



Blue REVIEW

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS

OCTOBER 2012

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Hospital Staff Volunteers Needed for ICD-10 Panel Discussion

BCBSIL is planning a panel discussion to review the successes and challenges that Hospital Information Management (HIM) staffs have encountered as they plan for the transition to the ICD-10 code set. We are looking for HIM executives to share their ICD-10 experiences to date in this panel discussion, which will be open to all providers.

BCBSIL is tentatively scheduling this event for the first quarter of 2013, with specific dates and times to follow. We are seeking hospital staff volunteers to participate in this important discussion. If you would like to join us on the panel, please submit your name and contact information, along with your organization's name, to icd@bcbsil.com.

Administrative Simplification: Past, Present and Future

Administrative Simplification was introduced as a component of the Health Insurance Portability and Accountability Act (HIPAA) to streamline administrative processes while increasing security of protected health information by standardizing electronic health care transactions between HIPAA-covered entities. Covered entities include all health benefit plans, health information technology vendors, physicians, facilities and other health care professionals.

Administrative Simplification is continuing as a provision of the Affordable Care Act (ACA). While HIPAA set the standard for electronic data interchange (EDI) transactions, new operating rules are being established under ACA to help promote greater uniformity in how electronic health care data is exchanged.

The Committee for Operating Rules on Information Exchange (CORE)¹ has designated a phased approach for health plans to implement operating rules for each EDI transaction. Implementation dates are tentative, pending publication of the final rules. The proposed deadlines are as follows:

- Eligibility and Benefits (ANSI 270/271) and Claim Status (ANSI 276/277) – Jan. 1, 2013
- Claims payment and remittance, which includes Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) – Jan. 1, 2014
- Referrals, preauthorizations, claim attachments – Jan. 1, 2016

Blue Cross and Blue Shield of Illinois (BCBSIL) will be making several enhancements prior to the first scheduled implementation deadline. Specifically, these enhancements will provide:

- Extended hours of online availability
- Ability to access past and future dates of service for eligibility and benefits
- More flexible parameters when searching by name to allow users a more comprehensive return of data meeting the search criteria
- A new notification process which will ensure that users are aware of any scheduled downtime or unscheduled outages

While you may see differences in the way information is returned – such as minimal screen changes – there is nothing you need to do at this time. Administrative Simplification under ACA can contribute to cost savings and help improve operational efficiencies for your office in the following ways:

- Reduced paperwork
- Streamlined daily operations resulting in less manual entry
- Less time spent on phone calls with health plans

For additional announcements related to this important initiative, please continue to watch the *Blue Review*, as well as the News and Updates section on our website at bcbsil.com/provider. We also encourage you to visit the Centers for Medicare & Medicaid Services (CMS) website at cms.gov, where you will find additional information in the Regulations and Guidance section under HIPAA Administrative Simplification.

¹ CORE is part of the Council for Affordable Quality Healthcare (CAQH) initiative. Providers may refer to the CORE section on the CAQH website at <http://www.caqh.org/benefits.php> for detailed information and related resources.



Pharmacy Program Updates

Standard Formulary Additions Effective Oct. 1, 2012

Based on the availability of new prescription medications and the Prime National Pharmacy and Therapeutics Committee review of changes in the pharmaceuticals market, some additions were made to the standard BCBSIL formulary effective Oct. 1, 2012.

Brand Medications Added to the Formulary Effective Oct. 1, 2012

Formulary Brand* (Tier 2 copayment/ coinsurance)	Drug Class/ Condition Used For
Cleocin 100 mg ovules	Bacterial vaginosis
Intelence 25 mg	HIV infection
Janumet XR	Diabetes
Juvisync	Diabetes/High cholesterol
Priftin	Mycobacterium tuberculosis
Viread oral powder	HIV infection

Please refer to the August 2012 *Blue Review* for a list of formulary deletions and dispensing limit changes effective Oct. 1, 2012. Current and past newsletter issues are available in the Education and Reference Center/*Blue Review* section of our website at bcsil.com/provider.

For the most up-to-date formulary information, visit the Pharmacy Program section of our website at bcsil.com/provider.

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

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.

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

Are you sure your claims reflect your records?

In last month's *Blue Review*, we presented an introductory article to help you become familiar with the general background, essential elements and potential impact of Risk Adjustment on your practice.

Risk Adjustment is already used in many Medicare, Medicaid and other governmental programs to identify differences in health care risk among specific patients – adjusting for variables such as member demographics and health status – in order to more accurately predict a member's severity of illness and related health cost expenditures. As a key component of the ACA, Risk Adjustment will be implemented for commercial lines of business in the individual and small group markets beginning in 2014.

Risk Adjustment methodology relies on complete and accurate diagnosis coding to define health status and assign accurate member risk scores.

WOULD YOU PASS AN AUDIT?

Audits will be conducted to determine accuracy and appropriateness of claims and encounter data coding relative to the patient's condition as documented in the medical record. In addition to evaluating for potential documentation errors, audit results will be used to help validate patient risk scores.

Will you be prepared in the event of an audit? It may be helpful to consider common documentation errors identified by medical record reviews and data analyses. For example, in addition to legibility and authentication, other common errors include instances where diagnosis details are omitted or inaccurate, or the documentation did not support the level of services billed and did not include key components of professional service documentation.¹

Key documentation components include history, examination and medical decision making. "Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option." Medical decision making may be evaluated based on "risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient's presenting problem, the diagnostic procedure and/or possible management options."²

It is clear that medical record documentation must support medical necessity and be appropriate for the chief complaint as well as the type and amount of service provided. But good documentation alone isn't enough – ongoing training to ensure accurate coding of documented conditions is also essential, whether you code the diagnoses yourself or a designee reads your documentation and codes your claims from the medical record.

WE'RE CONDUCTING A PILOT

In order to appropriately report risk scores to the Department of Health and Human Services (HHS) and prepare to implement ACA mandates, BCBSIL will be reviewing a sample of medical records for its commercial members. The purpose of this review is to verify that diagnosis codes reported to BCBSIL in claims and related transactions include all pertinent diagnosis codes at the accurate levels of specificity.

BCBSIL has identified a small number of providers to participate in this pilot audit. Pilot providers will be contacted to arrange for medical record access/retrieval and to complete a short documentation/coding practice survey. BCBSIL has retained MediConnect Global, Inc. (MediConnect), to assist in the pilot audit program. Participants in the pilot program will be notified by MediConnect and will be asked to submit medical records directly to MediConnect. A team of credentialed coders and clinicians will review medical record documentation in comparison to the diagnosis codes submitted by these providers to BCBSIL in claims and related transactions.

Please watch the News and Updates section of our Provider website at bcsil.com/provider for additional information, announcements and links to related resources.

1. Cahaba Government Benefit Administrators®, LLC website. Evaluation and Management (E&M) Services (Codes 99201 – 99499): Appropriate Medical Record Documentation. March 9, 2009. <http://www.cahabagba.com/part-b/education/cahaba-u-18370/evaluation-and-management-e-m-services-codes-99201-99499-appropriate-medical-record-documentation/>
2. CMS website. Medicare Learning Network (MLN) Matters: Evaluation and Management Services Guide. December 2010. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

Physical Medicine Utilization Management Program Announcement

BCBSIL is pleased to announce a new PPO physical medicine Utilization Management (UM) program, developed in partnership with OrthoNet LLC, a national orthopedic specialty benefit management company that is URAC* accredited in Health Utilization Management.

Effective in early 2013, professional providers will be responsible for obtaining prior authorization through OrthoNet™ for the following outpatient physical medicine services:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Chiropractic Services

WHY IS BCBSIL IMPLEMENTING THIS PROGRAM?

BCBSIL is implementing the program due to an increasing number of employer groups requesting management of escalating physical medicine costs, and to support quality while helping our members maximize benefits under their plans.

WILL OUTPATIENT PRIOR AUTHORIZATION BE REQUIRED FOR ALL MEMBERS?

Initially the program will apply to BCBSIL PPO members who are fully insured; however, expansion is likely to occur as plan sponsors elect to participate in the program. Excluded from the OrthoNet UM prior authorization program are:

- HMO members
- BlueCard® (out-of-area) members
- Members who live outside of Illinois (this includes Lake County, IN)
- Members with Medicare coverage primary and BCBSIL secondary

In the next few months, we will be publishing additional information on the prior authorization process for the outpatient physical medicine services noted above.

If you have any questions regarding this information, please contact your assigned Professional Provider Network Consultant (PNC). To find the name of your assigned PNC, visit the Education and Reference Center/Provider Network Consultant Assignments section of our website at bcsil.com/provider.

*URAC, formerly known as the Utilization Review Accreditation Commission, is a nonprofit organization that accredits health care organizations, including medical management organizations.

OrthoNet is a registered trademark of OrthoNet LLC, an independent third party vendor that is solely responsible for its products and services.

Please note that the fact that a guideline is available for any given treatment, or 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.



Credentialing/ Recredentialing Reminders

At this time, 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 and CNP. A complete listing of the specialists for each network is available in the Network Participation/Credentialing section of our Provider website at bcsil.com/provider.

If you are new to the credentialing process, you will receive a welcome packet from the Council for Affordable Quality Healthcare, Inc.® (CAQH) containing Universal Provider Datasource® (UPD) registration instructions and a personal CAQH Provider ID number. Please note that the credentialing process can take time to complete. Therefore, if you receive a letter, it is important to respond without delay.

Periodically, you will receive reminders from CAQH alerting you that your information needs to be verified for recredentialing purposes. To update your information in the CAQH, log on to the UPD at upd.caqh.org/oas. You should respond even if your data has not changed in order to "re-attest" that your information is correct.

A UPD Quick Reference Guide is available on the CAQH website at upd.caqh.org/oas. If you have any questions or need assistance with using the CAQH database, contact the CAQH Help Desk at 888-599-1771, or send an email to caqh.updhelp@acsgs.com.

As a reminder, PPO provider credentialing is currently in progress. To help determine whether or not you need to take action, along with why and how, please refer to the article on page 4 of our August 2012 *Blue Review*, available in the Education and Reference Center/*Blue Review* section of our Provider website at bcsil.com/provider. **It is important to take the necessary steps to maintain your PPO network status.**

The Council for Affordable Quality Healthcare, Inc. (CAQH) is a 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. CAQH is solely responsible for its products and services, including the Universal Provider Datasource.

2012 Coding Update for Fluoroscopic Guidance and CT Guidance

As a reminder, Current Procedural Terminology (CPT®) coding guidelines changed in January 2012, for CPT codes **77003 and 77012**.

According to the 2012 CPT codebook:

- CPT code 77003 is used to report fluoroscopic guidance and location of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)
- CPT code 77012 is used to report computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation

Please note that new text for both of these codes was added to the 2012 CPT codebook, which states: **Do not report 77003 and/or 77012 in conjunction with 27096, 64479-64484, 64490-64495, 64633-64636**. Fluoroscopic guidance and/or CT guidance (CPT codes 77003 and 77012) are included in the listed procedures and should not be reported separately.

CPT copyright 2010 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.



BCBSIL Guidelines for Appropriate Use of Modifier 50

Modifier 50 is used to identify bilateral procedures, which are typically performed on both sides of the body (mirror image) during the same operative session.

A recent audit of modifier 50 conducted by BCBSIL has resulted in refund requests for overpayment of services. This article provides general guidelines to assist you with proper use of modifier 50 when submitting professional claims to BCBSIL.

Please note that, for BCBSIL claims, bilateral procedures should be reported with one procedure code, appended with modifier 50. This information should appear on the electronic (ANSI 837P) or paper (CMS-1500) claim as one line item, with a unit number of 1. Modifier 50 is appended to the appropriate unilateral code as a one-line entry on the claim to indicate the procedure was performed bilaterally.

Electronic Claim (ANSI 837P) Guidelines:

Field 24D on the CMS-1500 equates to Loop 2400 (Service Line Level) – Segment SV101 (2-6) on professional electronic claims. Per the ANSI 5010 Technical Reports Type 3 (TR3s), usage of this field is Situational – it is “Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier.”

Paper Claim (CMS-1500) Example:

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS	F. CHARGES	G. DAYS OR UNITS	H. EPSDT	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
From	To	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY
MM	DD	YY			XX			19318	50		X	XXX	XX
												NPI	
												NPI	
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												NPI	
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												NPI	
25. FEDERAL TAX I.D. NUMBER				SSN	EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID	30. BALANCE DUE
						1234JED		YES NO		\$ XXX:XX		\$ XX:XX	\$ XX:XX
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS						32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()			
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)										I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234			
SIGNED						a. NPI				b. 0222222220 ZZ123456789X			

NUCC Instructional Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

BCBSIL holds providers accountable for their billing practices. Our Special Investigations Department (SID) utilizes various tools, including software systems, to help us identify unusual billing patterns and atypical use of CPT codes.

Provider claims with statistical abnormalities may be selected for further examination and investigation. If there is an issue of questionable billing practices, interviews and field audits may be conducted to demonstrate if there is probable cause to believe that claims were improperly submitted for payment. In some instances, the matter may be referred to our Network Management Department to conduct additional provider training and guidance.

Learn how health care fraud can affect your practice and your patients. View the SID Fraud Awareness Tutorial, located in the Education and Reference Center/Fraud and Abuse section of our Provider website at bcbsil.com/provider.

Provider Learning Opportunities

BCBSIL WEBINARS AND WORKSHOPS

Below is a list of complimentary training sessions sponsored by BCBSIL. For details and online registration, visit the Workshops/Webinars page in the Education and Reference Center of our website at bcbsil.com/provider.

WEBINARS

Electronic Refund Management (eRM)	Oct. 3, 2012	<u>All sessions:</u> 2 to 3 p.m.
	Oct. 10, 2012	
	Oct. 17, 2012	
	Oct. 24, 2012	
	Oct. 31, 2012	
iEXCHANGE® Enhancements Staff Session <i>Training relevant for registration/admitting staff, or staff responsible for claims</i>	Oct. 3, 2012	2 to 3:30 p.m.
	Oct. 10, 2012	9 to 10:30 a.m.
	Oct. 17, 2012	2 to 3:30 p.m.
	Oct. 24, 2012	10 to 11:30 a.m.
iEXCHANGE Enhancements Clinical Staff Session <i>Training relevant for utilization/case management staff</i>	Oct. 3, 2012	11 a.m. to 12:15 p.m.
	Oct. 10, 2012	2 to 3:15 p.m.
	Oct. 17, 2012	11 a.m. to 12:15 p.m.
iEXCHANGE Enhancements Administrator Session <i>Training relevant for iEXCHANGE office administrators</i>	Oct. 3, 2012	9 to 10 a.m.
	Oct. 10, 2012	11 a.m. to noon
	Oct. 17, 2012	9 to 10 a.m.
	Oct. 24, 2012	2 to 3 p.m.

WORKSHOPS

Availity® and RealMed® Learning Session Holiday Inn 222 Potomac Blvd. Mt. Vernon, IL	Oct. 23, 2012	Session 1 (Beginner) Registration: 9:30 to 10 a.m. Session: 10 a.m. to noon
		Session 2 (Advanced) Registration: 1:30 to 2 p.m. Session: 2 to 4 p.m.
Availity and RealMed Learning Session Best Western Clock Tower Resort & Conference Center 7801 East State St. Rockford, IL	Oct. 30, 2012	Session 1 (Beginner) Registration: 9:30 to 10 a.m. Session: 10 a.m. to noon
		Session 2 (Advanced) Registration: 1:30 to 2 p.m. Session: 2 to 4 p.m.

Availity is a registered trademark of Availity, L.L.C. RealMed is a registered trademark of RealMed Corporation, an Availity Company. Availity, L.L.C. and RealMed Corporation are independent third party vendors and are solely responsible for their products and services.

Fairness in Contracting

In an effort to comply with fairness in contracting legislation and keep our independently contracted providers informed, 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 Sept. 1, 2012, code A4223 was updated.

Effective Oct. 1, 2012, codes 83861, 86386 and G0433 were updated.

Effective Jan. 1, 2013, BCBSIL will be applying the following reimbursement methodology for the two immunization administration codes listed below.*

- **90460** – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
- **90461** – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component (list separately in addition to code for primary procedure)

*Note: The initial vaccine administration will be reimbursed at the full allowance. A multiple vaccine administration reduction will be applied on subsequent initial vaccine/toxoid component(s) and each additional vaccine/toxoid component(s) provided on the same date of service. The multiple vaccine reduction is consistent with BCBSIL's current reimbursement methodology.

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 in the Education and Reference Center/Forms section of our Provider website at bcbsil.com/provider.

BlueCard Tip:

Obtaining Medical Policy/Prior Authorization Information for Out-of-area Members

There is a “router” tool on our Provider website at bcsil.com/provider to assist you with obtaining Medical Policy and general Pre-certification/Preauthorization information for out-of-area Blue Cross and Blue Shield (BCBS) members. This online router will direct you to the Medical Policy or Pre-certification/Preauthorization section of the appropriate BCBS Plan’s website so that you may review out-of-area members’ Plan-specific guidelines **prior** to rendering services.

For your convenience, there are two links to the router tool on our Provider website:

- In the Claims and Eligibility/Prior Authorization section, the **Pre-cert/Pre-auth Router (out-of-area members)** link under “Related Resources,” or
- The **Medical Policy/Pre-cert (Out-of-area)** page in the Standards and Requirements section

To use the router tool, follow these simple steps:

1. Select the type of information being requested (“Medical Policy” or “General pre-certification/pre-authorization information”)
2. Enter the alpha prefix (first three letters of the member’s ID number)
3. Click on the **Go** button



2012 Annual HMO HEDIS® Report

Each year BCBSIL reports audited Health Care Effectiveness Data and Information Set (HEDIS) results for HMO Illinois and BlueAdvantageSM HMO. HEDIS is a nationally standardized set of measures related to important areas of care and service. Developed by the National Committee for Quality Assurance (NCQA), it is one of the most widely used set of health care performance measures in the United States.

The 2012 BCBSIL HMO HEDIS Report, which is based on 2011 data using HEDIS 2012 specifications, includes measures across domains of care that reflect: effectiveness of care, access/availability of care and utilization. Audited HEDIS results are reported for HMO Illinois and BlueAdvantage HMO combined. Overall, the HMOs exceeded the national average for 24 HEDIS indicators.

The following table includes HEDIS measures related to BCBSIL HMO quality improvement projects:

Care Provided to BCBSIL HMO Members <i>Effectiveness of Care</i>	HMO HEDIS Rate	2011 Quality Compass National Average
Prevention and Screening		
Adult BMI Assessment	82%	41%
Childhood Immunization Combination 3 Rate: • 4 DtaP, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV, 4 PCV	79%	75%
Breast Cancer Screening	72%	71%
Cervical Cancer Screening	76%	77%
Colorectal Cancer Screening	64%	63%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile	76%	35%
Cardiovascular Conditions		
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	63%	60%
Controlling High Blood Pressure	65%	63%
Comprehensive Diabetes Care		
Hemoglobin A1c Control (<8.0%)	60%	62%
Eye Exam (retinal exam)	64%	58%
LDL-C Control (<100 mg/dL)	52%	48%
Medical Attention for Nephropathy	87%	84%
Blood Pressure Control <140/80	47%	NA*
Behavioral Health		
Follow Up After Hospitalization for Mental Illness: 7-Day Rate	78%	60%

*Comparable results not available due to specification change. Results are rounded to the nearest percentage.

(continued next page)

The following HMO HEDIS measures were at least five percentage points below the Quality Compass national average and demonstrated opportunities for improvement:

- **Prevention and Screening** – Immunizations for Adolescents
- **Respiratory Conditions** – Appropriate Testing for Children with Pharyngitis, Appropriate Treatment for Children with Upper Respiratory Infection, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- **Access/Availability of Care** – Children and Adolescents' Access to Primary Care Practitioners
- **Utilization** – Well-Child Visits in the First 15 Months of Life (6+ visits); Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; Adolescent Well-Care Visits

The complete HMO HEDIS Report is available in the Clinical Resources/HEDIS and CAHPS Reports section of our website at bcsil.com/provider.

HEDIS is a registered trademark of NCQA.

NEW ACCOUNT GROUPS

Group Name	Group Number	Alpha Prefix	Product Type	Effective Date
Abbvie	778090-97	AXV	PPO (Portable)	Jan. 1, 2013
The Boeing Company	7NUS60, 7WEU60, 7SPE60, 7SPF60, 7IHD60, 7IM560, 7UW860, 7BNA60, 7AMP60	BHP	BlueEdge PPO/HSA (Portable)	Jan. 1, 2013
Citizens Equity First Credit Union (CEFCU)	700811-12	CJU	PPO (Portable)	Jan. 1, 2013
County of Adams	P47007	XOF	PPO (Portable)	Sept. 1, 2012
Discover Financial	256916, 256973 256917, 256974 256922 256975, 256977, 256919	LJX LJX LJX XOT	PPO (Portable) BlueEdge PPO/HCA (Portable) BlueEdge PPO/HSA (Portable) CMM	Jan. 1, 2013
EBY-BROWN	708710-11	EBY	BlueEdge PPO/HSA (Portable)	Jan. 1, 2013
Readerlink Distribution Services	P38636, P38638, P38970, P38972	RKH	PPO (Portable)	Jan. 1, 2013

NOTE: Some of the accounts listed above may be new additions to BCBSIL; some accounts may already be established, but may be adding member groups or products. The information noted above is current as of the date of publication; however, BCBSIL reserves the right to amend this information at any time without notice. The fact that a group is included on this list is not a guarantee of payment or that any individuals employed by any of the listed groups, or their dependents, will be eligible for benefits. Benefit coverage is subject to the terms and conditions set forth in the member's certificate of coverage.

Electronic Remittance Advice (ERA) Enrollment Process Change

The Electronic Remittance Advice (ERA) is a HIPAA-compliant electronic data file that can be used for automatic posting of payments to your patient accounts. The advantage of the ERA is that the payment information is received in your office on your scheduled pay cycle after claim finalization. Also, when you enroll for ERA, you will automatically receive the Electronic Payment Summary (EPS), which is a convenient alternative to your paper Provider Claim Summary (PCS).*

Effective Sept. 3, 2012, BCBSIL began processing ERA enrollment requests. Instead of faxing enrollment forms to Availity, as instructed in the past, the ERA Enrollment Form should now be faxed to our Electronic Commerce Services Department at 312-946-3500.

Providers/receivers requesting ERA setup are still required to first register with Availity in order to obtain an Availity Customer ID. The Customer ID is needed to activate the ERA request.

For more information and to get started with ERA and other electronic transactions, visit the Claims and Eligibility/Claim Payment and Remittance section of our Provider website at bcsil.com/provider. You may also call our Electronic Commerce Center at 800-746-4614 for enrollment assistance.

***Note:** BCBSIL does not charge for setup or delivery of the ERA to your mailbox on the Availity portal. You may incur fees for translation software, and, if you have designated a billing agent to receive the ERA on your behalf, they may charge a fee to deliver your files to you. If you utilize a software vendor, billing service or clearinghouse, it is very important to contact them so that you are aware of any fees for products or services they provide.

IN THE KNOW ✓

Triessent® Specialty Pharmacy Name Change

If you have patients in your practice on specialty medications administered through our specialty pharmacy program, Triessent, please take note of the following change:

Effective Nov. 1, 2012, Triessent will become Prime Therapeutics Specialty Pharmacy, LLC (Prime Specialty Pharmacy). New fax and phone numbers are as follows:

Prime Specialty Pharmacy
Phone: 877-627-MEDS (6337)
Fax: 877-828-3939

Prime Specialty Pharmacy will provide specialty pharmacy services to your Blue Cross and Blue Shield patients formerly served by Triessent. Letters have been sent to notify our members who may be affected by this change. Benefit coverage will not be affected by the transition to Prime Specialty Pharmacy.

For additional information, visit the Pharmacy Program/Specialty Pharmacy section of our Provider website at bsbsil.com/provider.

Note: Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage. 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.

Triessent is a registered trademark of Prime Therapeutics, LLC. Prime Therapeutics, LLC is an independent company providing pharmacy benefit management and specialty pharmacy services for BCBSIL members. Prime Therapeutics Specialty Pharmacy LLC (Prime Specialty Pharmacy) is a wholly owned subsidiary of Prime Therapeutics, LLC.

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 bcsil.com/provider.

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

BLUE REVIEW

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