‘HIT’ Focus | Health Information Technology

New! Single Sign-on to iEXCHANGE® through Availity®

Our recent Blue Review Special Edition newsletter presented an overview of Health Information Technology (HIT), with an emphasis on how you can take action and what BCBSIL is doing to provide support. Due to the importance of this initiative, we have added a ‘HIT’ Focus feature column in the Blue Review to continue to help keep you informed of some of the latest HIT news and updates.

You may already be using iEXCHANGE—our automated benefit pre-certification tool that supports direct submission, processing and online approval of inpatient medical/surgical procedures 24 hours a day, seven days a week. iEXCHANGE is accessible to independently contracted network physicians and facilities within Illinois and northwest Indiana via a Web-based application.

We’re pleased to announce that, effective Jan. 15, 2011, gaining direct access to iEXCHANGE became even easier, due to a new, single sign-on process through Availity. This enhancement eliminates the need for your office to go to separate Web locations for Availity and iEXCHANGE and it’s available at no cost to registered Availity users.

You must be a registered Availity user in order to request single sign-on access to iEXCHANGE. If you are already a registered Availity user, the iEXCHANGE single sign-on registration links can be found in the Authorization and Referrals section of the Availity provider portal. Please check with your Availity Primary Access Administrator (PAA) to request access.

Note: If you are already enrolled for iEXCHANGE, you may continue to gain access as you do today. However, we suggest that you consider signing up for single sign-on access through the Availity portal for simultaneous access to online pre-certifications and other BCBSIL transactions, such as eligibility & benefits, claim status and other services offered through Availity.

For more information about iEXCHANGE, visit the Education and Reference Center/Provider Tools section of our website at www.bcbsil.com/provider. If you have any questions about how to enroll, use, or manage your account, our iEXCHANGE Help Desk is available to assist you. Please e-mail us at iEXCHANGE_HelpDesk@bcbsil.com, or call (312) 653-3399.

Need more information about Availity? To register or to learn about the products and services available through Availity, visit www.availity.com, or call Availity Client Services at (800) AVAILITY (282-4548) for assistance.

Availity is a registered trademark of Availity, L.L.C., an independent third party vendor. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by third party vendors. The vendors are solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.
The 2010 HMO Member Survey was conducted in June and July of 2010. The primary purpose of this survey was to assess member satisfaction in a variety of areas at the MG/IPA level, including medical care and services rendered by HMO PCPs and Specialists, access to care and overall MG/IPA service. Survey recipients included a random sampling of adult patients who have been BCBSIL HMO members for at least one year. The overall response rate for this year was 26.7 percent.

2010 ACCOLADES

Many categories of the 2010 survey received a score of 90 percent or better, including the following:

- Overall member satisfaction with the MG/IPA, PCP and/or Specialist
- Rating of care and services provided by the PCP and Specialist (thoroughness of exams; explanation of medical tests and treatments; advice to stay healthy; respect shown and attention to privacy; and medical care received)
- Rating of availability and knowledge of staff (PCP office hours, and understanding of health care benefits obtained from PCP and Specialist office personnel)
- Usefulness of information contained in the Blue StarSM MG/IPA Report and Blue StarSM Hospital Report

Other results fell consistently in the 80 percent range, as indicated below.

### PCP Management/Coordination of the Member's Care

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of time between making an appointment and the date of appointment</td>
<td>88.5%</td>
</tr>
<tr>
<td>(Percent of “Excellent,” “Very Good,” or “Good” responses)</td>
<td></td>
</tr>
<tr>
<td>Length of time waited for an urgent appointment (within 24 hours)</td>
<td>87.1%</td>
</tr>
<tr>
<td>How often the PCP gave the member clear instructions on health problems or</td>
<td>87.8%</td>
</tr>
<tr>
<td>symptoms bothering the member (Percent of “Always” and “Usually” responses)</td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, how often the PCP gave the member easy-to-understand</td>
<td>88.8%</td>
</tr>
<tr>
<td>instructions about taking his or her medicines (Percent of “Always” and</td>
<td></td>
</tr>
<tr>
<td>“Usually” responses)</td>
<td></td>
</tr>
</tbody>
</table>

### Referral Process

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction with MGs/IPAs referral process (Percent of “Yes” responses)</td>
<td>87.8%</td>
</tr>
</tbody>
</table>

### Specialist-related Questions

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of Specialist after hours (Percent of “Excellent,” “Very Good,”</td>
<td>83.2%</td>
</tr>
<tr>
<td>or “Good” responses)</td>
<td></td>
</tr>
<tr>
<td>Availability of Specialist’s office hours (Percent of “Excellent,” “Very</td>
<td>88.1%</td>
</tr>
<tr>
<td>Good,” or “Good” responses)</td>
<td></td>
</tr>
<tr>
<td>Length of time between making an appointment and the date of appointment</td>
<td>83.7%</td>
</tr>
<tr>
<td>(Percent of “Excellent,” “Very Good,” or “Good” responses)</td>
<td></td>
</tr>
<tr>
<td>Length of time spent in the waiting room (Percent of “Excellent,” “Very</td>
<td>83.5%</td>
</tr>
<tr>
<td>Good,” or “Good” responses)</td>
<td></td>
</tr>
</tbody>
</table>

**BLUE RIBBONSM STATUS**

Of the 93 MGs/IPAs analyzed in 2010 for a Blue Ribbon Directory Indicator:

- Eighty-one received a Blue Ribbon.
- Six did not receive Blue Ribbon status.
- Six received an “Insufficient Responses” designation.

*Medical Group/Independent Practice Association
It is important to confirm that there is no conflict of interest between BCBSIL contracted HMO MGs/IPAs and the MG/IPA employees regarding UM issues. To help ensure we adhere to this requirement, BCBSIL and independently contracted HMO MGs/IPAs must affirm that their employees and contracting physicians abide by certain UM decision-making guidelines.

BCBSIL HMO employees affirm that:

1. UM benefit decisions are based on medical necessity, which includes appropriateness of care and services, and the existence of available benefits;
2. The organization does not specifically reward health plan staff, providers or other individuals for issuing benefit denials for any health care service or products; and
3. Incentive programs are not utilized to encourage decisions that result in under-utilization.

BCBSIL also affirms that there is no conflict of interest between the MGs/IPAs and BCBSIL HMO product (HMO Illinois and BlueAdvantage HMO) employees regarding UM issues.

HMO MGs/IPAs that contract with BCBSIL to participate in our HMO products must also affirm that their employees and contracted physicians follow established UM decision-making guidelines.

HMO MGs/IPAs must meet the following UM access standards:

1. Calls regarding UM decisions after normal business hours must be answered or taken via a voicemail system, answering machine or answering service;
2. Calls regarding UM decisions must be returned within one business day of receipt; and
3. Collect calls must be accepted ONLY in regard to UM decisions.

Annual statements regarding these guidelines are distributed to HMO product staff, MG/IPA physicians and staff, and BCBSIL HMO members.
Reminder to Facilities When Filing ER Claims

Often BCBSIL members seek Emergency Room services for symptoms that prove to be non-emergent after being diagnosed. For example, a patient with chest pains may believe they are experiencing a heart attack, but are later diagnosed with indigestion. We receive these types of ER claims where codes for the final diagnosis are indicated, but there is no documentation of the presenting symptoms.

To help ensure we have the proper information to consider the claim as an emergency service, please include the symptoms/reasons for the patient’s visit as well as the final diagnosis on ER claims. Facility claims submitted with only the final diagnosis without indicating the reason for the patient’s visit may be processed and paid at non-emergency levels, which impacts how a member’s benefits are determined.

CLAIM FILING GUIDELINES

Electronic Claim Submitters:
On the ANSI 837I (V4010A1) transaction and in Loop ID 2300 (Claim Information), utilize the “HI” segment (segment titled: Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information) when submitting claims electronically for the “Patient Reason for Visit” field. This information is required for all unscheduled outpatients visits.

- In the HI01-1 segment, enter the “BK” Qualifier – this qualifier denotes the Principal Diagnosis code (ICD-9-CM) that follows
- In the HI01-2 segment, enter the Principal Diagnosis code (the ICD-9-CM Code)
- In the HI02-1 segment, enter the “ZZ” Qualifier, this qualifier denotes the Patient’s Reason For Visit (ICD-9-CM) code that follows
- At the HI02-2, enter the Patient’s Reason for Visit diagnosis code (the ICD-9-CM Code)

Paper Claim Submitters:
On the UB-04, the reason for the patient’s visit should be reported in Form Locator 70 A-C on outpatient claims, and the final diagnosis code should be entered in Form Locator 67. For more information on institutional claim filing guidelines, please refer to the UB-04 Data Specifications Manual, available by subscription through the National Uniform Billing Committee (NUBC) at www.nubc.org.

If you believe we processed an ER claim incorrectly, please complete and submit a Provider Review Form, which can be found on our website at www.bcbsil.com/provider, in the Claims and Eligibility/Claim Review and Appeal section. Availity and RealMed® users can also utilize the new Claim Inquiry Resolution (CIR) function on the Electronic Refund Management (eRM) tool to request reconsideration of a finalized claim. If necessary, we may request the ER report to be reviewed by our Medical Review Unit.

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

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.
Transition Period Policy

Beginning Jan. 1, 2011, many Medicare Part D beneficiaries entered into a 90-day Transition Period. Part D plan sponsors are required by the Centers for Medicare and Medicaid Services (CMS) to provide for an appropriate transition period for new enrollees prescribed Part D drugs that may not be on their new plan’s formulary or included on the formulary, but subject to certain limitations (e.g., prior authorization or step therapy).

A Part D sponsor’s transition process is necessary with respect to: (1) the transition of new enrollees into prescription drug plans following the annual coordinated election period; (2) the transition of newly eligible Medicare beneficiaries from other coverage; (3) the transition of individuals who switch from one plan to another after the start of the contract year; (4) enrollees residing in long term care (LTC) facilities; and (5) in some cases, current enrollees affected by formulary changes from one contract year to the next. In addition, sponsors are expected to expedite transitions to formulary drugs for enrollees who change treatment settings due to changes in level of care.

In order to address situations in which an individual beneficiary first presents at a participating pharmacy with a prescription for a drug that is not on the formulary, unaware of what is covered by the plan or of the sponsor’s exceptions process for providing access to Part D drugs that are not covered, Part D sponsors must have systems capabilities that allow them to provide a one time, temporary supply of non-formulary Part D drugs. This one-time fill for patients in the retail setting (up to three x 31 day supply fills, unless the prescription is written for less than 31 days for patients in long-term care facilities) is to accommodate the immediate needs of an enrollee, as well as to allow the sponsor and/or the enrollee sufficient time to work out with the prescriber an appropriate switch to a therapeutically equivalent medication, or the completion of an exception request to maintain coverage of an existing drug based on medical necessity.

In addition to transition fills of non-formulary prescriptions, plan sponsors are required to provide each enrollee with a written transition notice, via U.S. First Class mail, within three business days of the temporary fill. New for the 2011 plan year, CMS is requiring that plan sponsors also “ensure that reasonable efforts are made to notify prescribers of enrollees who receive a transition notice after adjudication of a temporary fill” [42 C.F.R.§423.120(b)(3)(v)]. As a consequence of this new guidance from CMS (effective Jan. 1, 2011), BlueMedicareRx will be sending via U.S mail a copy of the member’s transition notice (labeled “PRESCRIBER COPY” on the top of the notice) as well as a cover letter to the prescriber of record. We are supportive of CMS’s new directive and hope that you will find this additional information valuable in obtaining appropriate drug therapy for your patients in the BlueMedicareRx Part D program.

References:

Medicare Part D Pharmacy Update:

High-tech Imaging Update for City of Chicago Members

The City of Chicago requires benefit authorization through ENCOMPASS Health Management Systems at (800) 373-3727 for prior approval of CAT scans, MRI scans and PET scans.* Claims submitted for these services without prior authorization through ENCOMPASS may be denied. As of Jan. 1, 2011, this applies to the entire City of Chicago group, including non-Medicare Retirees.

To identify City of Chicago members, look for the CTY alpha prefix on the member’s ID card. Group numbers are 016604, P16602, P16605, P16606, P16610, P16628, P16632, P16642, P16643, P17600, P18600, P18601 and P20600. Always refer to the back of the member’s ID card to verify prior authorization requirements and appropriate contact information.

*Note: The City of Chicago is an exception. For most other BCBSIL members with PPO or BlueChoice Select coverage, obtaining a Radiology Quality Initiative (RQI) number through American Imaging Management (AIM) is required by BCBSIL prior to ordering outpatient, non-emergency imaging studies. For complete information on AIM and the RQI process for high-tech imaging services, please visit the Claims and Eligibility/Prior Authorization section of our website at www.bcbsil.com/provider.
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 changes to the physician fee schedules. Be sure to review this area each month.

Effective Jan. 15, 2011, codes 22551 and J1559 were updated.

Effective Feb. 1, 2011, code J7330 was updated.

Effective March 1, 2011, the following code ranges will be updated: A9576-A9583, A9604, J0000-J9999, P9041-P9048, Q0181, Q0515, Q2009-Q3031, Q4074-Q4116, Q9951-Q9967, and S0012-S0191. Please note that not all codes in these ranges will be updated.

Effective April 5, 2011, code J1950 will be updated.

Effective May 1, 2011, codes E2402, A4930, A6550 and A7000 will be updated.

Annual and quarterly fee schedule updates can be requested by downloading the Fee Schedule Request Form, available on our website at www.bcbsil.com/provider, in the Forms section of our online Education and Reference Center. 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 Centers for Disease Control (CDC) has recently released the Sexually Transmitted Diseases (STDs) Treatment Guidelines, 2010. To obtain a copy of the 2010 STD Treatment Guidelines, you may visit the CDC’s website at http://www.cdc.gov/std/treatment/2010. You may also call (800) CDC-INFO (232-4636), or send an e-mail to cdcinfo@cdc.gov for assistance.

Over 19 million cases of STDs occur in the United States each year, with a disproportionate share among young people and racial and ethnic minority populations. The estimated annual direct medical costs of treating STDs and their sequelae are $17 billion. Left untreated, STDs can cause serious health problems ranging from infertility to increased risk of HIV infection. To stop these silent epidemics, the 2010 STD Treatment Guidelines, which update the 2006 STD Treatment Guidelines, advise physicians and other health care providers on the most effective treatment regimens, screening procedures, and prevention and vaccination strategies for STDs.

The recommendations have been developed in consultation with public and private sector professionals knowledgeable in the treatment of patients with sexually transmitted infections. CDC revises the STD Treatment Guidelines periodically, approximately every three to four years, using a scientific, evidence-based process. The guidelines are applicable to various patient-care settings, including family planning clinics, private physicians’ offices, managed care organizations, and other primary care facilities. Although the guidelines emphasize treatment, prevention strategies and diagnostic recommendations also are discussed.

Highlights of the 2010 STD Treatment Guidelines include:

- Expanded STD prevention recommendations, including pre-exposure HPV vaccine;
- Revised gonorrhea treatment regimens;
- New treatment regimens for genital warts and bacterial vaginosis;
- Discussion of the role of mycoplasma genitalium and trichomoniasis in the evaluation of urethritis and cervicitis and treatment-related implications; and
- Revised guidance on the diagnostic evaluation and management of syphilis.

These recommendations should be regarded as a source of clinical guidance, and not as standards or inflexible rules. These guidelines focus on the treatment and counseling of individual patients and do not necessarily address other community services and interventions that are important in STD/HIV prevention. Expanded STD screening and treatment are critical to reduce the severe impact of these diseases. The CDC’s STD Treatment Guidelines play a critical role in this effort, since it is the most widely referenced and authoritative source on STD treatment and management.

PREVENTION INITIATIVES

The CDC’s Division of STD Prevention met with community leaders and other partners who work with minority communities to help develop acceptable and effective approaches to reduce STD disparities. This workgroup produced a strategic plan to reduce STDs in groups with the highest reported cases of STDs, to prioritize and monitor activities, and to measure the effectiveness of those activities.

The contents of this article were provided by the CDC, Division of STD Prevention. BCBSIL is providing this information solely as a courtesy and BCBSIL is not responsible for the contents of this article. The author of this article is solely responsible for its contents. If you have any questions or comments regarding this article you should direct them to the author.

At BCBSIL, we encourage you to discuss STD prevention with your patients and remind them to visit the STD Awareness website at http://www.cdcnpin.org/stdawareness throughout the year for a variety of helpful resources. There are also a number of STD educational resources, including a video library, available on our Be Smart. Be Well* website at http://www.besmartbewell.com. The content on these sites may assist you in educating and motivating your patients in the prevention of STDs.
Pertussis remains an important concern for Illinois practitioners. For the first 48 weeks of 2010, 778 cases of pertussis were reported, compared to 603 during the same time period in 2009.

Pertussis, also known as whooping cough, is a highly contagious respiratory tract infection caused by the bacterium Bordetella pertussis. In the first half of the 20th century, whooping cough was a leading cause of childhood illness and death in the United States. With the introduction of an effective vaccine, the number of cases gradually declined, reaching a low in the mid-70s. Once infected with whooping cough, it usually takes three to 12 days for symptoms to appear. Initially mild, resembling a common cold, the signs and symptoms usually worsen and may result in severe and prolonged coughing attacks. Common complications include nausea and vomiting, pneumonia, encephalopathy, and seizures. Unfortunately, infections in infants can be particularly severe.

Use of appropriate antibiotics (i.e., azithromycin, clarithromycin, or erythromycin) early in the course of the disease is very important. If treatment for pertussis is started in the first two weeks or prior to the start of coughing paroxysms, symptoms may be lessened. In those patients diagnosed with whooping cough in the later stages, antibiotics have not been shown to be effective in altering the course of the illness. As a consequence, vaccination is the best defense against whooping cough. However, the immunity from vaccines wanes over time and pertussis booster vaccination rates in adolescents and adults continue to be low. There are currently two types of pertussis vaccines: a) DTaP for infants and children, and b) Tdap for adolescents and adults. Both vaccines protect against whooping cough, tetanus, and diphtheria. Getting vaccinated with Tdap is especially important for family members and/or caregivers of the very young.

The BCBSIL Preventive Health Care Guidelines, which include recommended immunization schedules from the Advisory Committee on Immunization Practices, are available in the BCBSIL Provider Manual, which is in the Standards and Requirements section of our website at www.bcbsil.com/provider. The Centers for Disease Control (CDC) website at www.cdc.gov also includes a variety of helpful educational and reference materials for health care professionals and their patients, such as answers to frequently asked questions about whooping cough, and a flyer with information on how parents can protect themselves and their children.

References:

The material in this article is for informational purposes only and is not a substitute for the sound medical advice of a doctor. Health care professionals should exercise their own independent medical judgment in treating patients.

Reminder! Do Not Bill for Treatment of Family Members

BCBSIL benefits are not available for services that a patient receives from a provider who is a member of their immediate family. An immediate family member is defined as:
- Current spouse
- Eligible domestic partner
- Parents and step-parents
- Children and grandchildren
- Siblings (including natural, step, half or other legally placed children)

BCBSIL does not expect to receive claims for services rendered by or for immediate family members and there will be no payment on claims submitted for services rendered by or for immediate family members. Should it be determined that a claim has been paid in error, BCBSIL will request a refund of the original payment.

The material in this article is for informational purposes only and is not a substitute for the sound medical advice of a doctor. Health care professionals should exercise their own independent medical judgment in treating patients.
Updated BlueCard Program Manual Now Available

A revised BlueCard Program Manual is now available on our website at www.bcbsil.com/provider. You will find a link to the new Manual in the Standards and Requirements/BlueCard Program section under Related Resources.

The BlueCard Program allows members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan’s service area.

The following information is included in the BlueCard Manual:

- How the BlueCard program works
- How to identify BlueCard members
- Claim filing guidelines
- Key contacts
- Answers to Frequently Asked Questions
- Glossary of BlueCard terms

Please review and become familiar with the procedures and guidelines outlined in the BlueCard Program Manual so that you may use it as a resource when providing services to out-of-area Blue Cross and Blue Shield (BCBS) members.

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 www.bcbsil.com/provider.

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

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