BlueCross BlueShield of Illinois

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Disrupt or be disrupted?

A message from Steve Hamman, Senior Vice President of Enterprise Network Solutions

It was not long ago when voice-controlled lighting, packages delivered by drones, and driverless cars were simply far-fetched cartoon images from the Jetson's television show in the early 1960s. Technology – and the innovation driving it – is shaping how we shop, travel and live our lives at home. *But what about health care?*

Imagine having access to all of your health information right at your fingertips. Where the click of a button on a smart device could help you monitor and manage your health. For example, let's say you or a family member has a chronic condition like diabetes. This push of a button could monitor vital statistics, flag an abnormal reading and automatically send the information to your physician or condition specialist. Within seconds, you may receive a text or phone call from a clinician advising you on ways to improve the reading, and more importantly, help manage your health all customized to you. Technology is shaping the future of health care delivery now.

Technology and Innovation

Technology and innovation often lead to industry disruption. Just ask Blockbuster Video. Industry disruptors are everywhere, so our approach at Blue Cross and Blue Cross of Illinois (BCBSIL) is relatively simple. *We want to help make the health care system work better for our customers and providers.*

One advantage is that we have the data and industry-leading data scientists and developers turning this data into actionable insights.

- For providers, this means more information exchange and guidance to help determine treatment plans for improved health outcomes and value.
- For our customers, this means helping them become more informed health care consumers and simplifying access to the care they need while managing their health.

At BCBSIL, we're dedicated to being part of the solution. We're continually evaluating the affordability and accessibility of care for our members, and implementing tools and services that help to improve outcomes for members while increasing administrative efficiencies for providers. And we collaborate with partners across the industry to ensure we're contributing to bringing forward quality in health care.

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Colorectal Cancer Screening Options and Statistics – Get the Conversation Started

Part 2 of a 4-part series discussing Colorectal Cancer Screening. Part 1 was published in the August 2017 issue of the Blue Review.

Will You Commit?

In 2017, the American Cancer Society (ACS) estimated there would be 135,430 new cases of colorectal cancer and 50,260 deaths nationwide. For Illinois alone, it was estimated that there would be 5,580 new cases of colorectal cancer with an estimated 2,030 deaths.[1] The incidence of colorectal cancer from 2008-2012 was highest among non-Hispanic blacks followed by non-Hispanic white, American Indian, Alaska Natives and then Hispanics. The incidence rate of colorectal cancer is lowest among Asian and Pacific Islanders. Death rates from colorectal cancer are reflective of the incidence rates.[1]

Colorectal cancer screenings are recommended for adults age 50 through 75 who are at average risk for colorectal cancer and who are asymptomatic. Some patients may need to be screened for colorectal cancer at an earlier age. Risk factors for colorectal cancer include older age, a personal history of colon cancer, polyps or inflammatory bowel diseases, family history of colon cancer or polyps, black adults
and/or male.[2]

Start the Conversation

Your recommendation that your patients get screened for colorectal cancer carries the greatest impact with your patients. Even though some screening methods are not appropriate or feasible for all patients, what is important is that the options are discussed. Keep in mind that some screening methods may not be covered and an out-of-pocket cost to the patient may result. Regardless of the method chosen, your encouragement to get a colorectal cancer screening will most likely result in your patients getting screened.

The American College of Gastroenterology recommends colonoscopy as the preferred cancer prevention screening method and Fecal Immunochemical Testing (FIT) as the preferred cancer detection option.[3]

Advantages of FIT include:

Primary Care Physicians (PCPs) may stock FIT tests in the office and dispense as appropriate following a brief discussion with their patients. Patients complete the test in the privacy of their own home.
Depending on the FIT test brand, testing may be accomplished with a single specimen.[2]

Colorectal Cancer Screening Options:

1. Colonoscopy – Screening and diagnostic follow up of positive results can be done during the same exam. Screening interval is every 10 years.[2]
2. Flexible sigmoidoscopy – Patients screened by flexible sigmoidoscopy may still require a colonoscopy. Screening interval is every five years or every 10 years with yearly FIT.[2]
3. Stool-based tests – Positive test results require further screening by colonoscopy.[4] This type of screening includes:

    - FIT or immunologic Fecal Occult Blood Test (iFOBT) – No dietary restrictions. FIT tests may be one or two sample tests. Screening interval is every year.[2]
    - Guaiac-based stool tests or gFOBT – Less sensitive than FIT testing and typically requires more samples and dietary restrictions. Screening interval is every year.[2]
    - Stool DNA with FIT testing, also known as Cologuard – Exact Sciences which is approved by the U.S. Food and Drug Administration (FDA).[2] Screening interval is every one or three years.[2]

4. CT colonography – Extra-colonic findings are common.[2] Screening interval is every five years.[2]
5. Serology – Methylated SEPT9 DNA is a new screening method. One test brand was FDA approved in April 2016.[2] The United States Preventive Services Task Force (USPSTF) does not give a screening interval for SEPT9 DNA testing.

According to the American Cancer Society, a stool specimen from a digital rectal exam tested for blood with a gFOBT or FIT is not an acceptable way to screen for colorectal cancer.[5] Research has shown that a stool specimen obtained by digital rectal exam will miss more than 90 percent of colon abnormalities, including most cancers.[5]

Learn more. The Centers for Disease Control & Prevention (CDC) is providing free continuing education for PCPs, nurses, nurse practitioners and clinicians who perform colonoscopies. Visit the CDC website to access Screening for Colorectal Cancer: Optimizing Quality* and other CDC training resources.

Thank you for your continued support and interest in colorectal cancer screenings for our members. Part 1 of the Colorectal Cancer Screening series – Colon Cancer Screenings Goal: 80% Participation by 2018 – Will you commit? – can be found in the August 2017 *Blue Review*.

References

[1](n.d.). American Cancer Society, Cancer Facts & Statistics. Retrieved Dec. 9, 2016.

[2](n.d.). Home – U.S. Preventive Services Task Force. Final Recommendation Statement: Colorectal Cancer: Screening - US Preventive Services Task Force. Retrieved Dec. 6, 2016.

[3]American College of Gastroenterology. Colorectal Cancer Screening. (n.d.). Retrieved Dec. 6, 2016

[4]Force, U. P. (2016). USPSTF Recommendation Statement: Screening for Colorectal Cancer. Retrieved Dec. 6, 2016.

[5]American Cancer Society Recommendations for Colorectal Cancer Early Detection. (n.d.). Retrieved Dec. 6, 2016.

*https://www.cdc.gov/cancer/colorectal/quality/

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Blue Cross Medicare Advantage℠ Providers are Prohibited from Billing Dually Eligible Individuals Enrolled in the QMB Program

As a reminder, the independently contracted providers participating in the Blue Cross Medicare Advantage (PPO)℠ (MA PPO) and/or Blue Cross Medicare Advantage (HMO)℠ (MA HMO) member products may not bill beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare cost-sharing. QMB is a Medicare Savings Program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability.

Please ensure that you and your staff are aware of the federal billing law and policies regarding QMB individuals. All MA PPO and MA HMO providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts. Providers who inappropriately bill QMB individuals are subject to sanctions.

The QMB program is a State Medicaid benefit that covers Medicare premiums and deductibles, coinsurance and copayments, subject to State payment limits. MA PPO and MA HMO providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses the providers for the full Medicare cost-sharing amounts.

Contact Customer Service at 877-774-8592 to learn about ways to identify QMB patients and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. For additional information, read the full Centers for Medicare & Medicaid Services (CMS) notice.

This is a brief description of some of the terms of the MA PPO and MA HMO plans. For more details, please refer to the applicable MA PPO or MA HMO plan document.

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Medicaid Claim Denials for No Drug Rebate Agreement on File

As a reminder, National Drug Codes (NDCs) and all other required data elements must be billed on medical claims for Illinois Medicaid members. Additionally, a signed Medicaid Drug Rebate Agreement from each drug's manufacturer, or pharmaceutical labeler, must be on file with the Centers for Medicare & Medicaid Services (CMS). This means that, even if the NDC is valid for the date of service and all other required elements are included, claims will be denied if there is no rebate agreement on file with CMS for a particular manufacturer.

For more information, refer to the Medical Providers section of the Illinois Healthcare and Family Services (HFS) website at illinois.gov/hfs, where you will find the following resources:

- List of Healthcare Common Procedure Coding System (HCPCS) codes requiring NDCs
- List of Pharmaceutical Labelers with Signed Rebate Agreements

Also refer to the Claims Handling for Medicaid Members and other Related Resources on the Medicare/Medicaid page in the Network Participation section of BCBSIL's Provider website.

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Pharmacy Change for ICP and FHP Members, Effective Sept. 1, 2017

Beginning Sept. 1, 2017, TRUEplus® and TechLITE® is the preferred brand for insulin pen needles, and TRUEplus is the preferred brand for insulin syringes for the Blue Cross Community Integrated Care Plan (ICP)℠ and Blue Cross Community Family Health Plan℠ (FHP) Medicaid formularies. Letters describing the change were mailed to members.

TRUEplus is the trademark of Trividia Health, Inc. and TechLITE is the trademark of ArkrayUSA, both separate companies that are manufacturers and marketers of advanced performance products for people with diabetes. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Trividia Health and ArkrayUSA. If you have any questions about the products or services offered by such vendor, you should contact the vendor directly.

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Integration of Prime Therapeutics® and Walgreens® Specialty Pharmacy and Mail Order Services

Blue Cross and Blue Shield of Illinois (BCBSIL)'s pharmacy benefit manager (PBM), Prime Therapeutics LLC (Prime), and Walgreens announced a strategic alliance in August 2016 to create a first-of-a-kind model for pharmacy benefit management that aligns a national pharmacy chain, a leading PBM and health plans, including a long-term retail pharmacy agreement. As part of this alliance, Prime and Walgreens have formed a combined company for specialty pharmacy and mail order services, headquartered in Orlando, FL.

Teams have been working to unite each organization's mail service and specialty pharmacy operations. As of mid-August 2017, all BCBSIL members whose pharmacy benefits are administrated through Prime will have been integrated into the new combined company's pharmacy systems.[1] A summary of the changes you might experience from this integration is included below for your reference.

Specialty Pharmacy Services

As of June 3, 2017, BCBSIL members were integrated into the new specialty pharmacy system. The new company is nationally accredited by Accreditation Commission for Health Care (ACHC) and URAC. Any additional accreditation and licenses will be pursued as needed. Additionally, a vast selection of previously labeled limited distribution products will be available through Prime Therapeutics Specialty Pharmacy (Prime Specialty Pharmacy).

There are no changes to the way you submit a prescription. The following remains the same:

- The name used when e-prescribing – Prime Therapeutics Specialty
- The benefit prior authorization process – Patient benefit prior authorization approvals on file were transferred and will follow the BCBSIL process for renewals
- The number you call to reach Prime Specialty Pharmacy – 877-627-MEDS (6337)
- The hours of operation – Monday through Friday, 8 a.m. to 8 p.m., ET

For prescriptions coming to your location, you may notice changes in Prime's communications and packaging, including:

- The use of the Prime Specialty Pharmacy and Walgreens names/logos may both appear on the packing receipt, enclosed information sheets, stickers on the box, etc.
- Cooler/cooler packaging and the box holding the medicine may look different
- The label affixed to the front of the box may show a dispensing location other than Orlando, FL

Mail Order Services

Covered 90-day supply mail order prescriptions are being filled by the PrimeMail by Walgreens Mail Service home delivery program as of July 1, 2017.

There is a new way to submit a prescription electronically:

For patients with expired/no remaining refill prescriptions, you will need to provide a new prescription. If submitting this prescription electronically after July 1, 2017, you will need to send it to Walgreens Mail Service in Tempe, AZ, or you can fax the prescription to 800-332-9581.

Please Note: Existing PrimeMail e-prescribing or fax methods you may be using currently can continue to be used for the immediate future but will be returned as "unable to fill" at some point later this year. Please take this opportunity to update any pharmacy information that may be stored in your patients' records. Also, if your patient had a current benefit prior authorization approval on file, it was transferred over to the new mail order system and will follow the standard BCBSIL process for renewals.

Members with prescription history within the last 12-18 months were notified of the specialty pharmacy and/or mail order service changes. Full integration of all mail service and specialty pharmacy services is expected to be completed by the first quarter of 2018. More information about the new combined company, including the official name, will be shared in future *Blue Review* issues and/or in the News and Updates section of our Provider website.

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

[1]Members with Medicare Part D or Medicaid coverage transitioned to the new mail order services as of earlier this year.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSIL contracts with Prime Therapeutics to provide pharmacy benefit management and other related services. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSIL and contracting pharmacies is that of independent contractors. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Prime has entered into an agreement with Walgreens, an independently contracted pharmacy, to form a combined specialty pharmacy and mail order services company, owned by Prime and Walgreens.

Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. For more complete details, including benefits, limitations and exclusions, members should refer to their certificate of coverage. Regardless of benefits, the final decision about any medication and pharmacy choice is between the member and their health care provider.

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No Cost-share Coverage for Statin Use to Help Prevent Cardiovascular Disease in Adults

The United States Preventive Services Task Force (USPSTF) issued a recommendation last November regarding statin use for the primary prevention of cardiovascular disease (CVD) in adults without a history of the disease. Their recommendation is that adults use a low-to-moderate dose statin to prevent CVD if they meet all the following criteria:

- Are between 40-75 years in age
- Have one or more CVD risk factors, such as hypertension, diabetes or smoking
- Have a calculated 10-year risk of 10 percent or higher for experiencing a cardiovascular event

As a result of this recommendation, Blue Cross and Blue Shield of Illinois (BCBSIL) will implement the following changes to statin coverage:

- BCBSIL will begin covering prescription statins for members between the ages of 40-75 without cost-sharing on Dec. 1, 2017, regardless of renewal date
- Prescription statins covered at no cost-share will include Lovastatin (20mg and 40mg) and Pravastatin (10mg, 20mg, 40mg, 80mg)
  -There will be an exception process for members who are unable to take generic medications
- Quantity limits will not be imposed

BCBSIL will issue additional reminders as we get closer to the December deadline.

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Visit Our Website for New Claim Payment and Remittance Resources

Blue Cross and Blue Shield Illinois (BCBSIL) recently updated the Claim Payment and Remittance page in the Claims and Eligibility section of our website at *bcbsil.com/provider*. This section of our Provider website focuses on electronic transactions that may help increase administrative efficiencies for your office while also helping to make it easier for you to conduct business with BCBSIL.

Recent improvements to the Claim Payment and Remittance page include resources to help you learn more about Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). In addition to new EFT and ERA Online Enrollment Tip Sheets, the page includes links to updated 835 EFT/ERA Companion Guides and other pertinent information.

Electronic options provide health care providers a more efficient alternative to the traditional paper methods. Providers may enroll for EFT and ERA through the Availity™ Web Portal, which also permits users to make any necessary set-up changes online. Once an organization is enrolled for ERA, providers and billing services also gain access to the Availity Remittance Viewer. This tool permits users to search, view, save and print remittance information, even if the ERA is delivered to a vendor and/or clearinghouse other than Availity.

Online EFT and ERA enrollment is available to registered Availity users. To register for Availity, simply go to availity.com and sign up today. There is no cost to register and become an Availity user. For providers who are unable to access Availity to complete the online EFT and ERA enrollment process, paper EFT and ERA enrollment forms are available in the Education and Reference Center/Forms section of our Provider website.

We encourage you to visit the Claim Payment and Remittance page and other pages in the Claims and Eligibility section of our Provider website for additional information on electronic options. For assistance with EFT and ERA enrollment through Availity, or to learn more about how to use the remittance viewer tool, contact a BCBSIL Provider Education Consultant at *ECommerceHotline@bcbsil.com* or 800-746-4614.

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Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois (BCBSIL) offers complimentary educational workshops and webinars with an emphasis on electronic options that can help create administrative efficiencies for the independently contracted providers who conduct business with us. A snapshot of upcoming training sessions is included below. For additional information, refer to the Workshops/Webinars page in the Education and Reference Center on our website at *bcbsil.com/provider*.

BCBSIL WEBINARS
To register now for a webinar on the list below, click on your preferred session date.

Descriptions:	Dates:	Session Times:
BCBSIL Back to Basics: 'Availity™ 101' *Join us for a review of electronic transactions, provider tools and helpful online resources.*	Sept. 19, 2017 Sept. 26, 2017	11 a.m. to noon
Introducing Remittance Viewer *Have you heard? This online tool offers providers and billing services a convenient way to retrieve, view, save or print claim detail information.*	Sept. 21, 2017	10 to 11 a.m.

AVAILITY WEBINARS

Availity also offers free webinars for their registered users. For a current listing of webinar topics, dates and times, registered Availity users may log on to the secure Availity provider portal – the Live Webinar Schedule is located under the **Free Training** tab. Not yet registered with Availity? Visit their website at availity.com for details; or call Availity Client Services at 800-AVAILITY (282-4548) for assistance.

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Fairness in Contracting

In an effort to comply with fairness in contracting legislation and keep our independently contracted providers informed, Blue Cross and Blue Shield of Illinois (BCBSIL) has designated space in the *Blue Review* to notify you of any significant changes to the physician fee schedules. Be sure to review this information each month.

Effective Aug. 15, 2017, the following code ranges were updated: 90630-90688 and Q2034-Q2039. Please note that not all codes in these ranges were updated.

The information above is not intended to be an exhaustive listing of all the changes. Annual and quarterly fee schedule updates can also be requested by using the Fee Schedule Request Form. Specific code changes that are listed above can also be obtained by downloading the Fee Schedule Request Form and specifically requesting the updates on the codes listed in the *Blue Review*. The form is available on the Forms page in the Education and Reference Center on our website at *bcbsil.com/provider*.

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ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes are periodically added to or deleted from the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and are not considered changes to the software version. Blue Cross and Blue Shield of Illinois (BCBSIL) will normally load this additional data to the BCBSIL claim processing system after receipt from the software vendor and will confirm the effective date via the News and Updates section of our website at *bcbsil.com/provider*. Advance notification of updates to the ClaimsXten software version also will be posted on our Provider website.

To help determine how some coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool. Refer to the Clear Claim Connection page in the Education and Reference Center/Provider Tools section of our Provider website for additional information on gaining access to C3, as well as answers to frequently asked questions about ClaimsXten. Updates may be included in future issues of the *Blue Review*. It is important to note that C3 does not contain all of the claim edits and processes used by BCBSIL in adjudicating claims and the results from use of the C3 tool are not a guarantee of the final claim determination.