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

July 2018

As providers, we all know that receiving care in an emergency department (ED) can be costly and time consuming. We also know that, in many cases, it can be avoided altogether. But every day, patients still show up to hospitals seeking care for issues that could – *and should* – be treated by their primary care provider (PCP). According to the Rhode Island Department of Health, our state could potentially save $90 million annually by ending these "preventable" emergency care visits.

Here at BCBSRI, we're committed to supporting the triple aim of better health for our state, a simpler patient experience, and lower costs. In that spirit, I ask that you remind your patients their PCP's office should be the first option to contact in the event of an acute medical issue.

Their PCP can then guide and advise them as to the appropriate setting of care based on their symptoms, their situation, and the time of day or day of the week. Our own internal member surveys support the fact that patients often do not have a good understanding of how to appropriately use the healthcare system, especially when they are sick.

In addition to educating our members, we also want to increase their access to high quality, affordable *after hours* care – and we're rewarding providers who help us in this endeavor by doing things like offering expanded office hours to their patients.

For example, BCBSRI offers incentives to providers for urgently scheduled visits that are rendered outside of the routine hours of 8:00 a.m. to 5:00 p.m. This would typically apply to care provided the same day or within 24 hours of the request for an acute problem or acute exacerbation of chronic illness. Having such an option available also helps keep folks out of the ED. (To find out more about our "After Hours: Special Services, Procedures and Reports" policy, click here.)

"It takes a team" is one of BCBSRI's driving mantras, and we certainly recognize the collaborative efforts of all our provider partners as we work together to make healthcare affordable and simple for all Rhode Islanders.

Gus Manocchia, M.D.
Executive Vice President
and Chief Medical Officer

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Choosing Wisely: Rethinking antibiotics for acute mild-to-moderate sinusitis

Matt Collins, M.D., MBA
Vice President,
Clinical Integration

With summer well underway, many in Rhode Island are experiencing seasonal allergies. Unfortunately, allergies can cause more than just uncomfortable symptoms. As the Centers for Disease Control and Prevention (CDC) notes, allergies are also risk factors for sinusitis.

When patients get sinusitis from allergies or a viral infection, they may think that a prescription for antibiotics is the wisest choice. But antibiotics are typically not needed to treat sinusitis and carry potentially harmful side effects.

As we advance antibiotic stewardship principles, we should be mindful of how our tendency to prescribe antibiotics affects the cost burden and increases antibiotic resistance. Consider this: *Choosing Wisely** and the American Academy of Family Physicians (AAFP) point out that sinusitis is responsible for $5.8 billion in annual healthcare costs, not to mention $16 million in office visits. This underscores the importance of delivering treatments that are medically necessary, especially for issues as common as sinus problems.

When is it appropriate to consider antibiotics for sinusitis?

Together with the AAFP, *Choosing Wisely* offers recommendations and clinical guidance on the appropriate use of antibiotics for acute mild-to-moderate sinusitis. Instead of writing a prescription right away, it's advised that patients wait to see whether their symptoms persist. Even for more common sinus problems, *Choosing Wisely* generally recommends that when treating sinus problems, we should hold off on prescribing antibiotics, unless symptoms exceed 10 days.

Choosing Wisely also recommends antibiotics not be prescribed for sinusitis, unless patients have:

- A fever above 102° F
- Worsening symptoms after they have appeared to improve
- Severe pain around the eyes and nose
- A skin infection or hot, red rash that quickly spreads

In most cases, symptoms will go away on their own and can be treated with over-the-counter products, rest, and proper hydration.

Tips for speaking with your patients about appropriate treatment for sinusitis

The AAFP offers a four-step framework on speaking with your patients about treating their sinusitis. The AAFP recommends that providers:

1. Provide clear recommendations
2. Speak with patients about their religious beliefs and cultural values
3. Provide empathy, partnership and legitimation
4. Confirm treatment agreement and work to overcome barriers

Click here to visit the AAFP's website to view more tips for communicating appropriate treatment options to your patients. There is also a helpful video of a provider walking through a similar conversation on antibiotics and sinusitis.

As you continue the valuable work of delivering high-quality, affordable healthcare to our members, I hope you will continue sharing with your patients when antibiotics are appropriate and when they are not. You may also print out *Choosing Wisely's* recommendations for patients on how to treat sinus problems. Together, we can ensure patients in Rhode Island are better informed and receiving the best care possible.

*Choosing Wisely is an initiative of the ABIM Foundation, in partnership with more than 80 specialty societies, to help clinicians and patients engage in conversations about the overuse of tests and procedures and to support physician efforts to help patients make smart, effective healthcare choices.

BCBSRI Update

PBF Introducing BCBSRI's Clinical Programs Guide

With the healthcare landscape growing more complex, BCBSRI remains committed to supporting PCPs in delivering high-quality, affordable care to our members. As part of this support, we're pleased to share with you our 2018 Clinical Programs Guide, which provides descriptive overviews of BCBSRI's current offerings for eligible members.

The programs listed in the guide are separated into the following clinical areas:

- Care management services
- End-of-life program
- Home-based services
- Behavioral health programs
- Pharmacy programs
- 2018 BCBSRI quality initiatives

We hope you find the guide useful and informative. If you have questions or suggestions on any of BCBSRI's clinical programs, please contact us at ClinicalPrograms@bcbsri.org.

PBF BCBSRI offers LGBTQ Safe Zone certification

BCBSRI encourages its in-network healthcare providers to collaborate with us in supporting lesbian, gay, bisexual, transgender, queer (LGBTQ) communities. Our goal is to help identify healthcare environments in which LGBTQ members can feel welcome and safe when seeking healthcare services.

BCBSRI welcomes all healthcare provider sites, including specialist offices and facilities, to pursue LGBTQ Safe Zone certification.

Healthcare settings that meet specific criteria are designated as LGBTQ Safe Zones and receive BCBSRI identification, including an award, a window cling, and a Safe Zone designation on BCBSRI's Find a Doctor tool.

As of July 2018, the following 14 practice sites in Rhode Island have been LGBTQ Safe Zone certified:

Medical

RI Women's Health & Midwifery

Thundermist Health Center of South County

Thundermist Health Center of West Warwick

Thundermist Health Center of Woonsocket

West View Nursing and Rehabilitation Center

Dental

Thundermist Health Center of South County

Thundermist Health Center of West Warwick

Thundermist Health Center of Woonsocket

Mental Health

Frank J. Canino, Ph.D.

Jayna Klatzker, LICSW

Jessica Peipock, LICSW

Brian C. Pilecki, Ph.D.

Laurie Thornton, MA, CAGS, LMHC

Wilder Therapy & Wellness

To learn more about how to become an LGBTQ Safe Zone certified provider site, please click here, or contact Guillaume Bagal, lead diversity and inclusion consultant, at (401) 459-1509.

BCBSRI Update

PBF Important: Verify your practice information!

BCBSRI regularly conducts quarterly fax-based validation and attestation of provider practice information displayed within our Find a Doctor tool. We contact provider offices directly, via fax, to ensure this information is accurate and up to date.

CMS requires providers to note whether the location included is the same as where a patient is able to make an appointment. CMS also requires providers to note whether they are accepting new patients.

Once your office has verified your information, please check the "attestation" box and fax it back to BCBSRI as soon as possible. Please note that even if your information is presently accurate and not in need of updates, your office is still expected to verify your information, check the attestation box, and fax the form back to BCBSRI.

If you have questions about these verification efforts, please email ProviderRelations@bcbsri.org.

Quality

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 our internal resources. This information helps us identify opportunities to enhance clinical care for your patients, who are our members. "Hints for HEDIS (and more)" contains resources and guidance to make it easier for providers to take advantage of these opportunities.

If you have any questions, comments, or ideas regarding any of BCBSRI's quality or clinical initiatives, please contact Monica Broughton, MPH, quality management analyst, at (401) 459-1146 or email monica.broughton@bcbsri.org.

Cervical cancer screenings

Routine screenings remain very effective in detecting cervical cancer and precancerous changes, which may otherwise develop undetected. Screening for cervical cancer is considered a preventive service. Preventive care is covered at no cost to the member per the Affordable Care Act.

Please discuss with patients who may be candidates for cervical cancer screenings the importance of receiving the following tests:

Test	Eligible population	Exclusions	Tips for success
Cervical cancer screening	• Women 21-64 years of age who have had a PAP test within the measurement year or prior two years - or - • PAP/HPV co-testing within the measurement year or prior four years.	• Women who have had a complete hysterectomy with no residual cervix. Please note that medical record evidence must indicate total/complete hysterectomy/absence of cervix. Hysterectomy alone will not exclude the member. • Members in hospice.	• Documentation in the medical record must include **both** a note indicating which date the test was performed and the result obtained. • Biopsies are not counted as evidence of screening. • Remind members that preventive tests are covered at no cost-share* to the member.

*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.

Medication reconciliation post-discharge

Medication reconciliation is necessary for patient safety and can reduce the chance of an adverse drug event for patients taking multiple medications. Discharge planning and home follow-up that includes medication management has been shown to reduce readmissions and the length of hospital stays. When patients discuss medication management with their providers, they can better understand their discharge information, treatment, and next steps.

This measure assesses the percentage of discharges occurring between January 1 and December 1 of the measurement year and applies to members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge, for a total of 31 days.

The following table contains information and tips on how to apply this measure:

Test	Eligible population	Exclusions	Tips for success
Medication reconciliation post-discharge	• Members 18 years of age and older for whom medications were reconciled between the date of discharge and 30 days after discharge, for a total of 31 days.	• Members in hospice.	• Submit a professional claim with the CPT II code 1111F. • Identify high-risk patients and shape the needed services. • Give patients a pharmacy contact at the time of discharge. • Provide patient interviews by case management or social services within 30 days to identify opportunities for improvement. • Conduct timely communication with care team and ambulatory provider. • If a patient is seen at the VNA post-discharge, please ensure all forms and notes are scanned into the patient's medical record.

Medical records

The following are requirements for notating medication reconciliation in a patient's medical records:

- 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 a notation that both lists were reviewed on the same date of service.
- Evidence that the member was seen for a post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Documentation in the discharge summary that discharge medications were reconciled with current medications. There must be evidence that the discharge summary was filed in the outpatient chart between the date of discharge and 30 days after discharge, for a total of 31 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 referencing the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinuation of all discharge medications.)

P Make the most out of CPT® Category II Codes

CPT Category II Codes® can close gaps in care for your patients, as set forth by the National Committee for Quality Assurance (NCQA). 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. Effective immediately, these codes can be submitted and used for claims with older dates of service.

If you have any questions, please contact your Provider Relations representative or email ProviderRelations@bcbsri.org.

P 2018 Clinical Practice Guidelines for Chronic Obstructive Pulmonary Disease and Diabetes

Please note that the 2018 Clinical Practice Guidelines for Chronic Obstructive Pulmonary Disease (COPD) and Diabetes were presented at the Professional Advisory Committee meeting on May 16, 2018. The guidelines were approved as revised. The next review is scheduled for May 2020.

Behavioral Health

PBF BCBSRI will no longer offer the On Track outcomes tool

Effective July 18, 2018, BCBSRI will no longer offer the On Track outcomes tool to our provider network. On Track is a patient-informed, quality measurement tool facilitated by our behavioral healthcare partner, Beacon Health Options. In addition, the financial incentives offered through On Track will no longer be available.

Providers may continue using On Track after July 18, 2018, but will be required to purchase the tool for their own use. If your practice is interested in continuing to use On Track, please contact the Center for Clinical Informatics by visiting acorncollaboration.org.

We remain committed to connecting providers with the tools they need to measure the quality of care they deliver to our members. Supporting providers as they measure quality remains at the forefront of BCBSRI's strategic objectives for behavioral health. We are currently exploring other quality measurement resources for our provider network. We look forward to sharing new quality measurement tools and resources with you in the future.

If you have any questions regarding the On Track tool or quality measurement in general, please contact Sarah Fleury, lead behavioral health clinical program specialist, at sarah.fleury@bcbsri.org or (401) 459-1384.

Pharmacy

Drug therapy review timeframes

Timeframes for 2018		
Plan	**Level of review**	**Turn around time**
Direct pay, small group, fully and self-funded large group *Non-coverage exceptions (PA, Step therapy, QL)*	Initial urgent	72 hours
	Initial standard	15 calendar days
	Appeal urgent (180 days to file appeal)	72 hours
	Appeal standard (180 calendar days to file appeal)	30 calendar days
	External appeal urgent	72 hours
	External appeal standard	10 calendar days
Direct pay, small group, fully and self-insured large group *Coverage exception (Rx is not listed on formulary)*	Initial urgent	24 hours
	Initial standard	72 hours
	External urgent	24 hours
	External standard	72 hours
Commercial *Coverage exceptions*	Initial urgent	72 hours
	Initial standard	15 calendar days
	Appeal urgent	72 hours
	Appeal standard	30 calendar days
	External appeal urgent	72 hours
	External appeal standard	10 calendar days
Medicare	Initial urgent	24 hours
	Initial standard	72 hours
	Appeal urgent	72 hours
	Appeal standard	7 calendar days

In order to meet the deadlines on the previous page, all relevant clinical information must be provided at the time a drug therapy review is requested. If the request form is missing medical information needed for Prime Therapeutics, LLC (Prime) to make a clinically appropriate decision, attempts to contact you will be made. If Prime reaches out to attain any necessary information that may be missing, it's imperative that you respond in a timely manner to provide this missing information. This is important, as cases will be denied if they lack essential and additional information within the indicated timeframes. Any information received after these deadlines expire will be considered an appeal and will be handled as such.

To avoid unnecessary review levels and delays in access to medications, we recommend taking the following steps:

- Utilize the ePA tool at covermymeds.com.
- If using fax forms, please select and complete the correct form. Please fill in **all** fields and provide **all** requested documentation.
- Whether using fax or the ePA tool, review your responses before submitting to ensure accuracy.
- Only use urgent requests when truly needed.
- Be aware of timeframes and deadlines for review, and respond when Prime reaches out for additional information.
- Take office closures and staff availability into account when submitting requests.

PBF Obtaining prior authorization for drug therapy reviews

Did you know that we offer a fast and seamless electronic way to submit requests for drug therapy review? CoverMyMeds is the electronic prior authorization (ePA) tool offered through BCBSRI and Prime. CoverMyMeds offers electronic submissions of prior authorizations for any prescription drug. When you submit prior authorizations electronically, they are seamlessly integrated with your electronic health record system offering you ePA functionality right in your office. Some of the benefits include:

- Reduction of administrative waste
- Faster determinations
- Validated and accurate prior authorization requests

To create a CoverMyMeds account:

- Go to www.covermymeds.com
- Click on "Create a Free Account"
- Log in with the email and password used to register your account

We encourage you to take advantage of the benefits ePA has to offer and make this your primary tool for requesting drug therapy reviews.

For questions regarding the status of an existing prior authorization, please call BCBSRI's Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050.

Reminder: Utilizing the correct form for claim adjustment requests

BCBSRI wants all practices to have their administrative issues resolved accurately and timely. This is why it is so important to ensure that the appropriate form is filled out and submitted correctly, as well as sent to the appropriate department.

As such, please remember that the Grievance & Appeals Unit (GAU) does not process claims adjustments. GAU is BCBSRI's internal review team for grievances and appeals and is not responsible for claim adjustments or processing.

If you are sending in a claim retraction, claim correction, or medical record, please use the Physician/Provider Claim Adjustment Request form that can be printed and downloaded by clicking here. This form must be mailed to our claims department at the following address, which is also listed on the bottom of the claim adjustment form:

Blue Cross & Blue Shield of Rhode Island
Attn: Basic Claims Administration – Inquiry Unit 00066
500 Exchange Street, Providence, RI 02903-2699

Please note that any claims submissions that are incorrectly sent to GAU to process of any kind may be returned, and you will be asked to submit the proper form to the proper BCBSRI department.

If you are looking to submit an appeal, please use the Physician/Provider Appeal Request form, which you can print and download by clicking here. If you have any questions regarding which form to use or the appropriate BCBSRI department to submit claim adjustments to, we welcome you to email ProviderRelations@bcbsri.org.

Medical records submissions

Effective immediately, please discontinue submitting medical records utilizing the *Medical Records Cover Sheet*. In order to provide more efficient processing of your medical record submissions, please follow the below submission requirements:

- If you have received a letter from BCBSRI requesting medical records, please attach the letter you received when submitting the associated medical records.
- If you have not received a letter, please utilize the updated Physician/Provider Claim Adjustment Request form, and then check off "medical records." This indicates that medical records are submitted per BCBSRI request. Please be sure to indicate the claim identification number applicable to the medical record submission.

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.

- Adult and Pediatric Feeding Disorders
- Autologous Chondrocyte Implantation
- Emergency Department - Waiver of Copayment
- Enhanced External Counterpulsation (EECP)
- Home Prothrombin Time Monitoring
- Manipulation Under Anesthesia
- Mobile Cardiac Outpatient Telemetry (MCOT)
- Prostate Specific Antigen (PSA) Screening Testing Mandate
- Retinal Telescreening
- Temporary Prostatic Stent
- High-Risk Pregnancy Services and Maternity Global Reimbursement

For your review, we also post monthly drafts of medical policies that are in the process of 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 in the Provider section of bcbsri.com. Once there, click on the Medical and Payment icon to view the relevant policy. From there, use the drop-down box to sort policies by draft.

PBF New policies

Please be advised that the following new policies have been created:

- Amniotic Membrane and Amniotic Fluid
- Lutathera (lutetium Lu 177 dotatate) PREAUTH
- LuxturnaTM (voretigene neparvovec-rzyl)
- Monitored Anesthesia Care for Gastrointestinal Endoscopic Procedures

To review the full text of each policy, please visit the Policies page, which is located in the Provider section of bcbsri.com.

PF Percutaneous tibial nerve stimulation

Effective September 1, 2018, percutaneous tibial nerve stimulation will require prior authorization for Commercial products. This service already requires prior authorization for BlueCHiP for Medicare. The percutaneous tibial stimulation service and corresponding CPT code will be located in the related policy and the Prior Authorization via Web-Based Tool for Procedures policy.

P New submission requirements for claims using modifier 59 and X {EPSU} modifiers

As published in June's issue of Provider Update, starting August 15, 2018, BCBSRI will require paper claim submission with supporting documentation for claims filed with modifier 59 or XE, XP, XS, XU (X {EPSU}) modifiers. This requirement reflects BCBSRI's efforts to align with CMS' National Correct Coding Initiative, which promotes accurate and appropriate claims submission practices. BCBSRI also works diligently to follow the recommendations on the use of modifier 59 set forth by the Office of Inspector General.

Once the claim is submitted on paper with supporting documentation, it will be reviewed to determine if it is coded correctly. If it is coded correctly, the claim will pay according to the BCBSRI allowance. **Please submit your paper claim on the CMS-1500 claim form with supporting documentation** (e.g., operative and medical notes).

To file a paper claim with supporting documentation, please follow these two steps:

1. Complete a CMS-1500 claim form
2. Submit the completed CMS-1500 form and supporting documentation to:

Blue Cross & Blue Shield of Rhode Island
Claims Department
500 Exchange Street
Providence, RI 02903-2699

Claims filed electronically and/or with no supporting documentation will be denied as provider liability and will be reflected on your remittance advice as "refile claim on paper with the supporting documentation." Members cannot be billed for incorrectly submitted claims. If your claim is not reviewed because of incorrect submission after August 15, 2018, you have the right to submit an adjustment using the Physician/Provider Claim Adjustment Request form, which is located on the provider portal on bcbsri.com.

For information, please read the Modifier 59 or X {EPSU} Guidelines policy or email ProviderRelations@bcbsri.org.

F Non-reimbursable health service codes

BCBSRI follows CMS' Hospital Outpatient Prospective Payment System 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.

Effective October 1, 2018, the following CPT codes will **not** be considered as separately reimbursed for facilities accepting BlueCHiP for Medicare and Commercial products:

- 93320
- 93321
- 93621
- 93622
- 93623
- 93662
- 94760
- 94761
- 96368
- 99292

Refer to the policy for Non-reimbursable Health Service Codes for more details. This may reflect a payment change for some facilities.

Policies

PF BlueCHiP for Medicare national and local coverage determinations policy

BCBSRI must follow 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 appropriate 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 BlueCHiP for Medicare's National and Local Coverage Determinations policy for further information on BlueCHiP for Medicare coverage.

PF CPT and HCPCS Level II Code changes

We have completed our review of the July 2018 current procedural terminology (CPT) and HCPCS code changes including any category II performance measurement tracking codes and category III temporary codes for emerging technology. These updates will be added to our claims processing system and are effective July 1, 2018. The lists include codes that have special coverage or payment rules for standard products. Some employers may customize their benefits. We have included codes for services that are:

- "Not Covered" – This includes services not covered in the main member certificate (e.g., covered as a prescription drug).
- "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 they are reported using another code and may not be billed to your patient.
- "Subject to Medical Review" – Preauthorization is recommended for Commercial products and is required for BlueCHiP for Medicare.
- "Invalid" – Use alternate procedure codes, CPT or HCPCS code.
- "Medicare Lab Network" – This includes codes that are reimbursed to a hospital laboratory outside of the laboratory network, physician or urgent care center providers for BlueCHiP for Medicare.
- "Pending CMS determination" – This includes BlueCHiP for Medicare Category III codes.

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

Blue Cross & Blue Shield of Rhode Island
Attn: Medical Policy, CPT review
500 Exchange Street
Providence, Rhode Island 02903-2699

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

Policies

CPT and HCPCS Code updates for July 2018

- 0505T – Pending CMS determination for BlueCHiP for Medicare and not medically necessary for professional and institutional providers for Commercial products.
- 0506T – Pending CMS determination for BlueCHiP for Medicare and not medically necessary for professional and institutional providers for Commercial products.
- 0507T – Pending CMS determination for BlueCHiP for Medicare and not medically necessary for professional and institutional providers for Commercial products.
- 0508T – Pending CMS determination for BlueCHiP for Medicare and not medically necessary for professional and Institutional providers for Commercial products.
- Q9994 – Not separately reimbursed for professional and institutional providers for BlueCHiP for Medicare and Commercial products.
- Q9995 – Not covered for professional and institutional providers for Commercial products, pharmacy benefit only.

PF Updated drug policies for BlueCHiP for Medicare

Effective June 1, 2018, the following policies are only applicable to BlueCHiP for Medicare:

- Benlysta (Belimumab)
- Botulinum Toxins Injections
- Brineura
- Exondys (Eteplirsen) for Duchenne Muscular Dystrophy
- Infused Drugs for Multiple Sclerosis (Lemtrada and Ocrevus)
- Injectable Agents for Asthma and Chronic Idiopathic Urticaria – Xolair, Cinqair, Fasenra, Nucala
- Krystexxa (Pegloticase)
- Kymriah
- Makena
- Parsabiv (etelcalcetide)
- Probuphine
- Prolia and Xgeva (Denosumab)
- Provenge (Sipuleucel-T) – Update effective 7/1/2018
- Radicava
- Soliris
- Sprinrava
- Stelara (Ustekinumab) Intravenous use for Crohn's Disease
- Xeomin
- Xiaflex (Clostridial Collagenase)
- Yescarta

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