BLUE REVIEW℠

For Providers

May 2024

Clinical Updates, Reminders and Resources

Use Our New Form for Anti-VEGF Intravitreal Injection Therapy Verification

Blue Cross and Blue Shield of Illinois reviews voluntary requests for recommended clinical review of anti-VEGF (vascular endothelial growth factor) intravitreal injections for certain eye conditions when services are proposed for our **commercial non-HMO** and **Federal Employee Program®** members. It's important to include all necessary information to support your RCR request.

Learn More

CMO Perspective Offers Ideas for Patient Discussions on Kidney Health

We invite you to read the latest *CMO Perspective* post, Chronic Kidney Disease: Help Your Patients Understand Risk Factors and Preventive Measures. In this entry, Dr. Derek Robinson, M.D. shares highlights from a March TV segment on CKD dangers and what patients can do to protect their kidneys.

Supporting Maternal Quality Care

Prenatal and postpartum care contributes to the long-term well-being of new mothers and their infants, according to the American College of Obstetricians and Gynecologists.
We encourage you to talk with our members about the importance of attending all care visits during and after pregnancy.

Learn More

Focus on Behavioral Health

Requests for Behavioral Health Documentation for Medicaid Members

Behavioral health providers may receive requests from BCBSIL for our Blue Cross Community Health Plans℠ and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ members' medical records and supporting documentation. We review documentation for behavioral health records to comply with regulatory standards and to monitor our members' care.

Learn More

Filing Claims for Applied Behavior Analysis Services – Use the Correct Place of Service Code

It's important that you use the correct Place of Service code when filing professional claims for Applied Behavior Analysis and other services that may be eligible for delivery in multiple locations. POS codes designate where the patient was located when they received services from you.

Learn More

Claims and Coding

Prior Authorization Code Updates for Some Commercial and Government Programs Members, Effective July 1, 2024

BCBSIL is changing prior authorization requirements that may apply to some commercial non-HMO and government programs (Blue Cross Medicare Advantage (PPO)℠, BCCHP℠ and MMAI) members. Refer to News and Updates for a summary of commercial and government programs changes and code updates.

Late and Added Charges Must Be Submitted as a Corrected Claim

Effective **July 1, 2024**, all late charges must be submitted to BCBSIL as a corrected claim after

the original claim has been processed.

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Avoid National Drug Code Billing Errors

Submitting claims with the appropriate NDC information is important for claims processing and may help you spend less time troubleshooting a rejected claim line.

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Coding Webinars: Arrhythmias and Rheumatoid Arthritis

Join our Coding Compliance team for two webinars on coding and guidelines.
These trainings are free to providers and coding professionals.

Learn More

Pharmacy Program

Pharmacy Program Updates: Prior Authorization Changes Effective June 1 and June 15, 2024

The pharmacy 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. FDA-approved labeling, scientific literature and nationally recognized guidelines. Read more on News and Updates for June 1 and June 15.

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.

Learn More

Community Involvement

BCCHP and MMAI Providers: Join Our Community Stakeholder Committee

We're hosting quarterly Community Stakeholder Committee meetings to find ways to better serve our BCCHP and MMAI members. We'd like to invite you to join us for our next committee meeting on **May 16, 2024**. Read more on News and Updates.

Notification and Disclosure

Has your information changed? Let us know!

When seeking health care services, our members often rely upon the information in our online Provider Finder®. Prospective patients can use this online tool to confirm if your practice is a contracted in-network provider for their health care benefit plan.

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. **Facilities** may only use the Demographic Change Form.

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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BLUE REVIEW℠
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May 2024

Use Our New Form for Anti-VEGF Intravitreal Injection Therapy Verification

Blue Cross and Blue Shield of Illinois reviews voluntary requests for pre-service recommended clinical review (previously, predetermination) of anti-VEGF (vascular endothelial growth factor) intravitreal injections for certain conditions of the eye when services are proposed for our **commercial non-HMO** and **Federal Employee Program®** members. BCBSIL offers the RCR process as a voluntary pre-service option that can help you avoid unexpected claim denials.

For the services referenced above, RCR determinations are made based on medical necessity criteria outlined in the following medical policies:*

- **BCBSIL Medical Policies** – OTH903.026, OTH903.027, OTH903.041, OTH903.043, OTH903.044
- **FEP® Medical Policies** – 5.90.026, 5.90.029, 5.90.05, 5.90.052

To help ensure we receive all necessary information to support your voluntary RCR request, a new **Anti-VEGF Intravitreal Injection Therapy Verification Form** is available on our Provider website. **The purpose of this form is to help you prepare, prior to submitting a voluntary RCR request to BCBSIL.**

Our therapy verification form includes detailed instructions and a Provider Questionnaire. Think of it as a worksheet to help clarify your request and expedite the RCR process.

Please refer to the applicable medical policy for specific coverage criteria.

Reminders and Related Resources

Submitting a voluntary RCR request doesn't replace checking eligibility and benefits.

- **Always check eligibility and benefits first** through Availity® Essentials or your preferred web vendor.
- This step confirms membership and other important information, such as prior authorization requirements and utilization management vendors, if applicable.
- Even if prior authorization isn't required for a commercial non-HMO member, you may still want to submit an RCR request to help avoid post-service medical necessity review.

If there's an adverse RCR determination (pre-service), you'll receive a letter from BCBSIL with more information. You'll have the option to request a peer-to-peer discussion or file an appeal. The member also will receive a letter. If a claim is denied (post-service), the notification process and options are the same.

- Follow the instructions on the adverse determination or claim denial letter you receive from BCBSIL.
- To speak with a physician, call the number on the letter. You'll need the case reference number found in the letter.
- You also have the right to appeal the adverse RCR determination or claim denial. Instructions on how to file an appeal are provided in the letter.

For more information, refer to the Recommended Clinical Review page in our Utilization Management section.

The RCR process isn't available for government programs (Illinois Medicaid and Medicare Advantage) or any of our commercial HMO members.

**The above list of medical policies may change. Check the website for any other policies that may apply.*

Checking eligibility and/or benefit information, obtaining prior authorization or the fact that a recommended clinical review (predetermination) decision has been issued 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, including, but not limited to, exclusions and limitations applicable on the date services were rendered. Regardless of any prior authorization or recommended clinical review (predetermination), the final decision regarding any treatment or service is between the patient and the health care provider.

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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Supporting Maternal Quality Care

Prenatal and postpartum care contributes to the long-term well-being of new mothers and their infants, according to the American College of Obstetricians and Gynecologists. We encourage you to talk with our members about the importance of **attending all care visits** during and after pregnancy.

We track the following Healthcare Effectiveness Data and Information Set measures related to our members' maternal health:

Prenatal and Postpartum Care measures the percentage of deliveries in which members:

- Had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with Blue Cross and Blue Shield of Illinois
- Had a postpartum visit on or between seven and 84 days after delivery

Prenatal and Postpartum Depression Screening and Follow-Up measures the percentage of deliveries in which members:

- Were screened for clinical depression during pregnancy and the postpartum period using a standardized instrument, and
- Received follow-up care within 30 days if the screening was positive

Tips To Close Gaps in Prenatal and Postpartum Care

- Check with our members to ensure that initial prenatal visits are scheduled in the **first 12 weeks of pregnancy** with an OB-GYN, primary care physician or other prenatal practitioner.
- A postpartum visit must take place on or between **seven and 84 days after delivery**. Be aware that

post-operative visits within six days after discharge don't count as a postpartum visit. Members who have cesarean sections should be reminded to schedule their postpartum care visit during the C-section post-op visit.

- Data for this measure is collected from claims and chart review for services performed by an OB-GYN, midwife, family practitioner or other PCP. Services provided during telehealth visits, e-visits and virtual check-ups are eligible for reporting to meet the measure.

Tips To Close Gaps in Prenatal and Postpartum Depression Screening and Follow-Up

- Ask members during their pregnancy and postpartum to complete an age-appropriate depression screener, such as the Patient Health Questionnaire-9 or -2, or the Edinburgh Postnatal Depression Scale.
- If the depression screening is positive, follow up within 30 days with one or more of the following, as appropriate:
    - Additional evaluation for depression
    - Suicide risk assessment
    - Referral to a practitioner qualified to diagnose and treat depression
    - Pharmacological interventions
    - Other interventions or follow-up for the diagnosis or treatment of depression
- Coordinate care between behavioral health and other health care providers. Consider case management.

Resources

- Preventive Care Guidelines for providers
- Perinatal Wellness Guidelines for members

Earn continuing education credit – watch a recording of our webinar **Maternal Mental Health: Pregnancy and Postpartum**. Sign in here (registration required) to access the recording.

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BLUE REVIEW℠
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Requests for Behavioral Health Documentation for Medicaid Members

Behavioral health providers may receive requests from Blue Cross and Blue Shield of Illinois for our Blue Cross Community Health Plans℠ and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ members' medical records and supporting documentation. We review documentation for behavioral health records to comply with regulatory standards and to monitor our members' care. This includes documentation for:

- Confidentiality and security standards
- Consent for treatment and medications
- Demographic information
- Allergies
- Medical and/or behavioral health history
- Treatment plans
- Discharge plans

Providers are required to comply with our requests for records, as indicated in the BCBSIL Provider Manuals and according to your contract terms.

Providing Documentation

We may contact you by fax, email or phone to provide the records needed and details on how you can return them to us.

If you receive a request:

- Please provide complete and accurate records and supporting documentation in the requested timeframe.

- Ensure a credentialed provider signs and dates all documents.
- Review with staff members documentation requirements and standards.

Patient authorization isn't required to release these records, as their collection is considered a component of health care operations under the Health Information Portability and Accountability Act. BCBSIL doesn't reimburse providers for the cost of medical records.

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Filing Claims for Applied Behavior Analysis Services – Use the Correct Place of Service Code

It's important that you use the correct Place of Service code when filing professional claims for Applied Behavior Analysis and other services that may be eligible for delivery in multiple locations. POS codes designate where the patient was located when they received services from you.

Remember: If you use the wrong POS code your claim may be denied, or payment may be delayed.

Familiarize yourself with using POS codes with guidance from the Centers for Medicare & Medicaid Services.

When filing claims, follow these examples of POS code guidance from CMS:

- **POS 3** is for use on claims for services provided in a school
- **POS 11** is for use on claims for services provided in the office
- **POS 12** is for use on claims for services provided in the patient's home
- **POS 49** is for use on claims for services provided in an independent clinic
- **POS 53** is for use on claims for services provided in a community mental health center
- **POS 99** is for use on claims for services provided in all other settings not listed above, including community and daycare locations

For More Information

Also refer to our Clinical Payment and Coding Policies page to review **CPCP011 Applied Behavior Analysis** and **CPCP022 Telemedicine and Telehealth**.

Note: Claims are subject to the terms of a member's coverage and medical necessity review.

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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Late and Added Charges Must Be Submitted as a Corrected Claim

Effective July 1, 2024, all late charges must be submitted to Blue Cross and Blue Shield of Illinois as a corrected claim after the original claim has been processed.

What are late charges?
Late charges, or additional charges, represent changes for items and services that were submitted after the bill was created and not included in the original bill.

How To Submit a Corrected Claim
When submitting a corrected claim for charges to a previously processed inpatient or outpatient claim for commercial members, remember these important tips:

- **The corrected claim should include all line items previously processed correctly.** Reimbursement for line items no longer included on the corrected claim may be subject to recoupment by BCBSIL.
- **The entire claim should be resubmitted with frequency code 7 (replacement of prior claim).** Do not submit a corrected claim using frequency code 5 (late charges). If the corrected claim is submitted using frequency code 5 this could result in a denial of the claim.

For more information refer to our Claim Submission page. Also see our Clinical Payment and Coding Policies page to view our revised **CPCP025 Corrected Claim Submissions** policy.

The information provided does not constitute coding or legal advice. Physicians and other health care providers should submit claims using the most appropriate code(s) based upon the medical record documentation, coding guidelines and reference materials.

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Avoid National Drug Code Billing Errors

Submitting claims with the appropriate NDC information is important for claims processing and may help you spend less time troubleshooting a rejected claim line.

One common error is using the NDC number from individual vials instead of the NDC number on the box when medication comes in a box with multiple vials.

- The best option is to use the NDC number on the box (outer packaging), along with the appropriate NDC unit of measure and NDC units.
- You should do this whenever possible to support accurate processing of your claim – with fewer unnecessary claim rejections.
- Not all NDC numbers on vials have manufacturer pricing to support an allowance, so outer packaging NDC numbers are the preferred method of NDC claim submission.

Providers participating in our PPO and Blue Choice PPO℠ networks may access and obtain the NDC Reimbursement Schedule by using the Plan Documents Viewer on Availity® Essentials.

For more information, refer to the NDC Billing Guidelines and other important information on our Specialty Pharmacy Program page.

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Coding Webinars: Arrhythmias and Rheumatoid Arthritis

Join our Coding Compliance team for the below webinars on coding and guidelines. They are free to providers and coding professionals.

The webinars include information on ICD-10-CM documentation and guidelines, sample coding case studies and tips on closing gaps in care for members. The webinars don't offer continuing education credits. We will present each webinar three times.

Coding for Arrhythmia, including Atrial Fibrillation, Atrial Flutter and Supraventricular Tachycardia

- May 17, 2024, from noon to 12:30 p.m. Register here.
- June 21, 2024, from noon to 12:30 p.m. Register here.

Coding for Rheumatoid Arthritis and Inflammatory Connective Tissue Disease

- May 31, 2024, from noon to 12:30 p.m. Register here.
- June 28, 2024, from noon to 12:30 p.m. Register here.

Visit our Webinars and Workshops page for more training opportunities.

The material presented in the webinars is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients' conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation, coding guidelines and reference materials. References to other third party sources or organizations are not a representation, warranty or endorsement of such resources or organizations. 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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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.

BCBSIL WEBINARS
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 Availity Essentials 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.*	May 1, 2024 May 15, 2024 May 22, 2024 May 29, 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.*	May 2, 2024 May 9, 2024 May 16, 2024 May 23, 2024 May 30, 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, how to verify patients' Eligibility and Benefits, and more online options.*	May 21, 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.*	May 16, 2024	1 to 2 p.m.
BlueApprovR: Prior Authorization Process and RCR Process *Learn how to access via Availity Essentials to submit and secure real-time approvals for specialty pharmacy drug, behavioral health clinical evaluation and medical surgical prior authorization and RCR requests for many BCBSIL commercial members.*	May 7, 2024 May 14, 2024 May 21, 2024 May 28, 2024	3 to 4 p.m.
Coding for Arrhythmia *Join our Coding Compliance team for a free webinar to*	May 17, 2024	Noon to 12:30 p.m.

discuss ICD-10-CM documentation and guidelines, sample coding case studies and closing gaps in care.		
Coding for Rheumatoid Arthritis *Join our Coding Compliance team for a free webinar to discuss ICD-10-CM documentation and guidelines, sample coding case studies and closing gaps in care.*	May 31, 2024	Noon to 12:30 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.*	May 9, 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 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.*	May 16, 2024	1 to 2 p.m.
Orientation Webinars for New Commercial Providers *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.*	May 22, 2024	1 to 2:30 p.m.

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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 BCBSIL ID card.

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BLUE REVIEW℠
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Has your information changed? Let us know!

When seeking health care services, our members often rely upon the information in our online Provider Finder®. Prospective patients can use this online tool to confirm if your practice is a contracted in-network provider for their health care benefit plan. Other providers may use the Provider Finder when referring their patients to your practice.

We encourage you to check your information as it appears in our Provider Finder on a monthly basis.

- Verify your information (name, specialty, address, phone and website URL) for our provider directory every 90 days. This is required by federal law.
- Update your data when it changes, including when you join or leave a network.
- If you leave a network, update your information immediately and according to your contract terms.

See below for reminders and instructions on how to update your data. **Updating your data will count as your 90-day verification.**

How To Make Demographic Changes

Online options are available for most changes you may need to request.

- **Professional Providers** – We recommend using the Availity® Essentials Provider Data Management feature to request changes to existing demographic information, such as service location, payment address, business website URL, hours of operation and languages spoken. See our PDM page and user guide for more details. If you're unable to use Availity, use our Demographic Change Form. You may specify more than one change within your request as long as all changes relate to the same billing (Type 2) National Provider Identifier. As a participating provider, your NPI(s) should already

be on file with BCBSIL. If needed, you can request deactivation of an existing NPI.

- **Professional Provider Groups** – Groups can verify **individual providers** using the Availity PDM feature or our Demographic Change Form.
- **Acute and Ancillary Facilities** – Facilities and ancillary providers may use **only** the Demographic Change Form to verify and update data. See our user guide for more details.

To enable us to meet the two-day directory update requirement defined by the CAA, **we won't accept demographic changes by email, phone or fax**. Any demographic updates requested through these channels will be rejected and closed.

For more information, refer to our Verify and Update Your Information page.

Request Addition of Provider to Group

If you need to add a provider to your current contracted group, complete the Provider Onboarding Form. Due to the credentialing requirements, changes aren't immediate upon submission of this form. The provider being added to the group won't be considered in-network until they're appointed into the network.

Other Information Changes

The following types of changes are more complex and require special handling.

- **Legal Name Change for Existing Contract** – If you're an existing provider that needs to report a legal name change, complete a new contract application to initiate the update process.*
- **Medical Group Change for Multiple Providers** – If you're a group (Billing NPI Type 2) and have more than five changes, please email our Illinois Provider Roster Requests team for a current copy of your roster to initiate your multiple-change request. (**Verification reminder:** Medical groups who update their provider information by roster can verify all their providers' information every 90 days by submitting a roster. When you submit a roster, all providers affiliated with this group and not listed with an update are verified as correct with no changes.)

*For status of your professional contract application, application, use the Case Status Checker.

If you have any questions, contact your assigned Provider Network Consultant.

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