BlueCross BlueShield of Illinois

BLUE REVIEW℠

For Providers

July 2024

Wellness and Member Education

Breast Cancer Screening for Members Ages 40 to 74

In line with new U.S. Preventive Services Task Force recommendations, breast cancer screening for our members should begin at age 40 rather than 50. We're updating our Preventive Care Guidelines to reflect this change.

Learn More

In-Home Test Kits for Colorectal Cancer Screening

We're providing in-home test kits this summer to certain members who, based on our data, need a colorectal cancer screening. We're working with vendors to send Fecal Immunochemical Test kits to selected members of Blue Choice Preferred PPO at no additional charge.

Learn More

Provider Education

Provider Learning Opportunities

We offer 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.

Learn More

Electronic Options

Coming Soon – New Learning & Training Center in Availity® Essentials

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Learn More

Network Innovation/Product Updates

Update Your Records: New Coupe Health Members

Starting in **October 2024**, providers in our commercial PPO network and Blue High Performance Network® may see members of our new Coupe Health benefit plan. This plan streamlines the payment process for your office and our Coupe Health members.

Learn More

Pharmacy Program

GLP-1 New to Therapy: Optional Benefit Program for Select Commercial Members

As of **April 1, 2024**, an optional GLP-1 New to Therapy benefit program became available for **some employer groups** with Prime Therapeutics. Read more on News and Updates.

Claims and Coding

Prior Authorization Requests May Be Needed Due to Pharmacy Claims Processing Error

Due to a system error, some members who have Prime Therapeutics as their pharmacy benefit manager received paid claims without following the necessary prior authorization steps. The error has been fixed.

Learn More

See Our Revised Clinical Payment and Coding Policy for Anesthesia Services, Effective Aug. 14, 2024

Effective **Aug. 14, 2024** (previously June 1, 2024), we're updating our policy for **Anesthesia Information (CPCP010)**.

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Clinical Updates, Reminders and Resources

Medical Policy Updates

Approved, new or revised medical policies and their effective dates are usually posted on

our website.

Learn More

Notification and Disclosure

ClaimsXten™ Quarterly Update Effective Aug. 19, 2024

We're implementing our third quarter code updates for the ClaimsXten auditing tool on or after **Aug. 19, 2024**.

Learn More

Provider Rights and Responsibilities

As a participating provider, you have certain rights and responsibilities that may affect your practice.

Learn More

Member Rights and Responsibilities

As a participating provider, it's important that you're aware of our members' rights and responsibilities.

Learn More

Reminders

Stay informed!

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

Verify and Update Your Information

Verify your directory information every 90 days. Use the **Availity® Essentials**

Provider Data Management feature or our Demographic Change Form. Learn more.

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.

Print

Print this month's newsletter in its entirety.

bcbsil.com/provider

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300 E. Randolph Street, Chicago, IL 60601

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for Providers

July 2024

Breast Cancer Screening for Members Ages 40 to 74

In line with new U.S. Preventive Services Task Force recommendations, breast cancer screening for our members should begin at age 40 rather than 50. We're updating our Preventive Care Guidelines to reflect this change. Screening should continue every other year until age 74.

Routine screening for breast cancer is the best way to detect it early, according to the Centers for Disease Control and Prevention. Breast cancer is easier to treat when it's caught earlier.

Tips To Close Gaps in Our Members' Care

Talk with our members about breast cancer risk factors and the importance of regular screening for women. We've created resources that may help.

- Breast cancer disproportionately affects Black women, according to the CDC. Talk with our members about the unique risks and barriers they may face, which can result in poorer outcomes than other women.
- Document screenings in members' electronic medical records. Indicate the specific date and result. This helps us track member progress on the quality measure Breast Cancer Screening from the National Committee for Quality Assurance.
- Document medical and surgical history in the medical record, including dates. Use correct diagnosis and procedure codes. Submit claims and encounter data in a timely manner.
- Offer telehealth services when available and appropriate for preventive care appointments.
- Follow up with members if they miss their appointment and help them reschedule.
- For members who need language assistance, let them know we offer help and information in their

language at no cost. To speak to an interpreter, members may call the customer service number on their member ID card.

- For Medicaid members who have transportation barriers, let them know we provide Medicaid members with free non-emergency transportation services.
- See our Health Equity and Social Determinants of Health page for more information on health equity.
- For men who are at high risk, the American Cancer Society recommends discussing with them how to manage risks.

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In-Home Test Kits for Colorectal Cancer Screening

We're providing in-home test kits this summer to certain members who, based on our data, need a colorectal cancer screening. We're working with vendors to send Fecal Immunochemical Test kits to selected Blue Choice Preferred PPO℠ members at no additional charge.

As a trusted provider, you may want to **encourage your patients to take advantage of this opportunity to learn more about their health** with a FIT kit. In 2023 we provided 18,032 FIT kits to our members.

- 1,965 members returned their kits and closed this gap in their care.
- Test results were sent to the members and to their health care providers. Of those kits, 85 were abnormal or positive, meaning the sample contained blood when collected.

Why Use FIT

The U.S. Preventive Services Taskforce recognizes annual FIT testing for **colorectal cancer screening starting at age 45.**

- FIT testing is appropriate screening for people with an average risk for colorectal cancer. Average risk means no family history of colorectal cancer, no personal history of inflammatory bowel disease, no previous polyps and no previous colorectal cancer.
- When compared to stool DNA tests, FIT kits have fewer false positives, which reduces unnecessary colonoscopies, according to the National Cancer Institute. Unlike stool DNA tests like Cologuard®, FIT kits require only a swab rather than a stool sample.

How In-Home Testing Works

The in-home testing process is easy for members:

- Vendors send the kits to a sample of eligible members who have a gap in care for colorectal cancer screening. Completing the kit is voluntary.
- The kits don't require fasting, dietary restrictions or preparation. Members may take medications according to their normal schedule.
- Members complete the test kit at home, provide the name of their health care provider, if available, and **mail the test for processing to the vendor by Dec. 31, 2024.** An addressed, postage-paid envelope is included with the kit.
- The vendor sends results to the member and to their provider in three to four weeks.

How You Can Help

- Consider discussing the importance of colorectal cancer screening and healthy lifestyle choices with your patients. If one of your patients receives a kit and calls your office with questions, discuss their screening options.
- Document any test results in your patient's medical record and discuss the results with your patient.

Cologuard is an independent company that has contracted with Blue Cross and Blue Shield of Illinois to provide laboratory services for members with coverage through BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Material presented 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.

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Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois 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.

Webinars Hosted by BCBSIL

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

Descriptions:	Dates:	Session Times:
Availity® Essentials, BlueApprovR℠ Prior Authorization and Recommended Clinical Review Tools *Learn how to electronically submit inpatient and outpatient prior authorization handled by BCBSIL using the Availity Authorizations tool. You'll also learn how to access and submit inpatient and/or outpatient medical/surgical, behavioral health and specialty pharmacy drug prior authorization requests, as well as recommended clinical review, through BlueApprovR.*	July 3, 2024 July 10, 2024 July 17, 2024 July 24, 2024 July 31, 2024	11 a.m. to 12:30 p.m.

Availity Essentials Claim Status, Clinical Appeals, Reconsiderations and Message This Payer *Learn how to verify enhanced claim status, submit clinical claim appeals reconsiderations requests and Message This Payer online using the Availity Claim Status tool.*	July 11, 2024 July 18, 2024 July 25, 2024	11 a.m. to 12:30 p.m.
Availity Essentials Instructor-Led Training *Register for this session to better understand how electronic transactions can work for your organization. You'll learn the importance of Manage My Organization, how to use the Patient ID Finder, instruction on how to verify patients' Eligibility and Benefits and more online options.*	July 16, 2024	11 a.m. to noon
Availity Remittance Viewer and Provider Claim Summary *These online tools give providers and billing services a convenient way to view claim detail information from the 835 Electronic Remittance Advice and the Provider Claim Summary. Attend a webinar to learn how to gain or grant access, conduct a search, view general and payer-specific information, and save or print results.*	July 18, 2024	1 to 2 p.m.
Monthly Provider Hot Topics Webinar *Stay up to date on the latest news from BCBSIL! Engage with our Provider Network Consultants to learn about upcoming initiatives, program changes and updates, as well as general network announcements.*	July 11, 2024	10 to 11:30 a.m.
Orientation Webinars for New BCCHP℠ and/or MMAI Providers *Learn how we can best work together to support the health of our Blue Cross Community Health Plans℠ and Blue Cross℠*	July 25, 2024	1 to 2 p.m.

Community MMAI (Medicare-Medicaid Plan) members. Ask questions and engage with our PNCs on topics such as network participation and benefits, claims, post-processing claim inquiries, supplemental resources, credentialing and contracting.

Orientation Webinars for New Commercial Providers July 17, 2024 1 to 2:30 p.m.

Learn how we can best work together to support the health of our commercial members. Ask questions and engage with our PNCs on topics such as care coordination, third party vendors, claims, prior authorization and required provider training.

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Coming Soon – New Learning & Training Center in Availity® Essentials

Starting in **August 2024**, some of the educational resources on our website are **moving to a new Learning & Training Center** within Availity Essentials. All **instructional user guides for Availity tools and instructor-led Availity trainings** will be available in this new location.

To access the Learning & Training Center: Log in to Availity and go to the Blue Cross and Blue Shield of Illinois-branded *Payer Spaces – Applications*. You must be a registered Availity user to view the information in the training center. If you haven't registered yet, go to Availity and get started today at no cost. For registration help, call Availity Client Services at 800-282-4548.

Our Provider Tools and Webinars and Workshops pages include detailed overviews of online options and training topics. You'll be redirected to Availity, when applicable, to view user guides, register for training and attend upcoming training sessions.

exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

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Access MCG Care Guidelines Clinical Criteria via Availity® Essentials

Blue Cross and Blue Shield of Illinois uses some, but not all, clinical criteria from MCG Care Guidelines when reviewing requests to determine medical necessity. Our clinical rationale outlined in provider correspondence and Clinical Payment and Coding Policies will guide you to the specific MCG Care Guidelines, when applicable.

As a helpful resource, you can access MCG Care Guidelines through Availity Essentials.

How to access MCG Care Guidelines through Availity:

- Log on to Availity Essentials
- Select *Payer Spaces* in the upper navigation bar
- Select the BCBSIL tile to navigate to our payer space
- Select the Resources tab
- Select *MCG Guidelines* and then follow the prompts

Once in the guidelines, you may open any category link and search for services by name and topic using the "control F" keyboard function.

MCG Care Guidelines are administered and provided by MCG Health, an independent company that has contracted with BCBSIL to provide care and disease management for members with coverage through BCBSIL. 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 third party vendors and the products and services they offer.

This content is for informational and educational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider, nor is the information presented intended to replace or supersede any requirements set forth in your contract with BCBSIL. Physicians and other health care providers should use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment.

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Update Your Records: New Coupe Health Members

Starting in **October 2024**, providers in our commercial PPO network and Blue High Performance Network® may see members of our new Coupe Health benefit plan. This plan streamlines the payment process for your office and our Coupe Health members.

Coupe Health is a copay-only plan, and members pay no deductibles or coinsurance. **You won't collect any copay from Coupe Health plan members.** Instead, if you are a professional or ancillary provider, Blue Cross and Blue Shield of Illinois will reimburse you directly for the full allowed amount, including the member share. If you are a facility or ancillary facility provider, BCBSIL will reimburse you consistent with your contractual arrangement and if applicable, the Uniform Payment Program, without change.

Check ID Cards to Identify Coupe Health Members

As with all our members, it's important to ask to see the member ID card before all appointments, and to check eligibility and benefits. Update your records if member ID numbers have changed. Use Availity® Essentials or your preferred vendor to check membership, coverage and prior authorization requirements, and to confirm that you're in-network for the member's policy. Emergency services are covered at the in-network benefit level.

If you have questions, call the customer service number on 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. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Coupe Health is an independent company that has contracted with Blue Cross and Blue Shield of State to provide an alternative health plan for members with coverage through BCBSIL.

Checking eligibility and benefits and/or obtaining prior authorization 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 prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and their health care provider.

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Prior Authorization Requests May Be Needed Due to Pharmacy Claims Processing Error

Due to a system error, some members who have Prime Therapeutics as their pharmacy benefit manager received paid claims without following the necessary prior authorization steps. The error has been fixed. Affected members may now need prior authorization approval for continued coverage of their drug.

Impacted PA Programs

- Acute Migraine
- GLP-1 Agonists
- Topiramate ER
- Winlevi

Letters are being sent to members whose benefits require prior authorization.

Next Steps

Please submit the PA request for your patient. Visit the Prior Authorization/Step Therapy Programs page for forms and more information. The PA program encourages safe, cost-effective medication use by allowing coverage when certain conditions are met. A clinical team of physicians and pharmacists develops and approves the clinical programs and criteria for medications that are appropriate for PA by reviewing U.S. Food and Drug Administration-approved labeling, scientific literature and nationally recognized guidelines.

Important Reminders

If your patients have any questions about their pharmacy benefits, please have them call the number on

their member ID card. Members may also visit our member site and log in to Blue Access for Members℠ or MyPrime.com for a variety of online resources.

Treatment decisions are always between you and your patients. Coverage is subject to the terms and limits of your patients' benefit plans.

Prime Therapeutics LLC is a pharmacy benefit management company. Blue Cross and Blue Shield of Illinois contracts with Prime to provide pharmacy benefit management and related other services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime. MyPrime.com is an online resource offered by Prime Therapeutics.

The information mentioned here is for informational purposes only 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.

Checking eligibility and benefits and/or obtaining prior authorization 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 prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider. If you have any questions, call the number on the member's ID card.

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See Our Revised Clinical Payment and Coding Policy for Anesthesia Services, Effective Aug. 14, 2024

What's changing?

Effective **Aug. 14, 2024** (previously June 1, 2024), we're updating our Clinical Payment and Coding Policy for **Anesthesia Information (CPCP010).**

The Details

Under this revised policy, we'll no longer offer additional reimbursement for services based on the use of physical status (P code) modifiers when appended to anesthesia services.

What You Need To Do

Refer to our Clinical Payment and Coding Policies page to view the revised policy.

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Coding Update: Reimbursement Change for Consultation Services, Effective Sept. 1, 2024

Effective **Sept. 1, 2024**, we're updating our Clinical Payment and Coding Policy for **Evaluation and Management Coding (CPCP024)**.

Under this revised policy, we'll no longer reimburse for outpatient or inpatient consultation services billed with Current Procedural Terminology (CPT®) codes 99242-99245 and 99252-99255. Consultation services should be reported with an appropriate office outpatient or inpatient evaluation and management code representing the location where the visit occurred and the level of complexity of the visit performed.

What You Need To Do

Refer to our Clinical Payment and Coding Policies page to review in detail the revised policy – **Evaluation and Management Coding CPCP024**.

other health care provider, nor is the information presented intended to replace or supersede any requirements set forth in your contract with Blue Cross and Blue Shield of Illinois. Physicians and other health care providers should use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment.

This material is for educational purposes only and is not intended to be a definitive source for coding claims. Health care providers are instructed to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials.

Any samples in this article are for illustrative and/or educational purposes only and should not be relied on in determining how a specific provider will be reimbursed. In the event of a conflict between the information in this article and your contract, your contract will control.

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Medical Policy Updates

Approved, new or revised medical policies and their effective dates are usually posted on our website. Medical policies, both new and revised, are used as guidelines for benefit determinations in health care benefit programs for most members, unless otherwise indicated. These policies may affect 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 Provider Manual for Blue Cross and Blue Shield of Illinois.

You may view active, new, and revised policies, along with policies pending implementation, by visiting our 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 also may 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. Click on the title of the draft policy you wish to review, and then select "Comments" to submit your feedback to us.

Visit the **Standards and Requirements** section of our website for access to the most complete and up-to-date Medical Policy information. You'll find a Recommended Clinical Review (Predetermination) Code List in the Related Resources on our Recommended Clinical Review (Predetermination) page. This list is updated on a monthly basis. In addition to medical policies, other policies and information regarding

payment can be found on the Clinical Payment and Coding Policies page.

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ClaimsXten™ Quarterly Update Effective Aug. 19, 2024

We're implementing our third quarter code updates for the ClaimsXten auditing tool on or after **Aug. 19, 2024**.

These quarterly code updates aren't considered changes to the software version. Code updates may include additions, deletions and revisions to:

- Current Procedural Terminology (CPT®) codes
- Healthcare Common Procedure Coding System codes

When applicable, we may post advance notice of significant changes, like implementation of new rules, in News and Updates on our Provider website. Information also may be included in *Blue Review*.

Use **Clear Claim Connection**™ to determine how certain coding combinations may be adjudicated when we process your claim. C3 is a free, online reference tool that simulates how our code-auditing software works.

Please note that C3 doesn't contain all our claim edits and processes. Its results don't guarantee the final claim decision.

For more information on C3 and ClaimsXten, refer to the Clear Claim Connection page. It includes a user guide, rule descriptions and other details.

This information doesn't apply to Medicare Advantage and Illinois Medicaid member claims.

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Provider Rights and Responsibilities

As a participating provider, you have certain rights and responsibilities that may affect your practice. Some of these are noted below. We publish this information for providers annually.

Your Credentialing Rights

- If you're applying or reapplying to participate in our networks, you have the right to:
- Review information submitted to support your credentialing application
- Update incorrect or conflicting information
- Receive the status of your credentialing or recredentialing application upon request

To learn more about these rights: Visit the Credentialing page on our website.

Case Management Programs

You can help our members maintain or improve their health by encouraging them to participate in relevant case management programs. These may include:

- Condition management programs to support members with specific conditions like asthma or diabetes
- Complex case management services for members facing multiple or complicated medical or behavioral health conditions
- Programs to help members transition home after a hospital stay or navigate the health care system
- Wellness and prevention programs for members of all ages

Members can access applicable services for complex and condition case management by:

- Asking to enroll, or having their caregiver ask to enroll
- Referral from a primary care physician, practitioner, hospital or other discharge planner
- Referral through utilization management programs

To refer members to any case management programs: Call the number on the member's ID card. Our clinicians will collaborate with you to provide our members with available resources and additional support.

Utilization Management Decisions

It's our policy that licensed clinical personnel make all utilization management decisions according to the benefit coverage of a member's health plan, evidence-based medical policies and medical necessity criteria. Decisions are based on appropriateness of care and service, and existence of coverage.

We prohibit decisions based on financial incentives. We don't reward practitioners or clinicians for issuing denials of coverage.

To obtain the criteria used for utilization management decisions: Call the number on the member's ID card. You can also refer to our medical policies, which are available for review online. See our Utilization Management section for prior authorization support materials and links to Blue Cross and Blue Shield of Illinois and vendor guidelines that may apply for some commercial and government programs members. Although medical policies can be used as a guide, providers serving our HMO members should refer to the HMO Scope of Benefits in the Provider Manual.

Federal Employee Program® members: In addition to the details provided above, visit fepblue.org for more information about our FEP® members. Call 800-227-6591 for questions regarding FEP prior authorizations. For FEP expedited appeals only, the fax number is 972-766-9776.

Blue Cross Community Health Plans℠ and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ members: You can search for prior authorization requirements for MMAI and BCCHP℠ members using our digital lookup tool.

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Member Rights and Responsibilities

As a participating provider, it's important that you're aware of our members' rights and responsibilities. A summary is provided below. Additional information can be found in the members' benefit booklet and on our Member website.

Member rights include the right to:

- Receive information about Blue Cross and Blue Shield of Illinois, our services, participating providers and facilities, and member rights and responsibilities
- Be treated with respect and dignity with recognition of their right to privacy
- Participate with providers in making decisions about their health care
- Have a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Voice complaints or appeals about BCBSIL or the services we provide
- Make recommendations regarding our member rights and responsibilities policy

Member responsibilities include a responsibility to:

- Provide, to the extent possible, information that BCBSIL and the provider and facility need to provide care
- Follow the plans and instructions for care that the member has agreed to with their provider
- Understand their health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible

Federal Employee Program® members: In addition to the details provided above, visit fepblue.org for

more information about our FEP® members.