BlueCross BlueShield of Illinois

BLUE REVIEW℠

For Providers

August 2024

August Spotlight

Has Your Information Changed? Update Us and the NPI Registry

Our members rely on accurate provider information to find care. When your practice address, phone number or other demographic information changes, please update us.

Learn More

Claims and Coding

Check Eligibility and Benefits: Don't Skip This Important First Step

Is your patient's membership with us still active? Are you or your practice/medical group in-network or out-of-network for a specific patient? Is prior authorization required for a particular member/service?

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Proper Billing for Supplies for Transcutaneous Electrical Nerve Stimulation Units

Incorrect coding on claims for Transcutaneous Electrical Nerve Stimulation Units and necessary supplies causes additional costs for you and our members. This article covers

tips to help ensure proper billing for medically necessary care and services.

Learn More

Check Prior Authorization Requirements for Procedure Codes Through Availity® Essentials or Our Automated Phone System

You can check prior authorization requirements for procedure codes online by using Availity Essentials Eligibility and Benefits. If you aren't able to check online, our interactive voice phone system has a new menu option to quickly confirm this information for our commercial members.

Learn More

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

We're changing prior authorization requirements that may apply to some commercial non-HMO and government programs [Blue Cross Medicare Advantage (PPO)SM, Blue Cross Community Health PlansSM and Blue Cross Community MMAI (Medicare-Medicaid Plan)SM] members. Refer to News and Updates for a summary of commercial and government programs changes and code updates.

Community

BCCHPSM and MMAI Providers: Join Our Community Stakeholder Committee

We're hosting quarterly Community Stakeholder Committee meetings to find ways to better serve our BCCHP and MMAI members. We'd like to invite you to join us for our next committee meeting on **Aug. 15, 2024.** Read more on News and Updates.

Education

Cultural Awareness Webinars: No-Cost Continuing Education Credit

We offer a suite of no-cost webinars that provide cultural awareness training and continuing education credit.

Learn More

Provider Learning Opportunities

We offer free webinars and workshops for the independently contracted providers who work with us. A preview of upcoming training sessions is included in this month's issue.

Learn More

Medicare

Medicare Providers May Treat Blue Cross Group Medicare Advantage Open Access (PPO)SM Members

If you're a Medicare provider, you may treat Blue Cross Group Medicare Advantage Open Access (PPO) members. This is an open access, non-differential national PPO plan without network restrictions.

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Notify Us if You Opt Out of Medicare

Blue Cross Medicare AdvantageSM plan and MMAI providers who choose to opt out of Medicare should immediately notify their Provider Network Consultant.

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Pharmacy

Pharmacy Program Updates: Prior Authorization Changes Effective July 1 and Oct. 1, 2024

The pharmacy PA program encourages safe, cost-effective medication use by allowing coverage when certain conditions are met. A clinical team of physicians and pharmacists develops and approves the clinical programs and criteria for medications that are appropriate for PA by reviewing U.S. FDA-approved labeling, scientific literature and nationally recognized guidelines. Read more on News and Updates for changes effective

July 1 and Oct. 1.

Quality Care

Physician Performance Insights Reports Coming Soon from PEAQ℠

In September, physicians eligible for our Physician Efficiency, Appropriateness, & Quality℠ program can view their Physician Performance Insights reports. PPI reports show how physicians compare to their peers and include information on improving performance.

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Provider Finder® to Rank Providers To Help PPO Members Find Care

Later this year, Provider Finder will add a tiering feature that shows how providers rank against peers in their working specialties for some PPO products. The tier will display only for members in employer groups with a tiered benefit option.

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Many children and adolescents are still catching up on missed routine immunizations and well-care visits, according to the Centers for Disease Control and Prevention. The CDC recommends that doctors and health care professionals encourage families to schedule vaccines and visits for their children.

Learn More

Reminders

Stay informed!

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

Verify and Update Your Information

Verify your directory information every 90 days. Use the **Availity® Essentials Provider Data Management** feature or our Demographic Change Form. Learn more.

Provider Training

For dates, times and online registration, visit the Webinars and Workshops page.

Contact Us

Questions? Comments? Send an email to our editorial staff.

Print

Print this month's newsletter in its entirety.

bcbsil.com/provider

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Has Your Information Changed? Update Us and the NPI Registry

Our members rely on accurate provider information to find care. When your **practice address, phone number** or other demographic information changes, take the following steps:

Update the National Provider Identifier Registry if you have an NPI

- Update your information through the National Plan & Provider Enumeration System website, **or**
- Download and mail in the Centers for Medicare & Medicaid Services' NPI update form

Instructions are provided online in the NPPES FAQs. See the CMS website for more on NPIs.

Update Blue Cross and Blue Shield of Illinois

- Update your demographic information via the Provider Data Management feature in Availity® Essentials, **or**
- Use our Demographic Change Form if you're unable to use Availity

You can also use these tools to verify that your directory information is accurate. Federal law requires that directory information be **verified every 90 days** even if it hasn't changed. Learn more.

Availity administrators should also keep their organization's provider information current in **Availity Manage My Organization** to ensure the associated provider data is accurate in the various Availity self-service tools. Manage My Organization is a separate function from Provider Data Management, and data should be updated in both tools.

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

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Check Eligibility and Benefits: Don't Skip This Important First Step

Is your patient's membership with us still active? Are you or your practice/medical group in-network or out-of-network for a specific patient? Is prior authorization required for a particular member/service?

Get Answers Up Front

Benefits will vary based on the service being rendered and individual and group policy elections. It's critical to check eligibility and benefits for each patient before every scheduled appointment. Eligibility and benefit quotes include important information about patients' benefits, such as membership verification, coverage status and applicable copayment, coinsurance and deductible amounts. Also, the benefit quote may include information on applicable prior authorization or pre-notification requirements.* When services may not be covered, you should notify members that they may be billed directly.

Don't Take Chances

Ask to see the member's ID card for Blue Cross and Blue Shield of Illinois 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 ID card if they have questions about their benefits.

Use Online Options

We encourage you to check eligibility and benefits via an electronic 270 transaction through Availity® Essentials or your preferred vendor. You can conduct electronic eligibility and benefits inquiries for local members, out-of-area BlueCard® and Federal Employee Program® members.

Learn More

For more information, refer to the Eligibility and Benefits page on our provider website. BCBSIL also offers educational webinars with an emphasis on electronic transactions, including eligibility and benefits inquiries. Refer to the Webinars and Workshops page for upcoming dates, times and registration links to sign up now.

*Note: For **commercial non-HMO members**, even if prior authorization isn't required, you still may want to submit an optional request for recommended clinical review (predetermination). This step can help avoid post-service medical necessity review. Checking eligibility and benefits can't tell you when to request recommended clinical review, since it's optional. There's a Recommended Clinical Review (Predetermination) Code List on our Recommended Clinical Review (Predetermination) page to help you decide.

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Proper Billing for Supplies for Transcutaneous Electrical Nerve Stimulation Units

Incorrect coding on claims for Transcutaneous Electrical Nerve Stimulation Units and necessary supplies causes additional costs for you and our members. Here are some tips to help ensure proper billing for medically necessary care and services.

TENS Unit Rental

One month of necessary supplies are included in the rental of a TENS unit. There's no need to order additional items such as electrodes, lead wires and batteries for the first month of use.

Trial Before Purchase

Our **Medical Policy MED201.040 r**ecommends a trial use of a TENS unit used daily or near daily for at least 30 days to establish efficacy of the treatment and compliance. The trial must be monitored by an appropriate provider. The ordering provider must deem the trial period successful, prior to ordering and dispensing a purchased TENS unit. Refer to the Medical Policies section of our website to view MED201.040 in detail.

TENS Unit Purchase

A purchased TENS unit includes lead wires, which usually last one year, and one month of necessary supplies including all electrodes, conductive paste or gel (if needed) and batteries.

Appropriate Coding

For the **TENS unit purchase or rental**, use Healthcare Common Procedure Coding System **code E0720**

or E0730 with applicable modifiers.

For **additional supplies** after the first month of use, use HCPCS **code A4595**. It includes all required electrodes and items such as conductive paste or gel, tape or other adhesive, adhesive remover, skin preparation materials, batteries and a battery charger.

Units To Be Billed for Supplies

A4595 – Replacement supplies:

- 2 Leads/1 unit per month
- 4 Leads/2 units per month

A4557 – Replacement lead wires:

- Lead wires – 2 electrode system/1 unit per year
- Lead wires – 4 electrode system/2 units per year

The following codes are **not** valid for claim submission for the TENS durable medical equipment benefit:

- A4556 [Electrodes (e.g., apnea monitor), per pair]
- A4558 (Conductive paste or gel)
- A4630 (Replacement batteries for a medically necessary patient-owned TENS unit)

Prescription Requirements

A prescription or order must be available if requested for DME rentals or purchase. The prescription or order must be signed by the member's treating, qualified health care provider. When a qualified health care provider completes and signs the prescription or order, they are attesting that the information indicated on the form is correct and that the requested services are necessary and appropriate. The provider's prescription or order must be renewed annually.

For more information on what a prescription or order should include for a TENS rental or purchase, refer to our Clinical Payment and Coding Policies page to view **Physical Medicine and Rehabilitation Services CPCP040**.

The prescription or order for DME should include:

- Member's name and date of birth
- Diagnosis
- Type of equipment/supplies
- Provider's rationale
- Date of prescription/order
- Date and duration of expected use
- Quantity (if applicable)
- Provider name, address and phone number

- Legible provider signature and date

The Medical Policies at Blue Cross and Blue Shield of Illinois are for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are instructed to exercise their own clinical judgment based on each individual patient's health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Some benefit plans administered by BCBSIL, such as some self-funded employer plans or governmental plans, may not utilize our medical policies. Members should contact the customer service number on their member ID card for more specific coverage information. Although medical policies can be used as a guide, providers serving HMO members should refer to the HMO Scope of Benefits.

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Check Prior Authorization Requirements for Procedure Codes Through Availity® Essentials or Our Automated Phone System

You can check prior authorization requirements for procedure codes online by using Availity Essentials Eligibility and Benefits. If you aren't able to check online, our interactive voice phone system has a new menu option to quickly confirm prior authorization requirements for procedure codes for our commercial members.

With this new IVR option, you can proceed directly to checking prior authorization requirements without speaking to customer service.

How to use it: When you call the customer service number on our members' ID cards, follow the prompts to "Check Procedure Code Requirements." Refer to the updated **Check Authorization by Procedure Code IVR Caller Guide** for more details.

Visit our website to learn more about prior authorization. Need IVR help? Email our Provider Education Consultants.

This information does not apply to our Blue Cross Medicare Advantage℠ or Medicaid members.

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. Certain employer groups may require prior authorization or pre-notification through other vendors. If you have any questions, call the number on the member's ID card. Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider.

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Cultural Awareness Webinars: No-Cost Continuing Education Credit

We offer a suite of no-cost webinars that provide cultural awareness training and continuing education credit. The self-guided courses include:

- Chronic Disease Management
- Creating a Welcoming Environment for LGBTQ+
- Cross-Cultural Care in Mental Health and Depression
- Disability Awareness for Quality Interactions
- Ensuring High-Quality Care for Patients with Limited English Proficiency
- Improving Adherence in Diverse Populations
- Negotiating a Difficult Diagnosis
- Working with Specific Populations: Hispanic/Latino
- And others

How To Attend

- Register or login here.
- Watch your email for instructions on accessing your account.

Credits vary by course. They include continuing medical education credits and continuing education units. You can view the full list of courses and credits offered when you sign in to your Quality Interactions account. Course instructions and help are available online.

Quality Interactions is a separate company that provides cultural competency training to health care professionals. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

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Medicare Providers May Treat Blue Cross Group Medicare Advantage Open Access (PPO)℠ Members

If you're a Medicare provider, you may treat Blue Cross Group Medicare Advantage Open Access (PPO) members. This is an open access, non-differential national PPO plan without network restrictions.

You may treat these members regardless of your contract or network status with Blue Cross and Blue Shield of Illinois. That means you don't need to participate in our Medicare Advantage networks or in any of our networks to see these members.

The **only requirements** are that you agree to see the member as a patient, accept Medicare and submit claims to the member's Blue Cross and Blue Shield Plan. Learn more about Illinois retiree groups with open access plans.

Check Member ID Cards

As with all our members, it's important to ask to see the member's ID card before all appointments and to check eligibility and benefits. You can identify these members by the plan type listed on their ID card. Use the **entire member ID number**, including the three-character prefix, when verifying benefits and submitting claims.

If you have questions, call the customer service number on the member's ID card.

Open Access Advantages

Blue Cross Group Medicare Advantage Open Access (PPO) is available to retirees of employer groups. It covers the same benefits as Medicare Advantage Parts A and B plus additional benefits depending on the plan. It includes medical coverage and may include prescription drug coverage.

Members' coverage levels are the same **inside and outside their plan service area nationwide** for covered benefits. Plan members may have to pay deductibles, copays and coinsurance, depending on their benefit plan.

Referrals aren't required for office visits. Prior authorization may be required for certain services from Medicare Advantage-contracted providers with BCBSIL.

For Reimbursement

Follow the billing instructions on the member's ID card. When you see these members, you'll submit the claims to BCBSIL and not Medicare.

- **If you're a Medicare Advantage-contracted provider with any BCBS Plan,** you'll be paid your contracted rate. You're required to follow utilization management review requirements and guidelines.
- **If you're a Medicare provider who isn't contracted for Medicare Advantage with any BCBS Plan,** you'll be paid the Medicare-allowed amount for covered services. You may not balance bill the member for any difference in your charge and the allowed amount.* You aren't required to follow utilization management guidelines. However, you may request a review to confirm medical necessity.

*Members may be responsible for cost share for supplemental dental services from non-contracted Medicare providers.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage Open Access (PPO) members, except in emergency situations.

Checking eligibility and benefits and/or obtaining prior authorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and their health care provider.

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Notify Us if You Opt Out of Medicare

Blue Cross Medicare Advantage℠ plan and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ providers who choose to opt out of Medicare should immediately notify their Provider Network Consultant at Blue Cross and Blue Shield of Illinois. In compliance with Centers for Medicare & Medicaid Services policy, we're required to **terminate providers from our Medicare Advantage and MMAI networks** if they've opted out of Medicare.

What It Means To Opt Out

Opting out means that a provider has decided for a two-year period that they won't participate in Original Medicare or Medicare Advantage Prescription Drug plans. If you opt out, you may not accept federal reimbursement or bill Medicare or Medicare Advantage plans for your services. Your decision to opt out is public on the CMS Opt-Out Dataset.

BCBSIL doesn't contract with providers who have opted out of Medicare for our Medicare Advantage or MMAI networks. In compliance with CMS policy, we may not pay providers who have opted out of Medicare for Medicare-covered services, except for emergency or urgent care services for our Medicare Advantage and MMAI members who haven't signed a private contract with you.

See the CMS website for more information.

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Physician Performance Insights Reports Coming Soon from PEAQ[SM]

In September, physicians eligible for our Physician Efficiency, Appropriateness, & Quality[SM] program can view their Physician Performance Insights reports. PPI reports show how physicians compare to their peers and include information on improving performance.

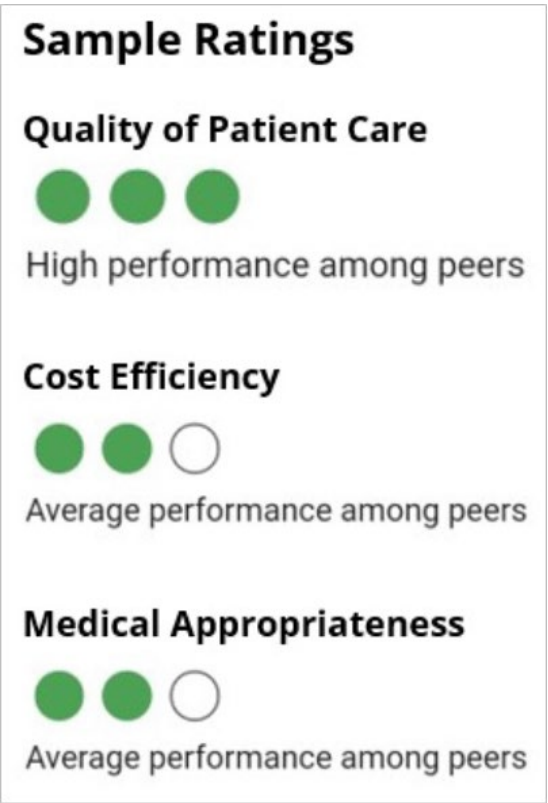
We make PPI reports available to physicians if they provided care to a minimum number of our members in the report timeframe and practice in the following specialties:

Medical	Surgical	Primary Care
Cardiology Endocrinology Gastroenterology Nephrology Neurology Obstetrics and Gynecology Pulmonary Medicine Rheumatology	Cardiothoracic Surgery General Surgery Ophthalmology Orthopedic Surgery Otolaryngology Urology Vascular Surgery	Family Medicine Internal Medicine Pediatrics

Options for Accessing Your Report

- Sign in to Availity® Essentials. In our Payer Spaces section on the Applications tab, select **PEAQ Report**. If you don't yet have an Availity account, register here at no cost.
- **Provider Network Consultant or PEAQ team**: Contact your Provider Network Consultant or email PEAQ Inquiries to request your report.

The PPI reports being released in September are based on this methodology. You can view and download last year's PPI report in Availity until the new report is released.



PEAQ Results Help Our Members

Provider Finder® includes performance ratings from the PPI reports released in 2023 for cost efficiency, medical appropriateness and quality of patient care. Provider Finder profiles for physicians who were highly rated in these areas display a **"Top Performing Physician" designation.**

The ratings and designation help our members **make informed care decisions**. Members who receive care from top performers may be eligible for Member Rewards.

Results from 2024 PPI reports will appear on Provider Finder in 2025.

For more information about PEAQ, visit our PEAQ page or email the PEAQ Inquiries team.

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Provider Finder® to Rank Providers To Help PPO Members Find Care

Later this year, Provider Finder will add a tiering feature that shows how providers rank against peers in their working specialties for some PPO products. The tier will display only for members in employer groups with a tiered benefit option. Members can use this information to take advantage of incentives such as lower copays and coinsurance for care from high performers.

Tiering is based on composite results of the Physician Efficiency, Appropriateness, & Quality℠ program. This evidence-based program evaluates primary care physicians and some specialists on components of cost efficiency, medical appropriateness, and quality of patient care.

Tiering applies to providers in the following specialties:

Medical	Surgical	Primary Care
Cardiology Endocrinology Gastroenterology Nephrology Obstetrics and Gynecology Pulmonary Medicine	Cardiothoracic Surgery Ophthalmology Orthopedic Surgery Urology Vascular Surgery	Family Medicine Internal Medicine Pediatrics

Rheumatology		

- **Tier 1** has lower member out-of-pocket costs. It includes behavioral health providers and physicians who have above average composite scores as compared to their peers.
- **Tier 2** has standard member out-of-pocket costs. It includes unscored providers* and physicians who have average composite scores as compared to their peers.
- **Tier 3** has higher member out-of-pocket costs. It includes physicians who have below average composite scores as compared to their peers.

*Unscored providers include those practicing in specialties evaluated by PEAQ who did not reach minimum criteria thresholds and those who practice in specialties that PEAQ does not currently evaluate.

If you have questions, contact PEAQ Inquiries. The full PEAQ methodology is on our PEAQ page.

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Encourage Routine Vaccines and Well-Care Visits for Children and Teens

Many children and adolescents are still catching up on missed routine immunizations and well-care visits, according to the Centers for Disease Control and Prevention. The CDC recommends that doctors and health care professionals encourage families to **schedule vaccines and visits** for their children. See our Children's Wellness Guidelines for a routine immunization schedule.

Tracking Our Members' Care

We track Healthcare Effectiveness Data and Information Set measures developed by the National Committee for Quality Assurance to help close gaps in our members' care.

Child Immunization Status tracks the percentage of 2-year-olds who received the following vaccines by their second birthday:

- Four diphtheria, tetanus and acellular pertussis
- Three polio
- One measles, mumps and rubella
- Three haemophilus influenza type B
- Three hepatitis B
- One chicken pox
- Four pneumococcal conjugate
- One hepatitis A
- Two or three rotavirus before 1 year of age
- Two influenza

Immunizations for Adolescents tracks the percentage of 13-year-olds who received the following vaccines by their thirteenth birthday:

- One dose of meningococcal vaccine
- One tetanus, diphtheria and pertussis
- The complete human papillomavirus vaccine series

Child and Adolescent Well-Care Visits

- Well-Child Visits in the First 30 Months of Life measures the percentage of children who had at least six well-child visits with a primary care physician during their first 15 months, and two or more well-child visits during their next 15 months.
- Child and Adolescent Well-Care Visits tracks the percentage of members ages 3 to 21 who received at least one well-care visit with a PCP or OB/GYN during the measurement year.

Tips To Consider

- Identify members who have missed vaccines or well-child visits. Contact their caregivers to schedule appointments.
- Check at each visit for any missing immunizations. Address common misconceptions about vaccines.
- Remind our members it's important to get a flu shot every year because new strains of flu virus appear each year. The CDC recommends that most people 6 months and older should get a flu vaccine every year.
- To document well-child visits, note that the visit was with a PCP and include in the medical record:
  - Date of visit
  - Health history
  - Physical and mental development history
  - Physical exam
  - Height, weight and body mass index percentile
  - Health education or anticipatory guidance, including physical activity, diet and nutrition
- We collect immunization data through claims and chart review. To document immunizations, you may include in the medical record any of the following:
  - Certificates of immunizations
  - Diagnostic reports
  - Subjective, objective, assessment and plan notes
  - Office or progress notes

Resources

- Our preventive care guidelines on immunization schedules
- Information on childhood vaccines and well-visits for our members
- CDC recommendations on COVID-19 vaccines for children and teens

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

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