https://www.nejm.org/doi/full/10.1056/NEJMra1404684.

[2,3] Temel JS, et al. "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer." *N Engl J Med* 2010. 363(8):733-742. Available at https://www.nejm.org/doi/full/10.1056/NEJMoa1000678

[4,5] Best and Worst States Providing Access To Palliative Care 2019: State-By-State Report Card Shows Rapid Growth, But Gaps In Care Remain. Center to Advance Palliative Care. Sept. 26, 2019. Available at https://www.capc.org/about/press-media/press-releases/2019-9-26/best-and-worst-states-providing-access-palliative-care-2019-state-state-report-card-shows-rapid-growth-gaps-care-remain/.

[6] American Board of Medical Specialties Board Certification Report, 2017-2018. Available at https://www.abms.org/media/194885/abms-board-certification-report-2017-2018.pdf.

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

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What You Need to Know About the 2019-2020 Flu Season

The Centers for Disease Control and Prevention (CDC) recommends yearly flu shots for all patients 6 months and older without vaccine contraindication. Providers may administer any U.S. Food and Drug Administration (FDA) approved, age-appropriate flu shot. Remember to review the current flu vaccine product table for the most recent updates on available products and their approved age ranges.[1]

What's different this flu season?[1]

- All standard adult and pediatric dose flu vaccines will be quadrivalent; no trivalent regular dose flu shots are available this season.
- Afluria Quadrivalent® is now licensed for children 6 months of age and older.
- Baloxavir (Xofluza™) is a new single-dose antiviral drug approved by the FDA for people 12 years and older who have had flu symptoms for less than 48 hours. Baloxavir (Xofluza) is not a substitute for early vaccination with the annual seasonal flu vaccine.

Reminders this Flu Season[2]

- Trivalent high dose or adjuvant containing flu vaccines for the elderly (65 and older) are made specifically to create a better or stronger immune response.
- Oseltamivir (Tamiflu®) is used for the treatment of influenza for patients 2 weeks or older who have had flu symptoms for less than 48 hours, as well as the prophylaxis of influenza in patients 1 year and older. Oseltamivir (Tamiflu) is not a substitute for early vaccination with the annual seasonal flu vaccine.
  - Oseltamivir (Tamiflu) is also available as a generic medication, which may have a lower cost to the member compared to a branded medication.

Coding Reminders

- Please file your claims with correct coding.*
- The American Academy of Pediatrics (AAP) coding chart recommends which billing code to use based on the vaccine administered. (This chart is not a comprehensive list.)
- Code descriptions are specific to the vaccine product.
- Code descriptions may include:

- Dosage amounts
- Trivalent vs. quadrivalent formulations
- Distinctive features (i.e., preservative-free, split virus, recombinant DNA, cell cultures or adjuvanted).

***Correct coding requires services to be reported with the most specific code available that appropriately describes the service.*

Note: If an HMO member is referred for a flu vaccine by their Primary Care Physician, the member's HMO medical group is responsible for paying for the service.

[1] CDC, Frequently Asked Influenza (Flu) Questions: 2019-2020 Season, Sept. 16, 2019. https://www.cdc.gov/flu/season/faq-flu-season-2019-2020.htm#

[2] CDC, Antiviral Drugs for Seasonal Influenza: Additional Links and Resources, Nov. 29, 2018. https://www.cdc.gov/flu/professionals/antivirals/links.htm

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

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

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

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

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

If you have questions regarding these requirements, contact your assigned PNC or send an email to *govproviders@bcbsil.com*.

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Changes to Medicare Advantage Payment Models for Skilled Nursing Facility and Home Health Care Claims

The Centers for Medicare & Medicaid Services (CMS) is launching new payment models for skilled nursing facilities and home health care. Blue Cross and Blue Shield of Illinois (BCBSIL) is aligning its payment models with CMS for Medicare Advantage claims. These changes will help support patient-focused, streamlined claims processes for skilled nursing facilities and home health agencies that are contracted to provide care and services for our **Blue Cross Medicare Advantage (PPO)℠, Blue Cross Medicare Advantage (HMO)℠, Blue Cross Medicare Advantage (HMO-POS)℠ and Blue Cross Community MMAI (Medicare-Medicaid)℠** members.

What is Changing?

- As noted in a September News and Updates, beginning **Oct. 1, 2019**, BCBSIL transitioned to CMS's Patient Driven Payment Model, which classifies skilled nursing facility claims into payment groups based on patient characteristics. This model replaces the Resource Utilization Group, Version IV (RUG-IV), which we will no longer support.
- Beginning **Jan. 1, 2020**, BCBSIL will adopt CMS's Patient-Driven Groupings Model for home health patients, as part of the Home Health Prospective Payment System. Under this new model, payment is based on 30-day periods rather than 60 days, and therapy service thresholds are eliminated.

Providers should use the new CMS classifications when submitting claims for skilled nursing facility and home health services for the members referenced above.

Learn More

Visit the CMS website for more information, including answers to frequently asked questions about CMS's payment model for skilled nursing facilities. Also refer to the CMS website for access to an interactive grouper tool and other details on the home health patient-drive groupings model.

between the member and their health care provider.

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Itemized Bills Required for BlueCard® Claims Over $200K

Beginning **Jan. 1, 2020**, Blue Cross and Blue Shield of Illinois (BCBSIL) will require facilities to submit an itemized bill for any BlueCard member billed at or more than $200,000 for inpatient care. An itemized bill helps ensure accurate claim payment and reduces the need to submit more information after claims are paid.

What has changed?
The claim amount requiring itemization is changing from the $250,000 threshold in 2019, to $200,000.

How to Submit Itemized Bills
You may submit itemized bills electronically for finalized claims using the Claim Inquiry Resolution (CIR) tool. Be sure to include the corresponding claim number.

More Information
Refer to the Clinical Payment and Coding Policy on our provider website for more information. If you have any questions, please contact your BCBSIL Provider Network Consultant (PNC).

What is BlueCard?
BlueCard is a national program that enables members of one Blue Cross and Blue Shield (BCBS) Plan to obtain health care services while traveling or living in another BCBS Plan's service area. BlueCard members usually have a suitcase logo* on their identification card.

As a reminder, it's important to check member eligibility and benefits through Availity® or your preferred vendor web portal prior to every scheduled appointment. For BlueCard members, you may also call the BlueCard Eligibility® line at 800-676-BLUE (2583). 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.

*Medicaid and State Children's Health Insurance Plan members will not have a suitcase logo.

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 member's ID card.

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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Time-Based Measurement Standard to Follow AMA: A Change in the Coding of Physical Medicine Service Units

On July 22, 2019, Blue Cross and Blue Shield of Illinois (BCBSIL) changed its time measurement standard for billing physical medicine services based on a regulation that was passed by the Illinois legislature. The regulation requires BCBSIL to move from the Centers for Medicare & Medicaid Services (CMS) to the American Medical Association (AMA) measurement standard for billing time-based services, such as physical medicine services. These are time-based codes within the Physical Medicine and Rehabilitation section of the Current Procedural Terminology (CPT®) code book.

When billing for time-based services, use the CPT codes in the AMA code book, except as required by federal law for Medicare and Medicaid patients. The AMA guidelines will apply to these physical medicine services:

97110, 97113, 97116, 97530, 97533, 97535, 97537, 97542, 97750, G0515

Services billed after July 22, 2019, will be paid retroactively using the new procedure code billing process.

As always, it's critical to check eligibility and benefits first, prior to rendering care and services to confirm coverage, network status and other important details. When you check eligibility and benefits online by submitting an electronic 270 transaction through the Availity® Provider Portal or your preferred web vendor portal, you may determine if benefit preauthorization/pre-notification may be required.

Payment may be denied if you perform procedures without benefit preauthorization when benefit preauthorization is required. If this happens, you may not bill our members.

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 offered by third party vendors such Availity. The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

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Provider Learning Opportunities

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

BCBSIL WEBINARS

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

Descriptions:	Dates:	Session Times:
BCBSIL Back to Basics: 'Availity® 101' *Join us for a review of electronic transactions, provider tools and helpful online resources.*	Nov. 5, 2019 Nov. 12, 2019 Nov. 19, 2019 Nov. 26, 2019	11 a.m. to noon
Introducing Availity 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. The Reporting On-Demand application allows users to readily view, download, save and/or print the Provider Claim Summary (PCS) and other reports online, at no additional cost.*	Nov. 14, 2019	11 a.m. to noon
Managed Long Term Services and Supports (MLTSS) Orientation *This webinar offers LTSS providers more information about the MLTSS program as it relates to our Blue Cross Community Health Plans℠ (BCCHP℠) product and how to navigate BCBSIL requirements, electronic options and online provider resources.*	Nov. 14, 2019	10 to 11 a.m.

BCCHP Ancillary Providers *This webinar is intended for the following provider types: Long Term Care Facilities (LTC), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Specialized Mental Health Rehab Facility (SMHRF), Supportive Living Facilities (SLF), Home Health, Hospice, Durable Medical Equipment (DME), Home Infusion, Dialysis*	Nov. 5, 2019	10 to 11 a.m.
Monthly Provider Hot Topics Webinar *These monthly webinars will be held through December 2019. They are customized for the BCBSIL contracted provider community. BCBSIL Provider Network Consultants (PNCs) will use this format to share upcoming initiatives, program changes and updates, as well as general network announcements.*	Nov. 6, 2019	10 to 11 a.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 for details; or call Availity Client Services at 800-AVAILITY (282-4548) for assistance.

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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. Our 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, we may conduct preliminary interviews and field audits 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 have been cases for 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.

We encourage members and providers to call the **BCBSIL Fraud Hotline at 800-543-0867** to report 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.

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Information about BCBSIL's Quality Improvement Program

Our Quality Improvement (QI) Program addresses both care and services provided to members. To learn more about our QI Program, call 312-653-3465 to request a QI Program summary. The summary includes information about the structure of the QI Program, outcomes of the program and its success in meeting goals.

This specific information only applies to non-government programs. For information regarding government programs such as Medicare and Medicaid, please refer to the applicable provider manual.

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HEDIS® Measure: Appropriate Testing for Children with Pharyngitis

Pharyngitis, or a sore throat, is one of the leading reasons for parents to bring their children to the doctor's office and may spread viral or bacterial sicknesses. Viral pharyngitis, which is 70% of the cases, does not require antibiotic treatment, yet approximately 75% of patients with pharyngitis are prescribed antibiotics.[1,2] According to the Centers for Disease Control and Prevention (CDC), proper testing and treatment of pharyngitis would reduce the unnecessary use of antibiotics and decrease the risk of antibiotic resistant bacteria.[3,4]

The Healthcare Effectiveness Data and Information Set (HEDIS) was developed and is maintained by the National Committee for Quality Assurance (NCQA) to standardize and measure quality for all patients. One of these measures focuses on the appropriate testing of pharyngitis in children ages 2 through 18 years old.

Below is the McIsaac clinical decision tool, which is one way to assist in the proper testing, treatment and diagnosis of pediatric pharyngitis.[5] Points in the decision tool are assigned to each set of criteria based on patient assessment. The total score the patient receives dictates the likelihood of viral vs bacterial causes for acute pharyngitis. While clinical decision tools, like the McIsaac clinical decision tool, don't replace the importance of the individual patient assessment, their use may help improve the accuracy and efficiency of your diagnosis.

McIsaac Clinical Decision Tool

Criteria	Points
Temperature > 38°C	1
No cough	1
Tender anterior cervical adenopathy	1
Tonsillar swelling or exudates	1

Age 3 – 14 years	1
Age 15 – 44 years	0
Age ≥ 44	-1
Total Score	

Total Score	Likelihood of GABHS* (%)	Suggested management
0	2 - 3	No culture or antibiotic is required
1	4 - 6	No culture or antibiotic is required
2	10 - 12	Culture all; treat only if results are positive
3	27 - 28	Culture all; treat only if results are positive
4 or 5	38 - 63	Treat with antibiotics on clinical grounds without culture

*Pharyngitis caused by group A beta-hemolytic streptococci (GABHS)

[1] Michigan Medicine, Pharyngitis, May 2013. http://www.med.umich.edu/1info/FHP/practiceguides/pharyngitis/pharyn.pdf

[2] Harold K Simon, MD, MBA. Pediatric Pharyngitis, 2014. http://emedicine.medscape.com/article/967384-overview

[3] CDC, Is It Strep Throat? 2013. http://www.cdc.gov/Features/strepthroat/

[4] CDC, Antibiotics Aren't Always the Answer, 2013. http://www.cdc.gov/features/getsmart/

[5] U.S. National Library of Medicine National Institutes of Health, The effectiveness of the McIsaac clinical decision rule in the management of sore throat: an evaluation from a pediatrics ward, October 2016. https://www.ncbi.nlm.nih.gov/pubmed/27331353

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New Names and ID Cards for Some Medicare Plans

Beginning **Jan. 1, 2020**, you may notice new names and ID cards for some of our Medicare plans. In addition to Blue Cross Medicare Advantage℠ plans, you may see the following new names for group plans offered by our members' benefit administrators. While some plan names have changed, your experience as a provider will be the same and members' benefits will not change.

The new member ID cards will include a Customer Service number for providers and the new plan names.

- **Blue Cross Group Medicare Advantage (HMO)℠** is the new name of Blue Cross Medicare Advantage (HMO)℠ for group Medicare members. This plan provides members access to providers within a defined network, with no out-of-network benefit.
- **Blue Cross Group Medicare Advantage (PPO)℠** is the new name of Blue Cross Medicare Advantage (PPO)℠ for group Medicare members. This traditional PPO allows members to seek care in network and out of network, typically providing cost savings for in-network care.
- **Blue Cross Group Medicare Advantage Open Access (PPO)℠** is the new name of Blue Cross Medicare Advantage (PPO) Employer Group℠. This plan offers members access to providers nationwide who accept assignments from Medicare and are willing to bill Blue Cross and Blue Shield of Illinois (BCBSIL). Because there are no network restrictions, coverage levels are the same for all care regardless of provider network affiliation.
- **Blue Cross Group MedicareRx℠** is the new name of Blue Cross MedicareRx (PDP)℠. It provides Medicare Part D prescription drug coverage.

The name of the BlueSecure℠ retiree group plan isn't changing. BlueSecure helps members cover some costs beyond what is covered by original Medicare. BlueSecure members can see providers who accept Medicare assignments and are willing to bill BCBSIL.

It's important to check eligibility and benefits for each patient before every scheduled appointment. Eligibility and benefit quotes include membership verification, coverage status and applicable copayment, coinsurance and deductible amounts. The benefit quote may also include information on applicable benefit preauthorization requirements. Ask to see the member's BCBSIL ID card and a driver's license or other photo ID to help guard against medical identity theft.

Checking eligibility and benefits and/or obtaining benefit preauthorization/pre-notification or predetermination of benefits is not a guarantee that benefits will be paid. Payment is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations and exclusions set forth in your patient's policy certificate and/or benefits booklet and/or summary plan description. Regardless of any benefit determination, the final decision regarding any treatment or service is between you and your patient. If you have any questions, please call the number on the member's ID card.

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Utilization Management Decisions Are Not Financially Influenced

We are committed to serving our members through the provision of health care coverage and related benefit services. Utilization management (UM) determinations are made by licensed clinical personnel based on a member's health plan's benefits, evidence-based medical policies and medical necessity criteria, and the medical necessity of care and service. All utilization management decisions are based on appropriateness of care and service and existence of coverage. Blue Cross and Blue Shield of Illinois (BCBSIL) prohibits decisions based on financial incentives, nor does BCBSIL specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

The criteria used for UM determinations are available upon request. Please call the number on the member's ID card for help.

Note: This article does not apply to HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠, BlueCare Direct℠ and Blue FocusCare℠, Blue Cross Medicare Advantage℠ (HMO and PPO) products.

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Procedure Code and Fee Schedule Updates

As part of our commitment to help inform our independently contracted providers of certain developments, we have designated a section in the *Blue Review* to tell you of any significant changes to the physician fee schedules. It's important to review this section each month.

Effective Jan. 1, 2020, Healthcare Common Procedure Coding System (HCPCS) codes Q5108 and Q5111 will be updated.

The information above is not intended to be an exhaustive listing of all the changes. Annual and quarterly fee schedule updates may also be requested by using the Fee Schedule Request Form. Specific code changes that are listed above may also be obtained by downloading the Fee Schedule Request Form and specifically requesting the updates on the codes listed in the *Blue Review*. The form is available on the Forms page on our Provider website.

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Important Dates and Reminders

Check here each month for a quick snapshot of recent implementations, upcoming changes, special events, important deadlines and other reminders. Blue Cross and Blue Shield of Illinois (BCBSIL) understands that provider offices are extremely busy and, while this list should not be interpreted as all-inclusive, we hope this abbreviated summary format is useful to you and your staff.

Confirmation of Recent Implementations

Topic	Brief Description	Date Implemented:	For More Information
Government Programs: Changes to Pre-service Appeals Process	For some government programs members, denied or partially denied benefit preauthorizations, BCBSIL will be the administrator instead of eviCore healthcare (eviCore).	**Beginning Nov. 1, 2019**	New and Exciting Functionality Coming to the Claim Research Tool (CRT) via Availity® Provider Portal (September 2019, *Blue Review*)
Commercial, Government and non-Uniform Payment Program (non-UPP) Providers: New Addresses for Claim Overpayment Refunds and Contractual Allowances	New addresses may appear on the refund request letter from BCBSIL. Overpayment refunds and contractual allowances will be forwarded for a minimum of 90 days.	**Dec. 1, 2019 for Overpayment Refunds** (previously Oct. 1, 2019) **Oct. 28, 2019 for Contractual Allowances** (previously Oct. 4, 2019)	Update: New Addresses for Claim Overpayment Refunds and Contractual Allowances (October 2019, News and Updates)

Upcoming Changes to Watch For

Topic	Brief Description	Target Implementation Date:	For More Information
Ambulatory Surgery Center (ASC) Update: Changes to Post-Payment Review Process for Implant Claims	Change Healthcare will provide post-payment review of ASC claims with implant charges; they will alert you of incorrectly paid claims and provide instructions on how to repay funds or appeal the decision.	**Beginning Dec. 15, 2019**	Post-payment Review for Implant Claims from Stand-alone Ambulatory Surgery Centers (September 2019, News and Updates)
Commercial Members: Laboratory Benefit Level Change	Non-preventive labs will no longer be covered at the no member cost-share level for some of our PPO and HMO members. Check eligibility and benefits.	**Beginning Jan. 1, 2020**	Laboratory Benefit Level Change for Some Members (September 2019, News and Updates)
BlueCard® Members: Itemized Bills Required for Claims Over $200K	The claim amount requiring itemization is changing from the $250,000 threshold in 2019, to $200,000.	**Beginning Jan. 1, 2020**	Itemized Bills Required for BlueCard Claims Over $200K (September 2019, News and Updates)
BCBSIL is aligning its payment models with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage claims.	BCBSIL will adopt CMS's Patient-Driven Groupings Model for home health patients, as part of the Home Health Prospective Payment System.	**Beginning Jan. 1, 2020**	Changes to Medicare Advantage Payment Models for Skilled Nursing Facility and Home Health Care Claims (September 2019, News and Updates)
Benefit Preauthorization Requirements – Changes Effective Jan. 1, 2020	It's important to remember that member contracts differ in their benefits, and details such as benefit preauthorization requirements are subject to change.	**Jan. 1, 2020**	2020 Benefit Preauthorization Requirements, Reminders and Resources (PPO – Commercial and Government Programs) (November 2019, *Blue Review*)
City of Chicago eliminating mandatory second surgical opinion	Employees will no longer be required to get a second surgical opinion from Best Doctors but providers are still responsible to obtain benefit preauthorization.	**Effective Jan. 1, 2020**	City of Chicago Discontinuing Second Surgical Opinion Requirement Jan. 1, 2020 (November 2019, *Blue Review*)

Respond Electronically to Claim-related Medical Record Requests from BCBSIL via Availity Provider Portal	The Medical Attachments application will allow electronic responses to claim-related medical record requests from BCBSIL, in addition to electronic responses to quality and risk adjustment medical record requests.	**Coming Soon** (previously listed as "After Oct. 1, 2019")	Respond Electronically to Medical Record Requests for Quality and Risk Adjustment, and Soon Claims, via Availity Provider Portal (September 2019, *Blue Review*)

Special Events and Activities

Topic	Brief Description	Important Date(s)	For More Information
2019 *Blue Review* Readership Survey	We value your input and ideas. Please complete our brief survey today.	**October and November 2019**	Your Feedback Is Important (October 2019, News and Updates)
Addressing the Maternal and Infant Health Crisis Through A Health Equity Lens	Join us at our free Blue University℠ event this fall in Chicago.	**Nov. 22, 2019**	Register today!
Monthly Provider Hot Topics Webinar	Our Provider Network Consultant team is hosting one-hour online training sessions every month to help keep you informed of important BCBSIL updates and initiatives.	**Through December 2019**	Watch the Provider Learning Opportunities or visit the Webinars and Workshops page for upcoming dates and online registration.

Deadlines and Other Reminders

Topic	Brief Description	Important Dates	For More Information
New Illinois legislation requires time-based measurement standard to follow American Medical Association (AMA) standard	BCBSIL changed its time measurement standard for billing physical medicine from CMS to AMA measurement standard.	**Effective July 22, 2019**	Time-Based Measurement Standard to Follow AMA: A Change in the Coding of Physical Medicine Service Units (October 2019, News and Updates)
Email Validation Survey	If you're on our *Blue Review* distribution list, you may receive an email validation survey from BCBSIL.	**Ongoing through 2019**	We're Conducting an Email Validation Survey (May 2019, News and Updates)
Some of our Blue	Access Health Corporation (an	Members have until **Nov.**	In-home Colorectal Cancer

Choice Preferred PPO℠ members may receive Fecal Immunochemical Test (FIT) Kits	independent company specializing in in-home diagnostic testing) will process tests and send results to our members and their specified primary care providers.	**15, 2019,** to complete and submit their in-home colorectal cancer screening tests for processing.	Screening Test Provided to Select Members (June 2019, *Blue Review)*
Government Programs Providers: Resubmit Claims Previously Incorrectly Rejected for Invalid National Drug Codes (NDCs)	BCBSIL has updated its systems per the Illinois Department of Health and Family Services (HFS); we are running reports to identify claims that rejected in error for invalid NDCs (dates of service on or after March 15, 2017).	Submit any claim previously incorrectly rejected for invalid NDCs through Availity or your preferred vendor portal by **Nov. 30, 2019.**	Update: Government Providers, Resubmit Claims Previously Incorrectly Rejected for Invalid NDCs (September 2019, News and Updates)
Remind your Medicare and Medicaid patients to schedule their annual wellness visits	Providers may increase Star ratings by promoting preventive care; participating members could receive $50 gift cards.	**Before Dec. 31, 2019**	CMS Star Ratings Matter: Encourage Members to Schedule Annual Wellness Visits (September 2019, *Blue Review)*

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

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. eviCore is an independent specialty medical benefits management company that provides utilization management services for BCBSIL. Change Healthcare Technologies LLC (Change Healthcare), an independent company, provides medical claims processing for BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity, eviCore, or Change Healthcare. 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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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 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, 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 Medical Policy page. 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 homepage.

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 section of our website for access to the most complete and up-to-date BCBSIL Medical Policy information. In addition to medical policies, other policies and information regarding payment can be found on the Clinical Payment and Coding Policies page.

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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ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes are periodically added to, or deleted from, the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and aren't considered changes to the software version. Blue Cross and Blue Shield of Illinois (BCBSIL) will normally load this data to the BCBSIL claim processing system after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSIL Provider website. We will also post advance notice of ClaimsXten software updates on our website.

To help determine how some coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to use Clear Claim Connection™ (C3). C3 is a free, online reference tool. Refer to the Clear Claim Connection page on our website for more information about C3, including frequently asked questions about ClaimsXten. Updates may be included in future issues of the *Blue Review*. Please note that C3 doesn't contain all of the claim edits and processes used by BCBSIL in adjudicating claims, and results from use of the C3 tool aren't a guarantee of the final claim determination.