BlueCross BlueShield of Illinois

Commercial Provider Manual

2026

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

January 2026

Table of Contents

Section 1: Overview

Introduction

Blue Cross Blue Shield of Illinois is pleased to welcome you as a participating health care provider. This provider manual explains the policies and procedures of our non-Government, non-HMO plans. We hope this will provide you and your office staff with helpful information as you provide care to our members. This manual applies only to the operations of our non-Government and non-HMO plans.

Section 2: Billing and Reimbursement

General Regulations

Contracted Provider Groups, Individual Providers, Facility Providers, and Ancillary Providers ("Contracting Provider") shall submit all claims for consideration for payment for Covered Services performed for members of Blue Cross and Blue Shield utilizing claim forms as set forth in the Billing and Reimbursement section of this manual. In addition to the instructions in this section and other sections of the manual, Contracting Provider shall adhere to the following policies with respect to filing claims for Covered Services to members of BCBS:

1. A Contracting Provider performing covered services for a member of BCBS shall be fully and completely responsible for all statements made on any claim form submitted to Blue Cross and Blue Shield of Illinois by or on behalf of the Contracting Provider. A Contracting Provider is responsible for the actions of staff members or agents.

2. All Covered Services provided for and billed for members of BCBS by Contracting Provider shall be performed personally by the Contracting Provider or under that provider's direct and personal supervision and in that provider's presence, except as otherwise authorized and communicated by BCBSIL. Direct personal supervision requires that a Contracting Provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.

3. A Contracting Provider must file complete and accurate claims with BCBSIL. In the event any Contracting Provider has received, either from BCBSIL or from the member, an amount in excess of the amount determined by BCBSIL to be payable with respect to services performed, such excess amount(s) shall be returned promptly to BCBSIL and/or to the member, as the case may be. In the event such overpayments are not voluntarily returned, BCBSIL will deduct overpayments (whether discovered by the Contracting Provider or BCBSIL) from future payments to Contracted Provider from BCBSIL.

4. BCBSIL considers abusive or fraudulent billing to include, but not be limited to, the following:
    - Misrepresentation of the services provided to receive payment for a non-covered service or additional payment for a covered service;
    - Billing in a manner which results in reimbursement greater than what would have been received if the claim were properly filed; and/or
    - Billing for services which were not rendered.

    If BCBSIL determines, in its sole discretion, that a provider has engaged in abusive or fraudulent billing practices, BCBSIL may take further actions up to and including termination of the provider from the Network.

5. To the greatest extent possible, the Contracting Provider shall report services in terms of the procedure codes listed in the most recent version of Current Procedural Terminology (CPT®) coding manuals and ICD-10 reference books. A description of the service, a copy of the hospital/medical records or other appropriate documentation may be submitted in some cases.

6. A Contracting Provider shall not bill or collect from the member, or BCBSIL, charges itemized and distinguished from the professional services provided. Such charges include, but are not limited to, malpractice surcharges, overhead fees or facility fees, concierge fees or fees for completing claim forms or submitting additional information to BCBSIL.

7. The determination as to whether any Covered Service meets accepted standards of practice in the community shall be made by BCBSIL. Fees for Covered Services deemed not to meet accepted standards of practice shall not be collected by Contracted Provider from the member or BCBSIL.

8. *Medically Necessary or Medical Necessity Medical Necessity means that, with respect to a Health Care Service, a Health Care Provider, exercising prudent clinical judgment, provided, or is proposing or recommending to provide, such Health Care Services in a manner that is: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate, in terms of type, frequency, extent, site of service, duration, and considered effective for the Covered Person's illness, injury, disease, or symptoms; (iii) not primarily for the Covered Person's or Health Care Provider's convenience; and (iv) not more costly than the same or a similar Health Care Service or sequence of Health Care Services that is at least as likely to produce equivalent therapeutic or diagnostic results in connection with the diagnosis or treatment of Covered Person's illness, injury, disease, or symptoms. For purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the view of physicians practicing in relevant clinical areas and any other relevant factors. The fact that services were recommended or performed by Provider, or a Participating Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after a proper Preauthorization by BCBS or its Utilization Review agent, or after the Covered Person receives the services, supplies, or medications and a Claim is submitted to and approved by BCBS. BCBS may consult with physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary. In the event that this definition of Medically Necessary or Medical Necessity conflicts with the definition of "Medically Necessary" or "Medical Necessity" set forth in a Covered Person's Coverage Agreement, the terms of the Coverage Agreement will control.*

9. **Note:** The definition above is used in most instances in member benefit plans and Contracting Providers' agreements. However, to the extent a member's benefit plan differs, that definition shall govern.

10. BCBSIL has the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary. A Contracting Provider shall render Covered Services as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or Contracting Provider. In the case of diagnostic testing, the tests should be essential to, and be used in, the diagnosis and/or management of the

patient's condition. Services should be provided in the most cost-effective manner and in the least costly setting required for the appropriate treatment of the member. Fees for Covered Services deemed not medically necessary shall not be collected from the member, unless the member requests the service(s), the Contracting Provider informs the member of his or her financial liability and the member chooses to receive the service(s). The Contracting Provider must document such notification to the member in the Contracting Provider's records and the member's written consent to accept financial responsibility for such services. The member's written consent must include an acknowledgement that, for not medically necessary services, (a) the services are not medically necessary, (b) BCBSIL will not be responsible for payment, and (c) the member will be financially responsible to the Contracting Provider for payment.

11. The Contracting Provider will maintain adequate medical and administrative records consistent with the standards of major organizations conducting accreditation and will permit the Plan or its agent or representative to review such medical records and administrative records regarding Covered Persons. The Contracting Provider will furnish to the Plan, or its agent or representative, necessary quality improvement data and will permit the Plan or its agent or representative to perform site visits to inspect and review such records and inspect the Contracting Provider's office facility and equipment during normal business hours for the purpose of the Plan's performing utilization management and quality improvement activities. Contracting Provider shall permit Plan or its Designees, upon reasonable notice and during normal business hours, to have, without charge, access to and the right to examine, audit, excerpt and transcribe any books, documents, papers and records relating to Covered Person's medical and billing information within the possession of the Contracting Provider and to inspect the Contracting Provider's operations, which involve transactions relating to Covered Persons and as may be reasonably required by the Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, Medical Necessity, appropriateness of care, and accuracy of billing and payment. The Contracting Provider shall make such records available to state and federal authorities, as well as any accrediting bodies which the Plan is accredited by or from which it is seeking accreditation, involved in assessing quality of care, fraud, abusive billing practices, or investigating Covered Person's appeal of an adverse benefit determination. The Contracting Provider agrees to provide the Plan or its Designees with appropriate working space. Upon reasonable request, photocopies of such records shall be provided to Plan, Payer or their Designee at no charge.

12. A Contracting Provider shall refer members of BCBS to a provider that participates in our networks. In instances where a referral is made to a provider that does not participate in a BCBSIL network, the provider will seek a written waiver signed by the member or the approval of BCBSIL. Referral to any other provider/facility, regardless of whether that provider/facility is a Contracting Provider, with which the Contracting Provider has a business interest, must be disclosed to the patient in writing at the time of the referral.

13. A Contracting Provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for referring a BCBS member to another provider, or in return for furnishing services to a member referred to him or her.

14. Contracting Provider will ensure that Covered Services reported on claim forms are supported by documentation in the medical record and adhere to the general principles of medical record documentation, including but not limited to the following, if applicable to the specific setting/encounter:

    - Medical records should be complete and legible;
    - Documentation of each patient encounter should include:
        - Reason for the encounter and relevant history;
        - Physical examination findings and prior diagnostic test results;
        - Assessment, clinical impression and diagnosis;
        - Plan for care; and
        - Date and legible identity of observer.
    - If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

15. Every subscriber of BCBS will be supplied with an appropriate identification card (can be physical or digital) and the Contracting Provider shall be responsible for verifying the eligibility and identity of the subscriber (e.g., government issued photo identification or other proof of identity). The identity of the subscriber must be verified each time services are provided.

16. Prior Authorization of benefits for services may be required in accordance with a member's benefit plan. Services that do not receive prior authorization could result in claims being paid at a lesser benefit level, a penalty, or a claims payment denial. The Contracting Provider may not seek reimbursement from the member if the Contracting Provider did not obtain prior authorization when required. If it is determined that a favorable prior authorization or predetermination of benefits decision was based on inaccurate or misleading information submitted by the Contracting Provider or the member, BCBSIL may refuse to pay the claim or seek recovery of paid claims. Charges for services which are not paid as the result of submission of false or inaccurate information by the Contracting Provider shall not be collected from the member.

17. A Contracting Provider is expected to complete all necessary information on the claim forms which will facilitate Coordination of Benefits with other third-party payers by BCBSIL. Failure by Contracted Provider to include all necessary information to facilitate COB may result in non- payment by BCBSIL.

18. Contracting Providers may not bill BCBSIL for health care services rendered to themselves or their immediate family members, or designate themselves as a primary care physician, for any purpose, for themselves or their Immediate Family Members. An "Immediate Family Member" is defined as: (i) current spouse; (ii) eligible domestic partner; (iii) parents and step-parents of the rendering provider, spouse or domestic partner; (iv) children and grandchildren (biological, adopted or other legally placed children) of the rendering provider, spouse or domestic partner; and, (v) siblings (including biological, adopted, step, half or other legally placed children) of the rendering provider, spouse or domestic partner. BCBSIL will not process any claims for services, nor make payment for any claims for services, rendered by a Contracting

Provider to him or herself, or to his or her Immediate Family Members. If BCBSIL determines that a benefit was paid in error, BCBSIL has the right to request and receive a refund of the payment from the Contracting Provider.

19. BCBSIL does not expect to receive claims for these services and will not make payment on claims submitted for services rendered by or for immediate family. Should it be determined that a benefit has been paid in error, Contracting Provider shall return the original payment. A Contracting Provider should be knowledgeable of our Medical Policies. Medical Policies serve as one of the sets of guidelines for benefit coverage decisions. Member benefit plans vary in coverage and some plans may not provide benefit coverage for certain services discussed in the medical policies. Benefit coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations and to applicable state and/or federal law. For additional information and to view all active, pending and draft medical policies please view our Medical Policies. Medical Policies are located on the Provider website under Standards and Requirements. In some cases, medical policies/guidelines used by Utilization Management vendors may apply, such as some services for which prior authorization may be required.

20. Checking benefits and eligibility, either online or via phone, is not a guarantee of benefits or payment. Benefits will be determined once a claim is received by BCBSIL and will be based upon, among other things, the member's eligibility, benefits, limitations and exclusions, terms of the member's certificate of coverage and medical policy in effect on the date services are rendered. BCBSIL reserves the right to request refunds for a variety of reasons including, but not limited to, those stated in paragraph #3 above.

21. In accordance with the terms of the Contracting Provider Agreements, Contracting Providers must maintain a current physical address (which is not a P.O. Box) and phone number at which the Contracting Provider can be reached. Such information may be placed on the Contracting Provider directory. The Contracting Provider must provide thirty (30) days prior written notice of any change in address, phone number and/or other change in employment status, such as retirement. Additionally, BCBSIL reserves the right to audit such information to verify its accuracy and the Contracting Provider shall be required to promptly provide and/or confirm such information as requested by BCBSIL. BCBSIL reserves the right to remove any Contracting Provider from its directory for failure to promptly provide and/or confirm the office address and phone number of the Provider. Further, BCBSIL reserves the right to terminate a Contracting Provider's Agreement if the Contracting Provider fails to promptly provide and/or confirm such information.

22. Contracting Provider authorizes Plan to obtain the clinical laboratory results for tests performed on Covered Persons as well as for tests performed on Plan's enrollees entitled to receive benefits under any health care benefit plan offered and/or administered by the Plan or its subsidiaries or another Blue Cross and Blue Shield Plan or their subsidiaries. Participating Provider shall inform Members that the Plan may receive the clinical laboratory results and shall include this, or a similar statement, in

any informed consent forms signed by the Member.

23. Provider acknowledges and agrees that BCBSIL may apply claim editing rules or processes, in accordance with correct coding guidelines and other industry-standard methodologies, including, but not limited to, the Centers for Medicare & Medicaid Services, CPT, Change Healthcare and Cotiviti coding process edits and rules.

24. A Contracting Provider must comply with appointment wait time standards for behavioral health services, routine primary care, and non-urgent specialty care as specified below, which are based on CMS guidelines. Members seeking an appointment must be able to schedule an appointment with Contracting Provider within the time frames specified below at least 90% of the time:

Provider specialty type	**Appointments must be available within**
Behavioral health	10 business days
Primary care (routine)	15 business days
Specialty care (non-urgent)	30 business days

25. A Contracting Provider must maintain at minimum, professional liability insurance in the amounts of:
    - **Physical Health Providers:** Not less than $1,000,000 per claim and $3,000,000 per aggregate.
    - **Mental Health Providers:** Not less than $1,000,000 per claim and $1,000,000 per aggregate.
    - **Bordering States**: Providers who are licensed and practice in the state of Indiana:
        - **All Providers:** Not less than $250,000 per claim and $750,000 per aggregate.

Third-Party Billing Requirements and Member Waivers

A Contracting Provider contracted with BCBSIL is required to submit to BCBSIL all claims for Covered Services rendered to members of BCBSIL ("Members"), whether or not the costs for such claims may be the responsibility of a third-party (e.g., an auto carrier when a person is injured in an auto accident). When a Contracting Provider submits a claim to BCBSIL seeking payment under the terms of that provider's Contracting Provider agreement with BCBSIL, all terms of the Contracting Provider agreement are applicable, and the Contracting Provider must accept reimbursement from BCBSIL as full and final payment for services rendered, excluding any applicable Member financial responsibility including, but not limited to, copayments and coinsurance. If it is later determined that another person or entity is liable to the Member, the Contracting Provider cannot refund the payment to BCBSIL and seek full billed charges from the liable person or entity.

However, if a Member voluntarily chooses to waive that member's benefits and agrees to provide a signed, written document to a contracted Contracting Provider, waiving that member's insurance benefits with BCBSIL for a particular claim(s) ("Waiver"), and allowing the Contracting Provider to seek payment only from the Member or one or more third-parties (collectively, "Third-Party"), BCBSIL will honor the Member's decision to waive his or her insurance benefits and the Contracting Provider may bill the Member or a Third-Party for Covered Services rendered. The Waiver must specifically state that the Member is: (i) voluntarily and knowingly waiving his or her health benefits with BCBSIL, and (ii) aware that the Contracting Provider is intending to seek payment from the Member or a Third-Party, which may include a recovery from the Member's potential or actual settlement dollars or award from such Third- Party, regardless of whether the Third-Party denies or admits liability for the Member's injury or illness, and (iii) aware that the Contracting Provider will seek that provider's full billed charges (or, if applicable, some other specifically identified amount) from the Member or a Third-Party, instead of the Contracting Provider's discounted rate with BCBSIL, and (iv) the Member may rescind the Waiver at any time, however, such retraction of the Waiver may not be retroactive, and (v) the Member understands that BCBSIL will have no responsibility for payment of any health care services covered by the Waiver which, but for the Waiver, would have been considered eligible for benefits and/or payable by BCBSIL under the Member's health benefit plan, even if no Third-Party is determined to be liable for the payment.

Nothing in this section changes, waives or amends any policies of BCBSIL relating to claims, claims submission to BCBSIL (including, but not limited to, format and timely filing requirements) or subrogation. This policy does not affect in any way coordination of benefits where the Member has health benefit coverage under more than one policy or plan. All policies remain in force and effect.

Third-Party Premium Payments

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, BCBSIL will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations or urban Indian organizations; and (3) state and federal Government programs.

BCBSIL may choose, in its sole discretion, to allow payments from not-for-profit foundations,

provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the Covered Persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSIL directly for any or all of an enrollee's premium.

Effective May 1, 2010, the following standard provisions apply to all Contracting Providers, unless the Contracted Provider's contract contains a provision(s) that specifies how disputes will be handled between the parties, in which case the contract language will govern.

Disputes

I. Any disputes arising out of the terms of the Provider Agreement (the "Agreement") shall be governed by and subject to the laws of the State of Illinois.

II. In order to avoid the cost and time consuming nature of litigation, any dispute between Plan and Contracting Provider arising out of, relating to, involving the interpretation of or in any other way pertaining to the Agreement, or any prior Agreement between Plan and Contracting Provider that relates to Provider's role as a Participating Provider for the Provider Networks indicated in the Agreement for Covered Persons, or any Laws relating thereto, shall be resolved using alternative dispute resolution mechanisms instead of litigation. Plan and Contracting Provider agree and acknowledge that it is their mutual intention that this provision be construed broadly so as to provide for individual mediation and/or arbitration of all disputes arising out of their relationship, including claims not yet filed that predate the Agreement, as third party payer and provider. The Parties further agree that resolution of any dispute pursuant to the Agreement shall be in accordance with the procedures detailed below:

Initial Resolution by Meeting or Mediation of Dispute

1. Plan or Contracting Provider, as the case may be, shall give written notice to the other of the existence of a dispute (the "Initial Notice").

2. Plan and Contracting Provider shall schedule a meeting not later than thirty (30) calendar days after delivery of the Initial Notice in order to attempt to resolve the dispute unless both Parties agree in writing to proceed directly to mediation. If the dispute is not resolved at any meetings held, the Parties shall submit the dispute to a mutually agreed upon mediator. The mediation process shall be subject to the following conditions

    a) The Parties agree to participate in the mediation confidentially and in good faith;

    b) The Parties agree to have present at the mediation one or more individuals in the Parties' employ with decision-making authority regarding the matters in dispute. Either Party may, at that Party's option, be represented by counsel;

    c) The mediation will be held within sixty (60) days of the mediator's acceptance of the matter unless the Parties agree on a later date. The mediation will be held in Chicago, Illinois;

d) The Parties shall each bear their own costs and shall each pay one-half of the mediator's fees and costs, unless the mediator determines that one Party did not participate in the mediation in good faith, in which case that Party shall pay all of the mediator's fees and costs;

e) The Parties agree that the obligation to mediate (but not the obligation to arbitrate) is not applicable to any dispute that was pending in any court on the effective date of the Agreement, or that had been submitted to binding arbitration on or before the effective date of the Agreement.

Binding Arbitration

In the event mediation is not successful in resolving the dispute, either Plan or Contracting Provider, on Contracting Provider's own behalf and not as a representative of a purported class, may submit the dispute to confidential, final and binding arbitration under the commercial rules and regulations of Arbitration of the American Arbitration Association, subject to the following:

1. The arbitration shall be conducted by a single arbitrator selected by the Parties from a list furnished by the American Arbitration Association. If the Parties are unable to agree on an arbitrator from the list, the arbitrator shall be appointed by the American Arbitration Association.
2. The arbitrator shall be required to render a written decision resolving all disputes, designating one Party as the "prevailing party."
3. Except in the case of fraud, no arbitration decision may require any adjustment in compensation or payments respecting any dispute involving services rendered more than twenty-four (24) months prior to receipt of the Initial Notice.
4. Neither Party shall be entitled to an award of lawyers', consultants', or witness fees, it being the intention of the Parties that each side shall bear its own lawyers', consultants' and witness fees. The costs of arbitration, including the arbitrator's fee and any reporting or other costs, but excluding lawyers', consultants' and witness fees, shall be borne by the non- prevailing Party unless the arbitrator determines as part of the award that such allocation is inequitable under the totality of the circumstances. In the event that the dispute in arbitration concerns the appropriateness of Plan's adjudications of Claims, the Party challenging the adjudications shall have the initial burden of proving that there is a reasonable probability that the disputed Claims adjudications were incorrect adversely to that Party. When the other Party reasonably determines that it is required in its defense, or is required by the discovery process or otherwise by Law, to research the basis for the adjudications of challenged Claims for which such reasonable probability has not been proven, the other Party shall be awarded the administrative cost for such research for each such Claim that is found in the arbitration proceeding, after such research, not to have been adjudicated incorrectly adversely to the challenging Party.
5. The arbitration hearing will be held in Chicago, Illinois;
6. The arbitrator may award declaratory or injunctive relief only in favor of the Party seeking relief and only to the extent necessary to provide relief warranted by that Party's individual claim. Contracting Provider and Plan agree that each may bring claims against the other only in its individual capacity, and not as a plaintiff or class

member in any purported class or representative proceeding. Further, unless both Contracting Provider and Plan agree otherwise, the arbitrator may not consolidate Contracting Provider's claims with the claims of any other Provider or third-party, and may not otherwise preside over any form of a representative or class proceeding; and

7. Facility acknowledges that this arbitration provision precludes Contracting Provider from filing an action at Law or in equity and from having any dispute covered by the Agreement resolved by a judge or a jury. Contracting Provider further acknowledges that this arbitration provision precludes Contracting Provider from participating in a class action filed by any other Contracting Provider or any other plaintiff claiming to represent Contracting Provider or Contracting Provider's interest. Contracting Provider agrees to opt- out of any class action filed against Plan that raises claims covered by the Agreement to arbitrate, including, but not limited to, class actions that are currently pending.

Exceptions. The provisions of this Article shall not be applicable to the following:

1. Any legal proceeding brought by a third-party against Plan or Contracting Provider (a "Defendant"), as well as any cross-claim or third-party claim by such Defendant against Plan or Contracting Provider.
2. Termination of the Agreement pursuant to a termination without cause.
3. Immediate termination of the Agreement if based on external data relating to loss of licensure, status, certification, maintenance of insurance, breach of warranty, inducement, or Plan's judgment relating to cases involving standard of care or patient safety. However, a wrongful termination claim may be brought to recover the contractual rates under the Agreement.

Electronic Claim Reconsiderations

Electronically submit Claim Reconsiderations for situational finalized claim denials (including BlueCard® out-of-area claims), via the Availity® Essentials "Dispute Claim" capability, anchored off the enhanced Member and Claim search options in Claim Status tool. For more information, refer to the Claim Reconsiderations Request page.

Electronic Clinical Claim Appeal Requests

The "Dispute Claim" capability also allows providers to electronically submit appeal requests for specific clinical claim denials through Availity. When applicable, Dispute Claim is available after obtaining Availity Claim Status results using the **Member** and/or **Claim Number** tab.

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. For more information, refer to the Clinical Claim Appeal page.

Timely Filing
Facility Providers
Claims must be filed with BCBSIL on or before December 31 of the calendar year **following** the year in which the services were rendered. Services furnished in the last quarter of the year (October, November and December) are considered to be furnished in the following year. For example, a claim with a service date between Oct. 1, 2022, and Sept. 30, 2023, must be filed before Dec. 31, 2024. Claims not filed within the above time frames will not be eligible for payment. Contracted Provider may not seek to collect reimbursement from the member for amounts not paid due to Contracted Provider's failure to comply with timely claim submission requirements.

Professional Providers: PPO, Blue Choice PPO,SM Blue HPNSM and MyBlue Plus (POS)
The Contracting Provider agrees to bill the Plan in a timely manner and in a method acceptable to the Plan for payment prior to charging the covered person for any deductible or coinsurance amount. The Plan will pay the Contracting Provider, directly and on a timely basis, for covered services rendered to a covered person as described in the covered person's applicable health care benefit contract. In no event will the Plan, its designee, a covered person, a covered person's representative, a payer or any other person or entity be obligated to pay all or any portion of any claim for covered services that is not received by the Plan within the one hundred and eighty (180) day period following:

- The date of discharge or transfer for inpatient Health Care Services;
- The date of service for all other Health Care Services that are not inpatient; or
- 180 days after the date of the Contracting Provider's receipt of the explanation of benefits from primary payer when Plan is the secondary payer. The Plan will consider any request for a reasonable extension of the 180-day time period for filing claims, on a case-by-case basis, if the contracted provider provides notice to Plan along with appropriate evidence of circumstances beyond the reasonable control of the contracted provider that resulted in the delayed submission of the claim. The Plan reserves the right, in its sole discretion, to determine whether a reasonable extension of the timely filing requirement should be granted.

Contracting Provider may not seek to collect reimbursement from the member for amounts not paid due to Contracting Provider's failure to comply with timely claim submission requirements.

Note: There are some employer groups that have different and specific time frames for filing claims. This information may be obtained when calling to verify eligibility and benefits.

Coordination of Benefits

Our Coordination of Benefits provisions are based on the National Association of Insurance Commissioners Model and the applicable Department of Insurance rules regarding Group Coordination of Benefits. The COB provision applies when a policy holder/subscriber or covered dependent has health care coverage under more than one plan.

Note: For self-insured plans, the COB rules may be different.

All payments made by BCBSIL are subject to the COB provisions of the applicable benefit plan.

When a covered person has other coverage under another group plan or any deductible, copayment or coinsurance balance, the total amount payable by the plan and the secondary carrier cannot exceed the maximum allowance or the contracted provider's fee, whichever is less.

Order of Benefit Determination Rules

If an insurance plan does not contain a provision for coordination of benefits, then that plan will have primary responsibility for payment of benefits.

If an insurance plan does contain a provision for coordination of benefits, the rules for establishing the order of benefit determination are:

1. The coverage under which the patient is the eligible person (rather than a dependent) is primary. The other coverage is secondary and only considers any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision, and as a result both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
    a) However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefit of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as dependent of the parent without custody.
    b) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers the child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.
    c) Notwithstanding the items above, if there is a court decree that would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If none of the rules above apply, then the coverage that has been in effect the longest is primary.

COB Investigation

If other party liability indications are present on the claim, or on the COB History File Index, that another carrier is primary, BCBSIL will investigate for other carrier information. Contracted providers will receive an informational message on the Electronic Remittance Advice or Provider Claim Summary that the other carrier Explanation of Benefits is needed to continue processing the claim. Members will also receive a similar message on the EOB, as well as receiving a Customer Service Questionnaire letter requesting other carrier information.

BCBSIL will pay as primary, assuming our subscriber/policy holder is primary on their own policy, unless other party liability is indicated on the claim or on the COB History File Index. Failure by Contracted Provider to provide BCBSIL with all necessary information to facilitate COB may result in non-payment by BCBSIL.

Claim Filing and Claim Submission

Electronic Claims

Electronic submission of professional and institutional claims (ANSI 837 transactions) helps optimize the flow of information between providers and health plans. Claims may be submitted via your practice management system, Availity Essentials, or your preferred web vendor portal. Refer to the Claims and Eligibility/Electronic Commerce and Claim Submission sections of our website for more information on electronic claim submission and other electronic transactions.

Paper Claims

Facility Providers

Facility providers filing paper claims with BCBSIL must use the UB-04 claim form. For assistance with completing the UB-04 claim form, refer to the National Uniform Billing Committee website.

Professional Providers

Professional providers filing paper claims with BCBSIL must use the CMS-1500 claim form. For assistance with completing the CMS-1500 claim form, refer to the National Uniform Claim Committee website. Contact your print vendor to request a supply of paper claim forms. The form also may be ordered online at **http://bookstore.gpo.gov**, **https://bookstore.gpo.gov** or by calling **202-512-1800**.

Paper Claim Submission

Paper claims should be sent to:

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, Texas 75266-0603

Ancillary Claim Submission

Submitting Claims

Laboratory claims for members of BCBS should be submitted through the Blue Plan where samples were collected.

Laboratory Medical Records

You should maintain valid laboratory medical records which include:

- A signed **valid requisition** received from the patient's treating physician or qualified health care provider who is treating the patient and will use the results in the management of the patient's specific medical problem.
- Documentation of the **services ordered.**
- **Results** of the services performed.

Records should be complete, legible and include the following requisition and results documentation.

More Information

- See the Medical Policy and Reimbursement Policies sections of our website.
- Check eligibility and benefits first through Availity Essentials or your preferred web vendor portal, prior to rendering services. This step will confirm prior authorization requirements and utilization management vendors, if applicable.
- You may also call the Customer Service number on the patient's member ID card for individual benefit and coverage information.

BCBSIL may automatically cancel a Provider Record ID that does not have any claim dates of service within a 24 month time period. Terming of the Provider Record ID might also result in termination of associated networks. Provider record IDs are specific to billing/rendering NPIs and Tax Identification Numbers.

Medicare Crossover

Crossover is the automatic process by which Medicare sends an electronic supplemental claim to private insurers. The electronic claim contains claim and remittance data used to calculate secondary payment liability. The claim and remittance information are released to an insurer based on a membership listing that the insurer sends to Medicare.

CMS has consolidated the Medicare crossover process from many crossover contractors to one contractor, Coordination of Benefits Contractor. Under this arrangement, COBC sends all supplemental claims to private insurers.

It is not necessary in most instances for contracted providers to submit either an electronic or a

paper claim to BCBSIL, because we receive the electronic crossover claim. There are some situations when a claim does not crossover because the member's Health Insurance Claim Number does not match our membership file. It is only when a claim does not crossover that providers need to file an electronic claim with BCBSIL.

We will reject paper secondary claims when we have established a verified crossover arrangement for a member through a positive match with the member's Medicare HICN. In those situations where there is no positive match, we will continue to process Medicare primary, BCBS secondary claims with existing procedures.

Before submitting a supplemental claim to BCBSIL, check to see if the claim automatically crossed over:

- The Medicare remittance advice will contain a message that the claim was forwarded through the crossover process.
- Crossover claim payments are highlighted with the message, "Medicare Crossover Claim" on the ERA, EPS or PCS.

Note: COBC will not crossover supplemental claims until claims have left the Medicare 14-day payment floor. For example:

- Electronic claims processed on July 7, will be released to the supplemental insurer after a 14- day payment floor, July 21.
- Paper claims processed on July 7, will be released after the 29-day payment floor instituted under the Deficit Reduction Act, August 5.

Do not resubmit a rejected claim by paper, because it will deny as a duplicate. Contracted providers must submit the rejected claim for review. Please follow the usual review request process by completing the appropriate form on the Forms page.

Coinsurance, Deductible

Contracted providers agree to bill the Plan for payment prior to charging the member for any deductible or coinsurance amount. Subsequent to receipt of payment from the Plan, the contracted provider shall bill the member for any deductible or coinsurance amount payable under the contract.

Copayments

Contracted providers may bill covered persons for copayment amounts at the time of service. Copayments should be listed on the member's ID Card. However, some employer groups choose not to display the copayment amount on the ID Card. Copayment amounts can be determined electronically by using Availity's Eligibility and Benefits Inquiry, your preferred web vendor, or by calling Provider Services at 800-972-8088.

Patient Cost Estimator

The Patient Cost Estimator, accessible in the Availity Eligibility and Benefits Inquiry response, will review the available information submitted, including primary diagnosis, procedures performed, benefits and contractual allowances. Then the PCE calculates an estimated out-of-pocket cost for services provided to members of BCBSIL.

Refer to the Patient Cost Estimator page for additional information.

The contracted provider understands and agrees that by using the PCE, available through Availity Essentials, or any other third party, that it agrees to the following terms and conditions:

PCE is not a guarantee of payment. Benefits will be determined once a claim is received by BCBSIL and will be based upon, among other things, BCBSIL policies and procedures, the member's eligibility, benefits, limitations and exclusions and the terms of the member's certificate of coverage in effect on the date services are rendered.

- The use of an PCE is to provide an estimate of the potential out-of-pocket costs that a member may be responsible for at a particular point in time.
- PCE is not a substitute for a recommended clinical review (formerly known as predetermination), prior authorization or a Radiology Quality Initiative number.
- A number of factors may impact the member's actual claim liability from the time an estimate is given to the time the claim is actually adjudicated, including, but not limited to, claims received but not yet adjudicated, medical policy and coordination of benefits and eligibility. Therefore, the member's actual liability may be different than the amount displayed by the PCE on a particular date.
- The PCE shall not override the terms of the member's coverage at the time services are rendered. In the event of a conflict the terms of the member's coverage document shall control.
- PCE is not a claims adjudication system. Claims will not be adjudicated until and unless billed to BCBSIL.
- The contracted provider may not collect an amount greater than the amount listed by the PCE at the time of service.
- In instances where the contracted provider has collected more money than the member's actual liability, as listed on the provider's EPS or PCS, or the member's EOB, the contracted provider agrees to refund the member within 30 days from the date the Contracted provider is notified by the EPS, PCS or any other documentation sent to the contracted provider, either in writing or electronically.
- In the event the overpayment is not returned to the member within this time frame, BCBSIL will be permitted to deduct the overpayment from future claim payments due to the contracted provider.

Note: BCBSIL reserves the right to revise the foregoing at any time without advance notification.

Balance Billing and Hold Harmless Provisions

All providers who contract with BCBSIL agree to accept a specific amount as full payment for each service covered by the patient's plan. The Contracting Provider agrees to bill BCBSIL before they ask for the patient's coinsurance and deductible, and they must not bill patients for any remaining balance above the agreed upon fee. If a contracted provider has balance billed one of our members, we will notify the contracted provider and the member that balance billing is not permitted under the contracted provider's contract.

BCBSIL also prohibits the Contracting Provider from charging patients for services that are deemed not medically necessary, unless the member requests the services, the contracted provider informs the member of his or her financial liability, the member chooses to receive the service(s) and the member accepts financial responsibility in writing. The contracted provider should document such notification to the member in the contracted provider's records. Both contracted hospitals and physicians have agreed to this provision in their contracts.

Participating Provider Retroactive Effective Date Requests

- No provider is considered to be a participating provider until they have completed the BCBSIL credentialing process and have been approved by BCBSIL (see the Credentialing Standards section for full requirements).
- Claims received prior to appointment or reappointment to the network may be treated as out-of- network until the provider has met all network requirements including but not limited to credentialing.
- On a case-by-case basis, BCBSIL reserves the right, in its sole discretion, to retroactively adjust effective dates. A provider must notify BCBSIL within 30 days of the appointment date to request consideration for a retroactive effective date. Any requests for a retroactive effective date that are granted by BCBSIL shall not be greater than 60 days from the approved provider's appointment date.
- Providers are strongly encouraged to submit all necessary documentation for participation at least 60 days prior to the intended effective date.
- Once credentialed, all providers are expected to comply with recredentialing standards.
- If a provider does not comply with recredentialing requirements before the current recredentialing cycle ends, BCBSIL reserves the right to treat all such claims as out-of-network.
- Providers will hold members harmless for dollar amounts over the Schedule of Maximum Allowance and any out-of-network member liability as a result of the provider's failure to complete the credentialing process in accordance with the terms set forth here and within credentialing policies.
- If a provider is terminated for not meeting recredentialing requirements, the provider will have 30 days from the termination date to rectify and apply for reinstatement. Providers who remain terminated beyond 30 days will have to reapply to the network under the normal course of business.

Reimbursement and Statement Reporting

The Participating Agreement between the contracted provider and BCBSIL now includes the following statements that have been inserted in the Billing and Reimbursement section, Article IV, Section 2, emphasizing the importance of participating in electronic transactions:

The PPO Plus Provider agrees to use his/her best efforts to participate with the Plan's Electronic Funds Transfer under the terms and conditions set forth on the Electronic Funds Transfer Agreement. The PPO Plus Provider also agrees to use his/her best efforts to participate with the Plan's Electronic Remittance Advice as described on the Electronic Remittance Advice Enrollment Form.

Please note: This Provider Manual is incorporated by reference into the PPO contract of all professional providers. As such, the language above applies to all existing professional PPO providers, effective Oct. 1, 2010.

Electronic Payment and Remittance Options
Both facility and professional providers will make best efforts to use the following electronic options that offer greater convenience, efficiency, and security of information over paper notification statement and payment.

Electronic Funds Transfer is a secure method of claims payment. Funds are electronically transferred directly into the bank account of your choice.

Electronic Remittance Advice is a HIPAA compliant electronic file that includes claim payment and remittance data. The ERA is received the day after claim finalization. The purpose of the ERA is to enable automated posting to your 835-compatible patient accounting system.

Electronic Payment Summary provides the same payment information as the paper PCS. It is received in your office the same day your ERA is delivered and can help streamline the payment and account reconciliation process.

To get started with EFT, ERA and EPS, visit the Claims and Eligibility/Claim Payment and Remittance section of our website.

Paper Provider Claim Summary
As noted above, electronic payment and remittance options are strongly preferred and encouraged. For providers who are not enrolled for EFT and ERA/EPS, the PCS is a paper notification statement or voucher that is mailed with the payment, if applicable, to providers contracted with BCBSIL after the processing of a claim has been completed. The content of each summary varies based upon the subscriber's benefit plan and services rendered, and explains payment, remittance information and any amount of the bill that is the patient's share. The voucher may include multiple transactions.

Refer to the appendix for PPO Facility Provider Claim Summary Example and PPO Professional Provider Claim Summary Example.

Reimbursement for Facility Providers
The base contract that is in effect with nearly all Illinois hospitals is the Plan contract. This

contract automatically renews annually unless cancelled. The terms of this agreement are based on the hospital's cost, plus an agreed upon margin (typically 5%) for inpatient services and charges for covered services for outpatient services. The contractual allowance represents the difference between the total amount paid to the hospital during the year and the total actual cost of the care provided (cost + 5% margin).

Illinois hospitals that have PPO-specific contracts will always have Plan contract agreements. Illinois hospitals can also have specific contracts for other products/networks (e.g., Blue Choice PPO℠, Blue HPN℠). The terms of these contracts stipulate that the hospitals agree to prospective and stabilized rates coupled with utilization controls. The calculation of the contractual payment is typically a per diem for inpatient services and a percentage of covered charges with payment maximums or caps for outpatient services. The claim's contractual allowance represents the difference between the contractual payment and the net covered charge.

Illinois Ancillary facilities such as Coordinated Home Care, Hospice, Skilled Nursing Facilities, Renal Facilities, Surgi-Centers, and Substance Abuse Facilities, may also have a contract with BCBSIL. Payment structure is typically a payment maximum or per diem. The claim's contractual allowance represents the difference between the contractual payment and the net covered charge.

All facility providers contracted with BCBSIL receive a monthly or quarterly Experience Report that lists all claims, accompanied by a cover letter that summarizes the figures for the year-to-date. The cover letter includes the repayment terms. The amount due must be paid within 30 days, unless providers participate in the Uniform Payment Program, in which case the amount due is deducted from the next month's UPP checks.

The Experience Report and cover letter are available electronically through Experian Health. Providers can also receive an electronic UPP check breakdown (0500 report) from their assigned clearinghouse of choice.

Refer to the appendix for Sample PPO and Experience Reports and Experience Report Sample Cover Letter.

Uniform Payment Program

BCBSIL employs the UPP mechanism for procedural payments of Gross Claims Funding and Contractual Allowance collections, as well as Special Payments / Collections. The UPP payment is monitored on a weekly basis and adjusted as necessary. The facility payment is comprised of:

- Weekly Gross Claims Funding
- Contractual Allowance Collections
- Other Special Payments or Adjustments
- Net Weekly UPP check

Providers participating in UPP will usually receive:

- **A Net Weekly UPP check**
  UPP checks are usually produced every Wednesday evening (with a Friday date) and mailed or sent via EFT to the provider's bank account.
- **Non-payment vouchers without a check attached**
  As non-payment vouchers are received, the provider credits the subscriber's ledger, and a corresponding debit is posted to their advance account. It is the provider's responsibility to maintain this daily log of nonpayment vouchers so that the voucher numbers and amounts can be matched against the information reported on the UPP monthly summary.
- **A monthly UPP Statement listing details (vouchers, advances (Weekly Gross Claims funding), credits, and weekly/monthly balances) of the month's activity.** This statement is available via Experian Health's OneSource.

Note: Those providers receiving EFT will receive an electronic UPP check breakdown (report UPT 0500) via their assigned clearinghouse. EFT deposits are generally received on the Monday following that Friday's UPP weekly check.

Posting Example
A patient's account is $5,000 and they have a comprehensive 100 percent contract.

Gross UPP amount	$5,000
Incentive contractual allowance	$1,000
Net UPP amount	$3,500

The posting would be:

a) To record the receipt of the weekly UPP check
b) To post the receipt of the UPP voucher

UPP Clearing Account	Incentive Contractual Allowance
5,000 (a)	1,500 (a)
5,000 (b)	

Cash Account
3,500 (a)

Patient's Ledger
5,000 (b)

Refer to the appendix for Uniform Payment Program Monthly Statement Sample.

For a more detailed explanation of the UPP process, please contact your assigned Provider Network Consultant.

Adjustments to Blue Cross Facility Claims

Late Charges and Corrected Claims

Late charges are charges that were not included in the original billing. All late charges and credits must be filed within 90 days of the original claim payment.

- Late charges should be submitted electronically in the UB-04 format. (Blue Cross no longer uses forms BC55 or BC177 to submit late charges.)

Corrected claims and late charges are submitted to correct the original claim.

- Submit **TOB X17 or X37** to replace a claim which includes additional charges that were not included in the original claims.

The following message will appear on your EPS when late charges, corrected or replacement claims are submitted:

The related ANSI Reason code B13 will appear on the ERA.

The following message will appear on your paper PCS when late charges, corrected or replacement claims are submitted:

This is a late charge or corrected claim. If any additions or corrections were necessary, the original claim has been adjusted.

If a late charge or corrected claim is submitted and we have no original claim on file, that claim will be processed as if it were the original claim.

Your EPS message will state:

We have adjusted the original claim for this service.

Your PCS message will state:

We have adjusted the original claim for this service.

Reimbursement for Professional Contracted Providers

Professional Contracted Providers

- Members must use providers contracted with BCBSIL to help maximize their benefits.
- Contracted providers are paid directly for covered services by BCBSIL.
- The member's benefit plan, in part, determines whether the services are covered and eligible for reimbursement.
    - Members with PPO and Blue Choice PPO polices – Schedule of Maximum Allowances
    - Members with Blue HPN – IL HPN Fee Schedule
    - Members with MyBlue Plus (POS) - Refer to your Provider Contract for reimbursement information
- Contracted providers receive an EPS or PCS that indicates the amounts billed and paid, covered services, non-covered services, deductible and coinsurance and patient share.

The SMA is based on a payment methodology called the Resource Based Relative Value Scale.

RBRVS has three main components:

1. Relative Value Units that are weights assigned for specific services based on:
    - Work: The physician's resources, including time and effort intensity
    - Overhead/practice expenses: Rent, salaries, equipment, supplies, etc.
    - Liability/malpractice insurance expenses

2. Geographic Practice Cost Index
    - Cost factors that reflect varying costs in different areas
    - A separate GPCI is applied to the RVU factors (work, overhead, liability) in each location

3. Conversion Factor
    - A number that converts relative weights created by RVUs and GPCIs for each procedure code into payment dollars. The weights are multiplied by the conversion factor to obtain the payment.

RBRVS Payment Formula

(Work RVU x Work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI) x Conversion Factor = Payment Amount

Refunds/Payment Recovery Program
The Payment Recovery Program allows recoupment of overpayments made to BCBSIL contracted facilities and professional providers in the PPO, Blue Choice PPO, Blue HPN, and MyBlue Plus (POS) product networks when payment errors have occurred. Overpayments can occur as a result of duplicate payments, non-covered services, COB, etc.

Refund Process
The following process is used to recover overpayments identified by BCBSIL:

1. A refund request letter, explaining the reason for the refund is sent to providers; it includes a remittance form and return address envelope. Contracted providers with access to our Electronic Refund Management tool have the option to receive overpayment notifications via email.

2. If we do not receive a response to our initial communication, a follow up letter/email is sent asking for payment.

3. If we do not hear from the contracted provider by phone, in writing or through eRM, or the contracting provider does not return the amount of the overpayment within 90 days from the date of the initial letter, BCBSIL will recover the overpayment by offsetting current claim payments by the amount due to us.

4. The patient information and recovery amount are explained on the EPS or PCS, as well as the ERA. If applicable, a summary will appear on the UPP Monthly Statement.

Refer to the appendix for Refund Request Letter Sample, Refund Request Follow-up Letter Sample and Provider Claims Summary Sample.

The EPS or PCS will display:
- The total amount recouped toward the overpayments
- The net amount after recoupment has been applied
- Information regarding the specific overpaid patient account (i.e., patient name, patient account number, service dates, etc.), the amount of overpayment recouped and the overpayment reason

The ERA will include:
- Information in a PLB segment when an overpayment is recovered by BCBSIL. The ANSI 835 version 5010A1 will be displayed as follows:
- PLB*12345697890*20241231*WO:02024123456789X00999999999*25.30~
- PLB01 = National Provider Identifier (NPI)
- PLB02 = Fiscal Period (CCYYMMDD)
- PLB03-01 = Adjustment Identifier (WO = Overpayment Recovery)
- PLB03-02 = Provider Adjustment Identifier = DCN # will be provided, as well as Patient Control Number
- PLB04 = Provider Adjustment Amount

The UPP Monthly Statement will display:
- A separate line for recoupment amounts if a refund is not received

Provider Credit Balances

Contracted professional and facility providers may submit unsolicited refunds when they identify a credit balance. Credit balances are submitted for the following reasons:

Billing Error	[This remark may apply if the provider has posted a credit for supplies or services not rendered; or if the provider canceled charge(s) for any reason. You must indicate if all charges were canceled or indicate the specific charges canceled for partial refund. *This option should not be used if one of the other options applies.]
COB Credit	A Coordination of Benefits credit payment was received under two different Blue Cross and Blue Shield memberships or from BCBS and another carrier. (Include a copy of the other carrier's Explanation of Benefits. Do not use for Medicare or Third Party Liability, such as Workers' Compensation.)
Corrected Claim	Payment received for charges that has been corrected. Include the correct claim number and/or copy of the corrected claim.
Duplicate Payment	A duplicate payment has been received from BCBSIL for one instance of service (e.g., same group and member number). (Include the duplicate claim number and/or explanation of benefits for duplicate payment. Do not use for COB, Medicare, Workers' Compensation or Third Party Liability.)
Not Our Patient	Payment has been received for a patient that did not receive services at this facility/treatment center.
Medicare Eligible	Medicare has paid as primary or reprocessed and payment from BCBS has exceeded the Medicare patient liability. Include a copy of Medicare's explanation of benefits.
Pricing	The payment from BCBSIL is more than the provider's contracted rate. Include details of expected reimbursement.
Workers' Compensation	Payment for the same service has been received from BCBS and a Worker's Compensation carrier.
Third Party Liability	Payment for the same service has been received from BCBS and a third-party liability carrier. Include a copy of the carrier's explanation of benefits.

Submitting a Refund

Electronic Refund Management
UPP and non-UPP contracted professional and facility providers can electronically submit refunds to BCBSIL using eRM. Refunds are applied real-time, eliminating the need to mail in a paper form. **Non-UPP providers** have the option to refund BCBSIL by check or by letting BCBSIL deduct the dollars from a future claim payment. **For UPP providers**, the dollars will be deducted from future payments. If a contracted provider identifies a credit balance, the request may be submitted online. The refund payment can be submitted by check or deducted from future payments.

Manual (Paper) Submission
Professional contracted providers not using eRM may use the Provider Refund Form. The completed Provider Refund Form must be submitted with payment to:

Remittance Mailing Address (USPS refunds)

Blue Cross and Blue Shield of Illinois, Refund and Recovery
P.O. Box 94075
Palatine, IL 60094-4075

Or

Courier Mailing Address (UPS, Fedex, etc. refunds)

Blue Cross and Blue Shield of Illinois, Refund and Recovery
Box 94075
5505 N. Cumberland Ave Suite 307
Chicago, IL 60656-1471

More Information About eRM
eRM is an online refund management tool that features many practice enhancing components, which will help simplify overpayment reconciliation and related processes, and is available to contracted providers at no additional charge. Registration with Availity is required prior to obtaining access to eRM. For more information, refer to the Electronic Refund Management page.

eRM offers the following features:

- **Single sign-on** – Current users can access eRM through Availity Essentials.
- **Electronic notification of overpayments** – Contracted providers have the option to replace paper requests for claim refunds with electronic notification. Contracting professional and facility providers receive a daily or weekly email that summarizes overpayment requests for each National Provider Identifier (NPI). This helps reduce the cost of maintaining overpayment records.
- **Ability to settle overpayment requests online** – BCBSIL can deduct the overpayment from a future claim payment. Details will appear on the EPS or PCS. Information in the eRM transaction history can also assist with recoupment reconciliations.
- **Ability to inquire about or dispute requests online** – If contracted providers have any disagreements or would like more information for each request, the request can be submitted online.

- **View overpayment requests** – Contracted providers can view and search/filter all new, outstanding and closed refund requests that contain an NPI related to an office or facility. Contracted providers can also view more details including claim, patient account number, service dates, overpayment reason, etc. eRM delivers real-time transactional history for each refund request, showing a complete audit trail for tracking when an action was taken on a particular item and who performed it (including closed requests).
- **Pay by check** – Contracted providers may select one or multiple requests and submit a refund by mailing a check. Contracted providers will be asked to include a system generated remittance form showing the refund details (generated within eRM). When the refund check is received, the check number that was sent to settle the overpayment will be noted.
- **Submit unsolicited refunds** – Contracted providers can submit a credit balance online and refund the payment by check, or refunds can be deducted from a future claim payment. The information will still be on the EPS or PCS. The details will be in the eRM transaction history to assist with all recoupment reconciliations. No other contact (e.g., phone inquiry) is necessary for the credit balance/overpayment situations.
- **System Alerts** – Contracted providers will receive notification via the eRM system in certain situations, for example if there is an inquiry response or if a check has been stopped or returned to BCBSIL due to a bad address.

eRM also includes a Claim Inquiry Resolution function that provides a method for inquiry submission related to High-Dollar, Pre-Pay Review requests for most Host (BlueCard® out-of-area) and IL Local claims (Medical Records and/or Itemized Bills) handled by BCBSIL. The CIR function is accessible via a tab within the eRM system.

How to Gain Access to eRM

Availity Essentials Users

Select Payer Spaces from the navigation menu and choose BCBSIL, select the Applications tab and then choose the Refund Management - eRM tile. If you are unable to access the Refund Management eRM link, please contact your Availity Administrator. If you do not know who the Availity Administrator is, select 'My Account' under 'My Account Dashboard' on the Availity home page. For technical assistance, contact Availity Client Services at 800-282-4548 for assistance or visit availity.com for more information.

Section 3: Electronic Commerce

Electronic Commerce Overview
Electronic Commerce involves information that is stored, displayed or transmitted electronically. Utilizing Electronic Commerce in day-to-day business operations is necessary for the secure and standardized exchange of clinical data between patients, providers, health plans and other health care stakeholders. BCBSIL offers a growing list of Electronic Commerce options – online, self-service tools, resources and support services – to assist you with providing health care services to your patients. It is important to take advantage of all Electronic Commerce options that are available to you as a network provider to help you remain competitive, as well as compliant, in some cases, with contractual and/or other requirements.

The contracting provider agrees to use his/her best efforts to participate with the Plan's Electronic Funds Transfer under the terms and conditions set forth on the Electronic Funds Transfer Agreement. The contracting provider also agrees to use his/her best efforts to participate with the Plan's Electronic Remittance Advice as described in the ERA Enrollment.

Electronic Commerce Transactions
Doing business electronically with BCBSIL involves Electronic Data Interchange, the computer-to-computer transmission of standardized information. EDI transactions are often identified by numbers assigned by the American National Standards Institute. Listed below are some of the administrative, clinical and financial electronic solutions offered and/or supported by BCBSIL. Please note that, for most electronic options, you will need to utilize an approved independent third-party vendor that can provide a secure connection to BCBSIL – see the Electronic Commerce Vendors listing at the end of this section for details.

Eligibility and Benefits Request (ANSI 270/271)
Before rendering services to our members, it is critical that you check participation and coverage details according to the member's benefit plan. You can verify commercial and government payers' membership and eligibility at a single location through Availity Essentials or your preferred electronic vendor. This step also helps you confirm benefit prior authorization requirements and other important information. Refer to the Eligibility and Benefits page for helpful resources, such as user guides to help you navigate Availity.

Electronic Prior Authorization (Availity Authorizations)
Authorizations in Availity Essentials allows the electronic submission of inpatient admissions and select outpatient services handled by BCBSIL. Additionally, providers can also check status on previously submitted requests and/or update applicable existing requests. Availity Authorizations is accessible to physicians, professional providers and facilities who have established a provider record with BCBSIL. Visit the Availity Authorizations page for more information.

Online Patient Cost Estimator
Online Patient Cost Estimator is available in Availity Essentials to help provide you with the opportunity to collect estimated patient financial responsibility at the time of service. Visit the Education and Reference/Provider Tools section of our website for additional information, such as the Patient Cost Estimator.

Electronic Health Record/Patient Care Summary
Registered Availity Essentials users may access the Patient Care Summary, which uses claim-based information to provide you with a consolidated view of a member's health care history at the point of care. This payer-based electronic health record can help you identify potential treatment issues such as clinical gaps in recommended care services, missed prescription refills and possible drug interactions. Visit the Patient Care Summary page for additional information.

Electronic Claim Submission (ANSI 837)
You can submit claims electronically, real-time or in batch, 24 hours a day, seven days a week. Electronic claim submission enables users to have same-day access to their batch reports, which allows for quicker error resolution and expedites the overall revenue management cycle process. All institutional or facility (UB-04) and professional (CMS-1500) claims can be filed electronically using your preferred electronic clearinghouse or practice management system. You may also file electronically at no charge through Availity Essentials. For additional information, visit the Electronic Claim Submission page.

Claim Status Request (ANSI 276/277)
After submission, check claim status online and in real-time using Availity Essentials or your preferred electronic vendor. For enhanced claim status, such as expanded search options, registered Availity users may access Member and/or Claim Number tabs in the Claim Status tool. Visit the Claim Status page for additional information.

Electronic Claim Reconsiderations
Use the preferred Claim Reconsideration Request option for situational finalized claim denials (including BlueCard® out-of-area claims) via the Availity "Dispute Claim" capability, anchored off the enhanced Member and Claim Number search options in the Claim Status tool. For more information, refer to the Claim Reconsiderations Request page.

Electronic Clinical Claim Appeal Requests
The "Dispute Claim" option also allows providers to electronically submit appeal requests for specific clinical claim denials through Availity. When applicable, Dispute Claim is available after obtaining Availity Claim Status results using the **Member** and/or **Claim Number** tab.

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. For more information, refer to the Clinical Claim Appeal page.

Electronic Funds Transfer (ANSI 835 EFT)
EFT is a secure method to receive claims payment, allowing electronic transfer of your claim reimbursement funds directly into the bank account of your choice. Enrollment allows you the option of selecting daily EFTs or a weekly payment schedule for commercial claims. Additional information, such as how to enroll for EFT online through Availity Essentials, is available in the Claims and Eligibility/Claim Payment and Remittance section of our website.

Electronic Remittance Advice (ANSI 835 ERA)
The purpose of this HIPAA-compliant data file is to facilitate automated posting of payments to your patient accounting system. You must be a registered Availity user to receive the ERA from BCBSIL. Additional information, such as how to enroll online for ERA, is available in the Claims and Eligibility/Claim Payment and Remittance section of our website.

Remittance Viewer
The remittance viewer offers providers and billing services a convenient way to view and help reconcile claim data provided in the 835 ERA by BCBSIL. You must be a registered Availity user to gain access to the remittance viewer. For additional information, refer to the Remittance Viewer page.

Electronic Payment Summary
When you enroll for the ERA, you automatically receive the EPS, which is an electronic version of the paper Provider Claim Summary. The EPS is received in your office the day after the claim has been finalized, and you may use the EPS as an added tool when reconciling payments from BCBSIL. **Note:** The EPS cannot be used for automatic posting and is only available in combination with the ERA.

Provider Claim Summary
Provider Claim Summary allows users to readily view, download, save and/or print the PCS online, at no additional cost. You must be registered with Availity to gain access to this tool. For additional information, refer to the Provider Claim Summary page.

Clear Claim Connection™
Clear Claim Connection (C3) is a free online reference tool that mirrors the logic behind ClaimsXten™ code-auditing software. You can use C3 to help determine how coding combinations on a particular claim may be evaluated during the adjudication process. To gain access to C3, you must be registered with Availity Essentials. For additional information, including an instruction document to assist you with using C3, visit the Education and Reference Center/Provider Tools section of our website.

Electronic Refund Management
Electronic Refund Management is an online tool that can help simplify your overpayment reconciliation and related processes. Prior to accessing eRM, you must be registered with Availity. A detailed explanation of eRM, its functionality and benefits are included in the Billing and Reimbursement section of this Provider Manual. Also refer to the Electronic Refund Management page.

Electronic Commerce Vendors
See below for an example of a multi-payer independent third-party vendor that can help provide a secure electronic gateway between your office and BCBSIL for the exchange of real-time member/claim-related health care data. Prior to conducting EDI transactions, you will need to confirm services are available and register with your selected vendor. In some cases, there may be a fee for services.

Availity Essentials
Availity Essentials provides access to eligibility and benefits, claim status, claims clearinghouse services and more. To register with Availity or learn more about services available to contracted providers, visit the Availity website, or call Availity Client Services at 800-282-4548.

Provider Learning Opportunities

The list of electronic options we support and make available for providers continues to expand. This section of our Provider Manual provides just a brief overview. Also watch for additional information and announcements in the Blue Review, as well as the News and Updates section of our website. Or, join us for a complimentary training session – refer to the Webinars/Workshops page for dates, times and online registration for upcoming sessions.

Section 4: Credentialing Standards

Overview Through the credentialing process, we review and validate the professional qualifications of physicians and certain other providers who apply for participation in our networks. This process ensures that providers meet our professional standards.

Network Eligible Providers Providers including, but not limited to, the provider types listed below, must complete the credentialing process and be recredentialed every three years:

- **Professional providers:** MD, DO, PsyD, PHD, AUD, BCBA, OD, DC, CNM, DPM, LCSW, LCPC, LMFT, PA, APN, APRN, ANP and CNP, CNS, RD, LAC and DN.
- **Institutional providers:** Hospitals and Ancillary (such as skilled nursing facilities, home health, home infusion, durable medical equipment suppliers, etc.)
- **Independent Labs**

Credentialing Process We use information from the CAQH Provider Data Portal to support the credentialing process.

The CAQH Provider Data Portal allows providers to self-report professional and practice information to BCBSIL. If you don't have a CAQH account already, you'll need to register.

Quick Tips

1. Complete all application questions.
2. Ensure all sections of the application are complete and accurate.
3. Authorize BCBSIL so we can access your credentialing information.
4. Attest to your data profile.
5. Upload supporting documentation.

Refer to the CAQH Provider Data Portal for Providers User Guide for additional information.

BCBSIL may contact you to supplement, clarify or confirm certain responses on your application. You may be required to submit additional documentation in some situations, in addition to the information you submit through the CAQH Provider Data Portal.

Data Verification We're working with Verisys to verify your credentialing data after you enter it into the CAQH Provider Data Portal. **Verisys may contact you on behalf of BCBSIL** and request that you:

- Re-attest to your data's accuracy, or
- Complete your credentialing application by entering or attaching missing information in CAQH Provider Data Portal

Please respond as soon as possible to help complete the credentialing process. You'll receive written notification of your status when the credentialing process is completed.

Credentialing Updates
Keeping your information current is your responsibility, and you must do so with CAQH and BCBSIL.

CAQH will send you automatic reminders to review and attest to the accuracy of your data. Use the CAQH Provider Data Portal to report any changes to your practice, in accordance with the time frames outlined in the state of Illinois Health Care Professional Credentials Data Collection Act, as follows:

- Within five business days for state health care professional license revocation, federal drug enforcement agency license revocation, Medicare or Medicaid sanctions, revocation of hospital privileges, any lapse in professional liability coverage required by a health care entity, health care plan or hospital, or conviction of a felony.

- Within 45 days from the date you knew of the change, for any other information provided on your credentialing application, i.e., practice address, hospital affiliation, etc.

You must enter your changes into the CAQH Provider Data Portal for us to access during the credentialing and recredentialing process. Only the health plans that participate in the CAQH Provider Data Portal and for which you have authorized access will receive any changes.

Update BCBSIL of Information Changes It is important that you **also** inform BCBSIL of changes to your practice or demographic information. Learn more on our Verify and Update Your Information page.

Check Credentialing Status To check the status of your credentialing process, enter your NPI or license number in our Credentialing Status Checker.

Recredentialing CAQH requires you to review and attest to your data once every six months. BCBSIL recredentials network providers every three years in accordance with state of Illinois requirements. The state selected the last digit of the physician's Social Security number to create the single cycle.

At the time you are scheduled for recredentialing, BCBSIL will add you to the CAQH roster to receive your application. If your application is expired or missing information, CAQH will contact to update your information. You will continue to receive recredentialing notices up to and including notice of termination of participation.

We work with Verisys to verify credentialing and recredentialing data. Verisys may contact you on our behalf and ask you to re-attest to your data accuracy.

Once the recredentialing process is completed, you are considered approved unless otherwise notified. If not approved, a letter with details will be mailed within 10 business days.

Appointment and Reappointment Reports
We apply a single credentialing process so that a provider is credentialed once and may then apply for any managed care network that requires credentialing prior to participation. We publish reports of credentialed and appointed providers to provide notification of their effective date with Blue Choice PPO, PPO, Blue HPN℠ and the HMO products. Visit the Appointment/Reappointment page for more information.

Network Deparcipation and Termination
Deparcipation means termination of participation of a practitioner from a network. When performance by a practitioner does not meet network standards, the network may place the provider on monitoring and/or undertake corrective action. Monitoring persists until the issues creating the action have been resolved, or the network takes other action, including involuntary/voluntary deparcipation. For providers participating in BlueHPN this may include maintenance of performance on certain quality measures.

IL Network Management/Enterprise Credentialing or the Special Investigations Dept. may report to the Provider Selection Committee any practitioner placed on monitoring/corrective action or deparcipated as a result of conduct or practice that could impair the integrity of other networks or is deemed to be unprofessional, unethical or illegal. Such conduct or practice includes, but is not limited to:

- Loss, suspension or probation of license or hospital privileges
- Felony charges
- A quality of care or member satisfaction issue
- Failure to meet site visit requirements.
- Refusal to cooperate with BCBSIL and/or contracted network policies and procedures.
- Suspected fraud
- Abusive billing practices
- Financial insolvency

A provider that receives a network departicipation/termination may have appeal rights, as determined by the PSC in the PSC's sole discretion. Providers may timely submit appeal requests along with supporting documentation, if applicable, for PSC's consideration per the instructions and within the designated appeal period stated in the departicipation/termination correspondence.
When a provider is terminated for administrative and/or performance issues related to network performance standards and unrelated to the physician's or professional provider's ability to practice, reporting is not required. In cases that involve suspected fraud by a physician or provider, the individual is reported to the SID, who may report the situation to the appropriate authorities.

Section 5: Health Care Medical Management

The Medical Management Department under BCBSIL helps ensure our members have access to affordable, quality health care. Our programs are designed to promote the optimal use of health care resources to improve health care outcomes. We believe the efficient and effective use of health care service results in quality health care outcomes. We use various resources, including MCG™ care guidelines, Medical Policies, and American Society of Addiction Medicine criteria, which are evidence and consensus-based guidelines to support effective care and efficient resource utilization. BCBSIL meets the Blue Cross Association Consortium requirements and is accredited by the National Committee for Quality Assurance.

Medical Management Accessibility

You may contact Medical Management at 800-572-3089 from 8 a.m. to 5 p.m., Monday through Friday. The hours for prior authorization requests are 7 a.m. to 7:30 p.m., Monday through Friday; and 7am-4:30 p.m. on weekends and holidays.

- Outside of regular business hours, calls are received through a contracted answering service.
- BCBSIL provides Telecommunication Device for Deaf/Text Telephone services and language assistance for incoming callers.
- Toll-free and collect calls are accepted throughout Illinois and all states within the Continental U.S., as well as Alaska and Hawaii.
- An Automated Call Directing system allows callers using touch-tone phones to self-direct to the appropriate area. Medical Management personnel will refer the caller or transfer the call to other appropriate departments as needed.
- Outbound calls to members and/or their authorized representatives, providers and vendors will be made during normal business hours.
- Service calls and messages are often responded to immediately during working hours, but no later than within one business day after receipt of a message.

Medical Management does not make determinations about whether services are medically appropriate. Medical Management reviews whether benefits are available. The final determination about what treatment or services should be received is between the patient and their health care provider.

Utilization Management

Based in part on industry and national standard of care guidelines, the UM program helps ensure that members of BCBSIL receive the appropriate level of care in the most cost-effective setting, through short-term discharge planning, facilitating transitions between levels of care or pre-admission and post-discharge calls. For additional information, you may refer to the Health Care Delivery Utilization Management and Reference policies and procedures located in the Provider Manual section on our Provider website. For MyBlue Plus POS, please refer to the MyBlue Plus Point of Service section of this manual.

UM Clinical Review Criteria

Utilization management reviews use evidence-based clinical standards of care to help determine whether a service may be covered under the member's benefit health plan. To view UM clinical review

criteria, refer to the Prior Authorization Support Materials (Commercial) page and the Medical Policies page.

UM Affirmation Statement
BCBSIL distributes an affirmation statement to all staff and practitioners involved in UM decision-making, affirming that:

- UM decisions are based on medical necessity, as defined in the member's benefit plan, which takes into consideration appropriateness of care and services, and the existence of available benefits. The organization does not reward health plan staff, providers or other individuals for issuing adverse determinations of coverage, care or service.
- Incentive programs are not utilized to encourage decisions that result in underutilization.

Types of UM Review
Types of utilization management review that may be conducted before services are rendered include **prior authorization recommended clinical review** and **prenotification.** Utilization management also may include **post-service review**.

An overview of prior authorization, recommended clinical review, and pre- notification guidelines and related information are included below as a reminder of definitions and important details. Special processes for MyBlue Plus POS Plan, out-of-area Blue Plan, Federal Employee Program members are referenced later in this section. For more information, refer to the Utilization Management section of our website.

Also watch our *Blue Review* and News and Updates for important announcements.

Prior Authorization

Prior authorization (also called benefit pre-certification or preauthorization) is the required process of determining whether the proposed treatment or service is medically necessary, as set forth in the member's benefit plan and according to our policies and procedures, by contacting BCBSIL or the appropriate benefit prior authorization vendor for prior approval of services.

Remember, member benefits and review requirements will vary based on the service/drug being rendered and the individual/group policy elections. **Always check eligibility and benefits first**, via Availity or your preferred web vendor, prior to rendering care and services. In addition to verifying membership/coverage status and other important details, **this step returns information on prior authorization requirements and utilization management vendors, if applicable.**

Verification of benefits and/or the approval of services via prior authorization is not a guarantee of payment. Payment 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 as well as any preexisting conditions waiting period, if any, at the time services are rendered.

Prior Authorization for Inpatient and Ancillary Medical Services
MyBlue Plus POS and most of our PPO member contracts require that prior authorization is requested from

BCBSIL or the prior authorization vendor, if applicable, for the following services:

- Inpatient hospital admission and rehabilitation
- Inpatient Skilled Nursing Facility admission
- Long-term acute care
- Coordinated home health care
- Inpatient hospice (some employer groups)
- Residential Treatment Center admission
- Partial Hospitalization Program admission

Many employer groups also require prior authorization for Private Duty Nursing, certain intravenous medication and certain outpatient services. When eligibility and benefits are verified, providers will be able to determine if a group requires prior authorization for outpatient services.

Prior Authorization for Outpatient Medical/Surgical Services
There may be general categories of covered services that require prior authorization.

To determine whether a specific service may require prior authorization, always check eligibility and benefits first via Availity or your preferred web vendor. This step returns important information, including prior authorization requirements and utilization management vendors, if applicable.

Refer to our Prior Authorization Support Materials (Commercial) page for more information, such as prior authorization code lists and links to our digital lookup tool, which allows you to conduct a search by service, code or category. These resources are updated when services are added, replaced, or removed.

If you have questions, call the Customer Service number on the member's ID card. You can use our automated phone system to check eligibility and benefits, determine if prior authorization is required, and initiate the prior authorization process, if applicable.

Time Frames
Prior authorization for elective or non-emergency admissions/selected outpatient services is required prior to admission, or the treatment start date. Specific time frames for prior authorization may vary according to the member's benefit plan. To help ensure clinical review and determination before the member's elective or non-emergency service, requesting prior authorization is recommended at least two weeks prior to the scheduled service or as early as possible.

For an emergency admission, notification should take place as soon as possible.

Responsibility for Prior Authorization
Unless the member's plan states otherwise, the provider is responsible for obtaining prior authorization for inpatient and outpatient, facility, and professional services, in those circumstances where authorization may be required. If prior authorization is not obtained and the services are thereafter denied as not medically necessary, the service or drug may not be covered consistent with the member's benefits and/or the ordering or servicing in-network provider may be held responsible for any associated charges and may not balance bill the member.

Most out-of-network services require utilization management review. Except for emergency services, if a provider or member does not obtain prior authorization for services from out-of-network providers and out-of-state Blue Cross and Blue Shield participating providers, the claim may be denied or may be

subject to post-service medical necessity review.

Note: The Host BCBS Plan's participating provider is required to obtain prior authorization for inpatient facility services for out-of-area members under BlueCard®. For more information, refer to the Utilization Review section of the Provider Manual for the BlueCard Program.

How to Obtain Prior Authorization
Some requests are handled by BCBSIL while others are handled by utilization management vendors. As noted above, when you check eligibility and benefits, in addition to confirming if prior authorization is required, you'll also be directed to the appropriate vendor, if applicable.

BCBSIL has contracted with Carelon to provide certain utilization management services for select outpatient services in the following categories:

- Advanced Imaging/Radiology (Carelon)
- Cardiology (Carelon)
- Molecular Genetic Lab Testing (Carelon)
- Musculoskeletal – Joint, Spine Surgery (Carelon)
- Musculoskeletal – Pain (Carelon)
- Radiation Therapy/Radiation Oncology (Carelon)
- Sleep (ASO – Carelon)
- Medical Oncology and Supportive Care (Carelon)

This delegation applies for some members of BCBSIL with the commercial PPO products/networks listed below:

- PPO
- Blue Choice Preferred PPO℠
- Blue Choice PPO℠
- Blue Options℠/BlueChoice Options℠
- High Performance Network
- MyBlue Plus Point of Service

For prior authorization requests handled by BCBSIL:
There are three ways to initiate your request:

- **Online (Availity Authorizations Tool) –** Registered Availity users may use Availity's Authorizations tool (HIPAA-standard 278 transaction). For instructions, refer to the Availity Authorizations User Guide and Behavioral Health Authorization User Guide.
- **By phone –** Call the prior authorization number on the member's ID card.

If the member's ID card is not available, providers may call the Customer Care Call Center at 800-572-3089 or the Provider Contact Center at 800-972-8088. Upon verification of eligibility and benefits, you will be advised on how to proceed.

For prior authorization requests handled by Carelon:
There are two ways to submit your request to Carelon:

- **Online** – The Carelon ProviderPortal is available 24x7.
- **Phone** – Call the Carelon Contact Center at 866-455-8415, Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a.m. to noon, CT on weekends and holidays.

Behavioral Health (Mental Health and Substance Use Disorder)
BCBSIL manages benefits for behavioral health care services for most PPO, Blue Choice PPO, and MyBlue Plus POS members; however, some employer groups are managed by other behavioral health vendors. For details, including prior authorization guidelines, refer to the Behavioral Health Program section of our website.

Out-of-Area Members Under BlueCard
An online "router" tool is available to help you locate Plan-specific prior authorization/pre-certification and medical policy information for out-of-area members under Blue Plan. Look for the Pre-cert Router (out-of-area) link under the Claims and Eligibility tab on our website. When you enter the three-character prefix from the member's ID card, you will be redirected to the appropriate Blue Plan's website for more information.

Predetermination of benefits requests for members with Blue Plan benefits in another state should be sent to the Plan indicated on the member's ID card. For additional information, refer to the Provider Manual for the BlueCard Program.

Federal Employee Program Members
For FEP members, you must contact the local Blue Plan where services are being rendered for prior authorization, regardless of the state in which the member is insured. A predetermination of benefits review is required for the following services: outpatient/inpatient surgery for morbid obesity; outpatient/inpatient surgical correction of congenital anomalies; and outpatient/inpatient oral/maxillofacial surgical procedures needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof, and floor of mouth.

Recommended Clinical Review
For commercial members, providers have the option of submitting a recommended clinical review request, which is a pre-service review of medical necessity for services that are not listed on prior authorization lists. Recommended Clinical Review is not required but can help identify services that may not be medically necessary and help reduce unnecessary denials based upon post-service medical necessity reviews.

- There is no reimbursement penalty if a provider does not elect to request recommended clinical review; however, services rendered may subsequently be reviewed for medical necessity.
- BCBSIL will review the recommended clinical review request to determine if the services meet required Medical Policy, American Society of Addiction Medicine, or MCG™ Care Guidelines criteria before services are provided.
- Once a recommended clinical review has been completed, the same services will not be reviewed for medical necessity again on a retrospective basis absent extenuating or special circumstances, and consistent with the member's benefit plan.
- Providers will be notified of the results of the recommended clinical review and may have the opportunity to appeal on behalf of the member if the recommended clinical review determination indicates that the proposed service does not meet medical necessity criteria.
- Submitted claims for services not included as part of a request for recommended clinical review may still be reviewed post-service for medical necessity.

Medical Policies are accessible online in the Standards and Requirements section of our website.

To determine if a recommended clinical review is available for a specific service, refer to our Medical Policy Reference List. This list is located on our Recommended Clinical Review (Predetermination) page, under the Related Resources. The list is updated when new services are added or when services are removed.

Note: A recommended clinical review approval does not guarantee payment for services. Providers should also verify eligibility and benefits since benefits are also subject to eligibility and coverage limitations at the time services are rendered.

How to Submit a Recommended Clinical Review Request
If you've decided you'd like to obtain a recommended clinical review, there are two ways to submit your request:

- **Online** – Use the Availity Attachments tool to quickly submit recommended clinical review requests to BCBSIL via the Availity Portal. For navigation tips, see our Recommended Clinical Review User GuideElectronic ***Electronic options are preferred to help expedite your request.***
- **By Fax** – If you don't have online access, you may download, complete and fax the Recommended Clinical Review Request (Predetermination) Form to BCBSIL along with necessary supporting documentation. ***Please note that faxed documents do not enter our system immediately.***

Pre-notification
Generally, pre-notification is the process by which BCBSIL must be notified before a member undergoes a course of care such as a hospital admission or a complex diagnostic test.

Pre-notification may be required for some members/services, as specified by the member's benefit plan. For example:

- Pre-notification **through BCBSIL** may be required for **maternal delivery** and some **dialysis** services.
- Pre-notification through **a vendor** may be required for **advanced imaging**, as outlined below.

Always check eligibility and benefits first, via Availity or your preferred web vendor, prior to rendering care and services. In addition to verifying membership/coverage status and other important details, this step returns information on prior authorization or pre-notification requirements and utilization management vendors, if applicable.

Radiology Quality Initiative Pre-notification Program
Carelon administers the RQI Program for BCBSIL. Obtaining an RQI number through Carelon is required prior to ordering non-emergent advanced imaging services (CT/CTA scans, MRI/MRA scans, Nuclear Cardiology studies, PET scans) for **some** members of BCBSIL.

Exceptions:

- Obtaining RQI numbers for members of Blue Choice Options℠ and Blue Choice Select PPO℠ is *not* required.
- **Certain employer groups may require prior authorization or pre-notification through other vendors for advanced imaging services.** Always check eligibility and benefits first, as

noted above. If you have RQ below when performed in a physician's office, the outpatient department of a hospital or a freestanding imaging center:

- CT scans
- CTA scans
- MRI, MRS, MRA scans
- Nuclear cardiology studies
- PET scans and Breast MRI (must meet medical policy criteria)

The RQI number is not required when the place of service is a hospital (inpatient), emergency room, urgent care, immediate care center or during a 23-hour observation period. The ordering physician must prospectively obtain the RQI number. The performing imaging provider cannot obtain an RQI number but should verify that an RQI number was issued prior to performing the service. Hospitals have access to the Carelon website to verify the RQI by entering the member's name and identification number. Facilities may not obtain an RQI on behalf of ordering physicians.

To obtain an RQI number, the physician may access the Carelon website at carelon.com or contact the Carelon Call Center at 800-455-8415. The RQI is valid for 30 days. There is no grace period if the service is not performed.

In addition to BCBSIL, other BCBS Plans may also have radiology management programs that are tied to member benefits. Therefore, it is important to check benefits for out-of-area members of BCBS prior to rendering services. For additional information, refer to the BlueCard Program Provider Manual.

Please note that the fact that a guideline is available for any given treatment, or that a service has been prior authorized or an RQI number has been issued 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.

Well-being Management Programs

Our Well-being Management and other health condition management programs take a more comprehensive approach to improving health outcomes and delivering cost savings through holistic health management, expanded utilization management, and increased digital engagement strategies.

- **Holistic Health Management:** This approach proactively engages the highest-risk, highest-cost members to ensure continuity and consistency of care. This clinical model is designed to address the problems and silos of traditional, episodic care management by offering a more comprehensive approach to preventive care, complex/chronic care management, and life-long wellness.
- **Expanded Utilization Management:** A more rigorous UM approach for inpatient, outpatient, and pharmacy services to align with evolving industry best practices regarding misuse and overuse. This pinpointed approach can help generate hard dollar savings for our clients and members.
- **Increased Digital Engagement Strategies:** Personalized engagement strategies meet members where they are and engage them through a variety of convenient channels, including the ability to engage with a health advisor beyond traditional telephonic channels or access to increased self- management resources and tools.

Holistic Health Management Program

As part of our Holistic Health Management Program, formerly known as our Case Management Program, Holistic Health Management services are available for many PPO, Blue Choice PPO and MyBlue Plus POS members. These services help to facilitate benefits for members to receive clinically appropriate care. Holistic Health Management is a collaborative process that assesses plans, and implements, coordinates, monitors and evaluates the options and services required to meet a member's health needs by using communication and available resources to promote quality and a cost-effective outcome.

Holistic Health Management also provides education and assistance for members with chronic medical conditions. Assistance may be available for unexpected catastrophic occurrences, psychosocial issues, and proactive management of anticipated medical management situations.

The objectives of the Holistic Health Management Program are designed to provide an individualized approach to managing a member's health care needs. The program is an effort to:

- Coordinate medically necessary health care services in a manner that enhances the member's quality of life.
- Coordinate medically necessary health care services that promote high quality, cost-effective services in a manner that achieves better outcomes.
- Involve the member or an authorized representative and the health care team in the development of a plan of care.
- Provide member and family education regarding the patient's benefits, disease process and choices regarding services including the right to refuse services.
- Offer support services and assist the member with the monitoring of his or her condition in an effort to prevent complications.
- Protect the welfare and safety of members and Holistic Health Management Coordinators
- Increase member and provider satisfaction by providing excellent customer service.
- Evaluate results of member and practitioner surveys annually and develop processes to improve as indicated.
- Establish guidelines for reasonable Holistic Health Management caseload and

maintain an adequate number of Holistic Health Management Coordinators to provide optimum service for the population served.

Holistic Health Management referrals may originate from a member, their family, physician, employer, hospital or discharge planner, Integrative Predictive Modeling, Condition Management/Wellness, Utilization Management, an account executive, private duty nurse or other provider of services. All Holistic Health Management Coordinators performing Holistic Health Management functions are Registered Nurses in the State of Illinois with current unrestricted licensure, a minimum of three years clinical practice experience and one year minimum of Health Insurance/Managed Care experience *preferred* and practice Holistic Health Management within the scope of their licensure (based on the standards of the discipline).

For additional information providers may contact a Case Manager by calling 888-978-9034.

The health condition management programs referenced here are not a substitute for the sound medical judgment of a member's doctor. The final decision regarding any treatment or services is between the patient and their health care provider.

Section 6: Pharmacy Benefit Management

Overview
BCBSIL utilizes Prime Therapeutics, a third-party vendor, as its pharmacy benefit manager to administer certain core services, including claims processing, retail pharmacy network management and other related services.

The goal of the Pharmacy Benefit Management program is to help:

- Manage rapidly rising drug costs,
- Maintain and improve the quality of care delivered to members of BCBSIL,
- Facilitate access, and
- Encourage appropriate use of cost-effective drug therapies.

To achieve this goal, BCBSIL employs a number of industry-standard management strategies in order to ensure appropriate utilization. These strategies include, but are not limited to, drug list management, benefit design modeling, specialty pharmacy benefits and clinical programs.

Pharmacy Network
Members of BCBSIL with a prescription drug benefit normally are required to use a pharmacy on the approved list of independently contracted participating pharmacies to best maximize their benefits. This pharmacy network can include retail for up to a 30/34-day or 90-day supply, home delivery for up to a 90-day supply or specialty pharmacy for up to a 30-day supply (except for certain U.S. Food and Drug Administration- designated dosing regimens). Pharmacy networks and supply limits are dependent upon the member's benefit plan.

Some members' benefit plans may include an additional preferred pharmacy network, which offers reduced out- of-pocket expenses to the member if they choose to utilize one of these pharmacies instead.

Patients should be encouraged to use one pharmacy for all their prescriptions to help better monitor drug therapy and avoid potential drug-related problems.

Drug List Management
The Drug Lists posted by BCBSIL are provided as a guide to help in the selection of cost-effective drug therapy. In addition to the list of approved drugs, the drug list describes how drugs are selected, coverage considerations and dispensing limits. As a reminder, drugs that have not received FDA approval are not covered under the member's pharmacy benefit for safety concerns.

Members of BCBSIL may have a pharmacy benefit of up to six tiers. Listed drugs may be covered at generic, brand and specialty tier levels. Depending on the member's benefit plan, drugs may be split between preferred and non- preferred within these tiers. Based on the benefit plan, members may pay a lower member share (out of pocket expenses) for prescription drugs in the lower tiers.

Some members' Drug List may only list generics and lower cost brand drugs. Some members' Drug List may reference all covered prescription drugs, and drugs not listed are not covered. If the drug is not covered, you may be able to submit a drug list coverage exception to BCBSIL for consideration (based on the member's benefit plan). Benefit coverage decisions will be sent within 72 hours of receiving the non-urgent request. Decisions will be sent within 24 hours of receiving an urgent, or expedited,

request. The member will also be notified of the decision. If the coverage request is denied, BCBSIL will let you and the member know the reason for the denial and provide instructions for an appeal. To start this process, you can find the coverage exception form in the Forms section of our Provider website under Pharmacy, or call the number on your patient's member ID card.

Please refer to the Drug List when prescribing for our members. Call the number on your patient's member ID card for assistance in determining the correct Drug List, if needed.

Note: The Drug List is a tool to help members maximize their benefits. The final decision about what medications should be prescribed is between the health care provider and the patient.

BCBSIL uses the Prime Therapeutics National Pharmacy and Therapeutics Committee for drug evaluation. The P&T Committee consists of physicians, pharmacists, pharmacoeconomists, medical ethicists, other health care professionals or health care administrators who are not employees or agents of Prime Therapeutics. The P&T Committee meets quarterly to review new drugs and updated drug information based on the current available literature. BCBSIL remains responsible for the determination of benefit coverage and approvals for prior authorizations, step therapy (where applicable) and/or dispensing limits.

BCBSIL provides notification to members of changes made to the Drug List by direct mailings. Notifications to physicians are posted in our newsletter and/or on our website. Changes to the Drug List are posted in the Provider section of our website and are made at least four times a year. To view the Drug Lists, refer to the Pharmacy Programs section of our Provider website under Prescription Drug List.

Over the Counter Equivalent Exclusion Program
As a means of keeping overall prescription drug costs more affordable, prescription versions of medications that are available OTC are usually not a covered benefit through our prescription drug card program. This means that members usually will not receive benefit coverage for brand and generic prescription medications that have OTC versions available at the same prescription strength. Members may still purchase the medication – either by prescription or over the counter – but they will be responsible for the full cost of the drug.

Generic Drugs
The FDA has a process to assign equivalency ratings to generic drugs. An "A" rating from the FDA means that the drug manufacturer has submitted documentation demonstrating equivalence of its generic product compared to the brand name product.

BCBSIL supports the FDA process for determining equivalency. Providers are encouraged to prescribe drugs that have generic equivalents available and should not add "dispense as written" unless medically necessary, and if clinically appropriate, coverage criteria that prevents use of a generic for a particular member has been met.

Some plans may require members to pay the difference between the brand-name drug and generic drug plus the prescribed drug's cost share.

If you determine that your patient cannot tolerate the available generic equivalent drug, some members' plans may allow you to submit documentation for consideration to waive any cost share penalties that may be applied to the member otherwise. If approved, the member would only be responsible for their

applicable cost share for the brand drug. Call the number on the member's ID card for assistance in completing this process.

Home Delivery Prescription Drug Benefit Program
With the home delivery program, members can obtain up to a 90-day supply of maintenance medications through the home delivery program. Maintenance medications are those drugs taken on an ongoing basis to treat chronic conditions such as high cholesterol, high blood pressure or diabetes. View the maintenance drug list, which is available in the Member section of our website, under Prescription Drugs.

If a member is starting a new medication for the first time, you should write two prescriptions:

- First prescription – A starter supply for up to 30 days that the member can fill right away at the local pharmacy, and
- Second prescription – Up to a 90-day supply of the medication to be mailed to the member's home.

To take full advantage of the program, the 90-day prescription should be written with three refills.

Via our secure Blue Access for Members℠ website at bcbsil.com/members, members of BCBSIL can view Mail Service Program information, connect to their home delivery pharmacy or download and mail the home delivery form. Members who are already registered with the home delivery program may ask their physician's office to send their prescription to the home delivery pharmacy electronically or by calling the pharmacy. The home delivery pharmacy will only accept a faxed prescription directly from a physician's office.

Providers who have questions about the home delivery program may call the number on the member's ID card.

Clinical Programs
BCBSIL offers a wide range of clinical programs to help enhance the level of care and outcomes for our members. The following clinical program offerings may be available depending on the benefit plan chosen.

Concurrent and Retrospective Drug Utilization Reviews
Concurrent DUR occurs at the point of sale (i.e., at the dispensing pharmacy). Network pharmacies are electronically linked to Prime Therapeutics' claims adjudication system. This system contains various edits that check each member's prescription at the point of service to help identify potential problems with a specific prescription before it is filled. Identified claims are flagged in the system and a message is sent to the pharmacy informing them of the potential problem. Examples of concurrent DUR include drug-to-drug interaction, overutilization (i.e., early refill attempts), safe and effective use of prescription opioids and therapeutic duplications. The system also alerts the pharmacist when the prescribed drug may have an adverse effect if used by elderly or pregnant members. The pharmacist must use his or her professional judgment and call the prescribing provider if a potential adverse event may occur.

Safety checks on prescription opioids address permissible quantity and medication dose, as recommended by the Centers for Disease Control and Prevention and other nationally recognized guidelines. The pharmacist will receive alerts advising if authorization may be required from BCBSIL before the full quantity of opioids as prescribed may be dispensed at the point of sale.

Retrospective DUR uses historical prescription and/or medical claims data to identify potential

prescribing and dispensing issues after the prescription is filled. Examples of retrospective DUR include appropriate use of controlled substances, adherence, polypharmacy and generic utilization programs. These programs aim to promote safety, reduce overutilization and close gaps in care. Retrospective DUR programs are developed based on widely accepted national practice guidelines. Individual letters may be mailed to providers identifying potential drug therapy concerns, together with a profile listing the member's prescription medications filled during the study period, references to national practice guidelines and/or an online survey to be completed.

Drug Dispensing Limits

Dispensing limits, also known as quantity limits, are placed on certain drugs to help promote appropriate utilization and prevent stockpiling of medications based on FDA-approved dosage regimens and product packaging. Dispensing limits are in accordance with generally accepted pharmaceutical and manufacturer's guidelines. Drug dispensing limits help encourage medication use as intended by the FDA. Dispensing Limits for each Drug List are posted in the Pharmacy Programs section of our website.

Prior Authorization

Prior Authorization Programs are designed to manage the use of certain medications which have the potential for off-label use or misuse. PA criteria are identified, developed and approved by a clinical team of physicians and pharmacists based on FDA-approved labeling, scientific literature and nationally recognized guidelines.

The PA Program includes management of specific medications but may not apply to all prescription drug benefit plans. To determine if a specific benefit plan includes the PA Program, and which drug categories are included in the member's plan, you may call the number listed on the member's ID card.

Changes to prior authorization requirements are posted on our Provider website and published in our newsletter.

Prime Therapeutics will handle all PA requests for members of BCBSIL who have Prescription Drug coverage. Physicians must complete and submit the uniform prior authorization request form to receive prior authorization for one of the medications listed. Continued use of the medication will be available if warranted by the patient's medical history and current medical condition. Links to the uniform PA form and program criteria summaries are located in the Pharmacy Programs section of our website.

Physicians can also submit the request electronically via the CoverMyMeds® website or fax forms from Prime Therapeutics. You can find links to CoverMyMeds and the fax forms on the Prior Authorization and Step Therapy Programs webpage.

For more information regarding this PA program, contact the Prime Therapeutics Clinical Review Department at 800-285-9426.

BCBSIL allows for certain off-label uses of drugs when the off-label use meets the requirements of our policy. For information about the PA medical criteria, please review our medical policies in the Standards and Requirements section of our website.

If you are prescribing and/or administrating select infusion drugs, you may need to submit a prior

authorization request to BCBSIL prior to administration of the drug. These infusion drugs are administered by health care professionals and typically covered under the member's medical benefit. For a list of the infusion drugs, please visit the Prior Authorization section of our website. Benefits can be determined by calling the number on the member's ID card.

Step Therapy
Some members' benefit plans may include Step Therapy. This program encourages the safe and cost-effective use of medications through a "step" approach. If part of the member's benefits, a prescription history for a "first-line" medication would be required before the benefit plan may cover a "second- line" drug. A first-line drug is recognized as safe and effective in treating a specific medical condition, as well as a cost-effective treatment option. A second-line drug is a less- preferred or potentially more costly treatment option. ST Programs are developed under the guidance and direction of independent, licensed physicians, pharmacists and other medical experts.

Process guidelines:

- **Step 1:** When possible, the prescriber should prescribe a first-line medication appropriate for the member's condition.
- **Step 2:** If the prescriber determines that a first-line drug is inappropriate and/or ineffective, the benefit plan will cover a second-line drug when certain criteria are met.

The ST Program includes management of specific medication categories. The list of drugs in these categories can be found in the Pharmacy Programs section of our website. Links to the forms and program criteria summaries are located on this page as well.

While physician fax forms are available, you can also submit the request electronically via the CoverMyMeds website. You can find the link to CoverMyMeds on the Prior Authorization and Step Therapy Programs webpage.

Physicians consulted for approval should write prescriptions based on the list of Step Therapy drugs covered by the drug list. This program will not apply to all prescription drug benefit plans. To determine if a specific benefit plan includes Step Therapy, and which drug categories are part of the member's plan, call the number listed on the member's ID card.

The ST Program is not a substitute for the sound medical judgment of a physician. The final decision about what medication should be prescribed is between the patient and the physician.

Member and Provider Education
Educational materials aimed to increase awareness and improve patient care management are available to members/employer groups and providers. Members receive materials that explain their pharmacy benefit program, help them understand drug costs and inform them on how to make educated decisions regarding their drug therapy.

Specialty and Complex Care Pharmacy Program and Pharmacy Network*
Specialty and complex care pharmacy medications are generally prescribed for people with complex, ongoing or rare medical conditions. They are only available at select pharmacies due to their limited or exclusive access. They have unique storage and shipment requirements. Patients taking these medications need to follow a clinical care plan that often changes dosing, monitors clinical results and/or offers counseling, education or individualized disease and drug care therapy.

The Specialty and Complex Care Pharmacy Program helps deliver these medications directly to members, and sometimes providers.

Specialty and complex care medication coverage is based on the member's benefit. Most specialty and complex care medications will require prior authorization. Some members of BCBSIL have a benefit plan that encourages utilization of an in-network specialty and complex care pharmacy for maximum benefit coverage, and some members' benefit plans may require them to only use a contracted in-network pharmacy to fill their prescription for coverage consideration. The pharmacists, nurses, and care coordinators in our contracted specialty and complex care network pharmacies are experts in supplying medications and services to patients with complex health conditions. A list of medications that BCBSIL identifies as being specialty and complex care medication is available on the Pharmacy Programs section of our website.

For information about medical criteria, please review our medical policies in the Standards and Requirements section of our website.

Please note: Depending upon administration (physician-administered or FDA-approved for self-administration), the member's plan will determine which benefit (medical coverage or pharmacy coverage) will cover the medication. Benefits may be confirmed by calling the number on your patient's ID card.

Self-Administered Specialty and Complex Care Medications

Specialty and complex care medications that are FDA-approved for self-administration are typically covered under the member's pharmacy benefit. Some members' benefit plans may require them to obtain these medications from an in-network specialty and complex care pharmacy provider and billed under the pharmacy benefit for your patients to receive coverage.

If services are submitted on professional/ancillary electronic (ANSI 837P) or paper (CMS-1500) claims for drugs that are FDA-approved for self-administration and covered under the member's prescription drug benefit, BCBSIL will notify the provider of the appropriate benefit to re-submit for coverage. In this situation, the following message will be returned on the electronic payment summary or provider claim summary: "Self-administered drugs submitted by a medical professional provider are not within the member's medical benefits. These charges must be billed and submitted by a pharmacy provider."

BCBSIL contracts with Accredo® to obtain specialty and complex care medications approved for self-administration. A list of these medications is available on the Specialty and Complex Care Pharmacy Program section of our website. To contact Accredo, call 833-721-1619, e-prescribe the prescription or visit accredo.com/prescribers for referral forms by therapy.

Other select in-network specialty and complex care (Pharmacy Match) pharmacies have also been contracted to obtain certain self-administered specialty and complex care medications for our members. For a complete list of these specific pharmacies, please visit the Specialty and Complex Care Pharmacy Program section of our website.

Split Fill Program
Some members of BCBSIL may have the Split Fill program as part of their benefit plan. This program applies to select medications that patients are often unable to tolerate. Under this program, members who are new to therapy (or have not had claims history within the past 120 days for the drug) are provided a partial, or "split," fill for up to the first three months of therapy, giving them the opportunity to try the drug at a prorated cost. This allows the member to make sure they can tolerate the medication and any potential side effects before continuing ongoing therapy.

The Split Fill program applies to a specific list of drugs known to have early discontinuation or dose modification. Each drug is evaluated using evidence-based criteria to determine the frequency and duration of a split fill. You can find the current list of drugs in this program from the split fill program link off our Specialty and Complex Care Pharmacy Program section on bcbsil.com/provider. Note: The list of drugs is subject to change at any time.

Members may use any in-network pharmacy that can dispense the medication. Members will pay an applicable prorated cost share for each fill received for the duration of the program. Once the member can tolerate the medication, the member will pay the applicable cost share amount for a full supply. All member share costs are determined by the member's pharmacy benefit plan.

Physician-Administered Specialty and Complex Care Medications
BCBSIL contracts with select specialty and complex care pharmacies to obtain specialty and complex care medications for physician administration to our members. These medicines are typically covered under the member's medical benefit.

By obtaining these specialty and complex care medications from these pharmacies, providers may benefit from:

- Integrated coordination of coverage between the member, provider and BCBSIL
- No up-front acquisition cost to providers for office-administered specialty and complex care medications
- Convenient delivery of medication to location of choice (i.e., provider's office, site of practice, home infusion)
- Injection supplies with every shipment, including alcohol swabs, needles and syringes (if applicable)
- Automatic coordination of refills
- Patient education materials and therapy starter kits from drug manufacturers
- 24-hour hotline staffed by nurses and/or pharmacists to call with medication and injection questions
- Compliance with nationally recognized guidelines and standards

Providers should only bill for the administration of the specialty and complex care medication(s) when the medication is received from these contracted pharmacies. Providers may not bill for the specialty and complex care medication. For a list of physician administered specialty and complex care medications and available network pharmacies, please visit the Specialty and Complex Care Pharmacy Program section of our website.

*The relationship between BCBSIL and the pharmacies is that of independent contractors.

Point-of-Use Convenience Kits Billing

BCBSIL reimbursement applies only to the drug component of a point-of-use convenience kit used in the

administration of covered, injectable medications. These prepackaged kits include the medication as well as non-drug supplies, such as alcohol prep pads, cotton balls, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze.

BCBSIL periodically checks the pricing of these kits to manage costs. Often, the cost of these convenience kits is more than the cost of its components when purchased one item at a time. The non-drug supplies are considered as part of the practice expense for the procedure performed and no additional compensation is warranted. Reimbursement for these kits may be updated based on the FDA-approved drug component.

Billing with National Drug Codes
BCBSIL requires the use of National Drug Codes and related information when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500 claims). **Professional/ancillary claims for drugs must include NDC data to be accepted for processing by BCBSIL.**

This information can also be submitted when NDC details may be needed on institutional/facility electronic (ANSI 8371) and paper (UB-04) claims. This includes drug-related Revenue Codes to report drug products used for services rendered at medical outpatient facilities as well as unlisted Healthcare Common Procedure Coding System or Current Procedural Terminology (CPT®) code(s) that require additional NDC information.

Examples of revenue codes that may require detailed coding are: 630 (DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL STANDARD ABBREVIATION: DRUGS), 636 (DRUGS REQUIRING DETAILED CODING STANDARD ABBREVIATION: DRUGS/DETAIL CODE), 891 (DRUG/CELL THERAPY/SPECIAL PROCESSED DRUGS) and 892 (SPECIAL PROCESS DRUGS – FDA APPR GENETEIC THERAPY).

Examples of unlisted HCPCS/CPT code descriptions that require additional NDC information are: J3490 (UNCLASSIFIED DRUGS) or C9399 (UNCLASSIFIED DRUGS OR BIOLOGICALS).

Even when not required by contract, BCBSIL would welcome voluntary reporting of NDC information. In those cases, it may be submitted with the related HCPCS/CPT or revenue code as additional information.

The NDC must be submitted along with the applicable HCPCS or CPT code(s) and the number of HCPCS/CPT units. It must be in the 11- digit billing format (no spaces, hyphens or other characters). The NDC qualifier, unit of measure and number of NDC units also must be included. The drug name, product strength of drug administered, whether a single or multi-dose vial and the exact dosage administered can be added. To obtain NDC reimbursement information, you can access the latest NDC Reimbursement Schedule through Blue Access for Providers, our secure provider portal. On the Availity site, there is a link to the NDC Calculator Tool, which can help you convert HCPCS and CPT units into the correct number of NDC units.

For additional information, refer to the NDC Billing Guidelines, located in the Claims and Eligibility/Claim Submission section of our website. You can also refer to the Unlisted/Not Otherwise Classified Coding Policy found on the Reimbursement Policies section of our website.

Medicaid Pharmacy Coverage
BCBSIL, through Prime Therapeutics, offers Medicaid prescription drug benefit coverage to eligible members who have Blue Cross Community Health Plans℠. Providers can find links to available drug lists, pharmacy directories, forms and other general pharmacy benefit information, including where to submit prescription exception requests for these members, at the Pharmacy Programs section of our website under Medicaid.

Medicare Part D Pharmacy Coverage
BCBSIL offers Medicare Part D prescription drug plan coverage to eligible members. The Centers for Medicare & Medicaid Services must review and approve every aspect of the program, including:

- How an insurance company sells its plans
- Benefits offered.

- Premiums charged.
- List of covered prescription drugs
- How plans communicate drug list changes to providers

CMS provides rigorous and proactive oversight of Medicare Part D by conducting routine audits to ensure plans are compliant.

Section 7: Behavioral Health Program

Behavioral Health Program (Mental Health and Substance Use Disorder)
Our Behavioral Health Program encompasses a portfolio of resources that help members of BCBSIL access benefits for behavioral health (mental health and substance use disorder) conditions as part of an overall care management program. BCBSIL has integrated behavioral health care management with our member Well-Being Management medical care management program to provide better care management services across the health care community. It also allows our clinical staff to assist in the early identification of members who could benefit from co-management of behavioral health and medical conditions.

The BH team utilizes nationally recognized, evidence based and/or state or federally mandated clinical review criteria for all of its behavioral health clinical decisions.

For its group and retail membership, licensed behavioral health clinicians under BCBSIL utilize the MCG™ care guidelines for mental health conditions. Licensed behavioral health clinicians under BCBSIL utilize the American Society of Addiction Medicine's The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions for addiction disorders. In addition to medical necessity criteria/guidelines, BH licensed clinicians utilize our Medical Policies, nationally recognized clinical practice guidelines (located in the Clinical Resources section of our website) and independent professional judgment to determine whether a requested level of care is medically necessary.

The appropriate use of treatment guidelines requires professional medical judgment and may require adaptation to consider local practice patterns. Professional medical judgment is required in all phases of the health care delivery and management process that should include consideration of the individual circumstances of any particular member. The guidelines are not intended as a substitute for this important professional judgment.

The availability of benefits will also depend on specific provisions under the member's benefit plan.

BCBSIL manages behavioral health care services for most **non-HMO** members who have behavioral health benefits (such as BCBSIL PPO, Blue HPN℠, Blue Choice PPO℠ and MyBlue Plus (POS) members). Exception: Behavioral health care services for some employer groups are managed by other behavioral health vendors. If there are questions, call the number on the member's ID card.

BCBSIL also manages behavioral health care services for **FEP** members. FEP members must request prior authorization for Applied Behavior Analysis services and FEP recommends members request an advanced benefit determination (or predetermination) for Transcranial Magnetic Stimulation. FEP members are not required to request prior authorization for any other outpatient behavioral health services, including Partial Hospitalization Programs.

Prior Authorization Requirements for Behavioral Health Services
Prior authorization is intended to facilitate the most appropriate level of care, in the most appropriate setting, at the right time. Prior authorization may be obtained by the member's PCP, treating specialist or facility. BCBSIL reviews requests for prior authorization, including medical necessity and benefit determinations, prior to services being rendered.

Recommended Clinical Review for Behavioral Health Services
Recommended clinical reviews are optional medical necessity reviews conducted before, during or after services are provided. Submitting a request prior to rendering services provides information of situations where a service may not be covered based on medical necessity criteria. The recommended clinical review process evaluates the medical necessity of a service but does not guarantee the service will be covered under the member's benefit plan.

Process for Verifying Benefits
In order to determine whether Prior Authorization is required or that Recommended Clinical Review is recommended, Behavioral health professionals and physicians should always verify eligibility and benefits prior to providing services:

- Online – Submit an electronic eligibility and benefits (HIPAA 270) transaction to BCBSIL via the secure Availity website, or through your preferred vendor portal; or
- Telephone – Call the number listed on the member's ID card.

Process for Requesting Prior Authorization and Recommended Clinical Review
Behavioral health professionals and physicians are responsible for requesting prior authorization and can request Recommended Clinical Review.

Online

- Submit requests electronically using our BlueApprovR tool. BlueApprovR is accessible through Availity.
- (If BlueApprovR is not available) Submit requests electronically using the Availity Authorizations tool.

Telephone

- If you are unable to submit a request electronically through BlueApprovR or Availity, call the number on the member's ID card.

Failure to obtain Prior Authorization when it is required for Behavioral Health Services

- If prior authorization is required but not obtained for behavioral health treatment, the behavioral health professional or physician may be subject to a penalty and will be asked to submit clinical information for a medical necessity review.
- Medically unnecessary claims will not be reimbursed. The member may be financially responsible for services that are deemed medically unnecessary.

Resources

Additional information on our Behavioral Health Program can be found on our website.

Verification of benefits and/or approval of services after prior authorization are 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.

Section 8: Quality Improvement

Programmatic Structure

Mission
Our mission is "To promote the health and wellness of our members and communities through accessible, cost-effective, quality health care."

Philosophy
Our philosophy is to provide products and services of the highest quality and value with a direct focus on supporting providers and meeting the needs of customers.

The Quality Improvement Program under BCBSIL is based on a view that the process for delivery of medical care and services can be continuously improved, and that data-driven monitoring and evaluation are an integral part of the managed care quality improvement.

The program integrates fundamental management techniques, existing improvement efforts and disciplined use of analytical tools for continuous process improvement.

Purpose and Scope
The purpose of the QI Program is to provide focus and structure of our quality improvement philosophy. The QI Program focuses on areas within products that are important to our customers and are critical in achieving corporate goals in a manner consistent with corporate values to identify, monitor and evaluate clinical, service and member experience improvement opportunities.

Goals
The following goals were designed to assist providers in meeting quality improvement and member experience goals:

- Monitor and help ensure compliance with State and Federal regulatory requirements and accreditation standards.
- Implement a standardized and comprehensive quality improvement program which will address and be responsive to the health needs of the member population, inclusive of serving the culturally and linguistically diverse membership.
- Develop a comprehensive, meaningful, and soundly executed Population Health Management strategy.
- Provide staff with training, information, and tools that help identify cultural and linguistic barriers and support culturally competent communications.
- Assess the cultural, ethnic, racial, and linguistic needs of members to deliver culturally competent services.
- Monitor and support the needs of members who have disabilities, to help improve their access to health care.
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity, and language needs.
- Develop, implement, and monitor action plans to improve medical and behavioral health care, as well as services.
- Identify opportunities to improve the outcomes, promote delivery and effective

management for populations with complex health needs, which may include the following conditions: physical or developmental disabilities, multiple chronic conditions, mental illness, organ transplants, HIV/AIDS, progressive degenerative disorders, metastatic cancers, and severe behavioral health conditions.

Quality Indicators and Monitoring Activities

Ongoing monitoring of specific quality indicators is an important component of the QI Program. Indicators are generally selected based on important aspects of care for members of BCBSIL, as well as their objectivity, measurability and validity, utilizing medical/surgical, behavioral health, pharmacy, and race/ethnicity/language data sources. Indicators may derive from the following existing measure and datasets:

Indicator Data Sources

A variety of internal and external data sources may be utilized in quality indicator monitoring. Including, but not limited to:

- Claims
- Medical records
- Surveys
- Enrollment data
- External data sources
- Health assessments
- Complaints and appeals databases
- Local and National benchmark data
- Centers for Medicare and Medicaid Services

Program Descriptions and QI Focus Areas

Activities to Improve Patient Safety and Safe Clinical Practice

The role of BCBSIL in improving patient safety involves fostering a supportive environment to assist providers in maintaining a safe practice. BCBSIL collaborates with network providers to improve the safety of clinical care and services. As part of this collaboration, providers agree that BCBSIL may use provider performance data for quality improvement activities, which include but are not limited to:

- Evaluating clinical practices against aspects of practice guidelines related to patient safety
- Investigating quality of care issues
- Using Utilization Management data to promote patient safety
- Distributing information to members, practitioners, and providers which improves knowledge regarding clinical safety as it relates to self-care
- Developing quality improvement activities that promote patient safety
- Distributing information to members, practitioners and providers which facilitates informed decisions based on safety
- Leveraging various pharmacy programs under BCBSIL that address patient safety, including:
    - Our Pharmacy Benefit Manager, Prime Therapeutics, offers the concurrent Drug Utilization Review program which screens prescriptions at the point of sale for potential drug problems such as drug-to-drug interactions
    - Prime Therapeutics works with BCBSIL to identify and notify members and practitioners who may be affected by product recalls or voluntary drug withdrawals
    - Ongoing retrospective drug utilization review programs tell practitioners about a

different medication management issue quarterly

Quality Improvement Audits

Auditors under BCBSIL conduct Provider Appointment Access & Availability telephonic audits for a network sample of Primary Care Physicians, High-Volume High Impact Specialists & Behavioral Health Providers. The purpose of the audit is to validate that providers are meeting the established time requirements for scheduling appointments. BCBSIL also conducts Medical Chart audits for a sample of network Primary Care Physicians & Behavioral Health Providers through a virtual chart review process to ensure preventive care visits include all required services.

Quality Improvement Committee

The Quality Improvement Committee under BCBSIL is responsible for evaluating, monitoring, and providing oversight and direction for the Quality Improvement Program and its activities. The QI Committee brings multidivisional staff together with employers, providers and members to:

- Review and approve the annual Quality Improvement Work Plan
- Review and approve the annual Quality Improvement Program Evaluations
- Monitor and analyze reports on quality improvement activities from subcommittees
- Provide oversight of delegated activities
- Review and approve the Case Management/Utilization Management Quality Improvement Projects
- Review and Recommend policy modifications as needed
- Review and analyze significant health care disparities in clinical areas
- Review and analyze information, training, and tools to staff as well as practitioners to support culturally competent communication
- Review and analyze onsite and telephonic audit results
- Review, analyze, and evaluate member complaints
- Review and analyze member and provider appeals
- Review, analyze, and evaluate populations with complex health needs
- Ensure and review practitioner participation in the QI program through project planning, design, implementation and/or assessment
- Ensure follow-up, as appropriate
- Maintain signed and dated meeting minutes

Population Health
Population Health is the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It emphasizes improving overall health and wellness while addressing factors such as social, economic, environmental, and behavioral influences that can contribute to disparities in health status and access to care across different populations.

BCBSIL employs a multi-faceted approach to promote health equity:

- We address the social determinants of health, such as limited access to healthy food, transportation, and housing to help enhance the overall health and well-being of all our members.
- We work to expand access to coverage and quality care for under-resourced and underserved communities and populations.
- We are continuously expanding our network of community partners and investing in community-based organizations, advanced technology platforms, and enhanced data capabilities. Our efforts to close care gaps and reduce fragmentation go beyond traditional clinical settings, by help eliminate barriers that hinder better outcomes for our members and the communities we serve.
- BCBSIL operates Blue Door Neighborhood Centers in three of Chicago's underserved communities – Pullman, Morgan Park, and South Lawndale – to provide services that support the whole person, addressing physical, mental, and social well-being.

Examples of Population Health Pilots and Initiatives:
Advancing maternal and infant health outcomes is a key priority for BCBSIL. In partnership with local organizations, BCBSIL is leading quality improvement efforts across the state to enhance safety and promote fairness in clinical care delivery. Through collaboration with non-profit organizations, technology partners, and healthcare providers, we are also supporting access to essential services – such as transportation, nutritious food, prenatal vitamins, health education, and other resources – in communities across Illinois.

BCBSIL has made a strategic investment in housing as a key driver of improved health outcomes and community well-being. The organization is funding non-profit organizations to provide new permanent and transitional housing across the state. The initiative is grounded in addressing social determinants of health – specifically, recognizing that housing insecurity correlates with worse health outcomes and higher care utilization.

BCBSIL is dedicated to strengthening professional education for our member-facing workforce to better support our diverse members. We offer ongoing culture of caring training for both our employees and our network of providers, to foster a more informed and compassionate approach to care and service.

Practitioner Credentialing and Re-credentialing
BCBSIL has implemented criteria for the selection and retention of network practitioners and providers. All contracted practitioners and providers must meet the applicable selection criteria.

The credentialing/re-credentialing process is designed to assess physician and provider compliance with BCBSIL participation criteria and the ability to deliver care and service to members. Physicians are re-credentialed at least once every three years, or more frequently as determined by the IL Provider Selection Committees. The scope of individual physicians credentialed and re-credentialed includes MDs, DOs, DPMs, DDSs, and contracted independent practitioners, such as nurse practitioners, chiropractors, physical therapists, mental health professionals, and essential community providers, as appropriate.

The physician and health care professional/practitioner credentialing/re-credentialing process include primary source verification consistent with National Committee for Quality Assurance and standards, states and federal regulatory requirements, as well as CMS and BCBSIL requirements.

BCBSIL monitors information from licensing agencies and updates from the National Practitioner Data Bank regarding sanctions and restrictions on licensure or scope of practice according to schedules dictated by the individual agencies. Additionally, the Debarment Screening Tool is reviewed to identify individuals and/or parties that have been sanctioned or debarred by any of the following six government listings:

- The Office of Foreign Asset Control Specially Designated Nationals
- The Office of Foreign Asset Control Sanctioned Countries
- The Office of the Inspector General
- System for Award Management Excluded Parties List System; Note: All exclusion records from GSA's Excluded Parties List System, including Office of Personnel Management were moved to SAM EPL on November 21, 2012.
- The Foreign Evaders Sanction List
- The Illinois Department of Public Aid - IL Medicaid Program

When participating physicians and providers are identified through any of the above queries, the physicians and providers are brought forth for disciplinary action up to and including termination.

Members Communication, Rights and Responsibilities

In accordance with federal and state regulatory requirements, and accreditation needs, BCBSIL is committed to ensuring our member's rights and responsibilities are respected, upheld, and available in various communication mediums to the member and participating providers.

The purpose is:

- To build up member confidence in the health care system, by making it easy for members to be involved in their own health care.
- To strongly support the importance of a good health care provider-patient relationship.
- To emphasize and support the importance of the members' rights and responsibilities with regard to their own health.

Components of the QI Program incorporating elements of member rights may include:

- Policies on inquiries and complaints
- Policies on appeals
- Policies on quality-of-care complaints
- Access standards
- Member involvement in satisfaction surveys

BCBSIL additionally has written policies that state its commitment to treating members in a manner that respects their rights, and its expectations of members' responsibilities, including:

- Member Rights and Responsibilities
- Information Disclosure
- Choice of Providers and Plans
- Access to Emergency Services
- Participation in Treatment Decisions
- Respect and Non-Discrimination
- Confidentiality of Health Information
- Complaints and Appeals

BCBSIL also holds forth certain expectations of members with respect to their relationship to the Plan and their individual health care practitioners. These rights and responsibilities are reinforced in member and provider communications, including our website. Other communication methods of the member rights and responsibilities statement include in writing, by mail, fax, or email. The Plan is responsible for assuring a mechanism is in place for existing members and practitioners to receive this information and any revisions as they occur. BCBSIL is committed to the cultural, linguistic, and ethnic needs of our members; thus, communication tools are available to support the diverse membership.

Member Education

BCBSIL features information in member publications and on our website to improve member knowledge about methods by which members may reduce the likelihood of errors in their care. An example is EMMI Solutions, online health education videos. EMMI programs provide practical information in an easy to understand format to empower members to manage their care more effectively and participate in treatment decisions. EMMI Solutions allows clinical staff to "prescribe" videos to members participating in care management programs.

Members receive an email with a link to a video tutorial relevant to their care plan. These modules support more informed decisions and help members understand symptoms, treatments, side effects and risks. Members can pause to take notes and the system generates a document to discuss with their physician.

In addition, BCBSIL has an online community called "Connect Community" where members can find content related to various diseases and prevention categories. This includes blog articles, videos, and links to authoritative sources of information (e.g. associations). Connect Community readers can comment on posts and share content with others via social media channels including Facebook, Twitter, and LinkedIn. For retail and on exchange small group members, new specific pages for Diabetes, Coronary Artery Disease, Colorectal Cancer Screening, and Flu Shot were created to select appropriate content for the Connect sites and EMMI video content related to those topics for our members. Members are directed to the pages via email and direct mail.

Member Experience

The monitoring, evaluation and improvement of member experience are important components of the QI Program. This is accomplished using surveys, as well as through the aggregation, trending and analysis of member complaint and appeal data, including the following categories: quality of care, access, attitude and service, billing and financial issues and quality of practitioner office site. In addition to the administration of surveys, BCBSIL encourages members to offer suggestions and express concerns utilizing customer service telephone lines and request for comments in survey instruments.

The following surveys are utilized in the assessment of member experience:

- Continuous Tracking Program: population-based member satisfaction survey which is administered on an ongoing basis to a sample drawn from the entire enrolled population.
- Case Management Survey, if applicable
- Behavioral Health Member Satisfaction Survey, if applicable
- Condition Management Survey, if applicable
- Special Beginnings® Survey, if applicable
- Consumer Assessment of Healthcare Provider and Systems®, if applicable
- Qualified Health Plan Enrollee Experience Survey, if applicable
- Customer Service Post-Interaction survey, if applicable

BCBSIL may also solicit input from members, employers, providers, and facilities by the following means:

- Ad-hoc advisory groups
- Face-to-face meetings
- Telephonic encounters

HEDIS®

For selected products, Healthcare Effectiveness Data & Information Set Performance Measures results are evaluated on an annual basis to monitor improvement. HEDIS data are collected from claims, encounters, and may be supplemented with medical chart review. HEDIS data submitted to National Committee for Quality Assurance, the Blue Cross and Blue Shield Association and other entities, are audited by an NCQA certified auditor.

Quality Rating System Measure Set

As part of the Affordable Care Act requirements, Centers for Medicare and Medicaid Services developed the Quality Rating System to:

- Inform consumer selection of Qualified Health Plans offered through a Health Insurance Marketplace
- Facilitate regulatory oversight of QHPs
- Provide actionable information to QHPs for performance improvement

QHP and Multi-State Plan issuers that offer coverage through a Health Insurance Marketplace are required to submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data to CMS as a condition of certification.

Qualified Health Plans Quality Improvement Strategy

As an issuer participating in a Marketplace, BCBSIL will implement and report on at least one Quality Improvement Strategy in accordance with section 1311(g) of the Affordable Care Act. The QIS will cover each state in which the Plan has participated in the Marketplace for two or more consecutive years and enrollment was >500 enrollees within a product type by State during the designated period of time.

BCBSIL will review data to identify the appropriate QIS for each Marketplace that includes at least one of the following:

- Activities for improving health outcomes;
- Activities to prevent hospital readmissions;
- Activities to improve patient safety and reduce medical errors;
- Activities for wellness and health promotion; and/or
- Activities to reduce health and health care disparities.

BCBSIL will use market-based incentives to improve the quality and value of health care and services specifically for Marketplace enrollees. All QIS activities will be linked to an incentive as defined by CMS. The market-based incentive types to be included are: 1) increased reimbursement or 2) other incentive. The incentive will be a provider market-based incentive, an enrollee market-based incentive, or both.

Each year, the status of each QIS will be determined based on the following:

- Continue the QIS without modification
- Continue the QIS with some modifications
- Discontinuing the QIS

If a decision is made to discontinue a QIS submitted during a prior period, a new QIS will be selected for the applicable Marketplace.

Continuity and Coordination of Care
Continuity and coordination of care are important elements of care and as such are monitored through the QI Program. BCBSIL monitors and identifies opportunities for improvement in the continuity and coordination of medical and behavioral health care. Initiatives are selected across the delivery system, including settings, transitions in care and patient safety.

Practice Guidelines
BCBSIL has developed and implemented both clinical practice and preventive care guidelines. The guidelines are developed and derived based upon a variety of sources, including recommendations from specialty and professional societies, consensus panels and national task forces and agencies, review of medical literature, and recommendations from ad hoc committees. Clinical practice and preventive care guidelines are updated at least every two years or more frequently, as needed.

Preventive care guidelines include age and gender-specific and perinatal evidence-based recommendations. Clinical practice guidelines such as Asthma, Chronic Obstructive Pulmonary Disease, and Diabetes include evidence-based recommendations.

Service Quality Improvement
The services provided by the Plans support members and the health care delivery system. Further, satisfaction with BCBSIL is often derived from the quality of service the members receive. Service standards have been established to prevent issues, whenever possible, and provide consistent, timely and accurate information and assistance to members, physicians, providers and other customers. The standards are routinely monitored and reported to the appropriate committees. Surveys and complaints are monitored to ensure the standards established are appropriate and meet the needs of the organization and customers.

Provider Quality Programs
BCBSIL manages several quality-related provider programs such as HMO Illinois®, our Accountable Care Organizations, in which we share savings for provider systems able to reduce costs while improving quality, and the Blue High-Performance Network (Blue HPN℠), which BCBSIL is offering in coordination with the Blue Cross and Blue Shield Association and Blue Cross plans nationally.

Performance Improvement Plans
At this time there are no requirements related to performance improvement plans. This may change in the future.

Care Management Programs
Please refer to the Health Care Medical Management section of the Provider Manual for BCBSIL.

Medical Policy Development and Reviews
Medical policies are the foundation of BCBSIL's utilization review program and establish evidenced-based clinical criteria that can be used to determine medical necessity of certain services and ensure members have access to appropriate care. BCBSIL has a unified process for development, review and update of medical policies.

A medical director under BCBSIL is assigned primary responsibility for representing BCBSIL as part of the broader Medical Policy Committee review process. A behavioral health practitioner under BCBSIL is included in the review process for policies involving behavioral health. The medical directors and the behavioral health practitioner, if applicable, work collaboratively to review and discuss both new and established policies, then reach a consensus on coverage recommendations for each medical policy.

Review of medical policies is an ongoing process. New technology is evaluated on a regular basis to determine the appropriateness of benefit coverage for advances in medical procedures, drugs and devices. Medical policies include a review of the scientific knowledge for the technology, product, device, procedure or drug currently available in the English language.

Resources for technology assessment and medical policy review may include, but are not limited to:

- Medical practice standards published by unaffiliated nonprofit professional associations for the relevant specialty
- Medical Policy Reference Manual for the Blue Cross and Blue Shield Association
- Medicare coverage policies, in the Medicare Coverage Database (MCD) including National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Government agencies or regulatory bodies involved in review of clinical standards for the industry (e.g. FDA)

Draft medical policies are submitted electronically to our medical directors and to an internal review committee comprised of departments within BCBSIL that may be impacted by the medical policy. Drafts are also posted in a dedicated area of the website that allows direct comment from external physicians, other practitioners and other stakeholders.

Delegation Oversight
The Plan may elect to delegate/authorize another entity to carry out functions that would otherwise be performed by the Plan. The Plan is responsible for delegate oversight and retains ultimate accountability for all delegated functions. Established criteria are in place to assess the ability of each potential delegate to perform required functions prior to entering into a delegation contract. Current delegates are subject to the same established criteria and are continuously monitored for compliance via standardized report submissions, annual audits and monitoring plan. All delegates must comply with the requirements as indicated by the Plan, the delegation agreement, accreditation standards (i.e., URAC, NCQA), U.S. Department of Labor Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act, and state and federal regulations.

External Accountability
The QI Program is designed to meet all applicable state and federal requirements (e.g. HIPAA etc.). Plan staff, in cooperation with our Compliance and Legal Departments, monitors state and federal laws and regulations related to quality improvement and reviews program activities to assure compliance. In addition, if the Plan achieves external accreditation/certification, maintenance of such accreditation/certification is monitored through the QI program.

Accreditation Matrix

BCBSIL maintains accreditation for the products identified from the listed accrediting bodies:

		NCQA	NCQA UM	URAC CM	URAC Health Plan
BCBSIL	PPO	No	Yes	No	No
	Retail PPO	Yes	No	No	No
	HMO	Yes	No	No	No
	Retail HMO	Yes	No	No	No
	HPN	No	No	No	No
	MyBlue Plus (POS)	In Process	No	No	No

Quality Improvement Program Documents

QI Program Description
The QI Program description is reviewed annually and is updated as needed. On an annual basis, the document is presented to the Quality Improvement Committee.

QI Work Plan
The QI Program Work Plan is initiated annually based upon the planned activities for the year and includes improvement plans for issues identified through the evaluation of the previous year's program. The Work Plan includes all aspects of the QI Program, and the activities must be appropriately linked to the established goals and objectives. The Work Plan will include a delineation of responsibility and time frames for accomplishing each planned activity. The QI Work Plan is presented to the QI Committee for review and approval. The document is updated throughout the year to reflect the progress on QI activities and new initiatives as they are identified.

QI Program Evaluation
On an annual basis, there is a written evaluation of the QI Program. The evaluation includes an assessment of progress made in meeting identified QI initiatives and goals and an evaluation of the overall effectiveness of the QI Program.

The QI Program is then updated accordingly. On an annual basis, the document is presented to the QI Committee for review and approval.

Disclosure of the QI Program Information
Information regarding the QI Program is made available to participating physicians with BCBSIL and other providers and to enrollees, upon request.

Section 9: Accreditation Requirements

National Committee for Quality Assurance (NCQA) Accreditation

Participating Providers agree to comply with the standard policies and procedures that are necessary for BCBSIL to obtain and maintain accreditation by the NCQA and from such other organizations that BCBSIL may seek accreditation or recognition from time to time. Participating Providers agree to the following requirements as outlined in the provider manual and as required by NCQA:

1. Participating Provider agrees to cooperate with utilization management and quality improvement (QI) clinical and service activities to improve quality of care and services and member experience of the BCBSIL and/or Participating Plan Hospitals, including, but not limited to, pre- certification and notification requirements, concurrent appropriateness and medical necessity review, case management and peer review, and member experience, as designated by BCBSIL. Cooperation includes collection and evaluation of data and participation in the organization's QI programs. The Participating Provider acknowledges that the utilization management, population health management and quality improvement activities of BCBSIL may change from time to time to include additional utilization management, population health management and quality improvement activities. BCBSIL will notify Participating Providers, through posting on our website and/or posting in *Blue Review*, the Participating Provider newsletter, of changes in the utilization management, population health management and quality improvement activities to allow the Participating Provider to comply. The Participating Provider agrees that BCBSIL may use performance data relating to the Participating Provider's provision of services, including, but not limited to, data relating to quality improvement and population health management activities, publicly reported data, network and/or tier status and cost sharing, as BCBSIL deems appropriate for quality improvement activities and to assist members and groups.

2. The Participating Provider agrees that it will maintain adequate medical and administrative records consistent with the standards of major organizations conducting accreditation and will permit BCBSIL, or its agents or representatives, to review such medical records and administrative records regarding covered persons. The Participating Provider agrees to furnish to BCBSIL or its agent or representative necessary quality improvement and population health management data and will permit BCBSIL or its agent or representative to perform site visits to inspect and review such records and inspect the Participating Provider's office facility and equipment during normal business hours as mutually agreed upon in advance for the purpose of BCBSIL's performing utilization management and quality improvement activities. Participating Provider shall permit BCBSIL or its designees, upon reasonable notice and during normal business hours, to have, without charge, access to and the right to examine, audit, excerpt and transcribe any books, documents, papers and records relating to covered person's medical and billing information within the possession of the Participating Provider and to inspect the Participating Provider's operations, which involve transactions relating to covered persons and as

may be reasonably required by BCBSIL in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, Medical Necessity, appropriateness of care, and accuracy of billing and payment. The Participating Provider shall make such records available to state and federal authorities, as well as any accrediting bodies which BCBSIL is accredited by or from which it is seeking accreditation involved in assessing quality of care, fraud, abusive billing practices or investigating covered person's grievances or complaints. The Participating Provider agrees to provide BCBSIL or its designees with appropriate working space. Upon reasonable request, photocopies of such records shall be provided to BCBSIL, payor or their designee at no charge.

3. Participating Provider shall obtain, analyze, store, transmit and report protected health Information in accordance with all state and federal laws, which includes maintaining and sharing member health records, in accordance with professional standards. As applicable, Participating Provider shall abide by all laws and BCBSIL procedures regarding privacy, confidentiality and accuracy of member's medical and prescription records and other health and enrollment information.

4. The Participating Provider agrees that they shall communicate all appropriate treatment options to members, regardless of cost or benefit coverage for such options.

Section 10: Fraud and Abuse Program

Special Investigations Department

Each year, fraud, waste, and abuse (FWA) costs the health care industry billions of dollars. FWA is a key driver of the rising cost of health care.

We are committed to:

- Controlling the rising cost of health care;
- Identifying, investigating, and preventing health care FWA;
- Protecting the integrity of our Provider Network; and
- Referring individuals and/or facilities that defraud or attempt to defraud BCBSIL and its clients to law enforcement.

To honor this commitment, BCBSIL established the Special Investigations Department which has adopted an aggressive and effective health care FWA investigation program. The SID employs the use of various investigative techniques, the diverse skills of its staff, and its unique relationship with internal and external partners, such as the law enforcement community. The SID follows the reporting requirements mandated by law (state and federal) as well as contractual obligation.

Departmental investigators come from law enforcement, health care, and insurance backgrounds to form an effective investigative team. These investigators occasionally interview members during the course of their investigations but strive to do so in a manner that does not interfere with the Provider/Patient relationship. SID also includes a robust Data Intelligence Unit (DIU) that data mines for anomalous billing, supports SID investigations and responds to demands for information from law enforcement agencies.

When no FWA is found, the case may simply be closed with no further action. If investigations reveal the existence of FWA, possible courses of action include (but are not limited to):

- Notifying and placing the Provider on Pre-Payment Review (PPR) for questionable billing;
- Seeking a refund from the Provider;
- Educating the Provider about billing errors;
- Terminating the Provider from our Network; and
- Referring the Provider to a state regulatory and/or law enforcement agency.

BCBSIL considers fraudulent billing to include, but is not limited to, the following:

1. Deliberate misrepresentation of the service provided in order to receive payment;
2. Deliberately billing in a manner which results in reimbursement greater than what would have been received if the claim were filed in accordance with BCBSIL billing policies and guidelines; and/or
3. Billing for services which were not rendered.

Pre-Payment Review

The SID and its internal partners may determine that it is appropriate to place a provider or specific codes on PPR to help prevent erroneous, fraudulent, or otherwise unclean claims from being paid. In this process, the provider's claims undergo an additional layer of scrutiny to verify eligibility for reimbursement. Consistent with their contractual obligations to provide BCBSIL with access to medical, billing, and financial records, a provider must supply documentation in support of the services billed on their claims. The documentation is reviewed by medical professionals and/or coding experts to determine whether the services were medically necessary, within terms of coverage according to members' benefits, rendered as billed on the claim and billed in compliance with our reimbursement policies, including but not limited to our clinical payment and coding policies.

The SID employs numerous investigative techniques in its mission. These may include review of claims and supporting records, data mining, and interviews. The SID may also use a Statistical Random Sample to select a representative set (sample) of claims to evaluate the adherence to our requirements.

Provider Responsibilities

Providers are responsible for:

- All statements made with any claim submitted to BCBSIL by or on behalf of the Provider; and
- The actions of staff members or agents.

Providers should be knowledgeable about our Medical Policies and our Reimbursement Policies These policies serve as one set of guidelines for coverage decisions. However, Medical Policy does not constitute plan authorization, nor is it an explanation of benefits, or meant to substitute for a **clinician's judgment.**

Providers should determine member benefits and eligibility prior to services, either electronically or by calling the Provider Telecommunication Center at 800-972-8088. If the Provider has a question as to whether a frequently billed service is a covered benefit under a Medical Policy, the Provider should address that question with his/her Provider Network Consultant. If there is a discrepancy between a Medical Policy and a member's benefit plan or contract, the benefit plan or contract will govern.

How to Report Health Care Fraud:

Providers who become aware of potential fraudulent or abusive billing by other providers should report those matters to the Fraud Hotline at 800-543-0867. The Fraud Hotline operates 24 hours per day, seven days per week. Suspicions of fraud can be reported anonymously.

Section 11: Ancillary

Coordinated Home Care Program

The Coordinated Home Care Program under BCBSIL is a program designed to help members maximize their benefits for home health care, when such benefits are available under the member's health benefit coverage. The program may be initiated by an inpatient facility to facilitate the early discharge of its patients into a program of home care. Such home care should be provided by an independently contracted participating provider which may be a hospital's duly licensed home health department or by other duly licensed home health agencies with which the inpatient facility may have referral arrangements. The covered person must require skilled nursing services on an intermittent basis under the direction of the covered person's physician. The program includes, but is not limited to, skilled nursing services by or under the supervision of a registered professional nurse, the services of physical, occupational and/or speech therapists and necessary medical supplies.

General Benefit Coverage Criteria
In order for services to be eligible for benefits under the CHC program, in most situations, the member must:

- Be under the care of a physician; and,
- Have an active written treatment plan and orders from the physician; and,
- Require skilled nursing services on an intermittent basis; and,
- Receive care from a licensed home health agency; and,
- Be recertified for continued care needed periodically by the attending physician.

Exceptions to the General Benefit Coverage Criteria

- Some benefit plans require a prior hospital or skilled nursing facility stay.
- Benefit plans requiring a prior inpatient facility stay may have different requirements as to the time the first coordinated home care visit must occur.
- Benefits for any Covered Service are limited to that which is set forth in the member's policy certificate and/or benefits booklet and/or summary plan description.

Eligibility and benefits should be determined electronically via Availity or the provider's preferred web vendor, or by calling Provider Services at 800-972-8088 to utilize the automated Interactive Voice Response phone system.

Providers may visit the Availity website to register or learn more about Availity's products and services. Providers also may contact Availity Client Services at 800-282-4548 for assistance.

Examples of services that are typically considered eligible for CHC benefits:

- Intermittent (one to two hours per visit) skilled nursing services by a registered nurse or a licensed practical nurse. Intermittent visits are not continuous care as rendered in private duty nursing. See Private Duty Nursing Note below.
- Physical, Occupational and Speech therapy.
- Medical Social Services.
- Medical supplies.

Examples of services that are not typically considered eligible for CHC benefits:

- Services of a home health aide.
- Private duty nursing (private duty nursing is defined as follows: Skilled nursing care provided in the patient's home on a one-to-one basis by an actively practicing RN or LPN under the direction of the attending physician.).
- Rental or purchase of Durable Medical Equipment.
- ***PHARMACEUTICALS, including but not limited to Specialty Pharmacy Drugs, Infused Drugs, Total Parenteral Nutrition and Enterals Note:*** all pharmaceuticals, including, but not limited to, specialty pharmacy drugs, infused drugs, total parenteral nutrition and enterals, which are Covered Services pursuant to the Covered Person's Coverage Agreement ("Pharmaceuticals"), must be billed by the dispensing pharmacy to BCBSIL on a CMS-1500 claim form with appropriate Healthcare Common Procedure Coding System, National Drug Codes and units where appropriate.
- ***Private Duty Nursing:*** Private duty nursing is **not** a CHC benefit. However, some members of BCBSIL may be eligible for private duty nursing under their benefit plan. Benefit coverage for private duty nursing is subject to the terms, conditions, limitations and exclusions of the member's health benefit plan. The provider must submit an electronic eligibility and benefits request or call the Provider Customer Center at 800-972-8088 to verify if private duty nursing is a benefit. Private duty nursing **must** be billed under a National Provider Identifier number using the CMS-1500 claim form.
- **Custodial care services** (services that do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed) are not covered.

Discharge Planning Guidelines

When a member is discharged from an inpatient setting to coordinated home care setting, the transition of care must comply with the following guidelines:

- Obtain the physician's orders, plan of treatment and other pertinent documentation.
- The agency's utilization review staff should ensure that the member care being received meets the program criteria.
- Confirm eligibility and benefits electronically via a third-party vendor portal, or by calling the BCBSIL PTC.
- Obtain prior authorization/pre-certification as required.

Prior Authorization/Pre-certification

Prior Authorization/Pre-certification for CHC is required by most benefit plans. Since members receiving CHC services have generally been discharged from an inpatient facility hospital, and planning for CHC services is part of inpatient discharge planning, some case management may be performed by the Medical Management Department. Please refer to the Contacts and Resources section of this manual for information and procedures on prior authorization/pre-certification.

Electronic Prior Authorization (Availity Authorizations) or Request, Verify or Obtain Prior Authorizations

Availity Authorizations tool is our online tool that allows the electronic submission of inpatient admissions and select outpatient services handled by BCBSIL. Additionally, providers can also check status on previously submitted requests and/or update applicable existing requests. For additional details, refer to the Availity Authorizations User Guide Availity Authorizations is accessible to physicians, professional providers and facilities who have established a provider record with BCBSIL. For more information about the Availity Authorizations tool, visit the Education and Reference Center/Provider Tools section of our website.

Verification of benefits and/or approval of services after prior authorization or predetermination are 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, copayments, coinsurance and deductibles, 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 as well as any pre existing conditions waiting period, if any.

Billing Requirements
CHC bills must be submitted in the UB-04 format either electronically or on the paper claim form. The following data elements are specific to CHC. For complete details, providers should reference the UB-04 Data Specifications Manual, available from the National Uniform Billing Committee.

Form Locator 4 Type of Bill	1st digit: Type of facility (3 = home health) 2nd digit Bill classification (2) 3rd digit: Frequency **Examples:** 321 for admit through discharge cycle billing 322 for 1st claim 323 for continuing claim 324 for last claim 325 for late charges 327 for replacement of prior claim
Form Locator 6 Statement Covers Period	Date for period of services (Continuing services should be billed at 30-day intervals, i.e., calendar months) **Exceptions:** Submit only one claim if the entire billing cycle is less than 40 days
Form Locator 15 Source of Admission	A code indicating the source of this admission (1 = physician referral)
Form Locator 17 Patient Status	Status code. Must be consistent with the Bill Type in Form Locator 4 (01 = discharge, 30 = still patient)

Institutional claims may be submitted electronically via the ANSI 837I transaction. Information on electronic Claim Submission is available in the Claims and Eligibility section of our website. Providers may also contact the Electronic Commerce Center at: ecommerceservicesil@bcbsil.com for assistance.

Note: This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims for any particular disease, treatment or service. Health care providers are instructed to submit claims using the most appropriate code based upon the medical record documentation and coding guidelines and reference materials.

Mailing Address for Paper Claims
Blue Cross and Blue Shield of Illinois
PO Box 660603
Dallas, TX 75266-0603

Coordinated Home Care Billing Example

1 A Home Health Agency
123 Main Street
Anytown, IL 60000
312-123-4567

2 A Home Health Agency
P.O. Box 123
My Town, IL 60000

3a PAT. CNTL # 09917765
b. MED. REC. # 1234567

4 TYPE OF BILL 322

5 FED. TAX NO. 45123456

6 STATEMENT COVERS PERIOD FROM 020119 THROUGH 022919

7

8 PATIENT NAME a Doe, Jane
b

9 PATIENT ADDRESS a 456 Main Street
b Anytown c IL d 60000 e 5999

10 BIRTHDATE 08101961
11 SEX F
ADMISSION 12 DATE 020119
13 HR
14 TYPE 1
15 SRC
16 DHR
17 STAT 30
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE 11 DATE 020119
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	270	Medical Supplies			5	75 00		
2	551	Skilled Nursing Visit	99341	020119	1	200 00		
3	551	Skilled Nursing Visit	99349	020519	1	150 00		
4	551	Skilled Nursing Visit	99349	020719	1	150 00		
5	551	Skilled Nursing Visit	99349	020919	1	150 00		
6	551	Skilled Nursing Visit	99348	021319	1	150 00		
7	551	Skilled Nursing Visit	99348	021519	1	150 00		
8	551	Skilled Nursing Visit	99348	022019	1	150 00		
9	551	Skilled Nursing Visit	99348	022219	1	150 00		
10	551	Skilled Nursing Visit	99348	022719	1	150 00		
11								
12	001	Total			14	1475 00		
13–22								
23		PAGE 1 OF 1	CREATION DATE	030119	TOTALS	1475 00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	Blue Cross 121		Y	Y		
B						
C						

56 NPI 0123456789
57 OTHER PRV ID

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane	18	XOM123456789	XYZ Company	M90026
B					
C					

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX E11.622 I10

67 A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX E11.622
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 1234567890 QUAL
LAST Black FIRST Michael

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Blue Cross Secondary Billing

On the next page is an example of a claim where Blue Cross is secondary to another insurance carrier. It is a discharge claim, due to the Type of Bill in Form Locator 4 (324), and the Patient Status (01) in Form Locator 17.

Form Locator 39	Value Code A3 identifies other insurance and the dollar amount paid by the insurance primary to Blue Cross
Form Locator 50	Identifies payer information by line item: Line A indicates Aetna is primary Line B indicates Blue Cross is secondary
Form Locator 58	Identifies the insured's name: Line A indicates the insured's name for Aetna Line B indicates the insured's name for Blue Cross

CHC Bill - Blue Cross is Secondary Billing Example

Field	Value
1	A Home Health Agency 123 Main Street Anytown, IL 60000 312-123-4567
2	A Home Health Agency P.O. Box 123 My Town, IL 60000
3a PAT. CNTL #	09917765
b. MED. REC. #	1234567
4 TYPE OF BILL	324
5 FED. TAX NO.	45123456
6 STATEMENT COVERS PERIOD FROM	030119
THROUGH	031819
7	
8 PATIENT NAME a	Doe, Jane
9 PATIENT ADDRESS a	456 Main Street
b	Anytown
c	IL
d	60000
e	5999
10 BIRTHDATE	08101961
11 SEX	F
ADMISSION 12 DATE	010518
13 HR	
14 TYPE	
15 SRC	1
16 DHR	
17 STAT	01
CONDITION CODES 18–28	
29 ACDT STATE	
30	

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
11	010519	16	031719	35	010719	17	020519	44	010819					

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A3	920 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	270	Medical Supplies			7	200 00		
2	421	Physical Therapy	97116		3	300 00		
3	431	Occupational Therapy	97535		3	300 00		
4	551	Skilled Nursing	99347	030119	1	100 00		
5	551	Skilled Nursing	99347	030519	1	100 00		
6	551	Skilled Nursing	99347	030819	1	100 00		
7	551	Skilled Nursing	99347	031419	1	100 00		
8	551	Skilled Nursing	99347	031819	1	100 00		
9								
10	001	Total				1300 00		
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE	031919	TOTALS	1300 00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	Aetna				920 00	
B	Blue Cross 121		Y	Y		380 00
C						

56 NPI: 0345678912
57 OTHER PRV ID:

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane	18	123456789	XYZ Company	
B	Doe, John	01	XOC123456789		P12345
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX: C85.95 | I66.9

68

69 ADMIT DX: | 70 PATIENT REASON DX: | 71 PPS CODE: | 72 ECI: | 73

PRINCIPAL DX: C85.95

74 PRINCIPAL PROCEDURE CODE / DATE; a. OTHER PROCEDURE CODE / DATE; b. OTHER PROCEDURE CODE / DATE; c. OTHER PROCEDURE CODE / DATE; d. OTHER PROCEDURE CODE / DATE; e. OTHER PROCEDURE CODE / DATE

75

Field	NPI	QUAL	LAST	FIRST
76 ATTENDING	1234567890		Black	Michael
77 OPERATING				
78 OTHER				
79 OTHER				

80 REMARKS

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Durable Medical Equipment

This document contains policies under BCBSIL applicable to DME providers and concerning DME, particularly life sustaining and non-life sustaining equipment as specified in your contract. All DME providers are required to abide by these policies and are accountable to deliver services and bill accordingly on a CMS-1500 claim form. Electronic billing of claims is required as well as electronic funds transfer and electronic remittance advice. In addition, all DME providers must have facility accreditation by a nationally recognized accreditation organization such as, The Joint Commission, Accreditation Commission for Health Care, Community Health Accreditation Partner, etc. in order to contract with BCBSIL.

DME: Definition

Equipment which consists of items that primarily and customarily serve a medical rather than a comfort or convenience purpose, are not useful to a person in the absence of illness or injury, withstand repeated use (are reusable), are appropriate for home use, and are ordered or prescribed by the attending physician.

Coverage for DME may include:

- Repair, adjustment or replacement parts and accessories necessary for the normal and effective functioning of the equipment
- Rental charges for the equipment if it can be rented for a cost less than the purchase of the equipment
- Purchased equipment when the purchase of the DME would be less expensive than the rental of the equipment

All DME suppliers must obtain signed physician orders and/or a Certificate of Medical Necessity prior to billing of any equipment. All orders/CMNs must contain the following information to be considered for payment:

- Date of order/CMN
- Patient name, address and member number
- Supplier name, address, telephone number
- Physician name, address and telephone number
- Patient diagnosis
- Equipment/supplies ordered
- Duration of need
- Statement of medical necessity for equipment
- Physician signature and date

Physician's orders must be renewed annually. Unless otherwise stated in a provider's contract with BCBSIL, DME that is supplied as part of an inpatient stay is covered by the global rate to the facility, and should not be separately billed by the DME provider to BCBSIL.

Life Sustaining DME:

The following equipment is considered life sustaining and will not be purchased:

1. **E0424:** Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
2. **E0431:** Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
3. **E0433:** Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
4. **E0434:** Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing
5. **E0439:** Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
6. **E0465:** Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube)
7. **E0466:** Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell)
8. **E0481:** Intrapulmonary percussive ventilation system and related accessories
9. **E0618:** Apnea monitor, without recording feature
10. **E0619:** Apnea monitor, with recording feature
11. **E1390:** Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
12. **E1391:** Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each
13. **E1392:** Portable oxygen concentrator, rental
14. **E1590:** Hemodialysis machine
15. **E1592:** Automatic intermittent peritoneal dialysis system
16. **E1594:** Cycler dialysis machine for peritoneal dialysis
17. **K0738:** Portable gaseous oxygen system, home compressor used to fill portable oxygen cylinders

Note: Stationary and portable oxygen equipment is billed as 1 unit per month.

All DME delivery, equipment set up and training is included in the equipment reimbursement rate and may not be billed separately.

Oxygen set up or installation of respiratory support systems, patient/caregiver instructions on equipment use and safety, and equipment maintenance/monitoring are included in the rental fee. DME providers supplying clinical respiratory equipment (oxygen, ventilators) are expected to have a licensed respiratory therapist on staff to provide patient education, clinical assessments and equipment recommendations, as appropriate, as part of their respiratory management program.

Oxygen Contents:

Oxygen container and contents are included in the allowance for rented oxygen systems and are not separately billable.

Oxygen Accessories:

Oxygen accessories which are included in the allowance for rented systems include: container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, tubing, supply reservoir, refill adaptor, oxygen carts, racks or stands. These accessories may not be billed separately.

Ventilator Accessories:

The rental allowance for ventilators (E0465, E0466) includes all accessories and supplies used with a ventilator including, but not limited to, battery, battery cables, battery charger, breathing circuit components, humidifiers, filters, etc.).

Home Apnea Monitors:

Home Cardiorespiratory Monitoring may be considered medically necessary for premature infants who are at high risk of recurrent episodes of apnea, bradycardia and hypoxemia, for up to three months after hospital discharge, or after the cessation of serious episodes for 14 consecutive days, whichever comes last.

The rental allowance is to include all supplies needed for the use of the apnea monitor. These items include, but are not limited to, belts, electrodes, wires and Ambu bag. Also included in the rental allowance is retrieval of recorded data from the event recorder and parental training sessions (instructions on monitor use, CPR, etc.).

These items may not be billed separately from the apnea monitor.

Non-Life Sustaining DME:

Items such as insulin pumps and external bone stimulation devices are generally available only as a purchase. All other equipment not listed as life sustaining (as above) will be paid as rental up to the allowed purchase price.

Continuous Positive Airway Pressure (CPAP)/Bi-level Positive Airway Pressure (BIPAP):

Sleep Lab Study results must be available and provided upon request. Although all DME is billed and paid as a rental up to the BCBSIL purchase price amount, there may be situations in which the member of BCBSIL requests that the CPAP/BIPAP be converted to a purchase at an earlier date to avoid the

continued need to pay monthly coinsurance amounts and or to meet a deductible. In this situation CPAPs/BIPAPs may not be converted to a purchase until after three months of patient usage and proven compliance. The DME provider must obtain evidence of continued CPAP/BIPAP usage/compliance from the patient and/or treating physician before converting to the purchase price. A memory card reading or electronic download is recommended. This information must be retained in the supplier's files and be available to BCBSIL upon request. Memory card/electronic downloading as well as CPAP/BIPAP initiation and management is included in the rental/purchase price and is not separately billable.

Masks must be fitted to individual patients by a qualified respiratory professional. The CPAP/BIPAP machines should include the necessary carrying case. This carrying case may not be billed separately.

CPAP Supply Utilization Limits:

BCBSIL follows the Medicare guidelines pertaining to limits on dispensing CPAP/BIPAP supplies.

Continuous Passive Motion Device:

The CPM device may be eligible for coverage for use postoperatively, as an adjunct to conventional physical therapy in the following situations only:

- Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a knee arthroplasty or arthroplasty revision. This may include patients with complex regional pain syndrome (reflex sympathetic dystrophy), extensive arthrofibrosis or tendon fibrosis, or physical, mental or behavioral inability to participate in active physical therapy.
- For up to six weeks during the non-weight bearing rehabilitation period following knee surgery for microfracture, osteochondral grafting, autologous chondrocyte implantation, treatment of osteochondritis dissecans, repair of tibial plateau fractures, and reconstruction of the anterior cruciate ligament.

All other uses of a CPM device **are considered experimental, investigational, and unproven.**

Please see medical policy number DME 101.023 for additional information.

Pneumatic Compression Devices:

- A pneumatic compression device may be eligible for coverage when utilized in the home for conditions as outlined in our Medical Policy on Outpatient Use of Pneumatic Compression Devices (MED202.060).
- Pneumatic compression devices utilized in an inpatient facility or Ambulatory Surgery Center are the responsibility of the inpatient facility and/or Ambulatory Surgery Center and may **not** be billed by the DME provider to BCBSIL.

Please see medical policy number MED 202.060 (Outpatient Use of Pneumatic Compression Devices) for specific medical necessity criteria.

Orthotics and Prosthetics:
Any custom orthotic or prosthetic services rendered by a DME provider are subject to the state law governing disbursement of these services. Services must be rendered by an Illinois State licensed orthotist, prosthetist and/or pedorthist. In addition, the DME provider must have dual facility accreditation to include the American Board for Certification in Orthotics and Prosthetics, and each licensed professional must be credentialed and certified by the American Board for Certification in Orthotics and Prosthetics, or the Board for Certification in Pedorthics, as applicable.

All orthotic/prosthetic charges/reimbursement are inclusive of the following: (i) patient evaluation and measurement; (ii) Covered Person/caregiver training; (iii) instruction literature; (iv) device fitting, casting, alterations and adjustments; (v) professional support, at no additional charge.

All providers are encouraged to review relevant Medical Policies prior to rendering services. It may be appropriate in some cases to submit an electronic predetermination of benefits request via the Availity Provider Portal using the Attachments tool or by completing a Predetermination Request Form for predetermination of benefit and medical necessity which may be submitted along with the appropriate medical necessity documentation.

Remember to refer to the Provider Manual for the BlueCard Program for important information to assist you when you are providing care and services to out-of-area members.

Verification of benefits and/or approval of services after prior authorization or predetermination are 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 copayments coinsurance and deductibles supporting medical documentation and other terms conditions limitations and exclusions set forth in the member's.

Extended Care Facility

An Extended Care Facility, also called a Skilled Nursing Facility, is an institution or distinct part of an institution that has a transfer agreement with one or more hospitals. An ECF/SNF is primarily engaged in providing comprehensive post-acute hospital and inpatient rehabilitative care and is licensed by the designated government agency to provide such services. The definition of an ECF/SNF does not include institutions that provide only minimal, custodial, ambulatory or part-time care services, or institutions that primarily provide for the care and treatment of mental illness, pulmonary tuberculosis or chemical dependency.

Definitions

Blue Cross Participating or Plan ECF/SNF

A ECF/SNF has a contractual agreement with BCBSIL to provide services to a covered person at the time services are rendered. ECFs/SNFs are those licensed by the appropriate state and government authorities to provide skilled care in accordance with the guidelines established by Medicare.

Examples of ECF/SNF services that may be eligible for benefits:

The facility must verify coverage for each admission and obtain benefits for that subscriber's plan by submitting an electronic eligibility and benefits request through the preferred third-party vendor portal, or by calling the Provider Customer Center at 800-972-8088:

- Semi-private room
- General nursing services
- Allowance for private room equal to semi-private room rate
- Use of special treatment rooms
- Laboratory tests
- Oxygen and oxygen administration
- Physical therapy
- Inhalation therapy
- Electrocardiograms
- Electroencephalograms
- X-rays (unless not covered by the certificate)
- Physician visits when available under the Blue Shield benefit
- Speech therapy
- Functional occupational therapy (helps restore functions of the upper body)
- Other medically necessary services when prescribed by the attending physician

Exclusions

- Transfers from the hospital to the ECF/SNF made solely for evaluation, observation or convenience;
- Diagnostic or therapeutic procedures not related to the condition for which the original hospital service was provided;
- Treatment for which a member receives or is eligible for care under Worker's Compensation or Federal Employer's liability laws;
- Items provided solely for comfort;
- Private duty nursing, blood plasma and special appliances.

Benefits are not available for custodial care services under most benefit plans. Custodial care services

do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Custodial care services include, but are not limited to:

- Assistance with activities of daily living (bathing, personal hygiene, feeding, meal preparation)
- Administration of oral medications
- Assistance with ambulation or walking
- Assistance with supportive or maintenance physical therapy
- Care due to incontinence
- Turning and positioning in bed
- Acting as a companion or sitter
- Nurse's aide services
- Ventilator management

Custodial care also means the provision of inpatient services and supplies to a covered person who is not receiving skilled nursing services on a continuous basis. The covered person is not under a specific therapeutic program which has a reasonable expectancy of effecting improvement in the covered person's condition within a reasonable period of time, and which can only be safely and effectively administered to an inpatient in the health care facility involved.

Member Eligibility

The types of services that are covered by employee benefit contracts vary considerably. Therefore, providers should always check member eligibility and benefits before rendering services.

Prior Authorization Requirements

Most benefit plans require prior authorization and approval for admission to an ECF/SNF. Specific timeframes for notification vary according to employer benefit requirements. Providers may complete prior authorization/pre- certification electronically through the Availity Authorizations tool (HIPAA-standard 278 transaction). For additional details, refer to the Availity Authorizations page in the Education and Reference Center/Provider Tools section of our provider website. Providers also may call the BCBSIL at 800-572-3089 to obtain information via the automated Interactive Voice Response phone system.

Refer to the Utilization Management page for additional information.

Verification of benefits and /or approval of services after prior authorization or predetermination are 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 copayments coinsurance and deductibles 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 as well as any preexisting conditions waiting period if any.

Claims Submission

Institutional claims may be submitted electronically via the ANSI 837I transaction. Information on electronic Claim Submission is available in the Claims and Eligibility section of our website. Providers may also contact the Electronic Commerce Center at ECommerceServicesIL@bcbsil.com for assistance.

Home Infusion Therapy Guidelines

The information in this section is provided as a supplement to the agreement between BCBSIL with the independently contracted Home Infusion Therapy providers participating in the various health benefit products offered by BCBSIL. This section is to familiarize providers with policies under BCBSIL concerning HIT, particularly billing of services. All HIT providers are required to abide by these policies and are accountable to deliver services and bill accordingly on a CMS-1500 claim form. Electronic billing of claims is required. In addition, all HIT providers must meet all credentialing requirements which include current accreditation by one of the nationally recognized accreditation organizations (Joint Commission, ACHC, CHAP. etc.) in order to contract with BCBSIL.

Specialty Pharmacy injectable/infusible medications may be required to treat complex medical conditions such as immune deficiency, hemophilia, multiple sclerosis and rheumatoid arthritis. Specialty medication coverage is based on the member's benefit. Prior Authorization or Recommended Clinical Review approval may apply to specific specialty medications. In accordance with their benefits, some members may be required to use a specific preferred specialty pharmacy in order for benefits to apply.

Self-Administered Specialty Medications
Specialty medications that are FDA-approved for self-administration are typically covered under the member's pharmacy benefit and may not be billed by the HIT provider to BCBSIL. Some members' plans may require them to obtain these medications from a specific preferred specialty pharmacy for benefit consideration. Information pertaining to the Specialty Pharmacy Program may be found at https://www.bcbsil.com/provider/pharmacy/pharmacy-programs/specialty-pharmacy.

Many intravenous/injectable therapies are subject to specific medical necessity criteria in order to be eligible for benefits. All providers are encouraged to review relevant Medical Policies, prior to rendering services. For non-HMO members of BCBSIL, it is highly recommended to complete a Recommended Clinical Review Request Form The Recommended Clinical Review Request Form may be submitted along with the appropriate medical necessity documentation, as required.

Services normally considered eligible
Intravenous solutions and/or injectable medications may be considered eligible for benefits, if all of the following as well as Medical Policy criteria are met:

1. Prescription drug is FDA-approved or meets benefit criteria for off- label use;
2. The provision of services in the home is not primarily for the convenience of the member, the member's caregivers or the provider;
3. Therapy is managed by a physician as part of a written treatment plan for a covered medical condition;
4. Home care is provided by a specialized home infusion company; and
5. Infusion in the home must be safe and medically appropriate.

Description
Home infusion and injectable therapy involves the administration of any of the following items:

- Nutrients

- Medications
- Solutions

These items may be administered intravenously, intramuscularly, enterally, subcutaneously or epidurally, as medically appropriate and ordered by the member's physician.

Infusion therapy originates with a prescription from a physician who is overseeing the care of the member and is designed to achieve physician defined beneficial outcomes.

Specific infusion therapies may include, but are not limited to, the following:

- Anti-infectives
- Blood transfusions
- Chemotherapy
- Immunosuppressive therapy
- Hydration therapy
- Immunotherapy
- Inotropic therapy
- Pain management
- Parenteral and enteral nutrition (refer to Medical Policy (MED201.011) Nutritional Support)

Prior Authorization Requirements

Many benefit plans require notification and approval prior to the provision of any home infusion services. Providers should inquire whether prior authorization/pre-certification is necessary when checking the member's eligibility and benefits. In order to help members maximize their benefits, most benefit plans require members to utilize in-network providers.

Refer to the Utilization Management page for additional information.

Verification of benefits and/or approval of services after prior authorization or predetermination are 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, copayments, coinsurance and deductibles, 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 as well as any preexisting conditions waiting period, if any.

Billing Guidelines

All claims for home infusion therapy must be submitted on a CMS-1500 Claim form or electronically with the appropriate National Drug Code with total units of measurement dispensed as well as the Healthcare Common Procedure Coding System drug code with appropriate units (per the description of the HCPCS code) per the dosage ordered and administered.

Here are some guidelines for appropriate submission of valid NDCs and related information:

- Submit the NDC along with the applicable HCPCS or CPT procedure code(s)
- The NDC must be in the proper format (11 numeric characters, no spaces or special characters)
- The NDC must be active for the date of service
- The appropriate qualifier, unit of measure, number of units and price per unit also must be included, as indicated below

Electronic Claims Guidelines

Field Name	Field Description	ANSI (Loop 2410) – Ref Desc
Product ID Qualifier	Enter **N4** in this field.	LIN02
National Drug CD	Enter the 11-digit NDC (without hyphens) assigned to the drug administered.	LIN03
Drug Unit Price	Enter the price per unit of the product, service, commodity, etc.	CTP03
NDC Units	Enter the quantity (number of units) for the prescription drug.	CTP04
NDC Unit / MEAS	Enter the unit of measure of the prescription drug given. (Values: **F2** – international unit; **GR** – gram; **ML** – milliliter; **UN** – unit)	CTP05-1

Paper Claims Guidelines

In the **shaded portion** of the line-item field 24A-24G on the CMS-1500, enter the qualifier **N4** (left-justified), immediately followed by the NDC. Next, enter the appropriate qualifier for the correct dispensing unit (**F2** – international unit; **GR** – gram; **ML** – milliliter; **UN** – unit), followed by the quantity and the price per unit, as indicated in the example below. (The HCPCS/CPT code corresponding to the NDC is entered in field 24D)

Example:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N423155019631 ML2 12.82													N	1B	1234567901
09	01	18	09	07	18	11		12405		1	25 64	4	N	NPI	0987654321

New drugs without a valid HCPCS code should be billed using the HCPCS code J3490 or J3590, as applicable, with the appropriate NDC number and units ordered and administered.

Physician orders must include, at a minimum, the following elements:

- Date of order
- Member name and address
- Diagnosis warranting infusion therapy treatment
- Name of drug, dosage, administration route, frequency of administration and duration of treatment
- Physician name, address and telephone number
- Physician signature and date

Infusion therapy supplies should be billed utilizing the appropriate per diem HCPCS codes (S codes) for the specific drug or drug category. All per diem codes are inclusive of the following:

- Administrative services
- Professional pharmacy services
- Care coordination
- Delivery
- All necessary supplies and equipment
- IV solutions and diluents

The per diem HCPCS code must be billed on the same claim as the corresponding drug for the same dates of service. Modifiers SH (second concurrently administered infusion therapy) and SJ (third or more concurrently administered infusion therapy) must be indicated with the HCPCS code, as appropriate. Reimbursement for the second or subsequent concurrent infusion of same therapy class will be at 50 percent of normal per diem for that code.

Nursing visits provided in tandem with HIT services, may only be billed, electronically or on a UB-04 claim form, by a licensed home health agency, separate and apart from the HIT services which must be billed on a CMS- 1500 or electronically.

In order to help members maximize their benefit, nursing services should be performed by a provider that has a Coordinated Home Care Agreement with BCBSIL. Please review the Coordinated Home Care section of the Provider Manual for additional CHC billing guidelines.

Remember to refer to the Provider Manual for the BlueCard Program for important information to assist you when you are providing care and services to out-of-area members.

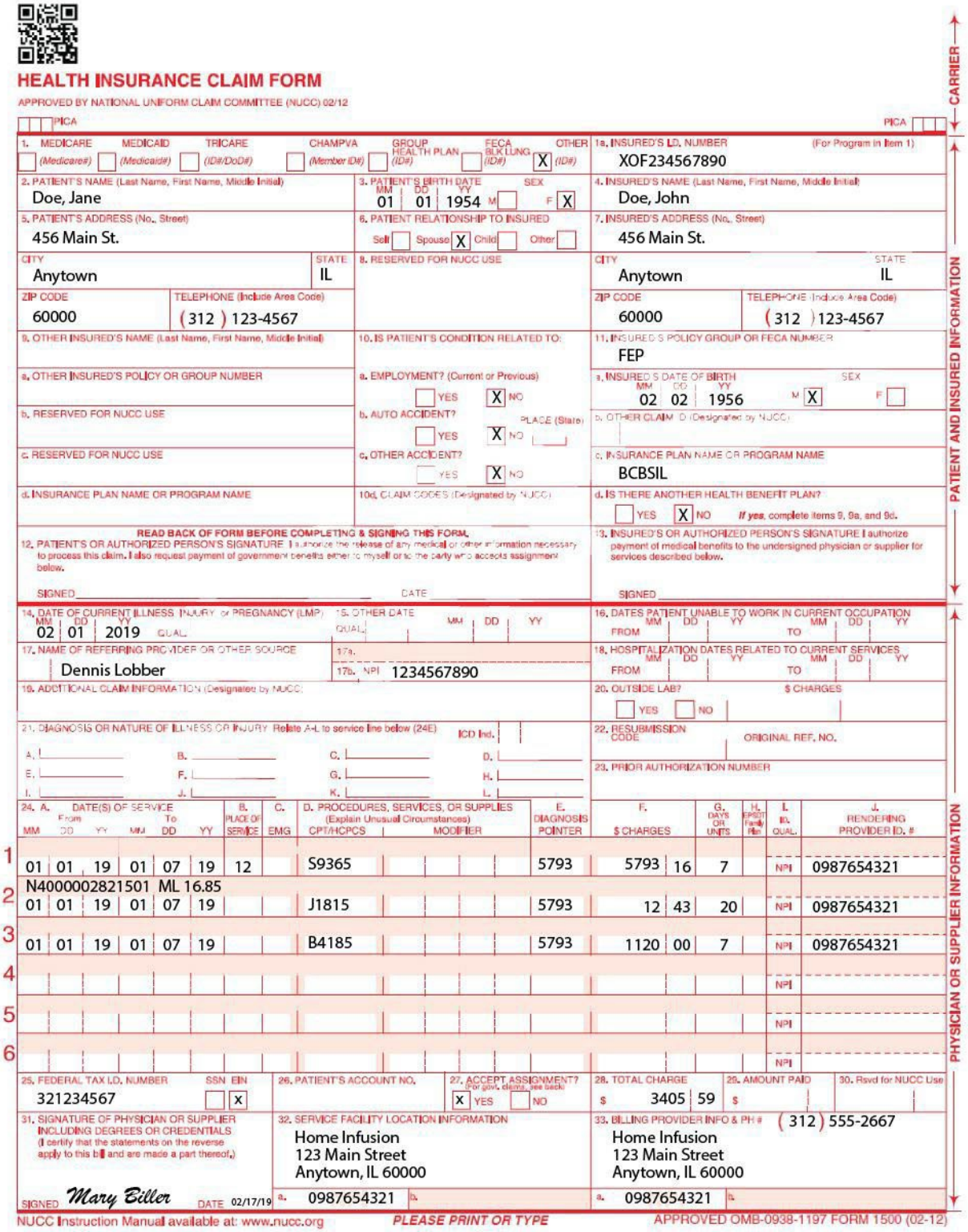
This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims for any particular disease, treatment or service. Health care providers are instructed to submit claims using the most appropriate code based upon the medical record documentation and coding guidelines and reference materials.

Home Infusion Therapy Billing Examples

The following billing examples are provided as a reference only. BCBSIL requires electronic submission of all claims.

Note: BCBSIL reserves the right to update these guidelines as necessary. Providers should review the guidelines posted in the Standards and Requirements section on our website periodically to ensure compliance.

Billing Example 1



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	X (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	XOF234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Doe, Jane
3. PATIENT'S BIRTH DATE / SEX	01 01 1954 M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Doe, John
5. PATIENT'S ADDRESS (No., Street)	456 Main St.
6. PATIENT RELATIONSHIP TO INSURED	Self Spouse X Child Other
7. INSURED'S ADDRESS (No., Street)	456 Main St.
CITY / STATE	Anytown / IL
8. RESERVED FOR NUCC USE	
CITY / STATE	Anytown / IL
ZIP CODE / TELEPHONE (Include Area Code)	60000 / (312) 123-4567
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	FEP
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES X NO
a. INSURED'S DATE OF BIRTH / SEX	02 02 1956 M X F
b. RESERVED FOR NUCC USE	
b. AUTO ACCIDENT? PLACE (State)	YES X NO
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	
c. OTHER ACCIDENT?	YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	BCBSIL
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. CLAIM CODES (Designated by NUCC)	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES X NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) / QUAL.	02 01 2019
15. OTHER DATE / QUAL.	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Dennis Lobber
17a. / 17b. NPI	1234567890
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? / $ CHARGES	YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) / ICD Ind.	A. B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 19	01 07 19	12		S9365		5793	5793 16	7		NPI	0987654321
2	N4000002821501 ML 16.85 01 01 19	01 07 19			J1815		5793	12 43	20		NPI	0987654321
3	01 01 19	01 07 19			B4185		5793	1120 00	7		NPI	0987654321
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	321234567 X
26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back)	X YES NO
28. TOTAL CHARGE	$ 3405 59
29. AMOUNT PAID	$
30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	SIGNED Mary Biller DATE 02/17/19
32. SERVICE FACILITY LOCATION INFORMATION	Home Infusion 123 Main Street Anytown, IL 60000 a. 0987654321 b.
33. BILLING PROVIDER INFO & PH #	(312) 555-2667 Home Infusion 123 Main Street Anytown, IL 60000 a. 0987654321 b.

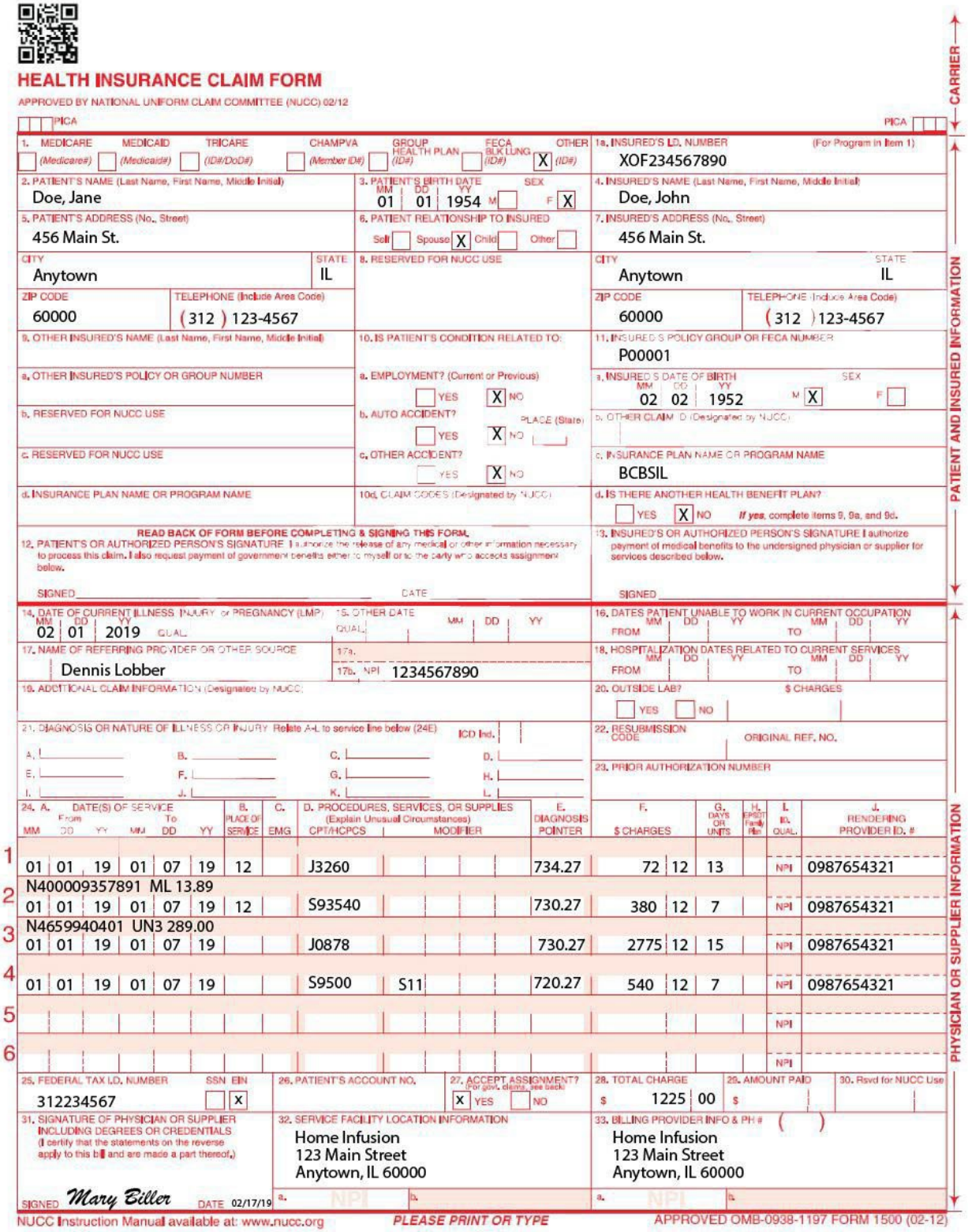
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Billing Example 2



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER [X] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): XOF234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane	3. PATIENT'S BIRTH DATE: 01 01 1954 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John	
5. PATIENT'S ADDRESS (No., Street): 456 Main St.	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 456 Main St.	
CITY: Anytown STATE: IL	8. RESERVED FOR NUCC USE
CITY: Anytown STATE: IL	
ZIP CODE: 60000 TELEPHONE (Include Area Code): (312) 123-4567	
ZIP CODE: 60000 TELEPHONE (Include Area Code): (312) 123-4567	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: P00001	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: 02 02 1952 SEX: M [X] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: BCBSIL	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 02 01 2019 QUAL. 15. OTHER DATE QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dennis Lobber 17a. 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 19 01 07 19	12		J3260		734.27	72 12	13		NPI	0987654321
2 N400009357891 ML 13.89 01 01 19 01 07 19	12		S93540		730.27	380 12	7		NPI	0987654321
3 N4659940401 UN3 289.00 01 01 19 01 07 19			J0878		730.27	2775 12	15		NPI	0987654321
4 01 01 19 01 07 19			S9500	S11	720.27	540 12	7		NPI	0987654321
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 312234567 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 1225 00
29. AMOUNT PAID: $	30. Rsvd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Mary Biller DATE 02/17/19	32. SERVICE FACILITY LOCATION INFORMATION: Home Infusion 123 Main Street Anytown, IL 60000 a. NPI b.		33. BILLING PROVIDER INFO & PH #: ( ) Home Infusion 123 Main Street Anytown, IL 60000 a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Hospice Care Program

Hospice can be defined as: A medically-directed, nurse-coordinated program providing a continuum of home and inpatient care for the terminally ill patient and family. It employs an interdisciplinary team acting under the direction of an autonomous hospice administration. The program provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses that are experienced during the final stages of illness and during dying and bereavement.

Benefits for hospice services may be available in both the home and an inpatient setting.

Hospice care is offered as a medical alternative to traditional forms of medical and nursing care. A major focus of hospice care is on the relief and control of pain and the physical and psychological symptoms associated with terminal illness.

The goal of hospice care is to enable persons who are at the end of their life to live at home or in another comfortable setting around their families, friends, and important possessions, as free as possible from the pain and other symptoms of terminal illness.

Equally important is the availability of a comprehensive range of support services designed to help both member and family cope with the stress, trauma and exhaustion that usually accompany terminal illness. Key among these are personal counseling for the member and family members, help with housekeeping chores and other duties, and hospice staff visits or other contact with family members for a period after the patient's death.

Hospice care is primarily home care but can also be provided through a hospital-based or skilled nursing facility- based program.

General Benefit Criteria

- Member must be under the care of a physician who provides written certification that the patient is terminally ill with a life expectancy of six months or less; and,
- The member will no longer benefit from curative therapies or has selected to receive hospice care rather than curative care; and,
- Care must provide both physical and emotional support to a terminally ill member and family, and services necessary for symptom management and pain relief; and,
- Hospice care may be provided in the home, hospital-based or skilled nursing facility-based programs, and freestanding hospice facilities.

Specific benefits and exclusions should be determined for each member via the provider's preferred third-party vendor portal, or by calling the Provider Customer Center at 800-972-8088 to utilize the automated Interactive Voice Response phone system.

Services Typically Considered Eligible as Hospice

- Skilled and unskilled nursing care
- Physical, occupational, speech, respiratory therapy
- Medical supplies
- Medications
- Social and spiritual services
- Physician visits
- Pain management services

- Dietary counseling

Services Not Typically Considered Eligible as Hospice

- Ambulance or medical transport (unless stated in member's contract)
- Home-delivered meals/meal prep
- Homemaker services
- Non-medical personal, legal or financial services
- Respite care
- Traditional curative care services for treatment of the terminal illness, condition, disease or injury

Prior Authorization

Prior Authorization is required by most member benefit plans. Providers should always verify prior authorization/pre-certification requirements via their preferred online vendor portal, or by calling the PTC to utilize the automated IVR phone system.

Please refer to the Utilization Management page for additional information.

Claim Submission

Hospice care program claims should be billed electronically or on a UB-04 claim form.

Institutional claims may be submitted electronically via the ANSI 837I transaction. Information on electronic Claim Submission is available in the Claims and Eligibility section of our website.

Mailing Address for Paper Claims

Blue Cross and Blue Shield of Illinois PO
Box 660603
Dallas, TX 75266-0603

Section 12: MyBlue Plus POS Plan

Plan Overview
The MyBlue Plus Point of Service Plan offers claims processing and health care management through Blue Cross and Blue Shield of Illinois, primary care provider election at the individual provider level with referrals required to access in-network benefits (except for PCP and Behavioral Health services) for professional providers, and an out-of- network benefit to provide additional access to care. The MyBlue Plus POS Plan requires the Member's PCP to manage all aspects of the patient's care, including referrals to other health care providers.

Additional requirements applicable to the MyBlue Plus POS Plan are included throughout the Commercial Provider Manual, and those provisions are intended to supplement the information and requirements that are contained herein.

Referral Notification Overview
The referral notification process is a mechanism by which PCPs can refer their patients for care and services by specialty care providers.

Who Requests Referrals?
Referrals should be requested by the patient's PCP.

When is a Referral Necessary?
Each MyBlue Plus POS member's assigned PCP is responsible for managing all aspects of the member's care, including referrals to other health care providers, and specialty providers. In order for the member to receive services at their in-network benefit, referrals must be made to health care providers who participate in the MyBlue Plus POS network. Authorization for out-of-network providers may be granted when a MyBlue Plus POS participating provider is not available. Referrals must be initiated by the PCP and must be approved before the service is rendered. If a PCP directs a member to an out-of-network physician, professional provider, or specialist provider, the referral must be authorized by the Utilization Management Department before the service is rendered in order for the member to receive services at their in-network benefit level.

Note: Specialty care physicians and professional providers cannot refer members to other specialty care physicians, or professional providers. The member's assigned PCP is responsible for managing the member's care, including all referrals.

Exceptions to Referral Requirements:

Referrals are not required for members to obtain services at their in-network benefit from the following in-network provider types: Outpatient facility services, Obstetrics, Gynecology, Retail Health Clinic, Immunization Clinic, Independent Labs, Prosthetics/Orthotics, Urgent Care Center, specific dialysis services provided by a Nephrologist at a dialysis center, another PCP or physician assistant with a relationship to the member's assigned PCP, or behavioral health services.

Particpating providers with MyBlue Plus POS specializing in obstetrics or gynecology may directly manage

and coordinate a woman's care for gynecological and obstetrical conditions, including obtaining referrals for gynecologically related specialty care and testing to participating health care providers with MyBlue Plus POS.

An approved referral is not verification and does not guarantee payment. Payment is subject, but not limited to, eligibility, contractual limitations, payment of premium on the date(s) of service, and our Policies and Procedures.

Benefit Decision
The decision to provide treatment is between the patient and the PCP, specialty care provider, and health care provider. BCBSIL's role is to determine what is considered covered and payable under the member's benefit plan. Note: Referral confirmation is not verification and does not guarantee payment. Payment is subject, but not limited to eligibility, contractual limitations, payment of premium on the date(s) of service, and Policies and Procedures.

Referral Notification Procedures

Availity Authorizations & Referrals

Availity's Authorizations & Referrals tool allows the electronic submission of inpatient admissions, select outpatient services and referral requests handled by BCBSIL. Additionally, providers can also check status on previously submitted requests and/or update applicable existing requests.

How to access and use Availity Authorizations & Referrals tool:
1. Log in to Availity
2. Select Patient Registration menu option, choose Authorizations & Referrals, then Referrals*
3. Select Payer BCBSIL, then choose your organization
4. Select a Request Type and start request
5. Review and submit your request

*Choose Authorizations instead of Referrals if you are submitting an authorization request.

If you are not yet registered with Availity, sign up at Availity at no charge. If you need registration assistance, contact Availity Client Services at 1-800-282-4548.

Phone
PCPs may contact Utilization Management at 800-572-3089 from 8 a.m. to 5 p.m. (CT), Monday through Friday.

Fax
PCPs may submit a paper referral request via fax to 866-589-8253.

Information Necessary for Referral Notification

Please have the following information readily available when initiating a referral notification:
- Patient's full name
- Member ID number
- Policy or group number

- Anticipated date(s) of service
- Diagnosis (ICD-10 code)
- Procedure(s) anticipated (CPT code)
- Referring physician or professional provider name
- Specialty care physician or professional provider name, NPI and phone number

Request for Out-of-Network Referrals When No In-Network Provider is Available

Utilization Management must review all requests for Out-of-Plan or Out-of-Network referrals before a member receives care, and the referral must be approved by BCBSIL in order for the member to receive services at their in-network benefit level. The PCP must contact the Utilization Management Department at 800-572-3089 to request an Out-of-Plan or Out-of-Network referral.

Out-of-State Care

Coverage for non-urgent and non-emergent out-of-state care will only be available if adequate care is not available in the member's service area. If needed care is not available in the member's service area, coverage may be available if a waiver is requested from and granted by BCBSIL before services are rendered.

Out-of-state care beyond the contiguous counties of Wisconsin, Iowa, Missouri, Kentucky, and Indiana ("Out-Of-Area Care") is not covered under either the member's in-network or out-of-network benefit. Out-of-Area Care- will only be covered if a waiver is requested from and granted by BCBSIL before services are rendered. A waiver will be denied if adequate care is available in Illinois or in the contiguous counties within applicable within applicable network adequacy standards. In the event a waiver is denied, Members will be redirected to available in-network providers in Illinois or the contiguous counties.

Services provided by in-network (BlueCard® contracted) providers within the bordering counties listed above do not require a waiver. Services provided by in-network providers that are outside the state of Illinois, or its contiguous counties will not be covered at either the members in-network or out-of-network benefit without an approved waiver.

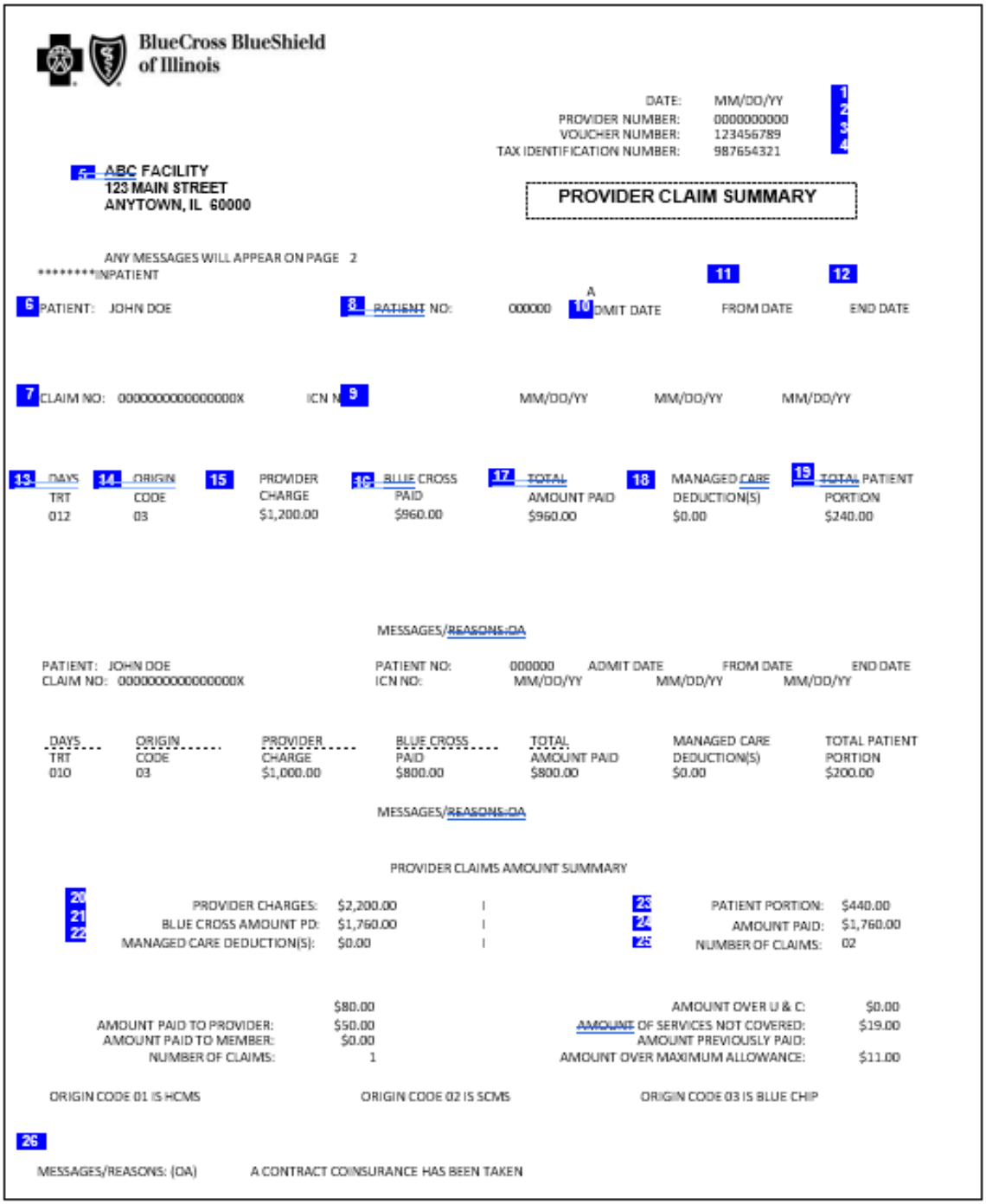
The member is responsible for securing the waiver, but the member's PCP may request it on their behalf. A waiver is not required for urgent or emergent care

Requesting a Waiver
Out-of-network providers outside the state of Illinois or its contiguous counties should call Customer Service at BCBSIL at 800-538-8833 to request a waiver. In-network providers outside the state of Illinois or its contiguous counties should request a waiver using the referral form on the Payer Space for BCBSIL at Availity.

Prior Authorization
The MyBlue Plus POS Plan requires prior authorization for some services, in addition to a PCP referral. For additional information on the prior authorization requirements refer to the Health Care Medical Management section of this manual.

Appendix

PPO Facility Provider Claim Summary Example/Field Explanations



BlueCross BlueShield of Illinois

DATE: MM/DD/YY (1)
PROVIDER NUMBER: 0000000000 (2)
VOUCHER NUMBER: 123456789 (3)
TAX IDENTIFICATION NUMBER: 987654321 (4)

5 ABC FACILITY
123 MAIN STREET
ANYTOWN, IL 60000

PROVIDER CLAIM SUMMARY

ANY MESSAGES WILL APPEAR ON PAGE 2
********INPATIENT

6 PATIENT:	8 PATIENT NO:	10 ADMIT DATE	11 FROM DATE	12 END DATE
JOHN DOE	000000	A MM/DD/YY	MM/DD/YY	MM/DD/YY

7 CLAIM NO:	ICN N 9
0000000000000000X	

13 DAYS TRT	14 ORIGIN CODE	15 PROVIDER CHARGE	16 BLUE CROSS PAID	17 TOTAL AMOUNT PAID	18 MANAGED CARE DEDUCTION(S)	19 TOTAL PATIENT PORTION
012	03	$1,200.00	$960.00	$960.00	$0.00	$240.00

MESSAGES/REASONS:OA

PATIENT: JOHN DOE
CLAIM NO: 0000000000000000X
PATIENT NO: 000000 ADMIT DATE MM/DD/YY
ICN NO: FROM DATE MM/DD/YY END DATE MM/DD/YY

DAYS TRT	ORIGIN CODE	PROVIDER CHARGE	BLUE CROSS PAID	TOTAL AMOUNT PAID	MANAGED CARE DEDUCTION(S)	TOTAL PATIENT PORTION
010	03	$1,000.00	$800.00	$800.00	$0.00	$200.00

MESSAGES/REASONS:OA

PROVIDER CLAIMS AMOUNT SUMMARY

20 PROVIDER CHARGES:	$2,200.00	23 PATIENT PORTION:	$440.00		
21 BLUE CROSS AMOUNT PD:	$1,760.00	24 AMOUNT PAID:	$1,760.00		
22 MANAGED CARE DEDUCTION(S):	$0.00	25 NUMBER OF CLAIMS:	02		
	$80.00			AMOUNT OVER U & C:	$0.00
AMOUNT PAID TO PROVIDER:	$50.00			AMOUNT OF SERVICES NOT COVERED:	$19.00
AMOUNT PAID TO MEMBER:	$0.00			AMOUNT PREVIOUSLY PAID:	
NUMBER OF CLAIMS:	1			AMOUNT OVER MAXIMUM ALLOWANCE:	$11.00

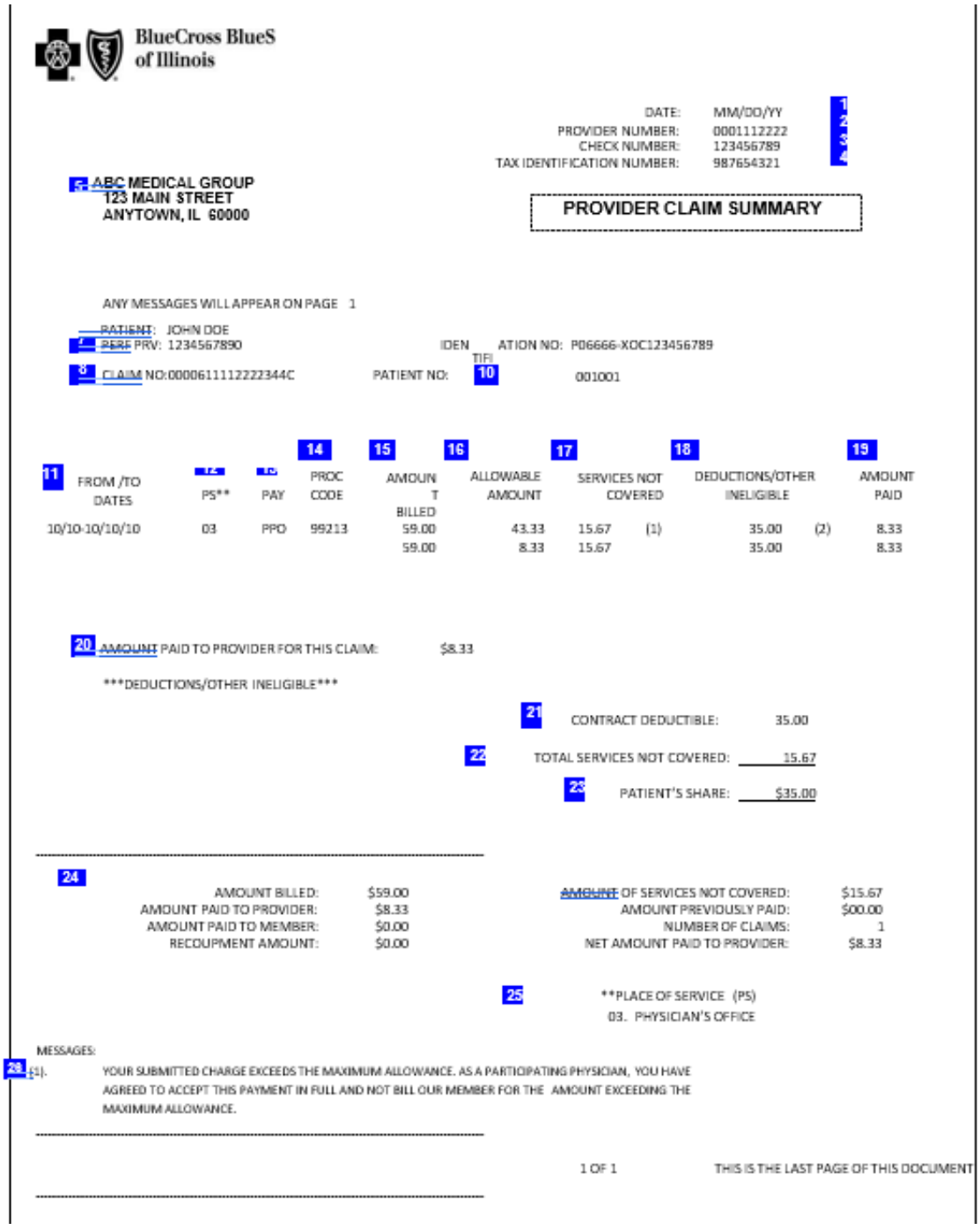
ORIGIN CODE 01 IS HCMS ORIGIN CODE 02 IS SCMS ORIGIN CODE 03 IS BLUE CHIP

26
MESSAGES/REASONS: (OA) A CONTRACT COINSURANCE HAS BEEN TAKEN

PPO Facility Provider Claim Summary Sample/Field Explanations (Continued)

1	**Date**	Date the summary was finalized
2	**Provider Number**	The facility's National Provider Identifier number
3	**Voucher Number**	The number assigned to the check for this voucher
4	**Tax Identification Number**	The number which identifies your taxable income
5	**Provider Name & Address**	The provider's name and address that rendered the services
6	**Patient**	The name of the individual who received the service
7	**Claim Number**	The Blue Cross number assigned to the claim
8	**Patient Number**	The patient's account number assigned by the provider
9	**ICN Number**	The number that identifies the group and member insured by BCBSIL
10	**Admit Date**	The date the patient was admitted to the provider for care (the Start of Care date could be different than the From/End dates).
11 12	**From Date/End Date**	Indicates the beginning and ending dates of services rendered
13	**Days Trt**	The total number of service days or treatments
14	**Origin Code**	BCBS identifying system codes
15	**Provider Charge**	The amount billed for each service
16	**Blue Cross Paid**	The amount paid for each service
17	**Total Amount Paid**	The amount paid to the provider
18	**Managed Care Deduction(s)**	The amount of any applicable cost containment or PPO reductions
19	**Total Patient Portion**	The total amount that is the patient's responsibility
20	**Provider Changes**	Total provider charges for this voucher
21	**Blue Cross Amount Paid**	Total Blue Cross payment for this voucher
22	**Managed Care Deduction(s)**	Total cost containment or PPO reductions for this voucher
23	**Patient Portion**	Total amount for which the patient is responsible
24	**Amount Paid**	Total amount paid for claims on this voucher
25	**Number of Claims**	Number of claims for this voucher
26	**Messages/Reasons**	This area includes the narrative for any codes relating to a denial of services or reduction in the amount paid

PPO Professional Provider Claim Summary Example/Field Explanations



BlueCross BlueS of Illinois

DATE: MM/DD/YY
PROVIDER NUMBER: 0001112222
CHECK NUMBER: 123456789
TAX IDENTIFICATION NUMBER: 987654321

5 ABC MEDICAL GROUP
123 MAIN STREET
ANYTOWN, IL 60000

PROVIDER CLAIM SUMMARY

ANY MESSAGES WILL APPEAR ON PAGE 1

PATIENT: JOHN DOE
PRV: 1234567890 IDEN TIFI ATION NO: P06666-XOC123456789
CLAIM NO:000061111222344C PATIENT NO: 10 001001

11 FROM /TO DATES	PS**	PAY	14 PROC CODE	15 AMOUNT BILLED	16 ALLOWABLE AMOUNT	17 SERVICES NOT COVERED		18 DEDUCTIONS/OTHER INELIGIBLE		19 AMOUNT PAID
10/10-10/10/10	03	PPO	99213	59.00	43.33	15.67	(1)	35.00	(2)	8.33
				59.00	8.33	15.67		35.00		8.33

20 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $8.33

DEDUCTIONS/OTHER INELIGIBLE

21 CONTRACT DEDUCTIBLE: 35.00

22 TOTAL SERVICES NOT COVERED: 15.67

23 PATIENT'S SHARE: $35.00

24

AMOUNT BILLED:	$59.00	AMOUNT OF SERVICES NOT COVERED:	$15.67
AMOUNT PAID TO PROVIDER:	$8.33	AMOUNT PREVIOUSLY PAID:	$00.00
AMOUNT PAID TO MEMBER:	$0.00	NUMBER OF CLAIMS:	1
RECOUPMENT AMOUNT:	$0.00	NET AMOUNT PAID TO PROVIDER:	$8.33

25 **PLACE OF SERVICE (PS)
03. PHYSICIAN'S OFFICE

MESSAGES:
26 (1). YOUR SUBMITTED CHARGE EXCEEDS THE MAXIMUM ALLOWANCE. AS A PARTICIPATING PHYSICIAN, YOU HAVE AGREED TO ACCEPT THIS PAYMENT IN FULL AND NOT BILL OUR MEMBER FOR THE AMOUNT EXCEEDING THE MAXIMUM ALLOWANCE.

1 OF 1 THIS IS THE LAST PAGE OF THIS DOCUMENT

PPO Professional Provider Claim Summary Example/Field Explanations (Continued)

1	**Date**	Date the summary was finalized
2	**Provider Number**	The physician's National Provider Identifier number
3	**Check or Voucher Number**	The number assigned to the check for this summary
4	**Tax Identification Number**	The number which identifies your taxable income
5	**Provider or Group Name & Address**	The provider/group address who rendered the services
6	**Patient**	The name of the individual who received the service
7	**Performing Provider**	The rendering provider's NPI
8	**Claim Number**	The Blue Shield number assigned to the claim
9	**Identification Number**	The number which identifies the group and Member insured by BCBSIL
10	**Patient Number**	The patient's account number assigned by the provider
11	**From/To Dates**	Indicates the beginning and ending dates of services rendered
12	**PS**	Place of service
13	**PAY**	Reimbursement payment rate that was applied in relationship to the member's policy type
14	**Procedure Code**	The code that identifies the procedure performed
15	**Amount Billed**	The amount billed for each procedure/service
16	**Allowable Amount**	The highest amount BCBSIL will pay for a specific type of medical procedure.
17	**Services not Covered**	Non-covered services according to the member's contract
18	**Deductions/Other Ineligible**	Program deductions, copayments and coinsurance amounts
19	**Amount Paid**	The amount Blue Shield paid to provider for this claim
20	**Amount paid to provider for this claim**	The amount Blue Shield paid to provider for this claim
21	**Contract Deductible**	The deductible amount applied to this claim (patient's responsibility)
22	**Total Services not Covered**	Non-covered services according to the member's contract
23	**Patient's Share**	Amount patient pays. Providers may bill this amount to the patient
24	**Claim Summary Section Totals**	This section indicates how this claim was adjudicated
25	**Place of Service**	The description for the place of service code used in field 14
26	**Messages**	The description for messages relating to: • Non-covered services • Program deductions • PPO reductions

Sample PPO Experience Report/Field Explanations

HEALTH CARE SERVICE CORPORATION
PPO EXPERIENCE REPORT
PPO DISCOUNT STATUS: Y
PROVNAME: ABC FACILITY
BLUE CROSS NO. 00000000000
REPYEAR: MM/DD/YYYY
SETTING: INPATIENT CLAIM TYPE: INPATIENT

FOR THE MONTH ENDED YYYY/MM/DD
With Bonus Settlement for the Month Ended YYYY/MM/DD

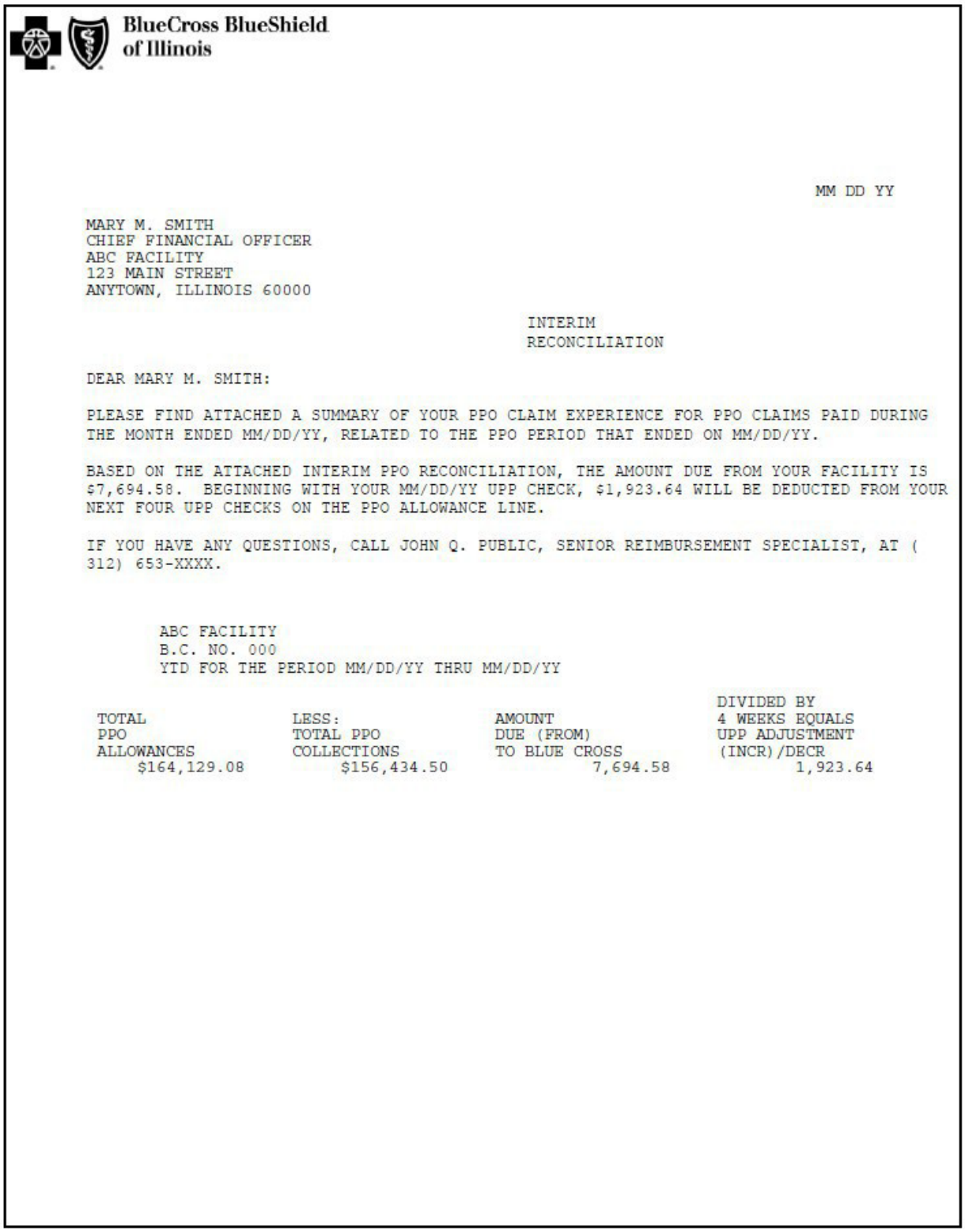
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
LAST NAME	F I	PROVIDER PATIENT NUMBER	SUB No.	GROUP NO.	ADMIT DATE	DISCH DATE	CA-SES	TOTAL DAYS	MED SURG DAYS	ICU DAYS	PSY DAYS	SUB ABUSE DAYS	TYPE	PRIMARY ICD-9 PROCCD	DRG IP CPT OP	SERV UNITS	COVERED CHARGES	TOTAL OTHER PMTS APPLIED	NET COV CHARGES	PPO PAYMENT	PPO ALLOWANCE
ADAMS	J	000000000	000000001111111111	123456	mm/dd/yy	mm/dd/yy	1	1	1	0	0	0	MLT DIEM	9604	449	0	14,817.37	2,798.00	11,238.97	.00	11,238.97
ADAMS	J	000000000	000000001111111111	123456	mm/dd/yy	mm/dd/yy	-1	-1	-1	0	0	0	MLT DIEM	9604	449	0	-14,817.37	-2,798.00	-11,238.97	.00	-11,238.97
BLACK	P	000000000	000000003333333333	XOP123	mm/dd/yy	M m/dd/yy	0	0	0	0	0	0	OB	741	371	0	2,581.20	.00	2,581.20	.00	2581.20
BURNS	S	000000000	000000008888888888	123456	mm/dd/yy	mm/dd/yy	1	5	5	0	0	0	LESSEROF	7935	210	0	10,307.24	313.19	9,994.05	9,994.05	.00
COLLINS	R	000000000	000000004444444444	123456	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB	640	391	0	2,974.00	.00	2,974.00	1,827.00	1,147.00
DAVIS	K	000000000	000000005555555555	123456	mm/dd/yy	mm/dd/yy	1	8	5	3	0	0	MLT DIEM	5779	303	0	92,082.22	25,126.00	305.69	.00	305.69
DOE	J	000000000	000000006666666666	P12345	mm/dd/yy	mm/dd/yy	1	2	0	2	0	0	MLT DIEM	3761	111	0	9,364.20	904.52	8,459.68	2,807.48	5,652.20
TOTAL CLAIM							3	15	10	5	0	0					117308.86	26344.42	24314.62	14628.53	9686.09
TOTAL INCURRED THRU 2005/12/31							3	15	10	5	0	0					117308.86	26344.42	24314.62	14628.53	9686.09
ADKINS	J	000000000	000000009999999999	123456	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB		391	0	1,889.00	84.80	1,804.20	1,193.20	611.00
ADAMS	M	000000000	000000001111111111	P12345	mm/dd/yy	mm/dd/yy	1	8	8	0	0	0	MLT DIEM		099	0	36,605.00	.06	36,604.94	23,359.94	13,245.00
BROWN	P	000000000	000000002222222222	XOP123	mm/dd/yy	mm/dd/yy	1	7	7	0	0	0	MLT DIEM	3950	554	0	79,217.80	100.00	79,117.80	20,515.00	58,602.80
COLLINS	R	000000000	000000003333333333	123456	mm/dd/yy	mm/dd/yy	1	3	0	3	0	0	LESSEROF		390	0	11,461.00	.00	11,461.00	11,461.00	.00
DAVIS	K	000000000	000000004444444444	123456	mm/dd/yy	mm/dd/yy	1	1	1	0	0	0	MLT DIEM		143	0	19,817.00	53.20	19,763.80	2,891.80	16,872.00
EVANS	S	000000000	000000005555555555	P12345	mm/dd/yy	mm/dd/yy	-1	-2	0	-2	0	0	MLT DIEM	9671	475	0	-41,309.00	-1,554.71	-39,454.29	-5,955.29	-33,499.00
OTOOLE	M	000000000	000000006666666666	XOP123	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB		391	0	2,096.00	94.51	2,001.49	1,183.49	818.00

Page 1

Sample PPO Experience Report/Field Explanations (Continued) – The Experience Report lists the following details on a claim-by-claim basis:

No.	Name	Explanation
1	**Last Name**	Last name of member.
2	**FI**	Member's first initial.
3	**Provider Patient Number**	Identification number assigned by provider.
4	**Sub No.**	Blue Cross member ID
5	**Group No.**	Member's BCBS group number.
6	**Admit Date**	Date of admission.
7	**Disch Date**	Date of discharge.
8	**Cases**	Each claim is listed as 1 case.
9	**Total Days**	The number of days paid on this claim.
10	**Med Surg Days**	Number of days not classified as ICU, Psych, Sub Ab, or Rehab.
11	**ICU Days**	Number of days paid for intensive level of care. Revenue Codes 174, 200-219.
12	**Psy Days**	Number of days paid for psych services.
13	**Sub Abuse Days**	Number of days paid for services related to substance abuse.
14	**Type**	A brief general description of the contract terms under which the service was discounted.
15	**Primary ICD-9 Proccd**	Industry defined claim level code that identifies the primary medical services performed.
16	**DRG IP** **CPT OP**	DRG value for inpatient claims, HCPCS code for outpatient medical claims.
17	**Serv Units**	If CPT fee schedule applies and claim is outpatient, then units of service provided.
18	**Covered Charges**	Amount billed by provider.
19	**Total Other Pmts Applied**	Any other charge for which the member is liable, i.e., deductible and coinsurance, coordination of benefits, non-covered charges
20	**Net Cov Charges**	Net payment calculated before discount; covered charges less member share and other payments applied.
21	**PPO Payment**	The contracted payment which varies for different provider types; each facility must refer to the terms of their specific contract.
22	**PPO Allowance**	The difference between the contracted payment and the total covered Blue Cross charges is the contractual allowance due to Blue Cross.

Experience Report Sample Cover Letter



BlueCross BlueShield of Illinois

MM DD YY

MARY M. SMITH
CHIEF FINANCIAL OFFICER
ABC FACILITY
123 MAIN STREET
ANYTOWN, ILLINOIS 60000

INTERIM
RECONCILIATION

DEAR MARY M. SMITH:

PLEASE FIND ATTACHED A SUMMARY OF YOUR PPO CLAIM EXPERIENCE FOR PPO CLAIMS PAID DURING THE MONTH ENDED MM/DD/YY, RELATED TO THE PPO PERIOD THAT ENDED ON MM/DD/YY.

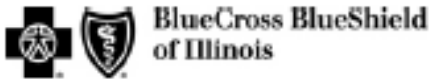
BASED ON THE ATTACHED INTERIM PPO RECONCILIATION, THE AMOUNT DUE FROM YOUR FACILITY IS $7,694.58. BEGINNING WITH YOUR MM/DD/YY UPP CHECK, $1,923.64 WILL BE DEDUCTED FROM YOUR NEXT FOUR UPP CHECKS ON THE PPO ALLOWANCE LINE.

IF YOU HAVE ANY QUESTIONS, CALL JOHN Q. PUBLIC, SENIOR REIMBURSEMENT SPECIALIST, AT (312) 653-XXXX.

ABC FACILITY
B.C. NO. 000
YTD FOR THE PERIOD MM/DD/YY THRU MM/DD/YY

TOTAL PPO ALLOWANCES	LESS: TOTAL PPO COLLECTIONS	AMOUNT DUE (FROM) TO BLUE CROSS	DIVIDED BY 4 WEEKS EQUALS UPP ADJUSTMENT (INCR)/DECR
$164,129.08	$156,434.50	7,694.58	1,923.64

Uniform Payment Program Monthly Statement Sample/Field Explanations



PAGE 1
1 CNT# 2

MM-DD-YY

ABC HOSPITAL
2 123 Main ST
Anytown IL 12345
ATTENTION: CONTROLLER

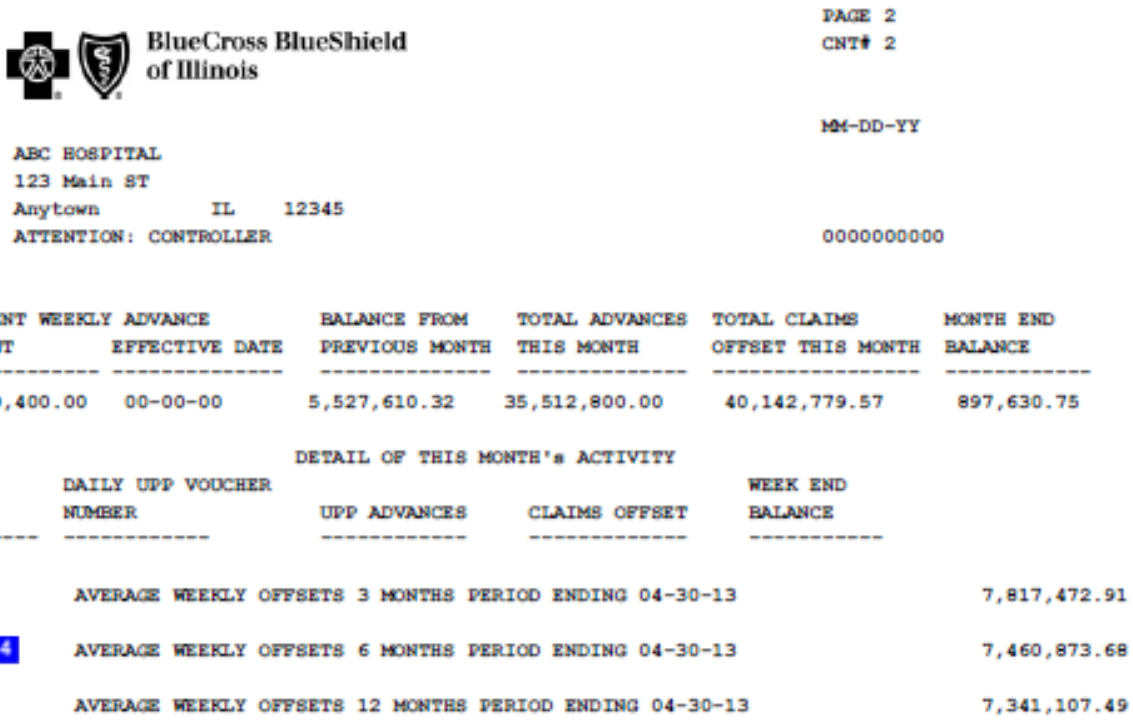
0000000000

3 CURRENT WEEKLY ADVANCE AMOUNT	EFFECTIVE DATE	4 BALANCE FROM PREVIOUS MONTH	5 TOTAL ADVANCES THIS MONTH	6 TOTAL CLAIMS OFFSET THIS MONTH	7 MONTH END BALANCE
9,620,400.00	00-00-00	5,527,610.32	35,512,800.00	40,142,779.57	897,630.75

DETAIL OF THIS MONTH's ACTIVITY

8 DATE	9 DAILY UPP VOUCHER NUMBER	10 UPP ADVANCES	11 CLAIMS OFFSET	12 WEEK END BALANCE
NATIONAL PROVIDER IDENTIFIER(S):			1295882561	1447423900
04 05 13	03071095		1,411,064.31	
04 04 13	03072094		1,680,047.37	
04 03 13	03069093		1,706,545.39	
04 02 13	03070092		3,059,442.47	
04 01 13	03075091		2,065,870.32	
04 05 13	70122245	7,794,400.00		3,399,040.46
01 31 13	06117606		450.00	
02 28 13	06119266		1,231.00	
04 01 13	03075091		-62,353.92	
04 12 13	03069102		1,469,827.16	
04 11 13	03071101		1,366,246.14	
04 10 13	03071100		1,585,037.56	
04 09 13	03070099		2,550,869.61	
04 08 13	03071098		2,236,429.22	
04 12 13	70122479	9,049,000.00		3,300,303.69
04 19 13	03071109		1,885,708.22	
04 18 13	03075108		2,159,448.02	
04 17 13	03073107		1,996,726.47	
04 16 13	03074106		1,725,890.68	
04 15 13	03073105		1,685,343.67	
04 19 13	70122705	9,049,000.00		2,896,186.63
02 28 13	06119266		7,388.75	
03 28 13	06120917		446.98	
04 26 13	03074116		1,437,448.28	
04 25 13	03070115		1,913,232.08	
04 24 13	03073114		1,505,720.11	
04 23 13	03076113		1,411,333.20	
04 22 13	03078112		2,354,341.10	
04 26 13	70122934	9,620,400.00		3,886,676.13
04 30 13	03074120		2,082,212.52	
04 29 13	03071119		1,697,520.86	
04 30 13	06123144		-610,577.90	
04 29 13	06122850		-180,110.10	
13 Totals		35,512,800.00	40,142,779.57	

Uniform Payment Program Monthly Statement Sample/Field Explanations (Continued)



BlueCross BlueShield of Illinois

PAGE 2
CNT# 2

MM-DD-YY

ABC HOSPITAL
123 Main ST
Anytown IL 12345
ATTENTION: CONTROLLER

0000000000

CURRENT WEEKLY ADVANCE AMOUNT	EFFECTIVE DATE	BALANCE FROM PREVIOUS MONTH	TOTAL ADVANCES THIS MONTH	TOTAL CLAIMS OFFSET THIS MONTH	MONTH END BALANCE
9,620,400.00	00-00-00	5,527,610.32	35,512,800.00	40,142,779.57	897,630.75

DETAIL OF THIS MONTH's ACTIVITY

DATE	DAILY UPP VOUCHER NUMBER	UPP ADVANCES	CLAIMS OFFSET	WEEK END BALANCE

AVERAGE WEEKLY OFFSETS 3 MONTHS PERIOD ENDING 04-30-13 7,817,472.91

14 AVERAGE WEEKLY OFFSETS 6 MONTHS PERIOD ENDING 04-30-13 7,460,873.68

AVERAGE WEEKLY OFFSETS 12 MONTHS PERIOD ENDING 04-30-13 7,341,107.49

Uniform Payment Program Monthly Statement Sample/Field Explanations (Continued)

No.	Field Name	Description
1	**Control Number (CNT #)**	The number assigned for this statement.
2	**Facility or Vendor Name & Address**	The facility or vendor who rendered the service(s).
3	**Current Weekly Advance**	Weekly Gross Claims Funding payment. Net of contractual allowance or adjustments.
	Amount	The amount of the Weekly Gross Claims Funding for the week.
	Effective Date	The date (Friday) for the check advance.
4	**Balance From Previous Month**	The difference between the UPP advance column (Gross Weekly Claims Funding) and offsets (remittances) as of end of previous month.
5	**Total Advances This Month**	The total amount of Gross Weekly Claims Funding for the month.
6	**Total Claim Offset This Month**	The sum of remittances and refunds to Blue Cross for the month.
7	**Month End Balance**	The Month End Balance is the Beginning Balance plus Advances (Gross Weekly Claims Funding) minus Offsets.
8	**Date**	The date the daily voucher was issued.
9	**Daily UPP Voucher Number**	The daily non-payment voucher number and or BC 370 number.
10	**UPP Advances**	Gross Weekly Claims Funding checks.
11	**Claims Offset**	Remittance Advice or BC 370.
12	**Week End Balance**	UPP advance column (Gross Weekly Claims Funding) plus or minus claim offsets.
13	**Totals**	Total UPP advance column (total Gross Weekly Claims Funding) plus or minus claim offsets.
14	**Average Weekly Offsets**	Average weekly offsets (remittance and BC-370 amounts) used to calculate future UPP payments.

Provider Claim Summary Sample

BlueCross BlueShield of Illinois

PROVIDER CLAIM SUMMARY

DATE: MM/DD/YY
PROVIDER NUMBER: 0000009999
VOUCHER NUMBER: 03099999
TAX IDENTIFICATION NUMBER: 999999999

UPP PROVIDER
STREET ADDRESS
CITY STATE 99999 - 9999

MESSAGES WILL BE EXPLAINED ON PAGE 1

**********OUT-PATIENT

PATIENT: JANE DOE	PATIENT NO: AAA99999	ADMIT DATE	FROM DATE	END DATE
CLAIM NO: 000012345678912OC		MM/DD/YY	MM/DD/YY	MM/DD/YY
GROUP-SUB NO: H99999 XOH888888888			ICN NO:	

DAYS TRT	ORIGIN CODE	PROVIDER CHARGE	BLUE CROSS PAID	TOTAL AMOUNT PAID	MANAGED CARE DEDUCTION(S)	TOTAL PATIENT PORTION	PROVIDER LIABILITY
007	03	$948.29	$948.29	$948.29	$ 0.00	$ 0.00	$ 0.00

RECOUPMENTS TAKEN

PAT NAME	PAT ACCT NO GROUP-SUBS NUMBER	CLAIM NUMBER	FROM/TO DATES	AMOUNT REASONS
SMITH A	01L1111111 - P88888 - 888888888	987654321980X	MM/DD – MM/DD/YY	$49.00 COORDINATION OF BENEFITS

PROVIDER CLAIMS AMOUNT SUMMARY

PROVIDER CHARGES:	$948.29	I	PATIENT PORTION:	$ 0.00
BLUE CROSS AMOUNT PD:	$948.29	I	AMOUNT PAID:	$948.29
MANAGED CARE DEDUCTION(S):	$ 0.00	I	NUMBER OF CLAIMS:	1
PROVIDER LIABILITY:	$ 0.00	I	RECOUPMENT AMOUNT:	$49.00
			NET AMOUNT PAID TO PROVIDER:	$899.29

ORIGIN CODE 01 IS HCMS ORIGIN CODE 02 IS SCMS ORIGIN CODE 03 IS BLUE CHIP

MESSAGES/REASONS:

NO MESSAGES FOR THIS DOCUMENT

H99999888888888000000030999999

Glossary of Terms

Appeal: A request by or on behalf of a member (with authorization) for a new review of an organization determination, as a result of an adverse benefit determination.

Care Coordinator: provides Care Management and, working with a member and care team, establishes a Care Plan for the member.

Care Management: is a program designed to assist Members in gaining access to services, including medical, social, educational, and other services, regardless of the funding source for the services. Care Management is a collaborative process that is designed to assist Members and their providers to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet the Member's needs across the continuum of care.

Carelon: BCBSIL has contracted with Carelon to manage benefit preauthorization requests for certain specialized clinical services for (Commercial) Members of BCBSIL. Carelon is an independent company that has contracted with BCBSIL to provide utilization management services for members with coverage through BCBSIL.

Care Plan: A care plan is a Member-centered, goal-oriented, culturally relevant, and logical written plan of care with a service plan component, if necessary, that is designed to assist the Member to obtain access, to the extent applicable, medical, medically related, social, behavioral, and necessary covered services, including long- term services and supports, in a supportive, effective, efficient, timely manner that emphasizes prevention and continuity of care.

Centers for Medicare & Medicaid Services: CMS is the federal agency responsible for administering Medicare.

Consumer Assessment of Healthcare Providers and Systems: Beneficiary survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of beneficiary experiences with health care.

Contracted Facility: Any independently contracted health facility, hospital, laboratory, or other institution licensed and/or certified by the State of Illinois and Medicaid to deliver or furnish health care services and which has a written agreement to provide services directly or indirectly to Members pursuant to the terms of the Agreement for facility services.

Contracted Provider: Any independently contracted physician or practitioner, to include, but not limited to, a physician, physical therapist, psychologist, and any other Provider of medical services, licensed and/or certified by the State of Illinois and Medicaid to deliver or furnish health care services and who has a written agreement to provide services directly or indirectly to Members pursuant to terms of their agreement with BCBSIL.

Covered Services: Those benefits, services or supplies that are covered and approved for a member set forth in the respective plan document.

Cultural Competence: Generally considered to be the understanding of those values, beliefs and needs that are associated with age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds of Members receiving health care services. Cultural competence also includes a set of competencies, which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Delegated Activities: Delegation occurs when an organization gives another entity the authority to carry out a function that it would otherwise perform. Delegation or Subcontracting is the process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities on behalf of the health plan, while the health plan retains final authority to provide oversight to the delegate.

Emergency Services: Covered inpatient or outpatient services that are furnished by a Provider qualified and appropriately licensed to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition.

Enrollment: The processes by which an individual who is eligible for a plan is registered in the plan, including transfers from one participating BCBSIL plan to another.

Facility: Hospital and ancillary providers, which include, but are not limited to: Durable Medical Equipment suppliers and Skilled Nursing Facilities.

HEDIS® (Healthcare Effectiveness Data and Information Set): A tool developed and maintained by the National Committee for Quality Assurance and its successor organization that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality. Ensures that Members will receive optimal preventive and quality care. Annually, the Quality Improvement Department collects, analyzes, and evaluates performance measures. The results are used to evaluate our adherence to practice guidelines and improve Member outcomes. The results are reported to Healthcare and Family Services in June

Hospice: An organization or agency, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital: A certified institution licensed in the State of Illinois, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Laws: Any and all applicable laws, rules, regulations, statutes, orders, and standards of the United States of America, the states or any department or agency thereof with jurisdiction over any or all of the Parties, as such laws, rules, regulations, statutes, orders, and standards are adopted, amended, or issued from time to time.

Medicaid: The program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

Medically Necessary Service: A service, supply or medicine that is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, for the prevention of future disease, to assist in the Member's ability to attain, maintain, or regain functional capacity or to achieve age- appropriate growth, or otherwise medically necessary and meets the standards of good medical practice in the medical community, as determined by the Contracted Provider in accordance with our guidelines, policies or procedures.

Medicare: Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities and people with End State Renal Disease or Amyotrophic Lateral Sclerosis.

Medicare Advantage Plan: A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit plan in the same service area.

Medicare Part D: the prescription drug coverage program offered by Medicare Member/Enrollee: The beneficiary, entitled to receive covered services, who has voluntarily elected to enroll in a plan. Member shall include the guardian where the Member is an adult for whom a guardian has been named; provided, however, that the plan is not obligated to cover services for a guardian who is not otherwise eligible as a Member.

Member Handbook: A document that describes the health care benefits covered by the plan. It provides the member with some form of documentation of what that insurance covers and how it works.

Non-Contracted Provider or Facility: Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the State of Illinois or Medicaid to deliver or furnish health care services and also being neither employed, owned, operated by, nor under contract with BCBSIL to deliver covered services to Members.

Participating IPA: Any duly organized Independent Practice Association, Independent Physician Association, organized Medical Group, Physician Hospital Organization or other legal entity organized to arrange for the provision of professional medical service which has in force a contract or agreement with BCBSIL to provide professional and ancillary services to members enrolled in BCBSIL as outlined in our Provider Manual and according to the member's plan of benefits outlined in his or her member handbook, coverage agreement, plan document, and/or benefit booklet.

Primary Care Physician: Any physician, who, within his or her scope of practice; is responsible for providing all preventive and primary care services to his or her assigned members.

Provider: Any contracted physician or practitioner, to include, but not limited to, a physician, physical therapist, psychologist, hospital facility, health care facility, laboratory, and any other provider of medical services, licensed in accordance with all applicable Laws.

Quality Improvement Organizations: comprising practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, ECFS/SNFs, HHAs, Medicare health plans and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in ECFS/SNFs, HHAs and Comprehensive Outpatient Rehabilitation Facilities.

Quality of Care Issue: A quality-of-care complaint may be filed through the grievance process and/or a Quality Improvement Organization. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration: A Member's first step in the appeal process after an adverse organization determination. BCBSIL or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative: An individual appointed by a member or other party, or authorized under state or other applicable law, to act on behalf of the Member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of the member or party in obtaining an organization determination, filing a grievance or in dealing with any of the levels of the appeal process, subject to the applicable rules described at 42 CFR Part 405.

Service Area: A geographic area approved by HFS within which an eligible individual may enroll in a participating plan under BCBSIL.

Skilled Nursing Facility: A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services. Temporary residence for patients undergoing medically necessary rehabilitative treatment outside of a hospital. Skilled nursing care is provided 24/7 by trained registered nurses in a medical setting under a doctor's supervision.

Timely Filing: refers to the period within which healthcare providers must submit claims to BCBSIL for services rendered. The specific timely filing requirements can vary among different plans.

The above information is provided as a general resource. This list is not all-inclusive. Participating providers should refer to their provider agreement for additional information.

Disclaimers

BCBSIL reserves the right to update the Provider Manual as necessary.

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.*

The information mentioned here 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. 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. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

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. Carelon Medical Benefits Management is an independent company that has contracted with BCBSIL to provide utilization management services for members with coverage through BCBSIL.

Prime Therapeutics LLC (Prime) is an independent pharmacy benefit management company. BCBSIL contracts with Prime to provide pharmacy solutions. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Accredo is a specialty pharmacy that is contracted to provide services to members of BCBSIL. The relationship between Accredo and BCBSIL is that of independent contractors. Accredo is a trademark of Express Scripts Strategic Development, Inc.

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

BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products or services they offer.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality HEDIS is a registered trademark of the NCQA.

MCG (formerly Milliman Care Guidelines) is a trademark of MCG Health, LLC (part of the Hearst Health network), an independent third- party vendor. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as MCG.