BlueCross BlueShield of Illinois

BLUE REVIEW℠

A Provider Publication

November 2021

Wellness and Member Education

Free Diabetes Awareness Month Programs and More at Blue Door Neighborhood Center℠

Our Blue Door Neighborhood Center (BDNC℠) locations will be offering free in-person and virtual **National Diabetes Awareness Month** events in November.

Read More

Supporting Quality Care: Managing Diabetes

More than 34 million Americans – just over one in 10 – have diabetes, according to the Centers for Disease Control and Prevention (CDC). Because symptoms can develop slowly, one in five don't know they have it. We encourage providers to talk with our members about diabetes.

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Pharmacy Program

Catch Up on Vaccines for All Ages

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Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Oct. 1, 2021 – Part 2

Based on the availability of new prescription medications and Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some additions, revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) were made to the Blue Cross and Blue Shield of Illinois (BCBSIL) drug lists. Changes effective on or after **Oct. 1, 2021**, are outlined here.

Quality Improvement and Reporting

Avoiding Antibiotics for Acute Bronchitis

Antibiotics only treat certain bacterial infections and don't work against viruses, which are often the cause of acute bronchitis, colds and flu. According to the CDC, at least 28% of antibiotics prescribed each year in doctor's offices and emergency departments aren't needed.

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Provider Education

2021 *Blue Review* Readership Survey Ends Nov. 30, 2021

The *Blue Review* is your provider newsletter, published monthly by BCBSIL. Its purpose is to deliver timely BCBSIL information that matters to you and your organization. Your feedback helps us monitor how we're doing and what we need to do to improve. The survey will only be open through **Nov. 30, 2021**. Your opinion makes a difference, so don't miss this opportunity to tell us what you think! **Take the survey now**.

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.

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What's New

BCBSIL Moves to Streamline Coordination of Benefits (COB) for Members with Secondary Coverage

In October 2021, BCBSIL began working with the Council for Affordable Quality Healthcare (CAQH®) to help identify some commercial members who have more than one health insurance policy.

Read More

Network Innovation/Product Updates

Blue Choice Opt PPO℠ Network Expanding Throughout Illinois

We're happy to announce that as of **Jan. 1, 2022**, the **Blue Choice Opt PPO network**, which includes Blue Choice Options℠ and Blue Options℠ plans, will be available throughout the State of Illinois.

Read More

Legislative Updates

Consolidated Appropriations Act and Transparency in Coverage Final Rule

The Consolidated Appropriations Act (CAA) of 2021 and the Transparency in Coverage Final Rule will impact many of our members starting **Jan. 1, 2022**. As providers caring for our members, you may be impacted as well.

Read More

Clinical Updates, Resources and Reminders

Prior Authorization Code Updates for Some Commercial Members, Effective Jan. 1, 2022

BCBSIL is changing prior authorization (PA) requirements that may apply to some **commercial non-HMO** members.

Read More

Government Programs Prior Authorization Update: Code Changes, Effective Jan. 1, 2022

BCBSIL is changing PA requirements for **Blue Cross Medicare Advantage (PPO)℠ (MA PPO), Blue Cross Community Health Plans℠ (BCCHP℠) and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠** members.

Read More

Claims and Coding

Coding Cancer and Cancer-Related Treatments

One in three people in the U.S. will be diagnosed with cancer in their lifetime, according to the American Cancer Society. Accurately and completely coding and documenting cancer and cancer-related treatments may help improve member outcomes and continuity of care.

Read More

Claim Editing Enhancements Coming Jan. 10, 2022

Effective **Jan. 10, 2022**, BCBSIL will be enhancing its claims editing and review process with Cotiviti for some of our **commercial non-HMO** members to help ensure accurate coding of services and to

ensure that services are properly reimbursed.

Read More

New Laboratory Policies Coming Jan. 1, 2022

Beginning **Jan. 1, 2022**, BCBSIL will implement new medical policies and a new program for claims for certain outpatient laboratory services provided to some of our **commercial, non-HMO** members.

Read More

Electronic Options

Submitting Electronic Replacement or Corrected Claims

The BCBSIL claim system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows you to submit changes to claims that were not included on the original adjudication.

Read More

Introducing Electronic Clinical Claim Appeal Requests via Availity® Provider Portal

The new Dispute tool allows providers to electronically submit clinical appeal requests for specific clinical claim denials through the Availity Portal. When applicable, the Dispute Claim option will appear in the Availity Claim Status tool results.

Read More

Has your information changed? Let us know!

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

Read More

Notification and Disclosure

ClaimsXten™ Quarterly Update Reminder

The ClaimsXten code auditing tool is updated quarterly. On or after **Dec. 13, 2021**, BCBSIL will implement the fourth quarter code update in the ClaimsXten tool.

Read More

Quick Reminders

Stay informed!

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

Update Your Information

Do you need to update your location, phone number, email or other important details on file with BCBSIL? Use our online forms to request an information change.

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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Free Diabetes Awareness Month Programs and More at Blue Door Neighborhood Center℠

Our Blue Door Neighborhood Center (BDNC℠) locations will be offering **free** in-person and virtual **National Diabetes Awareness Month** events in November. According to the Centers for Disease Control and Prevention[1] (CDC), in the last 20 years, the number of adults diagnosed with diabetes has more than doubled. The CDC indicates that managing blood sugar is the key to living well with diabetes, and eating well is the key to managing blood sugar.[2]

So, this November, your patients may benefit from free **nutrition classes** and **farmers markets** at BDNC. Or, maybe they would like to attend our virtual **Ask a Doctor** sessions to learn more about diabetes. Blue Cross and Blue Shield of Illinois (BCBSIL) encourages members and non-members to take advantage of this free programming as well as our popular **yoga, Zumba, Bingo, Bingocize®** and **meditation** classes.

Other events happening in November include:

- Prematurity Awareness Month virtual preterm birth education session with March of Dimes
  - English session: Monday, **November 1**, from 11 a.m. to noon
  - Spanish session: Wednesday, **November 17**, from 3 to 4 p.m.

- **Food as Medicine** at the BDNC in South Lawndale and virtually
  - Nutrition is a key component in preventing and managing diabetes
  - Learn how to use food to help improve your health
  - English session: Wednesday, **November 3**, from noon to 1 p.m.
  - Spanish session: Thursday, **November 18**, from noon to 1 p.m.

- **Friendsgiving Drive-Thru** at the BDNC in Pullman on **November 13**, from noon to 2 p.m.
  - To-go food tastings from local One Eleven Food Hall restaurants, fresh produce and protein boxes, fall-inspired recipe cards and fun giveaways while supplies last

- **Care Fair** at the BDNC in Morgan Park on **November 20**, from 11 a.m. to 3 p.m.
  - Affordable Care Act (ACA) and Medicare information in time for open enrollment
  - Flu and COVID-19 vaccines
  - Health information on diabetes and other conditions

- Prenatal and postpartum resources available from Special Beginnings®
- Fresh produce and poultry to the first 500 families

These are just a few of the programs that will be offered at BDNC in November. Your patients can check the calendars at BDNC at Morgan Park, BDNC at Pullman and BDNC at South Lawndale for details, dates and to register. They can also visit the BDNC Facebook page for other events and happenings at all three BDNC locations.

Supporting our members on their health education journeys and increasing access to health care where our members live, work and play is an ongoing priority at BCBSIL. We are also committed to strengthening the health of communities across the state. BDNC gives BCBSIL the opportunity to partner with you, the provider community, to truly make a difference in the lives of residents in our communities.

All programming – in person and virtual – at BDNC locations is **free and open to BCBSIL members and non-members**. If you or your patients have questions, email the BDNC or call 773-253-0900.

[1] CDC, What is Diabetes?, June 11, 2020. https://www.cdc.gov/diabetes/basics/diabetes.html

[2] CDC, Eat Well, Aug. 10, 2021. https://www.cdc.gov/diabetes/managing/eat-well.html

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Supporting Quality Care: Managing Diabetes

More than 34 million Americans – just over one in 10 – have diabetes, according to the Centers for Disease Control and Prevention (CDC). Because symptoms can develop slowly, one in five don't know they have it. We encourage providers to talk with our members about diabetes, including:

- Type 1 and Type 2 symptoms
- Regular eye exams to avoid vision loss, or diabetic retinopathy
- Screenings for kidney disease, or diabetic nephropathy

Why Diabetes Care Is Important

If left unmanaged, diabetes can lead to serious complications. These may include heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death. Providers play an important role in supporting our members through regular screenings, tests and office visits. See our preventive care and clinical practice guidelines on diabetes, and tools from the CDC.

Closing Care Gaps

As part of monitoring and helping improve quality of care, we track Comprehensive Diabetes Care (CDC). CDC is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA). The measurement tracks our members, ages 18 to 75 years old with diabetes (type 1 or type 2), who had each of the following completed during the measurement year:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Retinal eye exam
- Medical attention for nephropathy
- Blood pressure control (<140/90 mm Hg)

In addition to CDC, we track Kidney Health Evaluation for Patients with Diabetes (KED). This is a HEDIS measure developed by NCQA with input from the National Kidney Foundation. It applies to our members ages 18 to 85 years old with diabetes (type 1 or type 2) who received a kidney health evaluation. An evaluation is defined by an estimated glomerular filtration rate (eGFR)* and a urine albumin-creatinine ratio (uACR) during the measurement year.

Tips to Consider

- Identify care gaps and schedule lab tests before office visits to review results and adjust treatment plans if needed.
- Complete urine protein testing for attention to nephropathy at any office visit. Testing includes basic urinalysis by dip stick or tablet reagent.
- Document medication adherence to angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARB) when applicable.
- Repeat abnormal lab tests later in the year to document improvement.
- Monitor blood pressure status at each visit and adjust medications as needed for control.
- Encourage members with diabetes to have annual retinal eye exams by an eye care specialist.
- Communicate with members and other treating providers to ensure all tests are completed and results are documented in the medical record.

*BCBSIL's Medical Policy SUR703.007, Kidney Transplant, was updated recently with the following note: ***Per a joint statement by the National Kidney Foundation (NKF) and the American Society of Nephrology (ASN), race modifiers should not be included in equations to estimate kidney function.***

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Catch Up on Vaccines for All Ages

The COVID-19 pandemic has significantly disrupted routine immunizations for children, adolescents and adults, according to the U.S. Department of Health and Human Services. You may hear from our members about catching up on delayed vaccinations. We've created resources for them about staying current on routine vaccines. Examples of routine vaccinations include:

- **Influenza (flu) vaccine** annually for ages 6 months and older
- **Human papillomavirus (HPV) vaccine** for ages 9 to 14 years, or for ages 15 to 26 years if not received earlier, to protect against some cancers
- **Measles, mumps and rubella (MMR) vaccine** for ages 12 to 15 months; 4 to 6 years; and adults with no immunity or medical conditions
- **Pneumonia vaccine** for older adults and adults with health issues that weaken their immune system
- **Shingles vaccine** for adults ages 50 and older

See our preventive care guidelines on immunization schedules.

COVID-19 Vaccine: The Centers for Disease Control and Prevention (CDC) recommends the **COVID-19 vaccine** for everyone ages 5 and older and booster shots in certain populations. The CDC says that other vaccines may be given with the COVID-19 vaccine. The U.S. Food and Drug Administration granted full approval of the Pfizer COVID-19 vaccine for ages 16 and older, and emergency use authorization (EUA) for ages 5 to 15 years old. The Moderna and Johnson & Johnson vaccines have EUA for ages 18 years and older. Learn more about COVID-19 vaccines and coverage.

Closing Care Gaps

As part of monitoring and helping improve quality of care, we track two measures related to immunizations. Both are Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA).

1. Child Immunization Status, which tracks the percentage of children who received by their 2nd birthday a total of four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one MMR; three haemophilus influenza type B (HiB); three hepatitis B (Hep B); one varicella (VZV); four pneumococcal (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two flu vaccines.
2. Immunizations for Adolescents, which tracks the percentage of 13-year-olds who had one dose of meningococcal

vaccine; one tetanus, diphtheria and pertussis (Tdap); and the complete HPV vaccine series by their 13th birthday.

Tips to Consider

- Identify members who have missed vaccinations and contact them or their caregivers to schedule appointments.
- Check at each visit for any missing immunizations and deliver vaccines that are due.
- Address common misconceptions about vaccines.

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Avoiding Antibiotics for Acute Bronchitis

Antibiotics only treat certain bacterial infections and **don't work against viruses, which are often the cause of acute bronchitis, colds and flu**. According to the Centers for Disease Control and Prevention (CDC), at least 28% of antibiotics prescribed each year in doctor's offices and emergency departments aren't needed. We encourage providers to talk with our members about taking antibiotics only when necessary.
See our preventive care guidelines on immunization schedules.

Why It Matters
Antibiotics can cause side effects ranging from minor to severe, according to the CDC. These include rash, diarrhea, yeast infections and allergic reactions. Antibiotics also give bacteria a chance to become more resistant to them, making future infections harder to treat. More than 35,000 people die each year in the U.S. because of antibiotic-resistant infections, according to the CDC.

Closing Care Gaps
Blue Cross and Blue Shield of Illinois (BCBSIL) tracks Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) as part of monitoring and helping improve quality of care. AAB is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA). The measure tracks the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in the member receiving an antibiotic prescription. A higher ratio indicates appropriate treatment for acute bronchitis/bronchiolitis, meaning antibiotics weren't prescribed.

Tips to Consider
The CDC suggests alternatives to antibiotics for acute bronchitis and other conditions, including:

- Adequate rest and increased fluids
- Using a clean humidifier or cool mist vaporizer
- Inhaling hot shower steam or other sources of hot vapor
- Throat lozenges for adults and children ages 5 years and older
- Over-the-counter medications to treat symptoms

Consider providing our members handouts, such as these from the CDC, explaining that viruses, not bacteria, cause colds

and flu.

Register today to join a medical officer from the CDC Office of Antibiotic Stewardship for a **webinar on preventing antibiotics overuse**. The **free webinar** is **Nov. 16, 2021**, from 12:15 to 1 p.m., CT, and will provide information on:

- Avoiding antibiotic treatment for acute bronchitis and other viral illnesses
- How antibiotics can do more harm than good when used and not needed
- Alternatives to antibiotics

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Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois (BCBSIL) 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® Authorizations Tool *We are hosting one-hour webinar sessions for providers to learn how to electronically submit inpatient and outpatient benefit preauthorization requests handled by BCBSIL using Availity's Authorizations tool*.	Nov. 10, 2021 Nov. 17, 2021	11 a.m. to noon
Availity Claim Status *We are hosting complimentary webinars for providers to learn how to verify detailed claim status online using Availity's Claim Status tool.*	Nov. 4, 2021 Nov. 11, 2021 Nov. 18, 2021	11 to 11:30 a.m.
Availity Remittance Viewer and Reporting On-Demand *These online tools give providers and billing services a convenient way to view claim detail information from the 835 Electronic Remittance Advice (835 ERA) and the Provider Claim Summary (PCS). 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.*	Nov. 18, 2021	1 to 2 p.m.

BCBSIL Back to Basics: 'Availity 101' *Join us for a review of electronic transactions, provider tools and helpful online resources.*	Nov. 9, 2021 Nov. 16, 2021 Nov. 23, 2021 Nov. 30, 2021	11 a.m. to noon
BCCHP℠ and MMAI Required Provider Training Webinars *If you provide care and services to our Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ and/or Blue Cross Community Health Plans℠ (BCCHP) members, please join us for guided webinars that will review all the provider trainings required by the Centers for Medicare & Medicaid Service (CMS) and/or Illinois Department of Healthcare and Family Services (HFS).*	Nov. 17, 2021	1 to 3 p.m.
Electronic Clinical Claim Appeal Requests via Availity Provider Portal *We're hosting complimentary webinars for providers to learn how to use the new Dispute tool to electronically submit appeal requests for specific clinical claim denials and monitor the status through the Availity portal. This functionality is currently unavailable for Medicare Advantage, Medicaid and BlueCard® (out-of-area) claims.*	Nov. 8, 2021 Nov. 10, 2021 Nov. 12, 2021 Nov. 15, 2021 Nov. 17, 2021 Nov. 19, 2021 Nov. 22, 2021 Nov. 24, 2021 Nov. 29, 2021	1 to 2 p.m. 10 to 11 a.m. 10 to 11 a.m. 1 to 2 p.m. 10 to 11 a.m. 10 to 11 a.m. 1 to 2 p.m. 10 to 11 a.m. 1 to 2 p.m.
Medicaid HEDIS® 101 Training *This training will cover a wide range of quality improvement topics and resources to help improve Healthcare Effectiveness Data and Information Set (HEDIS) rates.*	Nov. 10, 2021	Noon to 1 p.m.
Medicaid HEDIS 102 Training *This training is designed for contracted providers working with new BCCHP and MMAI members. We'll review HEDIS measure updates, discuss strategies to sharpen your knowledge of HEDIS measures, and cover the measure year (MY) 2020 and MY 2021 HEDIS technical specifications and general guidelines.*	Dec. 8, 2021	Noon to 1 p.m.
Monthly Provider Hot Topics Webinar *These monthly webinars will be held through December 2021. They are customized for the BCBSIL contracted provider community. BCBSIL Provider Network Consultants (PNCs) will use this format to share upcoming initiatives, program changes and updates, as well as general network announcements.*	Nov. 10, 2021	10 to 11 a.m.
Provider Onboarding Form Training *These sessions will help you effectively navigate the Provider Onboarding Form and will discuss topics including: new group/provider contracting, adding a provider to a group, and how to submit demographic changes.*	Nov. 30, 2021	10 to 11 a.m.

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BCBSIL Moves to Streamline Coordination of Benefits (COB) for Members with Secondary Coverage

In October 2021, Blue Cross and Blue Shield of Illinois (BCBSIL) began working with the Council for Affordable Quality Healthcare (CAQH®) to help identify some commercial members who have more than one health insurance policy. By leveraging CAQH's COB Smart® database, we're collaborating with other health insurers to streamline benefit coordination.

Background: Historically, coordinating payments for members who have multiple policies has been a lengthy, manual process. This challenge has been costly for everyone across the health care industry. Tracking down multiple policies for members resulted in delayed and inaccurate payments, stakeholder abrasion, significant recovery activities and unnecessary administrative costs.

How It Works: CAQH is a non-profit alliance of health plans and trade associations that creates shared industry initiatives to streamline the business of health care. Its COB Smart database contains records for approximately 180 million insured members, representing more than half of the insured population in the U.S. We will use the database to identify members with overlaps in health coverage and facilitate more efficient claim adjudication.

No Action Needed: You don't need to do anything to benefit from this program. By collaborating with CAQH, BCBSIL is working to reduce the administrative burden and timelines required to coordinate these claims, resulting in faster and more accurate claims payments to you.

CAQH is an independent third party not-for-profit collaborative alliance of the nation's leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH is solely responsible for its products and services, including the COB Smart database.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Oct. 1, 2021 – Part 2

Posted October 7, 2021

This article is a continuation of the previously published Quarterly Pharmacy Changes Part 1 article. While that Part 1 article included the drug list revisions/exclusions, dispensing limits, utilization management changes and general information on pharmacy benefit program updates, this part 2 version contains the more recent coverage additions, utilization management updates and any other updates to the pharmacy program.

DRUG LIST CHANGES

Based on the availability of new prescription medications and Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some additions (new to coverage) and/or some coverage tier changes (drugs moved to a lower out-of-pocket payment level) will be made to the Blue Cross and Blue Shield of Illinois (BCBSIL) drug lists.

Please note: Revisions (drugs still covered but moved to a higher out-of-pocket payment level) and/or exclusions (drugs no longer covered) were included in the Quarterly Pharmacy Changes Part 1 article. Your patient(s) may ask you about therapeutic or lower cost alternatives if their medication is affected by one of these changes.

Changes effective Oct. 1, 2021 are outlined below.

Drug List Coverage Additions – As of Oct. 1, 2021

Drug[1]	Drug Class/Condition Used For
Basic, Basic Annual, Multi-Tier Basic, Multi-Tier Basic Annual, Enhanced, Enhanced Annual, Multi-Tier Enhanced and Multi-Tier Enhanced Annual Drug Lists	
APTIOM (eslicarbazepine acetate tab 200 mg, 400 mg, 600 mg, 800 mg)	Seizures
AYVAKIT (avapritinib tab 25 mg, 50 mg)	Cancer
COSENTYX (secukinumab subcutaneous soln prefilled syringe 75 mg/0.5 ml)	Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
FORTEO (teriparatide (recombinant) soln pen-inj 620 mcg/2.48 ml)	Osteoporosis
LINZESS (linaclotide cap 72 mcg, 145 mcg, 290 mcg)	Irritable Bowel Syndrome, Chronic Idiopathic Constipation
MOVANTIK (naloxegol oxalate tab 12.5 mg, 25 mg (base equivalent))	Opioid-Induced Constipation
PYRAZINAMIDE (pyrazinamide tab 500 mg)	Bacterial Infections
SKYRIZI (risankizumab-rzaa soln auto-injector 150 mg/ml)	Plaque Psoriasis
SKYRIZI (risankizumab-rzaa soln prefilled syringe 150 mg/ml)	Plaque Psoriasis
TRIKAFTA (elexacaf-tezacaf-ivacaf 50-25-37.5 mg & ivacaftor 75 mg tbpk)	Cystic Fibrosis
VERQUVO (vericiguat tab 2.5 mg, 5 mg, 10 mg)	Heart Failure
ZEGALOGUE (dasiglucagon hcl subcutaneous soln auto-inj 0.6 mg/0.6 ml)	Hypoglycemia

ZEGALOGUE (dasiglucagon hcl subcutaneous soln pref syringe 0.6 mg/0.6 ml)	Hypoglycemia
ZEJULA (niraparib tosylate cap 100 mg (base equivalent))	Cancer
Enhanced, Enhanced Annual, Multi-Tier Enhanced and Multi-Tier Enhanced Annual Drug Lists	
ARANESP ALBUMIN FREE (darbepoetin alfa soln prefilled syringe 25 mcg/0.42 ml, 40 mcg/0.4 ml, 60 mcg/0.3 ml, 100 mcg/0.5 ml, 200 mcg/0.4 ml, 300 mcg/0.6 ml)	Anemia
INTRON A (interferon alfa-2b for inj 10000000 unit, 18000000 unit, 50000000 unit)	Cancer
INTRON A (interferon alfa-2b inj 6000000 unit/ml, 10000000 unit/ml)	Cancer
Balanced, Performance, Performance Annual and Performance Select Drug Lists	
arformoterol tartrate soln nebu 15 mcg/2 ml (base equiv) (authorized generic for BROVANA)	Chronic Obstructive Pulmonary Disease (COPD)
calcitonin (salmon) inj 200 unit/ml (generic for MIACALCIN)	Hypercalcemia
COSENTYX (secukinumab subcutaneous soln prefilled syringe 75 mg/0.5 ml)	Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
CYCLOPHOSPHAMIDE (cyclophosphamide tab 25 mg, 50 mg)	Cancer
etravirine tab 100 mg, 200 mg (generic for INTELENCE)	Viral Infections
FORTEO (teriparatide (recombinant) soln pen-inj 620 mcg/2.48 ml)	Osteoporosis
FOTIVDA (tivozanib hcl cap 890 mcg, 1340 mcg (base equivalent))	Cancer
HETLIOZ LQ (tasimelteon oral susp 4 mg/ml)	Non-24 hour Sleep-Wake Disorder
INGREZZA (valbenazine tosylate cap 60 mg (base equiv))	Tardive Dyskinesia
isotretinoin cap 10 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg (generic for ABSORICA)	Acne
ketoconazole tab 200 mg	Fungal Infections
lopinavir-ritonavir tab 100-25 mg, 200-50 mg (generic for KALETRA)	Viral Infections
LUPKYNIS (voclosporin cap 7.9 mg)	Lupus Nephritis
MOVANTIK (naloxegol oxalate tab 12.5 mg, 25 mg (base equivalent))	Opioid-Induced Constipation
NOVOLOG FLEXPEN RELION (insulin aspart soln pen-injector 100 unit/ml)	Diabetes
NOVOLOG MIX 70/30 PREFILLED FLEXPEN RELION (insulin aspart prot & aspart sus pen-inj 100 unit/ml (70-30))	Diabetes
NOVOLOG MIX 70/30 RELION (insulin aspart prot & aspart (human) inj 100 unit/ml (70-30))	Diabetes
NOVOLOG RELION (insulin aspart inj 100 unit/ml)	Diabetes
NULIBRY (fosdenopterin hydrobromide for iv soln 9.5 mg)	Molybdenum Cofactor Deficiency (MoCD) Type A
rufinamide tab 200 mg, 400 mg (generic for BANZEL)	Seizures
SKYRIZI (risankizumab-rzaa soln prefilled syringe 150 mg/ml)	Plaque Psoriasis

SKYRIZI PEN (risankizumab-rzaa soln auto-injector 150 mg/ml)	Plaque Psoriasis
sodium fluoride rinse 0.2% (generic for PREVIDENT RINSE)	Dental Fluoride
TEPMETKO (tepotinib hcl tab 225 mg)	Cancer
tiopronin tab 100 mg (generic for THIOLA)	Homozygous Cystinuria
TRIKAFTA (elexacaf-tezacaf-ivacaf 50-25-37.5 mg & ivacaftor 75 mg tbpk)	Cystic Fibrosis
UKONIQ (umbralisib tosylate tab 200 mg)	Cancer
VERQUVO (vericiguat tab 2.5 mg, 5 mg, 10 mg)	Heart Failure
XCOPRI (cenobamate tab pack 100 mg & 150 mg tabs (250 mg daily dose))	Seizures
XPOVIO (selinexor tab therapy pack 40 mg (40 mg once weekly))	Cancer
XPOVIO (selinexor tab therapy pack 40 mg (40 mg twice weekly))	Cancer
XPOVIO (selinexor tab therapy pack 40 mg (80 mg once weekly))	Cancer
XPOVIO (selinexor tab therapy pack 50 mg (100 mg once weekly))	Cancer
XPOVIO (selinexor tab therapy pack 60 mg (60 mg once weekly))	Cancer
ZEGALOGUE (dasiglucagon hcl subcutaneous soln auto-inj 0.6 mg/0.6 ml)	Hypoglycemia
ZEGALOGUE (dasiglucagon hcl subcutaneous soln pref syringe 0.6 mg/0.6 ml)	Hypoglycemia
Balanced and Performance Select Drug Lists	
brinzolamide ophth susp 1% (generic for AZOPT)	Glaucoma, Ocular Hypertension
colchicine tab 0.6 mg	Gout
KLISYRI (tirbanibulin ointment 1%)	Actinic Keratosis
LINZESS (linaclotide cap 72 mcg, 145 mcg, 290 mcg)	Irritable Bowel Syndrome, Chronic Idiopathic Constipation
Performance, Performance Annual and Performance Select Drug Lists	
calcium acetate (phosphate binder) tab 667 mg	Hyperphosphatemia
fluocinonide cream 0.1%	Inflammatory Conditions
Balanced Drug List	
ABILIFY MYCITE MAINTENANCE KIT (aripiprazole tab 2 mg with sensor&strips (for pod) maint pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE MAINTENANCE KIT (aripiprazole tab 5 mg with sensor&strips (for pod) maint pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE MAINTENANCE KIT (aripiprazole tab 10 mg with sensor&strips (for pod) maint pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE MAINTENANCE KIT (aripiprazole tab 15 mg with sensor&strips (for pod) maint pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE MAINTENANCE KIT (aripiprazole tab 20 mg with sensor&strips (for pod) maint pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE MAINTENANCE KIT (aripiprazole tab 30 mg with sensor&strips (for pod) maint pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE STARTER KIT (aripiprazole tab 2 mg with sensor, strips & pod starter pak)	Schizophrenia, Bipolar Disorder

ABILIFY MYCITE STARTER KIT (aripiprazole tab 5 mg with sensor, strips & pod starter pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE STARTER KIT (aripiprazole tab 10 mg with sensor, strips & pod starter pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE STARTER KIT (aripiprazole tab 15 mg with sensor, strips & pod starter pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE STARTER KIT (aripiprazole tab 20 mg with sensor, strips & pod starter pak)	Schizophrenia, Bipolar Disorder
ABILIFY MYCITE STARTER KIT (aripiprazole tab 30 mg with sensor, strips & pod starter pak)	Schizophrenia, Bipolar Disorder
bepotastine besilate ophth soln 1.5% (generic for BEPREVE)	Allergic Conjunctivitis
BRONCHITOL (mannitol inhal cap 40 mg)	Cystic Fibrosis
BRONCHITOL TOLERANCE TEST (mannitol inhal cap 40 mg)	Cystic Fibrosis
CLEMASTINE FUMARATE (clemastine fumarate syrup 0.67 mg/5 ml (0.5 mg/5 ml base eq))	Allergic Conditions
ROSZET (ezetimibe-rosuvastatin calcium tab 10-5 mg, 10-10 mg, 10-20 mg, 10-40 mg)	Hypercholesterolemia
Performance Select Drug List	
BRIVIACT (brivaracetam oral soln 10 mg/ml)	Seizures
BRIVIACT (brivaracetam tab 10 mg, 25 mg, 50 mg, 75 mg, 100 mg)	Seizures

[1]Third-party brand names are the property of their respective owner.

Drug List Updates (Coverage Tier Changes) – As of Oct. 1, 2021

Drug[1]	**New Lower Tier**	**Drug Class/Condition Used For**
Balanced, Performance, Performance Annual and Performance Select Drug Lists		
APTIOM (eslicarbazepine acetate tab 200 mg, 400 mg, 600 mg, 800 mg)	Preferred Brand	Seizures
carbinoxamine maleate tab 4 mg	Non-Preferred Generic	Allergic Conditions
COMBIVENT RESPIMAT (ipratropium-albuterol inhal aerosol soln 20-100 mcg/act)	Preferred Brand	Chronic Obstructive Pulmonary Disease (COPD)
diazepam oral soln 1 mg/ml	Non-Preferred Generic	Seizures
paromomycin sulfate cap 250 mg (generic for HUMATIN)	Non-Preferred Generic	Parasitic Infections
PYRAZINAMIDE (pyrazinamide tab 500 mg)	Preferred Brand	Bacterial Infections
SOOLANTRA (ivermectin cream 1%)	Non-Preferred Generic	Rosacea
ZEJULA (niraparib tosylate cap 100 mg (base equivalent))	Preferred Brand	Cancer
Balanced Drug List		
cimetidine hcl soln 300 mg/5 ml	Non-Preferred Generic	Ulcers, Acid Reflux

[1]Third-party brand names are the property of their respective owner.

UTILIZATION MANAGEMENT PROGRAM CHANGES

- Effective **May 17, 2021**, the Xolair Specialty PA program and target drug Xolair was added to the Basic, Basic Annual, Enhanced, Enhanced Annual, Balanced, Performance, Performance Annual and Performance Select Drug Lists.

- Effective **July 1, 2021**, the target drug Zeposia was removed from the Multiple Sclerosis Specialty PA program and added to the Zeposia Specialty PA program, which applies to the Basic, Basic Annual, Enhanced, Enhanced Annual, Balanced, Performance, Performance Annual and Performance Select Drug Lists.

- Effective **Sept. 1, 2021**, the Verquvo PA program and target drug Verquvo was added to the Balanced, Performance, Performance Annual and Performance Select Drug Lists.

- Effective **Oct. 1, 2021**, the following changes will be applied:
    - The Constipation Agents PA program will no longer apply to the Performance and Performance Annual Drug Lists.

    - The Empaveli Specialty PA program and target drug Empaveli will be added to the Balanced, Performance, Performance Annual and Performance Select Drug Lists.

    - The Osteoporosis Specialty PA program will change its name to Parathyroid Hormone Analog Osteoporosis. The program includes the same targeted medication.

For the most up-to-date drug list and list of drug dispensing limits, visit the Pharmacy Program section of our Provider website.

If your patients have any questions about their pharmacy benefits, please advise them to contact the number on their member ID card. Members may also visit *bcbsil.com* and log in to Blue Access for Members℠ (BAM℠) or MyPrime.com for a variety of online resources.

Reminder: Split Fill Program Available to Select Members
BCBSIL offers its members and groups a Split Fill program to reduce waste and help avoid costs of select specialty medications that may go unused. Members new to therapy (or have not had claims history within the past 120 days for the drug) are provided partial, or "split," prescription fills for up to three months.

The Split Fill Program applies to a specific list of drugs known to have early discontinuation or dose modification. You can view the current list of drugs and find more information on the *Split Fill Program* on our Provider website.

Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSIL 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.

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Blue Choice Opt PPO℠ Network Expanding Throughout Illinois

We're happy to announce that as of **Jan. 1, 2022**, the **Blue Choice Opt PPO network**, which includes Blue Choice Options℠ and Blue Options℠ plans will be available throughout the State of Illinois. If you're currently contracted with Blue Cross and Blue Shield of Illinois (BCBSIL) for the Blue Choice Preferred PPO℠ network,* as of Jan. 1, 2022, **you'll also be an in-network provider** for members who access Tier 1 providers on the Blue Choice Options and Blue Options benefit plans.

Tiered products are designed to give the employer and the member the opportunity to help them self-manage their health care spending. With a tiered product, the member's benefit level of cost-sharing is determined by the network tier according to the contracted provider that renders the service. Keep in mind that an employer can customize the benefit levels for each tier.

Here is the general, basic benefit structure of a tiered product:

- Tier 1 is the highest benefit level and most cost-effective level for the member, as it is tied to a narrow network of designated contracted providers.
- Tier 2 benefits offer members the option to select a provider from a broader network of contracted PPO providers, but at a higher out-of-pocket expense.
- Tier 3 benefits, if offered, typically address the use of out-of-network providers as the highest cost option for covered services.

BCBSIL is committed to providing quality health insurance to all communities of Illinois. By expanding the Tier 1 service area for the Blue Choice Options and Blue Options benefit plans throughout Illinois, we are providing a lower-cost tiered PPO option to members in Illinois.

Remember, it's important to check eligibility and benefits for each patient before every scheduled appointment. When doing so, look for **Blue Choice Options** or **Blue Options** on the BCBSIL members' ID cards and verify eligibility and benefits through the Availity® Provider Portal or your preferred vendor portal. Eligibility and benefit quotes include important information about the patients' benefits, such as membership verification, coverage status and applicable copayment, coinsurance and deductible amounts. The benefit quote may also include information regarding applicable prior authorization requirements. When services may not be covered, you should notify members that they may be billed

directly.

Ask to see the member’s BCBSIL ID card for current information. Also ask for a driver’s license or other photo ID to help guard against medical identity theft. Remind your patients to call the number on their BCBSIL ID card if they have questions about their benefits.

*Hospital Sisters Health System (HSHS) is excluded in the Springfield and the Metro East area of Illinois. Genesis Health System is excluded in the Illinois Quad Cities.

Checking eligibility and/or benefit information 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 member’s ID card.

Information provided by BCBSIL is for informational 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. Any samples in this communication 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 presentation and your contract, your contract will control.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity.

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Consolidated Appropriations Act and Transparency in Coverage Final Rule

The Consolidated Appropriations Act (CAA) of 2021 and the Transparency in Coverage Final Rule will impact many of our members starting **Jan. 1, 2022**. As providers caring for our members, you may be impacted as well.

Here are highlights of changes we are making. This isn't a comprehensive review of all requirements. Some details may change if the federal government issues additional regulations or guidance. Watch News and Updates for more information and consult with your own legal advisors for information on obligations that may apply to you.

Provider Directory (plan years beginning on or after Jan. 1, 2022)
CAA requires provider directory information to be verified **every 90 days**. Providers and insurers have roles in fulfilling this requirement to maintain an accurate directory. Learn more.

Machine-Readable Files
Health insurers are required to publicly display certain health care price information via machine-readable files on their websites beginning in 2022. These machine-readable files will include negotiated rates with in-network providers, allowed amounts for out-of-network providers and may include prescription-drug pricing. Learn more.

ID Cards (plan years beginning on or after Jan. 1, 2022)
The CAA requires that member ID cards include deductible information and out-of-pocket maximums. We will provide new electronic cards for all members. Learn more.

Continuity of Care (plan years beginning on or after Jan. 1, 2022)
Most of our group and fully insured plans include a period of continuity of care at in-network reimbursement rates when a provider leaves our networks. The new legislation also requires continuity of care for affected members when:

- A provider's network status changes; or
- A group health plan changes health insurance issuer, resulting in the member no longer having access to a participating provider in our network. Learn more.

Surprise Billing Provisions of No Surprises Act (NSA) (plan years beginning on or after Jan. 1, 2022)
Under NSA, most out-of-network providers will no longer be allowed to balance bill patients for:

- Emergency services (learn about the updated definition of emergency services);
- Out-of-network care during a visit to an in-network facility; or
- Out-of-network air ambulance services, if patients' benefit plan covers in-network air ambulance services. Learn more.

Gag Clauses (effective Dec. 27, 2020)
CAA prohibits health insurers and group health plans from agreements with providers that include gag clauses related to provider cost and quality information. If any of our contracts include such CAA gag clause language, the contract language will be remediated, and in the interim, the language will be considered unenforceable as a matter of law.

More About the Legislation
Congress passed the CAA in December 2020. It includes the No Surprises Act (NSA), which addresses surprise medical billing for certain services. It also has requirements for health insurers and group health plans to provide information and tools for consumers to better navigate their health care.

The U.S. Department of Health and Human Services (HHS), the U.S. Department of the Treasury and the U.S. Department of Labor (the Departments) released the Transparency in Coverage Final Rule in October 2020. The rule requires certain health care price information to be made available to help consumers and other stakeholders make health care decisions.

Note: On Aug. 20, 2021, the Departments issued guidance in the form of frequently asked questions to address the implementation of aspects of the Transparency in Coverage Final Rule and the CAA. Specifically, the Departments indicated that they are delaying their enforcement of certain provisions. We are evaluating this guidance and will provide updates as needed.

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Prior Authorization Code Updates for Some Commercial Members, Effective Jan. 1, 2022

What's Changing: Blue Cross and Blue Shield of Illinois (BCBSIL) is changing prior authorization requirements that may apply to some **commercial non-HMO** members.

A summary of changes is as follows.

- **Jan. 1, 2022** – Addition of Genetic Testing Current Procedural Terminology (CPT®) codes to be reviewed by AIM Specialty Health® (AIM)
- **Jan. 1, 2022** – Removal of Genetic Testing codes previously reviewed by AIM
- **Jan. 1, 2022** – Addition of Cardiology codes to be reviewed by AIM
- **Jan. 1, 2022** – Addition of Cardiology (Echo) codes for some additional commercial non-HMO members to be reviewed by AIM

More Information: Refer to the Utilization Management section for the updated procedure code lists. These are posted on the Support Materials (Commercial) page.

Important Reminders

Always **check eligibility and benefits first** through the Availity® Provider Portal or your preferred vendor portal, prior to rendering services. This step will confirm 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 a voluntary predetermination request. This step can help avoid post-service medical necessity review. Checking eligibility and benefits can't tell you when to request predetermination, since it's optional. But there's a Medical Policy Reference List on our Predetermination page to help you decide.

Services performed without required prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Checking eligibility and/or benefit information and/or obtaining prior authorization 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. If you have any questions, call the number on the member's ID card.

AIM Specialty Health (AIM) is an independent company that has contracted with BCBSIL to provide utilization management services 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 any products or services provided by third party vendors.

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Government Programs Prior Authorization Update: Code Changes, Effective Jan. 1, 2022

What's Changing: Blue Cross and Blue Shield of Illinois (BCBSIL) is changing prior authorization (PA) requirements for **Blue Cross Medicare Advantage (PPO)℠ (MA PPO), Blue Cross Community Health Plans℠ (BCCHP℠) and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠** members.

A summary of changes (procedure codes being added or removed) is included below. For some services/members, prior authorization may be required through BCBSIL. For other services/members, BCBSIL has contracted with eviCore healthcare (eviCore) for utilization management and related services.

- **Jan. 1, 2022 –** Removal of Radiation Therapy codes previously reviewed by eviCore
- **Jan. 1, 2022 –** Removal of Genetic Lab codes previously reviewed by eviCore
- **Jan. 1, 2022 –** Removal of Musculoskeletal codes previously reviewed by eviCore
- **Jan. 1, 2022 –** Removal of Radiology codes previously reviewed by eviCore
- **Jan. 1, 2022 –** Removal of Specialty Pharmacy codes previously reviewed by eviCore
- **Jan. 1, 2022 –** Removal of Medical Oncology codes previously reviewed by eviCore
- **Jan. 1, 2022 –** Addition of a Specialty Drug code to be reviewed by eviCore
- **Jan. 1, 2022 –** Removal of a Specialty Drug code previously reviewed by eviCore
- **Jan. 1, 2022 –** Addition of Radiology codes to be reviewed by eviCore
- **Jan. 1, 2022 –** Addition of Genetic Lab codes to be reviewed by eviCore
- **Jan. 1, 2022 –** Removal of Physical Health codes previously reviewed by BCBSIL

More Information

Refer to the Utilization Management section of our Provider website. Updated MA PPO and Illinois Medicaid (BCCHP and MMAI) prior authorization summaries and procedure code lists are posted on the Support Materials (Government Programs) page.

Important Reminders

Always check eligibility and benefits first through the Availity® Provider Portal or your preferred vendor portal, prior to rendering services. This step will confirm prior authorization requirements and utilization management vendors, if applicable.

If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member. Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services.

Checking eligibility and/or benefit information and/or obtaining prior authorization 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. If you have any questions, call the 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. eviCore healthcare (eviCore) is an independent company that has contracted with BCBSIL to provide prior authorization for expanded outpatient and specialty utilization management for members with coverage through BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third party vendors. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors.

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Coding Cancer and Cancer-Related Treatments

One in three people in the U.S. will be diagnosed with cancer in their lifetime, according to the American Cancer Society. Accurately and completely coding and documenting cancer and cancer-related treatments may help improve member outcomes and continuity of care.

Below is coding-related information for outpatient and professional services from the ICD-10-CM Official Guidelines for Coding and Reporting.

Coding Cancer and Cancer-Related Treatments

- To properly code a neoplasm, specify if the neoplasm is benign, in situ, malignant or of uncertain histology. Any metastases should be noted.
- All known treatments and complications should be documented.
- A statement of “History of” indicates the condition is resolved. Don’t document “History of” for members with active cancer or current treatment.
- A code from Z85.x, Personal history of malignant neoplasm, is appropriate if a primary malignancy has been previously excised or eradicated from its primary site and there is no further treatment.

Sample ICD-10-CM Codes for Neoplasms	
Malignant neoplasms	**C00-C96**
In situ neoplasms	**D00-D09**
Benign neoplasm	**D10-D36**
Benign endocrine tumors	**D3A**
Neoplasm of uncertain behavior	**D37-D48**
Neoplasms of unspecified behavior	**D49**
Personal history of malignant neoplasm	**Z85.0-Z85.9**

Tips to Consider

- Include patient demographics such as name, date of birth and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure a credentialed provider signs and dates all documents.
- Document how each diagnosis was monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.

- Take advantage of the Annual Health Assessment or other yearly preventive exam as an opportunity to capture conditions impacting member care.
- Use ICD-10 Z codes for social determinants of health on the claims you submit to Blue Cross and Blue Shield of Illinois (BCBSIL) so we may better understand the unique, social needs of our members and help connect them with available resources.

Resources

ICD-10-CM Official Guidelines for Coding and Reporting *[See Chapter 2: Neoplasms (C00-D49)]*

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Claim Editing Enhancements Coming Jan. 10, 2022

Effective **Jan. 10, 2022**, Blue Cross and Blue Shield of Illinois (BCBSIL) will be enhancing its claims editing and review process with Cotiviti for some of our **commercial non-HMO** members to help ensure accurate coding of services and to ensure that those services are properly reimbursed.

What This Means for You: Under these new enhancements, you will continue to follow generally accepted claim payment policies. With your help, the improved claims review process will help our members get the right care at the right time and in the right setting.

These claim editing enhancements do not apply to professional services for our HMO members.

About the Guidelines: BCBSIL will continue to follow claim payment policies that are global in scope, simple to understand and come from recognized sources, such as the Centers for Medicare & Medicaid Services (CMS).

Using these guidelines will help ensure a more accurate review of all claims.

Note: Inaccurately coded claims could result in denied or delayed payment.

What's changing?
Components of the editing and review enhancements include:

Coding for services within the global surgical period – The global surgery package payment policies typically include all necessary services normally provided by the surgeon before, during and after a surgical procedure, and applies only to primary surgeons and co-surgeons. The global surgery package applies only to surgical procedures that have post-operative periods of 0, 10 and 90 days, as defined by CMS.

More Detail from CMS
The global surgery package includes:

- Review of preoperative evaluation and management visits after the decision is made to operate, where the visits occur one day prior to major surgery and on the same day a major or minor surgical procedure is performed.

- When a physician sees a patient within the global follow-up period of a surgical procedure that has a 10-, or a 90-day post-operative period, the physician should report the appropriate modifier(s), relevant to the circumstance, for the procedure performed.
- The physician should report the appropriate modifier (see below) for any surgical procedure performed within the follow-up period of the original surgical procedure, if applicable. The appropriate, applicable modifiers are as follows:
  - **58** – Staged or Related Procedure or Service by the Same Physician during the Postoperative Period
  - **78** – Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
  - **79** – Unrelated Procedure or Service by the Same Physician during the Postoperative Period

More Information: View our Clinical Payment and Coding Policies for more information on the global surgery package payment policies.

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New Laboratory Policies Coming Jan. 1, 2022

Beginning **Jan. 1, 2022**, Blue Cross and Blue Shield of Illinois (BCBSIL) will implement new medical policies and a new program for claims for certain outpatient laboratory services provided to some of our **commercial, non-HMO** members. Our New Laboratory Management Program will help ensure our members get the right care at the right time and in the right setting. It will also help you better prepare and submit claims that support and reflect high quality, affordable care delivery to our members.

Affected Members
The program will apply to some Fully Insured and Administrative Services Only (ASO) commercial members, while some Federal Employee Program® (FEP®) members will be added later. ***This program does not apply to government programs or any of our HMO members.***

See below for key points to help you prepare, including a list of training dates.

Medical Policy Updates
Watch for new and revised BCBSIL Medical Policies effective **Jan. 1, 2022**, related to certain laboratory, services, tests, and procedures. Also refer to our Clinical Payment and Coding Policies.

Affected Claims
Our new program will include the following outpatient laboratory claims:

- Dates-of-service on or after **Jan. 1, 2022**
- Performed in an outpatient setting (typically office, hospital outpatient, or independent laboratory)

Note: Laboratory services provided in emergency room, hospital observation and hospital inpatient settings are **excluded** from this program. Member contract benefits and clinical criteria still apply.

New Claim Simulation Tool
Effective **Jan. 1, 2022**, you can get free access to the program's **Trial Claim Advice Tool**, which allows you to input codes and diagnoses to see, before submitting a claim, the potential outcome of your claim. The Trial Claim Advice Tool is a free simulation tool and does not guarantee approval, coverage, or reimbursement of services. Responses consider

information entered through the tool for the date of service entered and historical claims finalized through the previous business day. Claims not yet finalized won't be considered. ***This program and Trial Claim Advice Tool do not apply to government programs or any of our HMO members.***

What you need to do:

- To access the Trial Claim Advice Tool, log on to the Availity® Provider Portal.
- To get to the Trial Claim Advice Tool, use the single sign-on feature via the BCBSIL-branded Payer Spaces section within the Availity portal.
- If you're not a registered Availity user, we encourage you to sign up before the January 2022 program activation, to gain access to the Trial Claim Advice Tool. Register on the Availity website today, at no charge. For registration help, call Availity Client Services at 800-282-4548.

Provider Training

Attend free webinars on how to use the Trial Claim Advice Tool and learn more about the Laboratory Management Program. ***This program does not apply to government programs or any of our HMO members.*** To register, select your preferred date and time from the list below:

- **Nov. 4, 2021 – noon to 1 p.m.**
- **Nov. 9, 2021 – 10 to 11 a.m.**
- **Nov. 11, 2021 – 11 a.m. to noon**
- **Nov. 17, 2021 – 11 a.m. to noon**
- **Nov. 23, 2021 – 10 to 11 a.m.**
- **Dec. 1, 2021 – 11 a.m. to noon**
- **Dec. 7, 2021 – 2 to 3 p.m.**
- **Dec. 15, 2021 – 11 a.m. to noon**
- **Dec. 28, 2021 – 11 a.m. to noon**
- **Jan. 5, 2022 – 11 a.m. to noon**

For More Information

Continue to watch the News and Updates for future program updates.

This program does not apply to government programs or any of our HMO members.

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Submitting Electronic Replacement or Corrected Claims

The Blue Cross and Blue Shield of Illinois (BCBSIL) claim system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows you to submit changes to claims that were not included on the original adjudication.

Claim Frequency Codes
The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “claim frequency codes.” Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim.

Use the below frequency codes for claims that were **previously adjudicated**:

Claim Frequency Codes			
Code	**Description**	**Filing Guidelines**	**Action**
5 - Late Charge(s) (Institutional Providers Only)	Use to submit additional charges for the same date(s) of service as a previous claim.	File electronically, as usual. Include only the additional late charges that were not included on the original claim.	BCBSIL will add the late charges to the previously processed claim.
7 - Replacement of Prior Claim	Use to replace an entire claim (all but identity information).	File electronically, as usual. File the claim in its entirety, including all services for which you are requesting reconsideration.	BCBSIL will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.

8 - Void/Cancel of Prior Claim	Use to entirely eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period."	File electronically, as usual. Include all charges that were on the original claim.	BCBSIL will void the original claim from records based on request.

Submitting Electronic Replacement Claims
When submitting claims noted with claim frequency code 7 or 8, the original BCBSIL claim number (also referred to as the Document Control Number or DCN) ***must*** be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The DCN can be obtained from the 835 Electronic Remittance Advice (ERA) or Electronic Payment Summary (EPS).* Without the original BCBSIL DCN, adjustment requests will generate a compliance error and the claim will reject. BCBSIL only accepts claim frequency code 7 to replace a prior claim or claim frequency code 8 to void a prior claim.

Specific information and examples for **Professional** and **Institutional** providers are included below.

Professional Providers:
Claim corrections submitted without the appropriate frequency code will deny and the original BCBSIL claim number will not be adjusted. For more information on submitting electronic replacement claims, refer to the table and example below.

Code	Action
7 - Replacement of Prior Claim	BCBSIL will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8 - Void/Cancel of Prior Claim	BCBSIL will void the original claim from records based on request.

An example of the ANSI 837 CLM segment containing the claim frequency code 7, along with the required REF segment and Qualifier in Loop ID 2300 - Claim Information, is provided below.

Claim Frequency Code

CLM*12345678*500***11:B:7*Y*A*Y*I*P~
REF*F8*(Enter the Claim Original Document Control Number)

Institutional Providers:
Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original BCBSIL claim number will not be adjusted. For more information on submitting electronic replacement claims, refer to the table and example below.

Code	Action
5 - Late Charge(s)	BCBSIL will add the late charges to the original claim processed claim.
7 - Replacement of Prior Claim	BCBSIL will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim. This code is not intended to be used in lieu of late charges.
8 - Void/Cancel of Prior Claim	BCBSIL will void the original claim from records based on request.

When submitting corrected institutional claims, take note of CLM05-2, the Facility Code Qualifier. In this instance, the CLM05-2 field would require a value of “A” indicating an institutional claim – along with the appropriate frequency code (7) as illustrated in the example below.

Note: If a charge was left off the original claim, submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.

Frequency Code 5, Late Charge(s) applies strictly to institutional claims.

For more information on professional electronic replacement claims, visit the Claim Submission section of our Provider website.

EPS files are not available for Blue Cross Community Health Plans℠ (BCCHP℠), Blue Cross Community MMAI (Medicare-Medicaid Plan)℠, Blue Cross Medicare Advantage (HMO)℠ and Blue Cross Medicare Advantage (PPO)℠ claims.

BlueCross BlueShield of Illinois

BLUE REVIEW℠

A Provider Publication

November 2021

Introducing Electronic Clinical Claim Appeal Requests via Availity® Provider Portal

Blue Cross and Blue Shield of Illinois (BCBSIL) is excited to announce a new and convenient electronic capability to submit appeal requests for specific clinical claim denials through the Availity Portal. This electronic option allows you to submit the clinical appeal request, upload supporting documentation, and monitor its status.

A ***clinical appeal*** is a request to change an adverse determination for care or services when a claim is denied based on lack of medical necessity, or when services are determined to be experimental, investigational or cosmetic.

This new online offering allows for:

- Status management
- Uploading clinical medical records with the appeal submission
- Viewing and printing confirmation and decision letters
- Generating a Dashboard view of appeal-related activity

Steps to submit appeal requests for clinical claim denials online:

- Log in to Availity
- Select *Claims & Payments* from the navigation menu, then choose *Claim Status*
- Search and locate the claim by using the Member ID or Claim Number
- On the Claim Status results page, select *Dispute Claim (when applicable)*
- Complete the *Dispute Request Form*
- Upload supporting documentation
- Review and submit your appeal request

For help with obtaining claim status online, please refer to the Claim Status Tool User Guide.

Training

BCBSIL is hosting complimentary webinars for providers to learn how to use this new electronic clinical claim appeal Dispute tool. To register for a training session, select your preferred date and time below.

- Nov. 8, 2021 – 1 to 2 p.m.
- Nov. 10, 2021 – 10 to 11 a.m.

- Nov. 12, 2021 – 10 to 11 a.m.
- Nov. 15, 2021 – 1 to 2 p.m.
- Nov. 17, 2021 – 10 to 11 a.m.
- Nov. 19, 2021 – 10 to 11 a.m.
- Nov. 22, 2021 – 1 to 2 p.m.
- Nov. 24, 2021 – 10 to 11 a.m.
- Nov. 29, 2021 – 1 to 2 p.m.
- Dec. 1, 2021 – 10 to 11 a.m.
- Dec. 3, 2021 – 10 to 11 a.m.

Availity Administrators need to assign their users the **Claim Status role** in Availity to ensure users can access and submit electronic appeals online. If your provider organization is not yet registered with Availity, you can sign up today at Availity, at no charge. For registration help, contact Availity Client Services at 800-282-4548.

For More Information

A new **Electronic Clinical Claim Appeal Request User Guide** is available in the Provider Tools section of our website. Visit the Webinars and Workshops page for more webinar sessions in **December 2021**. If you need further help, contact our Provider Education Consultant team.

Note: This information is not applicable to Medicare Advantage, Illinois Medicaid claims or BlueCard® (out-of-area) claims.

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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®. In particular, potential patients may use this online tool to confirm if you or your practice is a contracted in-network provider for their health care benefit plan. Other providers may use the Provider Finder to refer their patients to your practice.

Is your online information accurate? Check your information in Provider Finder. If changes are needed, please let us know as soon as possible. An overview of types of changes and how to request them is below.

New in 2021: Provider Onboarding Form Training Sessions
Our training schedule now includes a webinar to help you navigate our online Provider Onboarding Form. This training will cover how to request the addition of providers to your currently contracted group. We'll also discuss new group/provider contracting and how to submit demographic changes online. **This month's Provider Onboarding Form Training will be held on Nov. 30, 2021, from 10 to 11 a.m., CT – register now!**

Types of Information Updates

- **Demographic Changes** – Use the Demographic Change form to change existing demographic information, such as address, email, National Provider Identifier (NPI)/Tax ID or to remove a provider. You may specify more than one change within your request as long as all changes relate to the same billing (Type 2) NPI. As a participating provider, your NPI(s) should already be on file with BCBSIL. You may use this online form to request changes, such as deactivation of an existing NPI.
- **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 are not immediate upon submission of this form. The provider being added to the group will not be considered in network until they are 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 are an existing provider who 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 are 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.

Changes are not immediate upon request submission.

For status of your professional contract application, or if you have questions or need to make changes to an existing contract, email our Network Operations Provider Update team.

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ClaimsXten™ Quarterly Update Reminder

The ClaimsXten code auditing tool is updated quarterly. On or after **Dec. 13, 2021,** Blue Cross and Blue Shield of Illinois (BCBSIL) will implement the fourth quarter code update in the ClaimsXten tool.

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 (HCPCS) codes

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

Use **Clear Claim Connection™ (C3)** to determine how certain coding combinations may be adjudicated when we process your claim. C3 is a free, online reference tool that mirrors the logic behind BCBSIL's code-auditing software.

Please note that C3 doesn't contain all of 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 article doesn't apply to government programs (Medicare Advantage and Illinois Medicaid) member claims.

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