Blue Cross Blue Shield of Rhode Island

provider update

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

April 2017

According to numerous sources, healthcare costs in Rhode Island rank in the top 10 in the country. This statement may be surprising to some, but not to those of us who work in the state's healthcare industry, whether you are on the provider or payer side. And it's certainly not a surprise to our members and your patients who see more of their paychecks going toward the cost of receiving care.

This is a driving force behind Blue Cross & Blue Shield of Rhode Island's (BCBSRI) commitment to the triple aim—better health for our state, a simpler patient experience, and lower costs. But to understand the current situation, it's important to recognize what is fueling healthcare costs and what is contributing to Rhode Island's top 10 ranking. Two examples include:

- Rhode Island ranks #1 in the nation for those 85 or older. Typically, the older we get, the more healthcare services we need, which ultimately leads to higher utilization and costs.
- High rates of mental illness consume nearly 25% more of a Rhode Islander's household income compared to the national average.

It's also important to note that the story is more complex than that. The reality is that in some instances, private payers continue to pay providers and hospitals significantly more than the government does. Those are costs that, ultimately, we've had to pass on to our members.

With this in mind and with affordability standards we must follow from the Office of the Health Insurance Commissioner (OHIC), BCBSRI is focused on ways to make healthcare more affordable and has laid out a pathway that encompasses three elements:

- **Accelerate** – Collaborate with providers to grow the systems of care (SOC) approach, which has improved care and reduced emergency room visits. Our SOC approach supports the relationship between the primary care provider and the patient.
- **Innovate** – Make new products available that will result in lower premiums and overall costs.
- **Enable** – Make data available—through resources like the Blue Insights Population Health Management Tool—that helps providers close gaps in care for their patients.

For providers, these efforts mean we will continue to move toward a reimbursement model that embraces quality, value, and efficiency while following OHIC's affordability standards and alternative payment methodology mandates. And we will continue to invest in programs that support an enhanced primary care model, such as patient-centered medical homes and systems of care. We will also increase our efforts to work with specialists to develop new reimbursement models that align incentives with patient care outcomes. Ultimately, all of these initiatives will put us on the path to simpler, more affordable healthcare.

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

Contents

BCBSRI Update

PBF Important: Update your practice 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. The next round of quarterly validation will take place in June 2017. 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.

P Web-based referral management tool

This is a reminder that as of January 1, 2017, primary care providers (PCPs) were required to submit referrals through our web-based referral management tool for BCBSRI members who are enrolled in a referral-based plan. PCPs and specialists are required to use this tool to generate a referral and check the status of referrals from PCPs to specialists.

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 changed from a paper to a web-based process. Please note: NEHP cross-border referrals to providers in other New England states 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.

PCPs 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. 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 a 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).

Quality

PF 80% by 2018: National Colorectal Cancer Roundtable

BCBSRI has pledged "80% by 2018" as part of a National Colorectal Cancer Roundtable (NCCRT) initiative in which more than 1,000 organizations have committed to substantially reducing colorectal cancer as a major public health problem. We are all working toward the shared goal of ensuring that 80% of adults aged 50 and older are being regularly screened for colorectal cancer by December 31, 2018. For reference, the current screening rate in Rhode Island is approximately 75.4%.

The initiative—which is led by the American Cancer Society (ACS), the Centers for Disease Control and Prevention (CDC), and the NCCRT (an organization co-founded by ACS and CDC)—was created to get the word out that screening can save lives . . . **but only if people get tested**.

To put the importance and urgency of screenings into perspective, consider this: If participating organizations can achieve the nationwide goal of 80% by 2018, approximately 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030.

Here's how you can help:

- Educate patients who are receiving routine, preventive colorectal cancer screenings that they will **pay no cost share** when the screening is coded as preventive, including polyp removal, facility fees, etc. The following tests are included: colonoscopy, flexible sigmoidoscopy, CT colonography, guaiac-based fecal occult blood test/fecal immunochemical test, and stool DNA tests.
- To ensure correct application of the preventive benefit, services must be filed as indicated in the payment policies for Preventive Services for BlueCHiP for Medicare and Preventive Services for Commercial members.
- Consider signing the "80% by 2018" pledge.
- Encourage colorectal cancer screening by giving these free materials to your patients.

If you have any questions, please contact Courtney Reger, RN, BSN, BCBSRI clinical quality management analyst, by calling (401) 459-2763 or emailing courtney.reger@bcbsri.org. Thank you for your support.

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 (CAHPS), 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, BCBSRI clinical quality management analyst, at (401) 459-2763 or courtney.reger@bcbsri.org.

Urinary incontinence: How you can help

According to a recent survey of our members, 67% have reported experiencing a leakage of urine. However, only 35% have talked with a doctor, nurse, or other healthcare provider about their urinary incontinence. Many patients try to cope on their own by wearing absorbent pads, carrying extra clothes, or avoiding going out in public. It is important to remember that urinary incontinence is often an embarrassing topic for patients to discuss, so let us work together to screen patients for urinary incontinence and when applicable, discuss the simple, safe, and effective treatment options so patients can get back to their active and comfortable lifestyle.

Quality

Osteoporosis management in women who had a fracture

The HEDIS measure for Osteoporosis Management in Women Who Had a Fracture tracks the percentage of women ages 67 to 85 years old that have received a bone mineral density (BMD) scan or filled a prescription to prevent or treat osteoporosis within six months of a recorded fracture during the measurement year. HEDIS 2016 results indicate that only 37.35% of eligible female BlueCHiP for Medicare members met these criteria. This score ranks in the 50th national percentile, indicating opportunity for improvement.

We continue to partner with MedXM, a company specializing in heel ultrasounds, a diagnostic test that fulfills this measure. MedXM schedules in-home visits for female BlueCHiP for Medicare members who have had a fracture and no BMD scan recorded within six months of the incident. Members who meet these criteria will receive a letter from BCBSRI about MedXM, and a phone call from MedXM to schedule a visit from a technician who will complete a heel ultrasound. A fax notification will be sent to all PCPs listing their patients who will receive outreach from MedXM. PCPs will also receive a copy of the results to review and file in the patients' records.

There is no charge for this in-home visit and it will not affect your patients' healthcare coverage in any way. These visits are not meant to replace the care your patients receive through their PCP. MedXM is not involved in the care or treatment of the patient, nor will they prescribe medications. Patients will be encouraged to remain up-to-date with their preventive care and routine office visits with their PCP. **Please note: Practices that have access to our population health registry can proactively monitor their patients' information for this measure.**

Disease-modifying anti-rheumatic therapy for rheumatoid arthritis (ART)

Osteoarthritis (OA) and rheumatoid arthritis (RA) are the two most common forms of arthritis, but each has distinct disease processes. OA, a degenerative disease of the joints, is more common. RA is an autoimmune disease in which the body attacks its own healthy tissue around the joint areas. It is critical to properly diagnose patients and accurately code their records. **Some providers have reported that their EHRs supply "rheumatoid arthritis" as an initial choice when searching for arthritis diagnoses. Please use caution if this is the case in your practice.** An inaccurate diagnosis of RA can affect reimbursement, falsely elevate disease prevalence rates, and can prevent patients from obtaining life insurance. RA is normally confirmed by a series of tests. Once the diagnosis of RA is confirmed, please use appropriate coding.

For both HEDIS and CMS Stars, the ART measure evaluates the use of DMARD therapy in members 18 years and older with RA. The HEDIS 2016 rate for Medicare members was 76.80% which was at the 25th national percentile. The BCBSRI Quality Management department will be conducting ongoing provider assessments via fax to learn more about our RA patients and possibly impact the ART measure. We welcome your feedback and any suggestions you have to enhance these efforts. Please contact Courtney Reger, RN, BSN, BCBSRI clinical quality management analyst, at (401) 459-2763 or courtney.reger@bcbsri.org.

Below is specific guidance about coding for RA, followed by a summary of the measure, population, and tips for success.

Measure	Population: Numerator and denominator	Tips for success
Disease-Modifying Anti-Rheumatic Therapy for Rheumatoid Arthritis (ART)	Numerator: Members from the denominator who had at least 1 ambulatory prescription dispensed for a DMARD (see table on the next page) during the measurement year. *Exclusions:* Members diagnosed with HIV or members who are pregnant during the current year.	Only utilize codes for RA if diagnosis has been confirmed. For members with confirmed RA, DMARD therapy is the current standard of care.
	Denominator: Members 18 years and older with 2 of the following events on different dates in the measurement year: • Outpatient visit with any diagnosis of RA • Nonacute inpatient discharge with any diagnosis of RA	

NCQA table ART-C: Medications counted as DMARD therapy

Description	Prescription	J codes
5-Aminosalicylates	• sulfasalazine	
Alkylating agents	• cyclophosphamide	
Aminoquinolines	• hydroxychloroquine	
Anti-rheumatics	• auranofin • leflunomide • penicillamine • gold sodium thiomalate • methotrexate	J1600, J9250, J9260
Immunomodulators	• abatacept • certolizumab pegol • infliximab • adalimumab • etanercept • rituximab • anakinra • golimumab • tocilizumab	J0129, J0135, J0717, J0718, J1438, J1602, J1745, J3262, J9310
Immunosuppressive agents	• azathioprine • mycophenolate • cyclosporine	J7502, J7515, J7516, J7517, J7518
Janus kinase (JAK) inhibitor	• tofacitinib	
Tetracyclines	• minocycline	

Behavioral health measures: ADD and FUH

BCBSRI continues to expand our behavioral health provider and community collaboration. You can expect more initiatives designed to support members with behavioral health diagnoses, improved transitions of care, the continuation of our HealthPath program, and more. These HEDIS measures (ADD and FUH) emphasize the importance of careful medication management in adults and children with specific behavioral health diagnoses, and the importance of follow-up care after hospitalization. Each measure's specifications are detailed below.

Follow-up care for children prescribed ADHD medication (ADD)

The HEDIS measure Follow-Up Care for Children Prescribed ADHD Medication (ADD) is the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10 month period, one of which was within 30 days of when the first ADHD medication was dispensed. The measure looks at two rates—the initiation phase and the continuation/maintenance phase. Details about each phase, as well as tips for success, are listed below. **Please note that practices participating in our population health registry can monitor their panel's rates for this measure in the registry.**

Quality

Measure	Measure population	Tips for success
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	*Initiation Phase:* The percentage of children ages 6-12 years as of the index prescription date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had 1 follow-up visit with a practitioner with prescribing authority in the first 30 days of the Rx dispensation.	When prescribing a new ADHD medication, be sure to schedule a follow-up visit within 30 days to assess how the medication is working. Schedule this visit while your patient is still in the office. Schedule 2 more visits in the 9 months after the first 30 days to continue to monitor your patient's progress. **Telephone codes** can be used to help satisfy the requirements for the Continuation & Maintenance phase part of the measure. The following codes are covered, but not separately reimbursed, by BCBSRI: 98966, 98967, 98968, 99441, 99442, and 99443. You may use these codes to satisfy the numerator for the continuation measure if you do not see your patient face-to-face, but rather complete a follow-up call. Keep in mind that controlled substances should not be reordered without at least 2 visits per year to evaluate a child's progress and growth.
	Continuation & Maintenance Phase: The percentage of children ages 6-12 years as of the index prescription date (IPSD) with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	

Follow-up after hospitalization for mental illness (FUH)

The HEDIS measure Follow-Up After Hospitalization for Mental Illness (FUH) is the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. The measure looks at two rates:

1. The percentage of discharges for which the member received follow-up within 30 days of discharge

2. The percentage of discharges for which the member received follow-up within 7 days of discharge

Measure	Measure population	Tips for success
Follow-Up After Hospitalization for Mental Illness (FUH)	*30 day follow-up:* An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 30 days after discharge. This includes outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge. *7 day follow-up:* An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge. This includes outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.	Collaboration between the inpatient facility and outpatient provider is critical. If a provider is aware of an inpatient admission, efforts should be made to work with hospital discharge planners to set up appointments prior to the patient leaving the hospital. In an effort to improve the number and therefore the percentage of members who attend a follow-up behavioral health visit, and to improve transitions of care, BCBSRI will provide a $40 incentive payment to participating outpatient behavioral health providers who complete a visit with a member within the 7-day timeframe. Discharges to intermediate levels of care, as well as some types of member coverage, are not included in this pilot program. A detailed communication fully outlining the quality program was mailed to all participating behavioral health outpatient professional providers on July 1, 2016. The additional reimbursement will be effective for inpatient mental health discharges from July 1, 2016 through June 30, 2017. If you have any questions please contact Rena Sheehan, managing director of behavioral health, at (401) 459-1467 or rena.sheehan@bcbsri.org, or Sarah Fleury, lead behavioral health clinical program specialist, at (401) 459-1384 or sarah.fleury@bcbsri.org.

PBF Clinical practice guidelines

The 2017 Clinical Practice Guidelines for Well Adult, Tobacco Use & Dependence, and Acute Myocardial Infarction (AMI) were reviewed and approved by the Professional Advisory & Credentials Committee on January 18, 2017. The next review will take place in January 2019.

PBF Reminder: Commercial formulary update - April 1, 2017

The BCBSRI Commercial segment formulary for April is now available. You can view the summary that provides details on the changes scheduled. All members impacted by a change have received a written notification. The changes 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.

PBF GuidedHealth® clinical programs prescriber outreach begins

Now that Prime Therapeutics has several months of medical and pharmacy claims data available for analysis, the GuidedHealth suite of retrospective Drug Utilization Review (DUR) clinical programs have begun to identify drug therapy opportunities, and engage members and their providers to improve their care and lower costs.

As a result, providers will receive mailings containing detailed information regarding opportunities for improvement in several areas. These programs are designed to identify potential misuse and abuse, close gaps in care, improve adherence, discontinue unsafe medicine use, and promote preferred medicine use in the following areas:

Overutilization and drug safety

- **Controlled substances alert:** Discourages overprescribing controlled substance medicines in members demonstrating patterns associated with excessive use
- **Triple therapy alert:** Discourages prescribing combination of a benzodiazepine, a muscle relaxant, and an opioid in members demonstrating patterns of possible misuse or abuse
- **Opioid alert:** Discourages overprescribing opioids in members demonstrating patterns associated with excessive use of
  - High-dose opioids
  - Multiple providers
  - High-dose opioids by multiple prescribers
- **Polypharmacy:** Discourages duplicate treatment, member confusion, and medicine interactions by encouraging medicine review when multiple medicines are used regularly
  - Psychotropic
  - Stimulant
- **High-dose acetaminophen:** Discourages overprescribing acetaminophen to reduce the risk of harm to the liver
- **High-risk medications:** Discourages prescribing medicines that may be harmful when used by members age 64 and older
- **Antipsychotic use in dementia:** Discourages prescribing specific medicines that have serious warnings against their use in members with dementia

Underutilization and adherence

- **Adherence:** Encourages consistent use of medicines through evaluation of members' Proportion of Days Covered (PDC), a standard adherence calculation, for the following conditions:
  - Asthma
  - Cholesterol
  - COPD
  - Depression
  - Diabetes
  - Hypertension
  - Schizophrenia
- **Gaps in care:** Encourages prescribing medicine to members whose diagnosis suggests they would benefit when there is no record of treatment for the following conditions:
  - Cholesterol
  - Hypertension
  - Rheumatoid Arthritis
  - Pulmonary Arterial Hypertension
- **Asthma medication ratio:** Encourages prescribing medicines that help control asthma to members with a high utilization of rescue medications
- **Statin use in diabetics:** Encourages prescribing a cholesterol medicine (statin) to members with diabetes to reduce their risk of heart attack or stroke
- **Continuity of care:** Encourages medicine use for members who have no record of treatment after receiving a utilization management rejection at the pharmacy
  - Autoimmune
  - Cholesterol
  - Depression
  - Hypertension

In addition to the mailings sent to providers, pharmacists embedded in PCMHs as part of the Patient-Centered Pharmacy Program are provided data files on these and more clinical programs for their primary care patients.

BCBSRI encourages prescribers to utilize these reports to ensure the best outcomes for patients by considering the recommendations made, discussing them with the patients, and making changes as appropriate.

Behavioral Health

PB Behavioral health integration updates

As noted in the February edition of Provider Update, BCBSRI will now separately reimburse for collaborative care provided to members in a program that meets requirements that are aligned with the foundational elements of the Collaborative Care Model put forward by CMS. In order 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 submitting a detailed program description to BCBSRI. Program descriptions can be sent to BCBSRI for approval at BehavioralHealth@bcbsri.org.

Recently there have been questions from the provider community regarding specific diagnosis codes used in submitting claims for behavioral health integration.

- ICD 10 code F54, Psychological and behavioral factors associated with disorders or diseases classified elsewhere: The BCBSRI system is configured to process claims with this diagnosis code when submitted by a behavioral health provider.
- ICD-10 code F06.3: This diagnosis code is not definitive. Providers submitting claims with this code must code to the fifth digit in order for the claims to process correctly.

BCBSRI has also received questions recently regarding claims for two different rendering providers in the same office sharing the same tax ID and submitting claims with the same CPT code. In this scenario, claims will be processed according to a member's benefit. When two different rendering providers in the same office sharing the same tax ID submit claims with different CPT codes, these claims will also be processed according to a member's benefit. If the same rendering provider submits the same code for the same member twice on the same day, this will be denied as a duplicate claim.

Claims

PBF Claim status through BlueLine

When calling the BlueLine, please ensure the rendering provider NPI (box 24J on the CMS-1500 claim form) is entered to get the status of a claim, otherwise the message will be "there is no claim on file."

PBF Billing rules for dual-eligible beneficiaries

As required under 42 C.F.R. 422.504(g)(1)(iii), federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copays from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual-eligible program which exempts individuals from Medicare cost-sharing liability. Balance billing prohibitions may also apply to other dual-eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost-sharing.

Prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B. Low-income subsidy copays still apply for Part D benefits. Providers cannot discriminate against enrollees based on their payment status (e.g., QMB). Specifically, MA health providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program. Please refer to the Managed Care Manual, Ch. 4, Section 10.2.3, for more information.

PBF Update for all EDI trading partners

In late March, BCBSRI began returning 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.

PBF Claims adjustment requests and appeals

As a reminder, please only use the Claims Adjustment Request Form when submitting a corrected or adjusted claim. For true appeals, please use the Provider Appeal Request Form.

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 of bcbsri.com.

- Acupuncture Mandate
- Colorectal Screening Mandate
- Cosmetic Services/Procedures
- Coverage of Complications Following a Non-covered Service
- Durable Medical Equipment
- Electrogastrography (EGG)
- Fetal Surgery for Prenatally Diagnosed Malformations
- Fluoroscopy Without Films
- High-Tech Radiology Imaging
- Intravitreal Corticosteroid Implants
- Long-Term Acute Care Hospital (LTACH) Admission and Transition of Care Criteria
- Lyme Disease Diagnosis and Treatment Mandate
- Minimally Invasive Coronary Artery Bypass Graft Surgery
- Newborn Metabolic, Endocrine and Hemoglobinopathy, and the Newborn Hearing Loss Screening Programs Mandate
- Nutritional Counseling/Medical Nutritional Therapy
- Off-Label Use of Prescription Drugs Mandate
- Pediatric Feeding Disorders Treatment
- Pelvic Floor Stimulation as a Treatment of Urinary and Fecal Incontinence
- Progesterone Therapy as a Technique to Reduce Preterm Birth in High-Risk Pregnancies
- Rabies Treatment – Pre- and Post-Exposure
- Rhinomanometry and Acoustic Optical Rhinomanometry
- Radium-223, Xofigo; for treatment of metastatic, castration-resistant prostate cancer
- Skilled Nursing Facilities: Admission and Concurrent Review
- Unlisted Procedures

New medical policies

The following new medical policies were created for services that are not medically necessary. The full text of these policies is available in the Provider section of bcbsri.com.

- Laser Treatment of Onychomycosis
- Progenitor Cell Therapy for the Treatment of Damaged Myocardium due to Ischemia

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 section of bcbsri.com. 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.

PBF Provider guidelines for credit card on file requests

Increasingly, healthcare purchasers are selecting insurance plans that include higher deductibles and higher copays. This has led providers to evaluate and adjust their office policies related to the collection of patient cost share for services rendered. Provider practices may ask that members provide financial information (credit card, debit card, or HSA/FSA card) to be kept on file. Please see the full text of this policy.

Policies

PF Infertility Services Policy update

Effective March 1, 2017, the medical criteria in the Infertility Services Policy has been updated to reflect that **for members who are not in active infertility treatment and who are undergoing medical treatment that may result in infertility**, retrieval and cryopreservation of eggs, embryos, and sperm are covered when documentation confirms that member will be undergoing medical treatment (e.g., chemotherapy, radiation therapy) that is likely to result in infertility. Please note that fees associated with storage are not covered. 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.

PF Preauthorization via web-based tool for durable medical equipment

For claims filed with dates of service May 1, 2017 and after, the following services will be covered and will no longer require prior authorization:

- Insulin Pump, Ambulatory
- Glucose Monitoring Systems - This change is applicable to Commercial Products only. Continuous Glucose Monitoring for BlueCHiP for Medicare will remain a not covered service.

Please see the full text of this policy.

PF Preauthorization via web-based tool for procedures

For claims filed with dates of service May 1, 2017 and after, the following services will be covered and will no longer require prior authorization:

- Upper Gastrointestinal Endoscopy
- Enhanced External Counterpulsation (EECP) - This change is applicable to BlueCHiP for Medicare only. The service will remain not medically necessary for Commercial products.

Please see the full text of this policy.

For claims with dates of service on or after June 1, 2017, 69711, removal or repair of electromagnetic bone conduction hearing device in temporal bone, will no longer require prior authorization for Commercial Products and will be a covered service. Please see the full text of this policy.

PF Knee walkers

Effective for claims with dates of service of May 1, 2017 and after, E0118RR, Crutch substitute, lower leg platform, with or without wheels, (e.g., Roll-A-Bout Walker, Rolleraid, Turning Leg Caddy) or a kneeling crutch (e.g., iWALKFree), is medically necessary for short term as a rental only for use following a below-the-knee injury/condition when the member is non-weight bearing on one extremity and unable to safely use a standard walker or crutch. As this is for short-term rehabilitation, the rental period is limited to 4-month rental period. Please see the full text of this policy.

PF Noninvasive fractional flow reserve using computed tomography angiography

A new policy has been created for BlueCHiP for Medicare and Commercial products indicating that the use of fractional flow reserve using coronary computed tomography angiography preceding invasive coronary angiography in patients with suspected stable ischemic heart disease is considered not medically necessary, as there is insufficient peer-reviewed scientific literature that demonstrates that the procedure is effective. Please see the full text of this policy.

PF February 2017 proprietary lab analysis codes, CPT® code changes

We have completed our review of the 2017 Current Procedural Terminology® (CPT) Proprietary Lab Analysis (PLA) code changes. These updates will be added to our claims processing system and are effective February 1, 2017. The lists include codes that have special coverage or payment rules for standard products. (Some employers may customize their benefits.) We've included codes for services that are:

- "Invalid" – Use alternate procedure code, CPT, or HCPC code.

Please submit your comments and concerns regarding coverage and payment designations to:

Blue Cross & Blue Shield of Rhode Island
Attention: Medical Policy, CPT Review
500 Exchange Street
Providence, Rhode Island 02903

Please note that as a participating provider it is your responsibility to notify members about non-covered services prior to rendering them.

CPT 2017

0001U Invalid code for professional providers and institutional providers for BlueCHiP for Medicare and Commercial products

0002U Invalid code for professional providers and institutional providers for BlueCHiP for Medicare and Commercial products

0003U Not medically necessary for Commercial products

PBF April 2017 HCPCS Level II code changes

We have completed our review of the April 2017 Healthcare Common Procedure Coding System (HCPCS) code changes. These updates will be added to our claims processing system and are effective April 1, 2017. This list includes codes that have special coverage or payment rules for standard products. (Some employers may customize their benefits.) We have included codes for services:

- "Not Medically Necessary" – This indicates services where there is insufficient evidence to support.
- "Subject to Medical Review" – Preauthorization is recommended for Commercial products and required for BlueCHiP for Medicare.
- "Invalid" – Use alternate procedure code, CPT code, or HCPCS code.

Please submit your comments and concerns regarding coverage and payment designations to:

Blue Cross & Blue Shield of Rhode Island
Attention: Medical Policy, CPT Review
500 Exchange Street
Providence, Rhode Island 02903

Please note that as a participating provider, it is your responsibility to notify members about non-covered services prior to rendering them.

C9484 Not medically necessary for BlueCHiP for Medicare and Commercial products

C9485 Invalid code for professional providers for BlueCHiP for Medicare and Commercial products

C9486 Invalid code for professional providers for BlueCHiP for Medicare and Commercial products

C9487 Subject to medical review for BlueCHiP for Medicare and Commercial products

C9488 Invalid code for professional providers for BlueCHiP for Medicare and Commercial products

PF May 2017 proprietary lab analysis codes, CPT code changes

We have completed our review of 2017 current procedural terminology (CPT*) Proprietary Lab Analysis (PLA) code changes. These updates will be added to our claims processing system and are effective May 1, 2017. The list includes codes that have special coverage or payment rules for standard products. (Some employers may customize their benefits.) We've included codes for services that are:

0005U Not medically necessary for Commercial products