Blue Cross Blue Shield of Rhode Island

provider update

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

July 2017

Whether in last month's Provider Update, or in various meetings with the provider community, I've been speaking frequently on the issue of healthcare affordability. Last month, specifically, I wrote to you regarding our partnership with RowdMap, a healthcare data analytics partner, whose data will allow us to identify high-performing providers delivering high-value care.

This month, Blue Cross & Blue Shield of Rhode Island (BCBSRI) held two webinars to introduce our approach to high-value care and explain how our partnership with RowdMap will help us better understand specialist performance. Now we are extending those informational webinars to a monthly schedule, which is outlined below.

- Thursday, August 10 – noon to 1 p.m.
- Thursday, September 7 – noon to 1 p.m.
- Thursday, October 5 – noon to 1 p.m.
- Thursday, November 2 – noon to 1 p.m.
- Thursday, December 7 – noon to 1 p.m.

I encourage you to attend one of these webinars as they will give providers an opportunity to learn more about what constitutes high-value care as well as the impact of low-value care in Rhode Island. They will also familiarize you with our strategy around specialist utilization and readiness for alternative payment models.

If you'd like to attend one of the upcoming webinars, please register online or by calling Provider Relations at 1-844-707-5627.

I also encourage you to learn about your Provider Portrait Report based on the RowdMap data. You can request this information by emailing providerrequests@bcbsri.org.

Thank you for working with BCBSRI to improve the health of Rhode Islanders.

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

Contents

BCBSRI Update

BlueLine unavailable from September 15 to October 27

BlueLine, our automated response system for member eligibility, benefit information, and claims status inquires, will be temporarily unavailable from September 15, 2017 to October 27, 2017. During this time, please use the self-service options available on bcbsri.com.

If you have any questions, please contact the Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050, Monday through Friday, 8:00 a.m. to 4:30 p.m.

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.

In 2017, 11 practices were certified, including:

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

If you would like to become a BCBSRI LGBTQ Safe Zone certified practice, please contact Susan Walker, provider relations manager, at (401) 459-5381 or susan.walker@bcbsri.org.

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 contacting provider offices directly.

BCBSRI now conducts quarterly fax-based validation and attestation of provider practice information for the information we currently have displayed in our Find a Doctor tool. The next quarterly validation takes place in September 2017. When you receive this fax, please review and make any 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 the appropriate changes, check the "attestation" box, and fax it 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 email ProviderRelations@bcbsri.org. Thank you for your assistance.

PBF 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.

CPT® Category II codes

Did you know that the use of CPT Category II Codes can close gaps in care as set forth by the National Committee for Quality Assurance? While CPT Category II Codes are not reimbursed by BCBSRI, submission of these codes will greatly **reduce the HEDIS medical record review burden on your practice** by closing gaps in care through claims data. Here is a list of relevant CPT Category II Codes. These codes can be submitted effective immediately and can even be used for claims with older dates of service. If you have any questions, please contact your Provider Relations representative or email ProviderRelations@bcbsri.org.

Cervical cancer screening

Routine screening remains one of the most effective ways to detect cervical cancer and precancerous changes that might otherwise develop undetected. Preventive care is covered at no cost to the member according to the Affordable Care Act. Please discuss with patients (as appropriate) the importance of obtaining the tests listed below.

Test/Exam	Measure Population	Exclusions	Tips for Success
Cervical cancer screening	Women ages 21-64 who have had a Pap test within the measurement year or prior 2 years **OR** Pap/HPV co-testing within the measurement year or prior 4 years	• Women who have had a complete hysterectomy with no residual cervix. (Medical record evidence must indicate Total/Complete hysterectomy/Absence of cervix. Hysterectomy alone will not exclude member.) • Members in hospice	• Documentation in the medical record must include a note indicating the date when the test was performed and the result or finding. • Biopsies are not counted as evidence of screening. • Remind members that preventive tests are 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.

Quality

Medication reconciliation post-discharge

Discharge planning and home follow-up, including medication management, has been shown to reduce readmissions and reduce the length of a hospital stay. The purpose of this measure is to assess the percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Test/Exam	Measure Population	Exclusions	Tips for Success
Medication reconciliation post-discharge	Members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)	Members in hospice	• Submit a professional claim with CPT II code 1111F. • Identify high-risk patients and tailor services needed. • Give patients a pharmacy contact at discharge. • Provide patient interviews by case management or social services within 30 days to find opportunities for improvement. • Communicate in a timely manner with care team and ambulatory provider.

Medical record

Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria:

- Documentation of the member's current medications, with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service.
- Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Documentation in the discharge summary that the discharge medications were reconciled with the current medications. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge. Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.
- Documentation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications (i.e., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).

Behavioral Health

PB Behavioral health provider survey results

BCBSRI's Behavioral Health Department thanks all of the providers who responded to our recent email survey. The 222 respondents provided us with a depth of information regarding the current state of collaboration between behavioral health and primary care. The purpose of the survey was to learn more about our outpatient behavioral health provider community as well as gather information regarding ways in which behavioral health clinicians interact with primary care providers.

A majority of respondents indicated that they saw the value in collaboration with the primary care provider (PCP) and that it is important for them to have the PCP involved in the care they provide. Some areas of opportunity were also indicated, including utilization of better technologies to communicate, such as shared EMRs and email. Behavioral health providers also suggested that having a point of contact in a primary care office, such as a nurse care manager, has also been helpful in facilitating communication with the PCP. The Behavioral Health Department will use the survey feedback when implementing initiatives focused on integrating behavioral health and primary care.

B CODAC MAT Program

The CODAC Medication Assisted Treatment (MAT) Pilot Program is an outpatient buprenorphine/naloxone or buprenorphine program offered by CODAC, Rhode Island's first Center of Excellence for the treatment of opioid use disorders. This program is designed to provide comprehensive medication assisted treatment-related services to BCBSRI Commercial members to facilitate recovery from opioid use disorders. The goal of the program is to offer structured and intensive treatment that includes medication assisted treatment such as Suboxone® as well as nursing, counseling, and case management services that ultimately lead to recovery and the ability to maintain recovery in a less intensive treatment program.

B 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, including improved transitions of care and the continuation of our HealthPath program.

The HEDIS measures Follow-Up Care for Children Prescribed ADHD Medication and Follow-Up After Hospitalization for Mental Illness 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 on the next page.

Behavioral Health

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

The HEDIS ADD measure 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.**

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 with an ambulatory prescription dispensed for ADHD medication who had one 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 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)

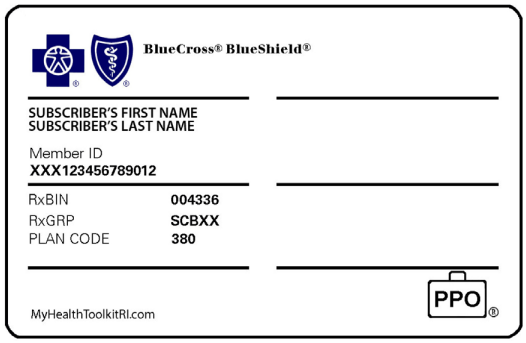
The FUH HEDIS measure is the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. The measure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

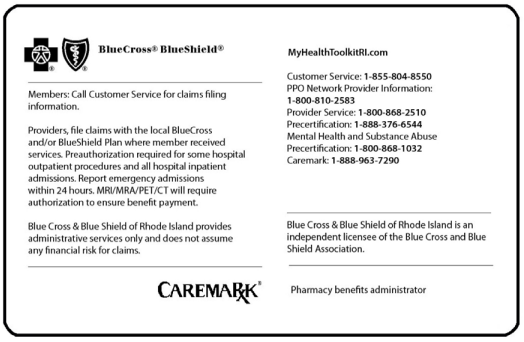
1. The percentage of discharges for which the member received follow-up within 30 days of discharge
2. The percentage of discharges for which the member received follow-up within 7 days of discharge

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.	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.
	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.	

PBF National employer group platform enhancement

BCBSRI currently offers a national solution to service the unique needs of select multi-state clients, including CharterCARE (CCHP). While the members associated with these accounts continue to be enrolled through BCBSRI and present BCBSRI membership ID cards, they will be serviced via National Alliance. National Alliance uses a different platform than our local membership. The National Alliance service center is located in Columbia, South Carolina. BCBSRI sample member ID cards associated with the National Alliance platform are shown below.



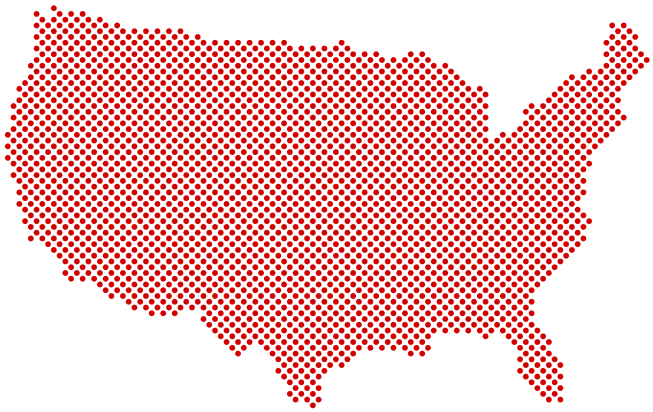


There are some features that are unique to this national platform. When a member presents this ID card, please do the following:

- To verify benefits, eligibility, and member liability, please visit www.myhealthtoolkitri.com. If this is your first time using the website, follow the prompts to create a user name and password.
- You can also visit www.myhealthtoolkitri.com to access and/or verify providers in the tiered network.*
- Look on the back of the member's ID card for phone numbers for preauthorizations. Employer groups that are managed through National Alliance will use their vendors, such as:
  - NIA for radiology management
  - Companion for behavioral health

If you have any questions, please don't hesitate to contact our Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050 (out of state only), Monday through Friday, 8:00 a.m. to 4:30 p.m.

*Employees and dependents of Prospect CharterCARE have access to a tiered network and are administered on the National Alliance platform, effective January 1, 2015. These members can be identified with a Member ID Prefix of "GTY."



Claims

PBF Important reminder for laboratory, imaging, durable medical equipment, and home infusion providers regarding ordering provider information

Effective September 1, 2017, BCBSRI requires providers to report the name and the Type 1 National Provider Identifier (NPI) of the ordering provider on the CMS-1500 claim form or electronic submission. The ordering/referring provider's name should be reported in box 17, and the Type 1 NPI should be reported in box 17b. When the ordering provider is also the performing provider, as is often the case with in-office clinical labs such as a urine dipstick, the performing provider should enter his or her information in boxes 17 and 17b. For electronic submitters, the Type 1 NPI of the ordering/referring provider must be in the 2310A Loop, NM109 segment.

When a service is incident to the service of a physician or non-physician practitioner, the name of the person who performs the initial service and orders the non-physician service must appear in box 17.

Missing or incomplete information will result in a claim being rejected back to the provider. Please see the full text of this policy.

PBF The Medicare National Correct Coding Initiative

BCBSRI follows the Medicare National Correct Coding Initiative (NCCI). NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. Please review the June edition of Provider Update for important coding guidelines.

PBF BlueCard program claims filing guidelines: Providers with multiple Blues plan contracts

The following scenario is a reminder about how to file claims when you have a provider contract with two Blue Cross and Blue Shield plans (for example, BCBSRI and Blue Cross Blue Shield of Massachusetts or BCBSRI and Anthem Blue Cross Blue Shield). These rules apply to both Commercial and Medicare Advantage members.

BlueCard submission claim filing determination example

Dr. Smith has a contract with BCBSRI.

Dr. Smith has a contract with Blue Cross Blue Shield of Massachusetts.

Dr. Smith has an office in Massachusetts in an area contiguous to Rhode Island.

Dr. Smith sees a Blue Cross Blue Shield of Massachusetts member in his Massachusetts office. The claim is filed to Blue Cross Blue Shield of Massachusetts.

Dr. Smith sees a BCBSRI member in his Massachusetts office. This claim is filed to BCBSRI and is considered a local in-network claim.

PBF Requirement to refer members to in-network providers for all BCBSRI products

As a BCBSRI-contracted provider, you have an obligation to coordinate members' care with contracted, in-network providers. This includes all services such as clinical laboratory and pathology services, durable medical equipment, radiology, and behavioral health providers.

The following laboratories are not a participating provider with BCBSRI:

- Lehigh Valley Toxicology
- Mercy Diagnostics
- Total Toxicology
- U.S. Lab & Radiology, Inc.
- Quest

Before you establish a referral relationship, please confirm that the provider currently participates in the BCBSRI network. One way to do that is by checking the participation status of providers on our Find a Doctor tool.

PBF FDR Medicare requirements

BCBSRI wants to remind you of requirements from the Centers for Medicare & Medicaid Services (CMS) for administrative and healthcare services between a Medicare Advantage Organization (MAO) and/or Part D Plan Sponsor, such as BCBSRI and First Tier, Downstream and Related Entities (FDR).

Hold harmless for MAs with enrollees eligible for both Medicare and Medicaid

For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Providers may not impose cost sharing that exceeds the amount of cost sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source.

Training requirements

Provider agrees to: (1) Ensure that all personnel (including contractors) directly involved in or responsible for the delivery of services related to their Agreement with BCBSRI complete the general compliance and fraud waste and abuse training modules developed by CMS (the "CMS Module") available on the CMS Medicare Learning Network (MLN), or complete existing Provider training which incorporates the CMS standardized training modules from the CMS website, without modification. This training must be provided initially, within ninety (90) days of hire, within ninety (90) days of execution of this agreement, if training has not previously occurred, and annually thereafter, as a condition of employment. (2) Provide an attestation of completion of this requirement, upon request, and be able to provide certificates of completion for all individuals taking the CMS Module, or other training, as described above, upon request by BCBSRI or CMS. The training can be accessed here.

Policies

PF Policies recently reviewed for annual update

The following policies were recently reviewed for annual update. The full text of these policies is available in the Provider section of bcbsri.com.

- Adrenal to Brain Transplantation
- Ambulance: Air and Water Transport
- Bariatric Surgery
- Cardiac Rehabilitation
- Enhanced External Counterpulsation
- Gait Analysis
- Image-Guided Minimally Invasive Decompression for Spinal Stenosis (Former Title: Image-Guided Minimally Invasive Lumbar Decompression IG-MLD for Spinal Stenosis)
- Intra-Articular Hyaluronon Injections for Osteoarthritis
- Mastectomy Hospital Stays Mandate
- Measurement of Serum Antibodies to Infliximab and Adalimumab
- Midlevel Practitioner
- Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease
- Percutaneous Tibial Nerve Stimulation
- Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
- Phototherapy for the Treatment of Seasonal Affective Disorder
- Phototherapy in the Home for the Treatment of Dermatological Condition
- Prophylactic Mastectomy
- Signal-Averaged Electrocardiography (SAECG)
- Skin Contact Monochromatic Infrared Energy as a Technique to Treat Cutaneous Ulcers, Diabetic Neuropathy, and Miscellaneous Musculoskeletal Conditions
- Reflectance Confocal Microscopy for Evaluating Skin Lesions for Suspected Malignancy
- Temporary Prostatic Stent
- Transcatheter Mitral Valve Repair
- Transcranial Magnetic Stimulation (TMS)
- Vertebral Axial Decompression

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.

PFB BlueCHiP for Medicare National and Local Coverage Determinations Policy

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

PF Homocysteine testing in the screening, diagnosis, and management of cardiovascular disease

Effective May 1, 2017, the policy has been updated to reflect an additional indication in which the testing is considered not medically necessary. Measurement of plasma levels of homocysteine is considered not medically necessary in the screening, evaluation, and management of patients with cardiovascular disease or patients with venous thromboembolism or risk of venous thromboembolism due to the large amount of evidence that homocysteine-lowering interventions do not improve health outcomes. This update applies to both BlueCHiP for Medicare and Commercial products. Please see the full text of this policy.

PBF Inactive Provider Termination Administrative Policy

BCBSRI is required to maintain participating provider network information and provider directories that are up-to-date. Provider directories with current information are essential to helping our members make informed healthcare decisions. In addition, accurate provider directories are required by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). This means that our directories must only contain information about providers who are actively seeing BCBSRI members.

As a result, effective September 1, 2017, BCBSRI will begin conducting administrative terminations of provider agreements for providers who have not submitted a claim for a period of one year. In addition, BCBSRI will deactivate any tax identification number that has not had any claims submitted under it within that time frame. Because this policy's effective date is September 1, 2017, the first look back period will review claims submitted prior to August 31, 2017.

Moving forward, administrative terminations will take place twice a year, on January 1 and July 1, and will look back at the previous year.

Prior to termination, BCBSRI is required to provide a 90-day written termination notice to the impacted provider that references fair hearing rights for such termination. Providers are instructed to contact provnrc@bcbsri.org if they receive a termination notice for inactivity but wish to remain a BCBSRI participating provider. If a provider is terminated due to inactivity after 90 days of being notified of termination and then wants to become a BCBSRI participating provider again, they must reapply through BCBSRI's standard credentialing processes.

Please see the full text of this policy.

PF Retinal telescreening for diabetic retinopathy

Effective September 1, 2017, the following policy changes were made:

- **BlueCHiP for Medicare** – CPT 92227 and 92228 will be covered only when filed by an optometrist or ophthalmologist. The service is considered medically necessary as a screening technique for the detection of diabetic retinopathy or for monitoring and management of disease in individuals diagnosed with diabetic retinopathy.
- **Commercial Products** – CPT 92227 will have the same provider restrictions as noted above and is medically necessary as a screening technique for the detection of diabetic retinopathy. CPT 92228 will be not medically necessary for all other indications, including the monitoring and management of disease in individuals diagnosed with diabetic retinopathy, as the evidence is insufficient to determine the effects of the technology on health.

In addition, it is incorrect coding to file for these services using 92250 fundus photography with physican review, interpretation and report, unilateral or bilateral. Please see the full text of this policy.

Policies

F Non-reimbursable health service codes

The Non-reimbursable Health Service Codes Policy lists covered service codes for which providers will not be separately reimbursed. For outpatient hospital services, BCBSRI follows the Centers for Medicare and Medicaid (CMS) Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule for all codes that are covered. Codes with a status indicator of "N" on Addendum B are set up in our claims processing system as covered but not separately reimbursed as CMS considers payment packaged into payment for other services. These codes will be added to the spreadsheets found in Non-Reimbursable Health Service Codes policy. Updates are posted quarterly to the CMS OPPS website by CMS. BCBSRI updates codes considered packaged into Ambulatory Payment Classifications (APC) rates on a quarterly basis based upon this CMS fee schedule. Please see the full text of this policy.

PF Update to CPT code 83861

In the November/December 2016 issue of Provider Update, it was communicated that CPT code 83861—microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality—was changed to a covered and not separately reimbursed service. After careful consideration, that determination has been have rescinded. Effective January 1, 2017, 83861 will be a covered and separately reimbursed service for both Commercial and BlueCHiP for Medicare products. Claims will be adjusted to pay by our claim system once the system has been updated.

PF Corneal collagen cross-linking

Effective August 1, 2017, a new policy has been created for corneal collagen cross-linking for the treatment of progressive keratoconus or corneal ectasia for Commercial products only. Prior authorization is recommended for Commercial products via the online tool for participating providers. Corneal collagen cross-linking is considered not medically necessary for BlueCHiP for Medicare for all indications, as the evidence is insufficient to determine the effects of technology on health outcomes. Please see the full text of this policy.

PF Epidural injections without imaging

Effective January 1, 2017, we have changed our coverage determination for CPT codes 62320, 62322, 62324, and 62326 from not medically necessary to medically necessary with prior authorization. Prior authorization is required for BlueCHiP for Medicare and recommended for Commerical products via the online tool for participating providers. Please see the full text of this policy.

P Collaborative care model

The Centers for Medicare and Medicaid Services established three codes (G0502, G05023, and G0504) to describe services provided as part of the psychiatric Collaborative Care Model. In the final rules, CMS put forth specific requirements that must be met in order 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 providers (PCPs) must be able to demonstrate that they are providing services under the collaborative care model by submitting a detailed program description to BCBSRI. After BCBSRI reviews and approves the program description, the provider will be reimbursed for collaborative care services provided to BCBSRI Medicare Advantage members. Collaborative care is not separately reimbursed for Commercial products. Please see BCBSRI's Collaborative Care Management policy.

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 that includes administration of validated scales and results 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 (e.g., 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 inform 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. All program descriptions can be sent to Behavioralhealth@bcbsri.org.

PBF July 2017 CPT and HCPCS Level II code changes

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

- **"Invalid"** – Use alternate procedure code, CPT code, or HCPCS code.
- **"Not Covered"** – This includes services not covered in the main member certificate (e.g., covered as a prescription drug).
- **"Medicare Lab Network"** – Codes that are reimbursed to a hospital laboratory outside of the laboratory network, physician, or urgent care center providers for BlueCHiP for Medicare.
- "**Not Medically Necessary"** – This indicates services where there is insufficient evidence to support.
- **"Not Separately Reimbursed"** – Services that are not separately reimbursed are generally included in payment for another service or are reported using another code and may not be billed to your patient.
- **"Subject to Medical Review"** – Preauthorization is recommended for Commercial products and required for BlueCHiP for Medicare.

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 is a registered trademark of the American Medical Association.

Policies

CPT Updates

Code	Comments
90587	Not covered for institutional and professional providers for BlueCHiP for Medicare
0469T	Not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products
0470T	Not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products
0471T	Not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products
0472T	Not medically necessary for institutional and professional providers for Commercial products
0473T	Not medically necessary for institutional and professional providers for Commercial products
0475T	Not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products
0476T	Not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products
0477T	Not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products
0478T	Not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products

HCPCS Updates

Code	Comments
C9489	Subject to medical review for institutional and professional providers for BlueCHiP for Medicare and Commercial products
C9490	Invalid code for professional providers for BlueCHiP for Medicare and Commercial products
C9745	Invalid code for professional providers for BlueCHiP for Medicare and Commercial products
C9746	Invalid code for professional providers for BlueCHiP for Medicare and Commercial products
C9747	Not medically necessary for institutional and professional providers for BlueCHiP for Medicare and Commercial products
K0553	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
K0554	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
Q9985	Not separately reimbursed for institutional providers for BlueCHiP for Medicare and Commercial products
Q9986	Subject to medical review for institutional and professional providers for BlueCHiP for Medicare and Commercial products
Q9987	Medicare Lab Network: allowed for hospitals only outside of the Medicare laboratory network
Q9989	Subject to medical review for institutional and professional providers for BlueCHiP for Medicare and Commercial products