Blue Cross Blue Shield of Rhode Island

provider update

P=Professional | **B**=Behavioral Health | **F**=Facilities

March 2017

In 2016, Blue Cross & Blue Shield of Rhode Island (BCBSRI) introduced a web-based referral management tool designed to help primary care providers (PCPs) better manage the care of their BCBSRI patients. The launch was considered "soft" as we were not yet denying claims for lack of a referral. That changed on January 1, 2017, when use of the online tool became mandatory. Since then, more than 20,000 referrals have been created for our members.

This milestone and the introduction of a web-based tool are important. Why? It means the provider community is using the online tool. More importantly, however, it means PCPs are using a tool that positions them to better manage the care of their patients.

Referral-based products are not a new concept and are certainly not new to Rhode Island. Many plans, including BCBSRI, have made referrals a requirement for some products. Patients experience better outcomes when the PCP is more involved in the referral process, allowing for more coordinated care. Moving to a web-based referral platform allows PCPs to easily create a referral, and the specialist can see that referral online.

Below are some things to keep in mind regarding the use of the referral tool:

- Web-based referrals are required for all BlueCHiP Commercial, BlueCHiP for Medicare Advance, and New England Health Plan (NEHP)* products.
- Referrals can be backdated 30 days from the date the referral is entered in the referral tool.
- To ensure appropriate claims payment to the specialist, PCPs need to select the applicable practice location for the specialist being referred to.
- Referrals, once entered in the referral tool, are good for six months.
- If you are a PCP or a specialist and don't currently have access to the referral tool, visit our secure Provider site, click Referrals, and begin the registration process.

Additional information about referral tool processes and requirements can be found on page 4.

We appreciate your efforts to help us keep healthcare affordable and simple for our members and your patients. We know that more coordinated care results in better outcomes.

If you have any questions about the referral tool, please call our Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050 (out-of-state only) or contact your Provider Relations Representative.

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

*Please note, NEHP cross-border referrals to providers in other New England states will continue to follow the traditional fax-based process. However, when a Rhode Island PCP refers a NEHP member to a Rhode Island specialist, it needs to be submitted through the web-based tool.

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BCBSRI Update

P 2017 PCP Quality Incentive Program

BCBSRI's 2017 PCP Quality Incentive Program supports improvements in quality as measured by nationally recognized programs, such as the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS). Each relies on specific metrics—Health Care Effectiveness Data and Information Set for NCQA and Star Ratings for CMS—to measure health plans. Higher scores can indicate improved care outcomes for your patients and our members.

The 2017 PCP Quality Incentive Program breaks down key measures into three groups:

- Adult: BlueCHiP for Medicare
- Adult: Commercial
- Pediatric: Commercial

Adult program measures include: breast cancer screenings, adult BMI assessment, diabetes, controlling high blood pressure, and colorectal cancer screening. For the pediatric program, the measures include well-child counseling for nutrition, well-child counseling for physical activity, well-child BMI assessment, and adolescent immunization status. For 2017, we have added a new measure for the pediatric program: developmental screening in the first three years of life. Please note that the Survey of Wellbeing of Young Children has been added as a tool that meets the measurement criteria.

To assist PCPs with closing gaps in care, we encourage you to use our web-based Blue Insights Population Health Management Tool, also known as the population health registry. Introduced in late 2015, Blue Insights displays timely data for your attributed members, such as prospective preventive and chronic disease gaps in care, your high-risk Blue Cross patients, utilization information, Rx data, and other providers who have treated your patients.

If you have questions about the program or about the Blue Insights Population Health Management Tool, please email PopulationHealthRegistry@bcbsri.org or contact your provider relations representative.

Thank you for your continued partnership and collaboration with us. Now more than ever, we need to work together to find ways to improve the health of Rhode Islanders while driving toward affordable and cost-effective care.

PBF Important: Update your practice information!

When our members have up-to-date information about your practice, it helps ensure a positive experience for them and for you. Having accurate information is so important that it's a CMS requirement and a contractual obligation under your BCBSRI provider agreement. Providers must give BCBSRI a 60-day notification of any provider or practice changes.

Please take a moment to review your practice information in our Find a Doctor tool, focusing on the following areas:

- Your first and last name
- Practice name
- Practice location or locations
- NPI
- Specialty and sub-specialties
- Panel status
- BCBSRI product participation
- Practice phone number or numbers
- Wheelchair accessibility

Panel status refers to whether or not you are accepting new patients, which applies to specialists as well as PCPs.

If updates are needed, please fill out and submit the BCBSRI Practitioner Change Form. If you have any questions, please email ProviderRelations@bcbsri.org or call your provider relations representative.

Quarterly validation on provider information

We are committed to ensuring that the information included in our Find a Doctor tool is accurate and up-to-date. That's why we are now conducting quarterly validation by reaching out directly to provider offices.

In March, we began to reach out to provider offices via fax requesting validation and attestation of the practice and provider information that we currently have listed in our directory. When you receive this fax, please review and make needed updates. It's important to note if the location included is where a patient can make an appointment to see the provider (this is a CMS requirement) and whether the provider is accepting new patients (also a CMS requirement).

Once you've reviewed, please make appropriate changes, check the "attestation" box and fax back to us as soon as possible. Even if the information is accurate, you are expected to check the attestation box and return the form. If you have questions about our verification efforts, please send an email to ProviderRelations@bcbsri.org. Thank you for your assistance.

BCBSRI Update

PBF BCBSRI offers LGBTQ Safe Zone certification!

BCBSRI encourages healthcare providers in our participating network to collaborate with us in support of the LGBTQ (lesbian, gay, bisexual, transgender, queer) community. Our goal is to identify environments in which LGBTQ members feel welcome and safe when seeking healthcare services locally. Healthcare settings that meet specific criteria will be referred to as LGBTQ Safe Zones and receive BCBSRI identification, such as an award, window cling, and designation in the Find a Doctor tool. More information about our program and the requirements can be found by clicking here.

2016 was a great year for the program. Twelve practices were certified, including:

- Three health centers
  - Thundermist Health Center of South County
  - Thundermist Health Center of West Warwick
  - Thundermist Health Center of West Woonsocket
- Three dental clinics
  - Thundermist Health Center of South County – Dental Services
  - Thundermist Health Center of West Warwick – Dental Services
  - Thundermist Health Center of West Woonsocket – Dental Services
- Four behavioral health providers
  - Jayna Klatzker, LICSW
  - Jessica Peipock, LICSW
  - Laurie Thornton, MA, CAGS, LMHC
  - Wilder Therapy and Wellness
- One partial hospitalization program
  - Rhode Island Hospital Partial Hospitalization Program
- One specialty practice
  - R.I. Women's Health & Midwifery

If you have questions, please contact Susan Walker, provider relations manager, at (401) 459-5381 or susan.walker@bcbsri.org.

BCBSRI Update

P Web-based referral management tool is now mandatory

Last year, BCBSRI introduced a web-based referral management tool. All primary care providers (PCPs) and specialists are required to use this tool to launch a referral and check the status of referrals from PCPs to specialists. Effective January 1, 2017, primary care providers are required to submit referrals through the web-based referral management tool for BCBSRI members who are enrolled in a referral-based plan.

The products that require web-based referrals include all BlueCHiP Commercial, BlueCHiP for Medicare Advance, and New England Health Plan (NEHP) products. These products have always required a referral, but the method has changed from a paper to a web-based process. Please note, NEHP cross-border referrals to providers in other New England states will continue to follow the traditional fax-based process (i.e., a Rhode Island PCP referring a NEHP member to a Massachusetts specialist). However, when a Rhode Island PCP refers a NEHP member to a Rhode Island specialist, it needs to be submitted through the web-based tool.

Primary care providers are responsible for generating referrals to specialists for members enrolled in these products. Specialists are responsible for ensuring a referral is in place prior to rendering services. Referrals can be backdated 30 days from the date the referral is entered in the referral tool. If services are rendered without a referral being entered in the referral management tool, the claim may be denied.

How to determine if your patient has a referral-based plan

1. Review our BCBSRI Product Overview. It outlines which plans require a referral for specialist visits and which do not.

2. Log on to the secure Provider site and go to the Patient Eligibility section to verify medical benefits. Click the Medical Benefits tab and select the applicable Service Category and Service Type to see if a referral is required.

Please note that some systems of care (SOCs) have developed an alternative process to submit an online referral to BCBSRI. If you are a PCP and are affiliated with an SOC but are unsure if you need to follow an alternate process, please contact the SOC administrative staff for clarification.

If you have any questions about the referral management tool or the BCBSRI products that require web-based referrals, please call our Physician & Provider Service Center at (401) 274- 4848 or 1-800-230-9050 (out of state only).

PF Hints for HEDIS (and more)

As part of our ongoing efforts to provide the highest quality care to our members, BCBSRI reviews data from the Healthcare Effectiveness Data and Information Set (HEDIS®), CMS Stars, Consumer Assessment of Healthcare Providers and Systems, Medicare Health Outcomes Survey, and internal resources. This helps us identify opportunities to enhance clinical care for your patients, our members. "Hints for HEDIS (and more)" provides guidance and resources to help address these opportunities. If you have any questions, comments, or ideas regarding any of our quality or clinical initiatives, please contact Courtney Reger, RN, BSN, quality management analyst, at (401) 459-2763 or courtney.reger@bcbsri.org.

Screening for colorectal cancer

Routine colonoscopy remains the gold standard because of the ability to detect colon cancer and precancerous changes that might otherwise develop unnoticed. However, for members who refuse to have a colonoscopy done, there are alternatives. **Please see this clinician's reference guide to high-quality fecal occult blood testing (FOBT) programs.**

Preventive care such as a colonoscopy is covered at no cost to the member, according to the Affordable Care Act. As of June 2016, the U.S. Preventive Services Task Force (USPTF) has updated screening guidelines. It is recommended that adults aged 50-75 undergo regular screening. Methods and screening intervals vary and may depend upon patient risk profile, health status, and other factors.

The HEDIS measure for Colorectal Cancer Screening (CCS) evaluates the percentage of eligible members who have had FOBT, flexible sigmoidoscopy, colonoscopy, CT colonograpy, or DNA-FIT test during certain time frames. The measure is summarized below, along with tips for success.

Test/Exam	Measure Population	Exclusions	Tips for Success
Colorectal Cancer Screening	Adults ages 50 to 75 who have had one of these types of screenings: • FOBT during the measurement year • Flexible sigmoidoscopy in the measurement year (or the four years prior to the measurement year) • Colonoscopy during the measurement year (or the nine years prior to the measurement year) • CT colonography during the measurement year or the four years prior to the measurement year • FIT-DNA during the measurement year or the two years prior to the measurement year	• Colorectal cancer • Total colectomy	• A digital rectal exam is not counted as evidence of a colorectal screening. • Talk with patients about what to expect from the recommended screening (procedure preparation, anesthesia, etc). This may allay fears about the test and help patients schedule tests more readily. • Preventive tests covered with no copay/cost share.*

*When suspicious tissue is encountered during routine screening and removed or sampled for biopsy, a test typically considered preventive may be coded as diagnostic. In this case, the member may be subject to copays or cost-sharing based on their respective benefit plan.

BCBSRI supports the American Cancer Society and the National Colorectal Cancer Roundtable (NCCRT) in reaching an 80% screening rate for colorectal cancer by 2018. The NCCRT has a number of helpful resources on their website. Together we can unite our voices, experiences, and resources toward ensuring that less people hear the words, "you have colorectal cancer."

Pharmacy

PBF Commercial formulary update: April 1, 2017

The next scheduled update of the BCBSRI Commercial segment formulary is April 1, 2017. You can view the summary that provides details on the changes scheduled. All members impacted by a change will receive a written notification. The changes for April 1, 2017 predominately involve tier changes associated with updates in Medi-span designations, which are related to the transition of pharmacy claims processing to Prime Therapeutics, LLC. Selected brand name drugs now available with generic equivalents will be excluded. The brand names involved are listed for reference.

PF Epi-Pen and related products

An authorized generic version of Epi-Pen® (epinephrine) has been made available from Mylan, the same manufacturer of the brand product. Effective April 1, 2017, the brand version of the product will be excluded from the BCBSRI Commercial formularies. The new authorized generic version will be covered at a lower generic formulary copay. The generic product did not receive an interchangeable designation from the FDA, so prescribers should write for epinephrine auto injector (Epi-Pen generic) to allow the pharmacy to dispense the new authorized product without delay. Comparable products include Adrenaclick® and its generic, available at a higher non-preferred brand copay, and Auvi-Q®, recently re-introduced to the market but which will be excluded from the formulary.

Epi-Pen remains the Preferred Brand product on the BlueCHiP for Medicare formulary. Auvi-Q, Adrenaclick, and the generic versions of Epi-Pen and Adrenaclick remain non-formulary for BlueCHiP for Medicare members.

Epinephrine Auto Injector Coverage as of 4/1/2017					Commercial		BlueCHiP for Medicare	
	Label Name	Strength	Manufacturer	NDC	Large Group 4 & 5 Tier & Traditional Formularies	Small Group & HSRI Formularies	Individual Formulary	Group Formulary
PEDIATRIC DOSE	**Epi-Pen Jr 2-Pak**	0.15mg/0.3ML	Mylan	49502-0501-02	Non-Formulary	Non-Formulary	3 – Preferred Brand	2 – Preferred Brand
PEDIATRIC DOSE	*Epinephrine Inj Generic of Epi-Pen Jr*	0.15MG/0.3ML	Mylan	49502-0101-02	1 – Generic	2 – Non-Preferred Generic	Non-Formulary	Non-Formulary
PEDIATRIC DOSE	**Adrenaclick Inj**	0.15MG/0.15ML	Amedra	52054-0803-02	3 – Non-Preferred Brand	4 – Non-Preferred Brand	Non-Formulary	Non-Formulary
PEDIATRIC DOSE	*Epinephrine Inj Generic of Adrenaclick*	0.15MG/0.15ML	Impax	54505-0101-01 54505-0101-02	3 - Non-Preferred Brand	4 - Non-Preferred Brand	Non-Formulary	Non-Formulary
PEDIATRIC DOSE	**Auvi-Q**	0.15/0.15ML	Sanofi Kaleo	00024-5831-02 60842-0022-01	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary
ADULT DOSE	**Epi-Pen 2-Pak Inj**	0.3MG/0.3ML	Mylan	49502-0500-02	Non-Formulary	Non-Formulary	3 – Preferred Brand	2 – Preferred Brand
ADULT DOSE	*Epinephrine Inj Generic of*	0.3MG/0.3ML	Mylan	49502-0102-02	1 - Generic	2 – Non-Preferred Generic	Non-Formulary	Non-Formulary
ADULT DOSE	**Adrenaclick Inj**	0.3MG/0.3ML	Amedra	52054-0804-02	3 – Non-Preferred Brand	4 – Non-Preferred Brand	Non-Formulary	Non-Formulary
ADULT DOSE	*Epinephrine Inj Generic of Adrenaclick*	0.3MG/0.3ML	Impax	54505-0102-01 54505-0102-02	3 - Non-Preferred Brand	4 – Non-Preferred Brand	Non-Formulary	Non-Formulary
ADULT DOSE	**Auvi-Q**	0.3MG/0.3ML	Sanofi Kaleo	00024-5833-02 60842-0023-01	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary

Claims

PBF Update for all EDI Trading Partners

In late March, BCBSRI will return an Unsolicited 277CA (005010X0214) claim status response (accepted or rejected) for every claim submitted by our paperless providers. These files will be placed into the Trading Partners' Mailbox on the EDI Gateway on a daily basis as files are received.

F Claims filing update for institutional providers

As communicated in the October 2015 edition of Provider Update, BCBSRI made an update to claims filing for institutional providers. Consistent with industry standards, we require all inpatient institutional claims, as well as specific outpatient claims, to be filed with the admission date, time, and diagnosis code on paper and electronic 837I transactions. This applies to those institutional providers who file the following types of bills: 12X, 22X, 32X, 34X, 81X and 82X.

If you have any questions regarding these claim filing changes, please contact our Facility Call Center at (401) 274-3103 or 1-800-637-3718, ext. 6067 (out-of-state only).

Contracting & Credentialing

PBF Medicare Opt Out

Effective January 1, 2017, BCBSRI has enforced the Medicare Opt Out process, which has been established by the Centers for Medicare and Medicaid Services (CMS). This was first communicated in the November/December 2016 edition of Provider Update.

When a provider opts out of Medicare, CMS prohibits Medicare Advantage plans from paying or reimbursing providers or beneficiaries for services provided by the Medicare opt-out provider except when the services are emergent or urgent. Once the provider has opted out of Medicare, they must enter into a private reimbursement contract with each Medicare beneficiary to whom they render covered services for non-emergent or non-urgent care.

Medicare opt-out affidavits

In order for a provider to opt out of Medicare, the provider must file an affidavit with all Medicare Administrative Contractors (MACs) that have jurisdiction over them, advising that the provider has opted out of Medicare. The affidavit must be filed within 10 days of entering into the first private contract with a Medicare beneficiary. Please refer to the Medicare Benefit Policy Manual, Chapter 15, section 40.09 for instructions on affidavit requirements.

Opt-out guidelines

- Opt-out affidavits signed prior to June 16, 2015, will not automatically renew every two years. Therefore, these providers who sign valid opt-out affidavits will be required to file renewal affidavits annually.
- Opt-out affidavits signed on or after June 16, 2015 will automatically renew every two years. Therefore, providers who sign valid opt-out affidavits will no longer be required to file renewal affidavits.
- Opt-out periods cannot be terminated early unless the provider is opting out for the first time and the affidavit is terminated no later than 90 days after the effective date of the provider's first opt-out period.
- Providers who wish to rescind their opt-out status must notify each MAC with whom the original opt-out affidavit was submitted. This action must occur in writing at least 30 days prior to the start of the next two-year opt-out period.

Reimbursement guidelines for BCBSRI Commercial members with Medicare as primary coverage

If a provider who has opted out of Medicare renders services to a BCBSRI Commercial member who has federal Medicare as their primary insurance coverage, BCBSRI will allow 20% of the current Rhode Island Medicare Fee Schedule. In this instance, the provider should file a paper claim with BCBSRI directly and collect the remaining balance from the Medicare beneficiary in accordance with the private contract they have in place with them. Paper claims can be mailed to:

Blue Cross & Blue Shield of Rhode Island
ATTN: Basic Claims
500 Exchange Street
Providence, RI 02903

If you have any additional questions please refer to the Medicare Benefit Policy Manual, Chapter 15.

Policies

PF Policies recently reviewed for annual update

The following policies were recently reviewed for annual update. The full text is available on the Policies page of the Provider section.

- Anesthesia Services (former title: Monitored Anesthesia Care (MAC))
- Breast Ductal Lavage for Detection of Breast Cancer
- Breast Prosthesis and Mastectomy Bras Mandate
- Breast Reconstruction Mandate
- Chromoendoscopy as an Adjunct to Colonoscopy
- Cone Beam Computed Tomography
- Contraceptive Drugs and Devices Mandate
- Dermatologic Applications of Photodynamic Therapy
- Drug Testing
- Epidural Injections Without Imaging
- Endometrial Ablation
- Health and Behavior Assessment/Intervention
- Hospital-Based Clinics
- Immunizations Adult and Pediatric
- Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids
- Mammograms and Pap Smears Mandate
- Occipital Nerve Stimulation – Insertion
- Orthognathic Surgery
- Payment Adjustments for Error and Hospital-Acquired Conditions
- Postpartum Hospital Stays Mandate
- Prolonged Physician Services
- Psychological and Neuropsychological Testing
- Pulsed Radiofrequency for the Treatment of Chronic Pain
- Radiopharmaceuticals
- Routine Foot Care and Nail Debridement
- Termination of Pregnancy
- Thermography
- Transplants: Travel and Lodging Expenses
- Visual Screening for Children Aged 0-5 Years

For your review, we also post monthly drafts of medical policies being created or reassessed. As a reminder, you can provide comments on draft policies for up to 30 days. Draft policies are located on the Policies page of the Provider site. Once on that page, click the drop-down box to sort policies by draft.

PBF BlueCHiP for Medicare Products

BCBSRI must follow the Centers for Medicare and Medicaid Services (CMS) guidelines for national coverage determinations (NCD) or local coverage determinations (LCD). Therefore, policies for BlueCHiP for Medicare may differ from policies for Commercial products. In some instances, benefits for BlueCHiP for Medicare may be greater than what is allowed by CMS.

In the absence of an applicable NCD, LCD, or other CMS-published guidance, BCBSRI will apply policy determinations developed using peer-reviewed scientific evidence. BCBSRI will continually review NCD and LCD updates and implement applicable policy changes.

Due to the ongoing effort to follow CMS NCDs and LCDs, many BCBSRI policies are now applicable to Commercial products only. In these instances, please refer to the BlueCHiP for Medicare National and Local Coverage Determinations policy for further information on coverage for BlueCHiP for Medicare.

Policies

Collaborative care model

CMS has established three codes (G0502, G05023, and G0504) to describe services provided as part of the psychiatric collaborative care model. The CMS final rules on Medicare Payments for Integrated Behavioral Health Services put forth specific requirements that must be met to submit for payment using these codes. The requirements are aligned with the foundational elements of the Collaborative Care Model put forward by CMS. To ensure adherence to these requirements, primary care physicians must be able to demonstrate that they are providing services under the collaborative care model by emailing a detailed program description to BCBSRI at behavioralhealth@bcbsri.org.

After BCBSRI reviews and approves the program description, the provider will be reimbursed for collaborative care services provided to BlueCHiP for Medicare members. Collaborative care is not separately reimbursed for Commercial products. Please see BCBSRI's Collaborative Care Management Policy for additional information.

BCBSRI will review program descriptions to ensure fidelity to the collaborative care model as defined by CMS's 2017 final rule on Medicare Payments for Integrated Behavioral Health Services. Program descriptions should include policies, procedures, and documents to demonstrate the ability to meet the following requirements:

- Plan for identification, outreach, and engagement of patients directed by a primary care provider
- Job description for the behavioral health care manager that demonstrates a collaborative, integrated relationship with the rest of the team members as well as formalized training or specialized education in behavioral health
- Initial assessment, including administration of validated scales and resulting in a treatment plan
- Evidence of a compact/contract with a consulting psychiatrist
- Written workflows documenting:
    - Psychiatrist consultation/referral process
    - Evidence-based treatment interventions to be used in working with patients (behavioral activation, problem-solving treatment, other focused treatment activities)
    - Plans for ongoing collaboration and coordination with PCP and any other treating providers
    - Relapse prevention planning and preparation for discharge from active treatment
- Demonstrated use of a registry for tracking patient follow-up and progress
- Evidence of weekly caseload review with psychiatric consultant
- Evidence of monitoring of patient outcomes using validated rating scales

BCBSRI will notify the provider via email if their program description meets requirements. Providers will be able to submit claims 60 days after program approval. No retroactive payments will be made for services rendered.

Policies

PF Subcutaneous implantable cardioverter-defibrillator

Effective April 1, 2017, insertion of a subcutaneous implantable cardioverter-defibrillator will require prior authorization for Commercial products. The service already requires prior authorization for BlueCHiP for Medicare. The service and the corresponding CPT code(s) can be found in the Preauthorization via Web-Based Tool for Procedures policy.

PF Correct coding reminder for examination/consultation prior to a screening colonoscopy

As a reminder, HCPCS code S0285 identifies a pre-operative examination/consultation prior to a preventive colonoscopy under the Affordable Care Act for Commercial members. This went into effect on July 1, 2016. Please see the full text of this policy.

PF Peripheral subcutaneous field stimulation

Effective April 1, 2017, peripheral subcutaneous field stimulation for the treatment of chronic neuropathic pain has been updated to reflect that this service will now be submitted using unlisted CPT 64999, following the unlisted process. Please see the full text of this policy.

PF ClaimsXten specialty pharmacy

Specialty pharmacy claims auditing will be implemented using the following parameters:

- HCPCS J-code and diagnosis as defined by the U.S. Food and Drug Administration (FDA) labeling and standard reference compendia
- HCPCS J-code and maximum billable units
- HCPCS J-code and age
- HCPCS J-code with any combination of the elements listed above

This rule will modify or deny claim lines found not payable according to guidelines provided by the FDA and standard reference compendia. Updates to specialty pharmaceuticals guidelines will be added to our claims processing system quarterly.