

BLUE REVIEWSM

A newsletter for contracting institutional and professional providers

October 2017

Overcoming Barriers to Colorectal Cancer Screenings

Part 3 of a 4-part series discussing Colorectal Cancer Screening.

Colorectal Cancer (CRC) screenings can be a highly effective preventive measure that offers your patients the possibility of the best possible outcomes. The U.S. Preventive Services Task Force (USPSTF) has found convincing evidence that screening for colorectal cancer with several different methods can accurately detect early-stage colorectal cancer and adenomatous polyps.¹

The rates of new colorectal cancer cases and deaths among adults aged 50 or older are decreasing in this country due to an increase in screenings and changes in some [risk factors](#) (e.g., a decline in smoking).²

The biggest influencer to motivate patients to get screened is you and your staff. One way to help your patients is to discuss overcoming barriers to CRC screening.

Patient Concerns

When some of our members were asked in a 2016 survey why they chose **not** to complete CRC screenings, the top three reasons were:

- *I did not know that the test was covered by my insurance.*
- *I am afraid of the test/discomfort.*
- *I do not have symptoms.*

See below for examples of additional patient concerns, along with suggestions for what you and your staff can do to help.

Embarrassment/Awkwardness

Patients may feel embarrassed about bowel functions and/or tests that involve stool collection.

- Inform patients that there are several screening options available, including simple take home tests that can be completed in the privacy of their own home.

Misconceptions about Cancer and Cancer Screenings

Some patients may feel that being asymptomatic equates to an absence of cancer.

- Sensitivity to personal and cultural fears surrounding cancer itself is important. Let patients know that many people diagnosed with colon cancer do not have any symptoms or a family history for the disease, which is why screening is so important even when they feel healthy.

Lack of Information

Information about available testing options and processes isn't always readily available.

- Discuss the variety of CRC screening options, as well as individual considerations that may impact CRC screening test selection. Offer a questionnaire at check-in to expedite CRC screening selection and to allow the patient time to formulate questions about CRC screenings.
- Once a CRC screening option is agreed upon, explain the expectations and process. Assure the patient that medications for discomfort will be provided for CRC screening procedures. Also consider directing the patient to the local [American Cancer Society](#)[®] for informational brochures and other patient resources.³

Concerns Regarding Costs and/or Interruption of Daily Life Responsibilities

Although CRC screenings are a preventive measure, there may be affiliated out-of-pocket costs. Loss of work and/or lack of transportation may be a concern with a flexible sigmoidoscopy or colonoscopy.

- Inform patients that preventing colorectal cancer or finding it early does not have to be expensive. There are simple, affordable tests available.
- Encourage Blue Cross and Blue Shield of Illinois (BCBSIL) members to call the Customer Service number on their ID card to discuss benefits and coverage.

Provider Concerns

Listed below are examples of concerns that may apply to you and your staff, along with suggestions to help you transform any challenges into opportunities to motivate your patients to get screened.

Visit Time Constraints

Addressing acute or chronic conditions may take precedence over preventive care during a visit.

- Train your staff to identify patients with gaps in preventive care to allow for focused and efficient use of your time. Office systems that “flag” patients needing CRC screenings are advantageous. Having printed materials available in the waiting room may also encourage conversations.

Familiarity with Recommended CRC Screening Options

Various factors can help determine which option may be best for each patient.

- Review last month's *Blue Review* article, [Colorectal Cancer Screening Options and Statistics – Get the Conversation Started](#), which discusses available CRC screening methods, such as direct visualization tests, stool-based tests and serology.

Office Process

- Identify a CRC screening champion in your office to train staff in identifying patients who are due for screenings.
- Standing orders will allow key staff to assess, implement and follow-up with patients regarding their selected CRC screening option.
- Stocking Fecal Immunochemical Testing (FIT) kits in the office, to dispense during visits, can be effective. **When patients agree to FIT testing, allow them to open the kit, handle the materials and complete the paperwork.** The mystery will be removed if they can visualize the test and ask questions. They will also be more likely to complete the CRC screening if they feel confident in the process.

Resources to Follow Up on Positive CRC Screenings

You may be concerned that patients with positive CRC screening results may not have access to gastroenterologists or cancer treatment specialists.

- Review the availability of local resources to help alleviate this concern or have patients call the number on their BCBSIL member ID card to discuss available resources.

BCBSIL, the American Cancer Society and the National Colorectal Cancer Roundtable have signed a pledge to have 80 percent of BCBSIL's members, ages 50 to 75, screened for colorectal cancer by 2018. Click the links below to read parts 1 and 2 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](#)

References:

¹[Final Recommendation Statement: Colorectal Cancer: Screening](#) (n.d.). USPSTF, Release Date June 2016.

²[Tests to Detect Colorectal Cancer and Polyps](#). Retrieved from NIH National Cancer Institute.

³American Cancer Society, [Find Local ACS](#)

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 own 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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Antidepressant Medication Management Initiative

Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to helping improve the rate at which our members remain on antidepressant medications after they have been newly diagnosed and treated for depression.

Did you know?

- According to the American Psychological Association (APA), major depressive disorder is a chronic condition that requires patients to participate actively in and adhere to treatment plans for long periods, despite the fact that side effects or requirements of treatment may be burdensome.¹
- APA guidelines recommend antidepressants as the initial treatment for mild to moderate depression.¹

The goal of BCBSIL's Antidepressant Medication Management Initiative is to increase antidepressant medication adherence. The program is targeting members age 18 and older with at least one of the following:

- At least one principal diagnosis of major depression in an outpatient, emergency department, intensive outpatient or partial hospitalization setting
- At least two visits in an outpatient, emergency department, intensive outpatient, or partial hospitalization setting on different dates of service with any diagnosis of major depression
- At least one inpatient (acute or non-acute) claim

BCBSIL measures adherence for both the acute and continuation phases as outlined in Healthcare Effectiveness Data and Information Set (HEDIS[®]) 2017 specifications:

- **Effective Acute Phase:** Percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks)
- **Effective Continuation Phase:** Percentage of newly diagnosed and treated members who remained on an antidepressant for at least 180 days (6 months)

Comprehensive analysis of claims data submitted to BCBSIL will be conducted quarterly and annually by BCBSIL.

We appreciate the care and services you provide to help improve the health and well-being of our members. BCBSIL's Antidepressant Medication Management Initiative is intended to supplement the service and treatment that members receive from their health care providers. Below are a few tips and strategies you may want to discuss with your patients on antidepressants.

- Assess and acknowledge potential barriers to treatment adherence, including lack of motivation, side effects of treatment, and logistical, economic or cultural barriers to treatment.
- Collaborate with the patient (and if possible the family) to minimize the impact of these potential barriers.
- Give patients realistic expectations during the different phases of treatment, including the time course of symptom response and the importance of adherence for successful treatment.
- Address misperceptions, fears and concerns about antidepressants with the patient.
- Educate about major depression, the risk of relapse and the early recognition of recurrent symptoms, and the efficacy of Cognitive Behavioral Therapy in combination with medication.
- Inform patients about the need to taper antidepressants rather than discontinuing them prematurely.
- Discuss common side effects of antidepressants with the patient. Encourage the patient to identify side effects they would consider reasonable and those they would consider unbearable.
- Explain when and how to take the medication, reminder systems, information about continuing the medication after symptoms of depression improve, strategies to incorporate medication into the daily routine, and ways to help minimize the cost of antidepressant regimens to improve patient adherence.

¹Practice Guideline for the Treatment of Patients with Major Depressive Disorder 3rd Edition (2010), American Psychiatric Association.
https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

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Predetermination of Benefits: Electronic Request Reminders and Paper Process Changes

As a reminder, predetermination of benefits requests may be submitted electronically to Blue Cross and Blue Shield of Illinois (BCBSIL) through iExchange[®], our online benefit preauthorization and predetermination of benefits tool. Providers also may upload attachments, check status and obtain online approval information via iExchange. This online tool is available to all physicians, professional providers and facilities contracted with BCBSIL. iExchange may be accessed directly or through the Availity[™] Web portal and is designed to help save you time by reducing the amount of calls and written inquiries submitted to BCBSIL.

If you need to submit a paper predetermination of benefits request to BCBSIL, it is important to send the pertinent medical documentation using our Predetermination Request Form. This form is available in the [Education and Reference Center/Forms](#) section of our website at bcbsil.com/provider. **Beginning Dec. 1, 2017, paper predetermination requests must be submitted using the Predetermination Request Form. Please note that, as of Jan. 1, 2018, paper requests that are received at BCBSIL without the Predetermination Request Form will be returned to the submitting provider, along with instructions to resend the request using the appropriate form.**

Checking eligibility and benefits is always an important first step, prior to submitting predetermination of benefits and other pre-service requests. Eligibility and benefits requests may be submitted electronically through Availity, or your preferred Web vendor. **Predetermination of benefits requests are not a substitute for the eligibility and benefits process.**

To learn more about [iExchange](#) and other electronic options, visit the [Provider Tools section](#) in our online Education and Reference Center. For personalized online training regarding electronic tools, contact our Provider Education Consultants at PECS@bcbsil.com.

Note: This information does not apply to HMO Illinois[®], Blue Advantage HMOSM, Blue Precision HMOSM, Blue Cross Community OptionsSM (MMAI, ICP, FHP and MLTSS), Blue Cross Medicare Advantage HMOSM or Blue Cross Medicare Advantage PPOSM members.

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

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National Drug Code (NDC) Billing Update for Medicare Advantage Claims

Beginning Dec. 15, 2017, Blue Cross and Blue Shield of Illinois (BCBSIL) will activate edits to validate NDCs that are submitted on electronic and paper, professional and institutional Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM claims. These validation edits are being implemented to align with the Centers for Medicare & Medicaid Services (CMS) encounter data submission requirements. Providers should confirm that the NDCs submitted on any claims are appropriate for services rendered and active for the date(s) of service billed.

The table below specifies which NDC-related elements must be entered if NDCs are included on **electronic** professional and institutional claims for Medicare Advantage members. Claims submitted containing NDCs may be rejected if any of these data elements are missing or incorrect. Rejected claims must be resubmitted with the correct data. If you use a billing service or clearinghouse, please share this information with your vendor.

Elements Required when NDC is Present on Electronic Claims	Professional Electronic Claim (837P) Loops and Segments	Institutional Electronic Claim (837I) Loops and Segments
Current Procedural Terminology (CPT [®]) or Healthcare Common Procedure Coding System (HCPCS) Code	Loop 2400, SV101-1 = HC Loop 2400, SV101-2 = [CPT/HCPCS code]	Loop 2400, SV202-1 = HC Loop 2400, SV202-2 = [CPT/HCPCS code]
If the CPT/HCPCS code in SV101-2 (<i>professional claim</i>)/SV202-2 (<i>institutional claim</i>) is an unlisted procedure code or Not Otherwise Classified (NOC) code, a description is required	Loop 2400, SV101-7	Loop 2400, SV202-7
Line Item Charge Amount	Loop 2400, SV102	Loop 2400, SV203
Unit of Measurement Code	Loop 2400, SV103 = UN	Loop 2400, SV204 = UN
Service Unit Count	Loop 2400, SV104	Loop 2400, SV205
NDC Qualifier	Loop 2410, LIN02 = N4	Loop 2410, LIN02 = N4
NDC (11-character alpha-numeric value containing no spaces, hyphens or special characters)	Loop 2410, LIN03 = NDC Number	Loop 2410, LIN03 = NDC Number
Quantity/Dosage* (Number of NDC units)	Loop 2410, CTP04	Loop 2410, CTP04
Unit of Measure (UOM = UN, ML, GR or F2)	Loop 2410, CTP05-1	Loop 2410, CTP05-1
Prescription Number (<i>when applicable</i>)	Loop 2410, REF01 = XZ REF02 = [prescription number]	Loop 2410, REF01 = XZ REF02 = [prescription number]

If NDCs are submitted on **paper** professional (CMS-1500) and institutional (UB-04) claims for Medicare Advantage members, the following NDC-related elements must be included:

Professional Paper Claim (CMS-1500) Fields and NDC-related Information	Institutional (UB-04) Form Locator Numbers and NDC-related Information
<ul style="list-style-type: none"> 24A (<i>shaded area</i>) – NDC Qualifier, NDC 11-digit number, Unit of Measure Qualifier and Unit Quantity 24D – CPT/HCPCS code 24G – HCPCS unit 	<ul style="list-style-type: none"> 42 – Revenue code 43 – Revenue Code Description, NDC Qualifier, NDC 11-digit number, Unit of Measure Qualifier and Unit Quantity 44 – HCPCS code 45 – Service/Assessment Date 46 – Service Units

*For assistance with calculating the number of NDC units, independently contracted BCBSIL providers may access the NDC Units Calculator Tool at no cost through our secure site – look for the **National Drug Codes (NDCs): Billing Resources** link on our Provider website Home page at bcbsil.com/provider. The NDC Units Calculator Tool is also available via the [Availity™ Web Portal](#).

For additional claim-related information, refer to the appropriate Provider Manual in the Standards and Requirements section on our website at bcbsil.com/provider. As always, your assigned BCBSIL Provider Network Consultant is available to provide assistance to you and your staff.

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Confirmation: Four New ClaimsXten™ Rules Implemented Sept. 18, 2017

Effective Sept. 18, 2017, Blue Cross and Blue Shield of Illinois (BCBSIL) implemented four new rules in the ClaimsXten software database. These new rules are defined as follows:

- **Add On Without Base Code** – This rule identifies claim lines containing a Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) add-on code billed without the presence of one or more related primary service/base procedure codes. According to the American Medical Association (AMA) in the CPT Codebook, Introduction – Instructions for Use of the CPT Codebook, Add-on Codes, “add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code.”
- **Global Component Billing** – This rule identifies procedure codes that have components (professional and technical) to help prevent overpayment for either the professional or technical components or the global procedure. The rule also identifies when duplicate submissions occur for the total global procedure or its components across different providers.
- **Duplicate Component Billing** – This rule identifies when a professional or technical component of a procedure is submitted and the same global procedure was previously submitted by the same provider ID for the same member for the same date of service.
- **New Patient Code for Established Patient** – This rule identifies claim lines containing new patient procedure codes that are submitted for established patients. According to the AMA CPT Codebook guidelines, “A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the last three years.” Similar guidance is provided by the Centers for Medicare & Medicaid Services (CMS): According to Pub 100-04, Medicare Claims Processing Manual Ch. 12, Physicians/Non-Physicians Practitioners, Section 30.6.7, Subsection A, “Medicare interprets the phrase ‘new patient’ to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.”

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 that mirrors the logic behind BCBSIL’s code-auditing software. Refer to the Clear Claim Connection page in the Education and Reference Center/Provider Tools section for answers to frequently asked questions about ClaimsXten and details on how to gain access to C3. Additional information also may be included in upcoming issues of the Blue Review.

This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims. Health care providers are instructed to submit claims using the most appropriate code based on the medical record documentation and coding guidelines and reference materials

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Looking at Variability in Pricing Solutions Through Shared

How often someone uses health care services, where they go for care and how much they pay for care are a few of the foundational elements in the ongoing national struggle to control rising health care costs.¹

An independent study published by [Health Care Cost Institute](#) shows that employers and insurers that provide private health care coverage can pay for services that vary widely in price, depending on the state where people live. Further, they found that prices can even vary across a broad range within the same cities and metropolitan areas, based on site of service and contracting rates. Those price differences exist for even the most routine diagnostic procedures.²

Wide differences in price for the most common medical services comprises one potential cost driver that Blue Cross and Blue Shield of Illinois (BCBSIL) works to impact. We believe that variability of pricing is a leading cause of unnecessary health care expenditures for our members. For example, based on 2016 BCBSIL claims data, an MRI of the brain can cost anywhere from \$682 to \$3,849 in Chicago, IL.*

Broad ranges in pricing across the state are found in many common as well as high-cost procedures. Moreover, there is no consistent correlation between cost and quality (i.e., higher cost does not necessarily equate to higher quality).³

While many health care consumers may have yet to establish a habit of researching how much a procedure will cost them in advance,⁴ BCBSIL is working to change that behavior. Our Benefit Value Advisor program helps members get cost estimates, schedules appointments, assists with benefit preauthorization and provides educational resources to help members learn more about certain procedures such as CAT scans, MRIs, endoscopy and colonoscopy procedures, as well as surgeries such as joint replacement and bariatric surgery.

Amy Barbour, a customer service specialist in the Benefit Value Advisor program, says the typical member's mindset about health care is at odds with how Americans generally approach other choices. "While people would never dream of not knowing the price of a part for a car repair," she says, "in the medical world, not knowing the cost doesn't seem to throw them for a loop."

But Barbour believes things are slowly changing. "Ten years from now," she says, "I think it will be unheard of to not know health care costs in advance."

At BCBSIL, we believe that cost and quality transparency and actionable data will help enable payers and providers to better collaborate on ways to help make health care more affordable. BCBSIL is rolling out new data solutions this year and next to help inform providers' clinical decisions and perhaps give them deeper insights into their care costs and quality.

Providers also will have increased electronic access to members' health summaries before or at the time of service. With access to these health summaries, providers may see unmet health care needs to address, or they may be able to avoid the cost and inconvenience of a member receiving redundant or unnecessary treatment.

Additionally, new performance and quality reporting will likely be more readily available to help providers pinpoint and prioritize opportunities for cost and quality improvements. These tools help make transparent information that can help identify factors that explain the cost impact caused by variability in pricing.

These are just a few examples of how BCBSIL is helping to make the health care system work better, together with providers, for the benefit of health care consumers.

**Based on claims data from the entire 2016 calendar year, excluding government programs claims.*

¹<https://www.newyorker.com/news/news-desk/health-cares-cost-conundrum-squared>

²<http://www.healthcostinstitute.org/wp-content/uploads/2016/12/2015-HCCUR-11.22.16.pdf>

³<http://www.nytimes.com/2007/06/14/health/14insure.html?mcubz=3>

⁴<https://www.beckershospitalreview.com/finance/70-of-consumers-don-t-price-shop-for-healthcare-services-5-things-to-know.html>

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Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois (BCBSIL) offers 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		
<i>To register now for a webinar on the list below, click on your preferred session date.</i>		
Descriptions:	Dates:	Session Times:
BCBSIL Back to Basics: 'Availity™ 101' <i>Join us for a review of electronic transactions, provider tools and helpful online resources.</i>	Oct. 10, 2017 Oct. 17, 2017 (Special training for Availity Professional Claim Entry) Oct. 24, 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.	Oct. 19, 2017	10 to 11 a.m.
iExchange®: New Enrollee Training <i>Learn how to gain access to and begin using our online benefit preauthorization/predetermination of benefits tool.</i>	Oct. 12, 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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Fairness in Contracting

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

Effective Jan. 1, 2018, procedure codes in range 0359T-0374T will be updated.

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

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ClaimsXtenTM 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. 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 ConnectionTM (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.

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