Completing the Transition to ICD-10

In accordance with the U.S. Department of Health and Human Services (HHS) mandate, valid ICD-10 codes are required on claims submitted to Blue Cross and Blue Shield of Illinois (BCBSIL) for dates of service or inpatient discharge dates on or after Oct. 1, 2015. ICD-10 codes also are required for benefit preauthorization requests submitted on or after Oct. 1, 2015. Use of other codes, such as Current Procedural Terminology (CPT®), HCPCS and Revenue Codes, is not affected by the transition to ICD-10.

Here are some key points to keep in mind:

• **Use of ICD-10 is federally mandated.** All Health Insurance Portability and Accountability Act (HIPAA) covered entities must comply, regardless of each patient’s type of health insurance.

• **Coding directly in ICD-10 is encouraged.** Coding in ICD-9 and mapping to ICD-10 may be seen as an interim solution, but is not recommended as a best practice.

• **ICD-10 is date of service/discharge date driven.** Resubmission or adjustments of previously filed claims must be submitted with the code set used on the original claim.

• **Only one code set per claim is allowed (all ICD-9 or all ICD-10).** Claims that contain both ICD-9 and ICD-10 codes will not be accepted.

• **Non-compliant claims may be rejected by your clearinghouse before reaching BCBSIL.** You will need to watch electronic reports and work with your clearinghouse to correct and submit affected claims.

Visit the ICD-10 page in the Standards and Requirements section of our website at bcbsil.com/provider for answers to frequently asked questions, among other resources. Also watch the News and Updates for announcements, such as dates and times of educational webinars. If you need assistance with ICD-10 questions, email us at icd@bcbsil.com, or contact your assigned Provider Network Consultant.

Blue Cross Community Options℠ – Electronic Claim Submission Reminders

General information on how to conduct business with us is available in the Claims and Eligibility section of our website at bcbsil.com/provider. However, if you provide care and services for Blue Cross Community MMAI (Medicare-Medicaid Plan)℠, Blue Cross Community ICP℠, or Integrated Care Plan, or Blue Cross Community Family Health Plan℠ (FHP) members, you should be aware of some key differences when submitting electronic Blue Cross Community Options claims.

For example, all electronic Blue Cross Community Options claims for MMAI, ICP or FHP members must be submitted using the new Payer ID – MCDIL – which was implemented in December 2014 to help expedite claim processing. Transitioning to this Payer ID is important as, in the near future, claims submitted with the old Payer ID (00621) will no longer be accepted.

In addition to the new Payer ID, electronic claim system edits have been implemented to help provide more accurate adjudication and reporting to the state. To view a listing of system edits (such as Taxonomy Codes) and required data elements, refer to the Electronic Claim Submission Reminders for MMAI/ICP/FHP document in the Network Participation/Blue Cross Community Options section of our Provider website, under the Related Resources.

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PHARMACY PROGRAM UPDATES

Pharmacy Program Changes, Effective Oct. 1, 2015

STANDARD DRUG LIST (FORMULARY) CHANGES
Based on the availability of new prescription medications and the Prime National Pharmacy and Therapeutics Committee’s review of changes in the pharmaceuticals market, some revisions were made to the BCBSIL standard drug list effective Oct. 1, 2015.

BRAND MEDICATIONS ADDED TO THE DRUG LIST, EFFECTIVE OCT. 1, 2015

<table>
<thead>
<tr>
<th>Preferred Brand</th>
<th>Drug Class/Condition Used For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnuity Ellipta</td>
<td>Asthma</td>
</tr>
<tr>
<td>Pazeo</td>
<td>Ophthalmic Antihistamine</td>
</tr>
<tr>
<td>NovoEight</td>
<td>Hemophilia</td>
</tr>
</tbody>
</table>

DISPENSING LIMIT CHANGES
The BCBSIL standard prescription drug benefit program includes coverage limits on certain medications and drug categories. Dispensing limits are based on U.S. Food and Drug Administration (FDA) approved dosage regimens and product labeling.

EFFECTIVE OCT. 1, 2015, DISPENSING LIMITS WERE ADDED FOR THE FOLLOWING DRUGS:

<table>
<thead>
<tr>
<th>Drug Class and Medication</th>
<th>Product Strength(s)</th>
<th>Dispensing Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (GLP-1 Receptor Agonists)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bydureon (exenatide)</td>
<td>2 mg syringe</td>
<td>4 syringes per 28 days</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lyrica (pregabalin)</td>
<td>25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg capsule</td>
<td>90 capsules per 30 days</td>
</tr>
<tr>
<td>Lyrica (pregabalin)</td>
<td>225 mg, 300 mg capsule</td>
<td>60 capsules per 30 days</td>
</tr>
<tr>
<td>Lyrica (pregabalin)</td>
<td>20 mg/mL oral solution</td>
<td>900 mL solution per 30 days</td>
</tr>
<tr>
<td>Hypercholesterolemia (HoFH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juxtapid</td>
<td>5 mg, 10 mg</td>
<td>30 capsules per 30 days</td>
</tr>
<tr>
<td>Oral PAH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tyvaso starter kit</td>
<td>0.6 mg/mL</td>
<td>1 kit per 180 days</td>
</tr>
<tr>
<td>Tyvaso institutional starter kit</td>
<td>0.6 mg/mL</td>
<td>1 kit per 180 days</td>
</tr>
<tr>
<td>Tyvaso</td>
<td>0.6 mg/mL, 4 pack carton</td>
<td>7 packages per 28 days</td>
</tr>
<tr>
<td>Tyvaso</td>
<td>0.6 mg/mL refill kit</td>
<td>1 package per 28 days</td>
</tr>
<tr>
<td>Ventavis</td>
<td>10 mcg/mL, 20 mcg/mL</td>
<td>270 ampules per 30 days</td>
</tr>
<tr>
<td>Thrombopoietin Receptor Agonists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promacta</td>
<td>25 mg</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Promacta</td>
<td>75 mg</td>
<td>60 tablets per 30 days</td>
</tr>
</tbody>
</table>
UTILIZATION MANAGEMENT PROGRAM CHANGES

Effective Oct. 1, 2015, the Proton Pump Inhibitors (PPI) step therapy program was removed from all BCBSIL prescription drug benefit plans. Members are encouraged to use available less costly options, such as a covered prescription-strength generic or over-the-counter product.

Additionally, specific targeted drugs were added to current Prior Authorization (PA) programs for standard pharmacy benefit plans, upon renewal.

TARGETED DRUGS ADDED TO CURRENT PHARMACY PA STANDARD PROGRAMS, EFFECTIVE OCT. 1, 2015

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Targeted Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxycycline/Minocycline</td>
<td>Doxycycline 75 mg, Doxycycline 150 mg capsules, Doxycycline Monohydrate</td>
</tr>
<tr>
<td>Erythropoiesis Stimulating Agents (ESAs)</td>
<td>Mircera</td>
</tr>
<tr>
<td>Pulmonary Arterial Hypertension (PAH)</td>
<td>Tyvaso, Ventavis</td>
</tr>
</tbody>
</table>

Targeted mailings were sent to members affected by dispensing limit and prior authorization program changes per our usual process of member notification prior to implementation. For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of our website at bcbsil.com/provider.

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

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

The use of drug lists, dispensing limits and other conditions for prescription drug benefit coverage is solely for that purpose and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member’s certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.
Credentialing Application Process Changes, Effective Jan. 1, 2016

Effective Jan. 1, 2016, the Council for Affordable Quality Healthcare, Inc. (CAQH) ProView™ credentialing application process must be completed prior to sending BCBSIL an application to create a new practice or add a provider to an existing contracted group.

If the credentialing application process is not completed, the provider’s request for network participation will not be processed. The provider will then have to reapply once the CAQH ProView credentialing application is complete.

The following professional provider types must complete the credentialing process and be recredentialed every three years: MD, DO, PSYD, DC, CNM, LCSW, LCPC, LMFT, DPM, PA, APN and CNP.

WHAT IS CAQH PROVIEW?
CAQH ProView, previously known as CAQH Universal Provider Datasource®, is an online provider data-collection solution. It helps streamline provider data collection by using a standard electronic form that meets the needs of nearly every health plan, hospital and other health care organization.

CAQH ProView enables physicians and other health care professionals in all 50 states and the District of Columbia to enter information free-of-charge into a secure central database and authorize health care organizations to access that information. CAQH ProView helps eliminate redundant paperwork and reduces administrative burden.

HOW DO PROVIDERS ACCESS CAQH PROVIEW?
Providers can self-register at https://proview.caqh.org/pr and complete the application. Once completed, providers may select the organization that they authorize to share their information with or provide a global authorization.

QUESTIONS? NEED ASSISTANCE?
Providers may contact the CAQH Help Desk at providerhelp@proview.caqh.org or 888-599-1771.

The Help Desk operates every Monday through Thursday between 6 a.m. and 8 p.m., CT and Friday from 6 a.m. to 6 p.m., CT.

CAQH is an independent third party not-for-profit collaborative alliance of the nation’s leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. BCBSIL makes no representation or warranty regarding any services or products offered by CAQH. CAQH is solely responsible for its products and services, including the ProView database.

Complex Case Management for HMO Members

Attention, HMO Physicians: Complex case management services may be available for your BCBSIL HMO Illinois®, Blue Advantage HMO™ and Blue Precision HMO™ members through your Medical Group/Independent Practice Association (MG/IPA). Your HMO patients may be added to this program if the HMO member has a complex chronic condition or an acute condition, requiring multiple services. Please contact your MG/IPA for more information about this program.

The case management program is not a substitute for the sound medical advice of a doctor. Members are instructed to discuss any questions or concerns with their health care provider.

Provider Claim Summary (PCS) Update: ‘Ntwk Diff’ Column

Recently, you may have noticed a new column titled “Ntwk Diff.” that has been appearing on some of your patients’ PCSs. An August 2015 system update is the cause of this unintended occurrence. There are no financial impacts associated with this anomaly to either your practice or the member’s claim record on which this column may appear. A solution to prevent this erroneous column from being displayed on the PCS was implemented earlier this month.
More Enhancements Coming to the iExchange® Benefit Preauthorization Tool

We’ve made enhancements and continue to improve iExchange, our Web-based benefit preauthorization tool. iExchange supports requests for benefit preauthorizations for services such as Behavioral Health, Pharmacy, and Medical/Surgical Treatment.

iExchange allows you to submit initial and extension benefits requests for approval prior to services being rendered. We strongly encourage you to verify your patients’ eligibility & benefits to determine coverage and benefit preauthorization requirements prior to using the tool. This flexible tool provides real-time responses for direct submission of inpatient admissions and select outpatient medical services, including benefit preauthorization submissions after regular business hours and on weekends.

Recently, BCBSIL deployed what was formerly known as the Patient Clinical Summary. iExchange now offers an updated version called the Health Summary. Providers are able to receive additional data in the Health Summary, including more real-time data, which is the result of BCBSIL’s efforts to give you access to more data and better analytics that can help improve the health of your patients. The Health Summary will display the following information which is based upon claims data received by BCBSIL:

- Conditions – chronic and acute
- Health status measures
- Plan and care data
- Medications
- Lab and test results/procedures
- Visits

COMING SOON TO iEXCHANGE
iExchange will soon support submission of online requests and required documentation for predetermination of benefits. Instead of faxing clinical information, attachments will be able to be submitted electronically. Watch our Provider website and Blue Review for more information.

This article does not apply to HMO members.

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.

Information provided on the Health Summary is based upon information BCBSIL has received from a variety of sources including claims data and other providers. Health care providers should not rely solely upon the information provided by the Health Summary and are strongly encouraged to get a more complete medical history and other information from their patient.

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

Although medical policies can be used as a guide, 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 website at bcbsil.com/provider.

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

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

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

The BCBSIL Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient’s health care needs. Some benefit plans administered by BCBSIL, such as some self-funded employer plans or governmental plans, may not utilize BCBSIL Medical Policies. Members should contact their local customer service representative for specific coverage information.
Beginning on or after Dec. 14, 2015, BCBSIL will enhance the ClaimsXten code auditing tool by adding incidental edits to our claim processing system for Healthcare Common Procedure Coding System (HCPCS) codes for Compression Device Accessories (such as E0655 through E0673). This new edit will be effective for claims submitted with dates of service on or after the implementation date.

When codes such as E0655 through E0673 are billed for Compression Device Accessories along with code E0676, the all-inclusive code for Compression Devices, the accessories will be denied as inclusive to the device and therefore ineligible for separate payment.

To help determine how 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 that mirrors the logic behind BCBSIL’s code-auditing software.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the Education and Reference Center/Provider Tools/Clear Claim Connection section on our Provider website. Additional information also may be included in upcoming issues of the Blue Review.

ClaimsXten and Clear Claim Connection are registered trademarks of McKesson Information Solutions, Inc., an independent third party vendor that is solely responsible for its products and services. If you have questions regarding this product, please direct your questions to McKesson.

Provider Learning Opportunities

Complimentary training sessions are offered throughout the year with an emphasis on electronic transactions. A snapshot of upcoming training sessions is included below so you can mark your calendar. For additional information or to register online, visit the Workshops and Webinars page in the Education and Reference Center on our website at bcbsil.com/provider.

WEBINARS

Back to Basics: Availity 101
Nov. 3, 2015 – 11 a.m. to noon

iExchange Training
Nov. 18, 2015 – 2 to 3 p.m.

Introducing Remittance Viewer
Nov. 11, 2015 – 1 to 2 p.m.

Professional Provider Workshop Make-Up Webinars

Offered as a follow-up to the professional provider workshops that took place earlier this year, these webinars will include a discussion about health care reform-related initiatives and enable providers to ask questions to address individual concerns or areas of interest.

Oct. 28, 2015 – 9:30 a.m. to 12:30 p.m.

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 as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.
Changes Slated for Illinois Retail Market in 2016

The individual market has evolved significantly since the opening of the Health Insurance Marketplace in 2014. These changes require BCBSIL to make adjustments to our 2016 product offerings for the individual (retail) market that will allow us to continue offering affordable health insurance options.

In 2016, BCBSIL will expand the Blue Choice Preferred PPOSM, so that it will be an option in every county across the state. We also are expanding our Blue Precision HMOSM, and intend to offer a new direct network HMO product for the Greater Chicago area, in collaboration with Advocate Health Care – BlueCare Direct. The broad PPO that was offered for the individual market in 2014 and 2015 will not be offered in 2016 for the individual market.

The change does not affect the options available to our employer group customers and members enrolled in those plans. The broad PPO plan will continue to be available to employer groups across Illinois. In addition, individual broad PPO members enrolled in plans in place prior to March 23, 2010 (grandfathered plans), transitional (grandmothered) plans, and BCBSIL members enrolled in Medicare Supplement or Medicare Advantage plans will not be affected by these changes in 2016.

These changes to our individual Health Insurance Marketplace products will become effective Jan. 1, 2016. There will be no change to 2015 coverage. Individual health insurance members enrolled in the broad PPO plan can continue to use their existing coverage through the end of 2015, as long as they continue to pay their monthly premiums on time.

To help ensure there is no gap in coverage for our members currently enrolled in the individual health insurance plans that will not be offered in 2016, we will automatically transition affected members to a comparable plan, effective Jan. 1, 2016. This includes members enrolled in Blue Cross and Blue Shield multi-state plans that use the broad PPO network.

It is important to make sure providers and hospitals are in a member’s network when making referrals for additional medical services. By staying in-network, members may reduce or even avoid additional out-of-pocket expenses.

We are committed to working with contracted providers to minimize the impact of this change to our members’ ongoing care. Watch our Provider website and Blue Review for more information.

If you have questions, you may contact your BCBSIL Provider Network Consultant. BCBSIL members can call the Customer Service number listed on the back of their ID card.
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*Blue Review* is a monthly newsletter published for institutional and professional providers contracting with Blue Cross and Blue Shield of Illinois. We encourage you to share the content of this newsletter with your staff. *Blue Review* is located on our website at [bcbsil.com/provider](http://bcbsil.com/provider).

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

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Chicago, Illinois 60601-5099  
Email: bluereview@bcbsil.com  
Website: [bcbsil.com/provider](http://bcbsil.com/provider)

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