Blue Cross Blue Shield of Rhode Island

provider update

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

November/December 2016

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

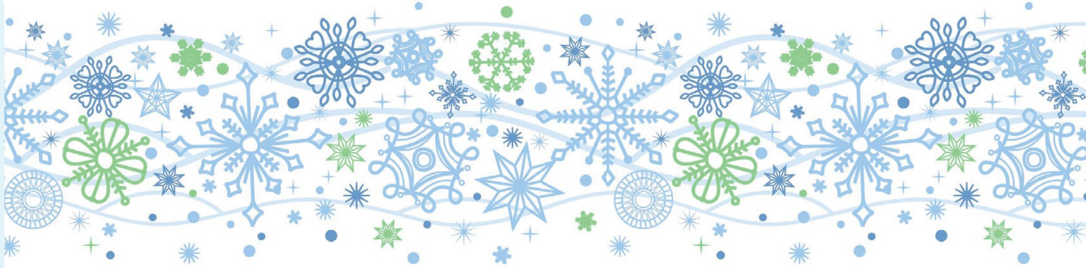
Greetings,

Our monthly newsletter includes news and updates for physicians, providers, and facilities in our network. It's full of important and useful information impacting how we do business together.

As always, please contact us with any comments or questions you have. We look forward to your continued partnership and collaboration.

Contents

BCBSRI Update	*Pages 1-3*
Quality	*Pages 4-8*
Pharmacy	*Page 9*
Behavioral Health	*Page 10*
Contracting & Credentialing	*Page 11*
Policies	*Pages 12-13*



Happy holidays and best wishes for a healthy new year from all of us at Blue Cross & Blue Shield of Rhode Island!

BCBSRI Update

PBF Preparing for flu season

As winter approaches, so does flu season. We appreciate all you do to ensure your patients are given the appropriate immunizations. As a reminder, it's important to file claims accurately, and applicable G codes must be filed for our BlueCHiP for Medicare members. Please review the 2016/2017 Influenza & Adult Pneumococcal Immunization Summary Sheet for claims filing guidelines.

PBF "Commendable" rating from NCQA

Recently, we learned that we once again scored a 4.5 Health Insurance Plan rating out of a possible 5 from the National Committee for Quality Assurance (NCQA) for our Commercial product. This score and its associated rating of "commendable" puts us in the top 11% of health plans nationwide. That's great company to be in—and we couldn't have done it without your help!

Last year, NCQA changed its rankings methodology and adopted a rating system with a scale of 1 to 5 (in half-point increments) where a 5 is the highest score and 1 is the lowest. This is a method similar to CMS' Five Star Quality Rating system. Plans were evaluated on the combined scores for health plans in the Healthcare Effectiveness Data and Information Set, commonly called HEDIS; the Consumer Assessment of Healthcare Providers and Systems or CAHPS; and NCQA Accreditation standards scores. These scores effectively measure consumer satisfaction, disease prevention, and treatment. The ratings were published by NCQA in its Private Health Insurance Plan Ratings 2016-2017 report.

BCBSRI Update

PBF Thank you for helping us achieve a 4.5 star Medicare rating!

We're extremely proud that we've earned a rating of 4.5 stars for our 2017 plans from the Centers for Medicare and Medicaid Services (CMS) as part of their Five-Star Quality Rating System*. The high-quality care that you provide to our members helped us achieve this notable accomplishment, and we appreciate your dedication and support.

What is the Five-Star Rating System?

The Five-Star Rating System is CMS' measurement of the quality and performance of all Medicare Advantage plans. It is designed to promote improved patient care, improved health, and lower healthcare costs.These ratings give Medicare customers a comparison tool to evaluate Medicare Advantage plans from various insurers when it's time to enroll each year. There are 43 total rating measures across five main categories:

- Staying healthy
- Managing chronic conditions
- Member complaints
- Member experience with plan and providers
- Customer service

Specific measures include ratings for pharmacy, grievance and appeals, the enrollment process, and many more areas where our members interact with us and with their providers.

What does the rating mean?

It means that our members—as well as CMS—have rated BCBSRI Medicare plans very high in terms of quality, service, and many other factors. Some of the specific measures where we were rated highest include overall health plan customer service, drug plan customer service, and in the area of "member complaints and changes in the performance" of our health and drug plans.

Want to learn more?

To learn more about the CMS Five-Star Rating System, visit CMS.gov or Medicare.gov.

PBF Important: Update your practice information!

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

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

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

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

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

**Medicare evaluates plans based on a 5-star rating system. Star ratings are calculated each year and may change from one year to the next.*

BCBSRI Update

P Weekly training webinars available for Blue Insights Population Health Management Tool

BCBSRI is pleased to offer a weekly training webinar for the Blue Insights Population Health Management tool. This web-based solution provides timely data that allows providers to manage populations of patients and monitor their opportunity for our PCP Quality Incentive Program.

Blue Insights will allow you to view:

- Prospective preventive and chronic disease gaps in care
- Your attributed members
- Providers who also treated your patient(s)
- Your high-risk patients and a report on your high-risk engagement
- Utilization information on your patients over the course of 24 months, which includes inpatient, ER, ambulatory surgery, radiology, and pharmacy
- Rx data to assist you in tracking whether the patient(s) filled their prescriptions

Training webinars are held on Thursdays from noon to 1:00 p.m. To enroll, please email PopulationHealthRegistry@bcbsri.org. For additional training and questions, please contact your provider relations representative or email ProviderRelations@bcbsri.org.

P Primary care providers – can you volunteer at Rhode Island Free Clinic?

Physicians and nurse practitioners—active or retired—who would like to volunteer to provide low-income, uninsured Rhode Island adults with primary care now have a new opportunity at the RI Free Clinic, which is offering expanded hours to welcome new patients. All new RI Free Clinic patients are Rhode Island adults who meet low-income eligibility requirements, are residents, and have no insurance.

The following hours are open to volunteers:

Mornings: Monday–Friday, 9:00 a.m.–noon

Afternoons: Monday–Thursday, 1:00 p.m.–4:00 p.m.

Evenings: Tuesday, Wednesday, & Thursday, 6:00 p.m.–9:00 p.m.

"Spending time at the Clinic reminds me of why I became a doctor," says Dr. Caroline Troise, an internal medicine specialist with Anchor Medical Associates, who is also RI Free Clinic's volunteer medical director. "One doesn't have to travel to another country to care for the needy. Your help is needed, and gratefully received, right here."

Medical malpractice is available to volunteer providers through the Clinic. Retired physicians who volunteer are also eligible for free Rhode Island medical licenses.

RI Free Clinic is located at 655 Broad Street in Providence. In 2015, the Clinic provided nearly 2,000 patients with a comprehensive medical home, thanks to a dedicated statewide corps of nearly 700 volunteers and community partners, including BCBSRI.

For information, please contact Collin Connor at (401) 274-6347, ext. 327 or cconnor@rifreeclinic.org.

PF Hints for HEDIS (and more)

As part of our ongoing efforts to provide the highest quality care to our members, BCBSRI reviews data from the Healthcare Effectiveness Data and Information Set (HEDIS®), CMS Stars, Consumer Assessment of Healthcare Providers and Systems, Medicare Health Outcomes Survey, and internal resources. This helps us identify opportunities to enhance clinical care for your patients, our members. "Hints for HEDIS (and more)" provides guidance and resources to help address these opportunities. If you have any questions, comments, or ideas regarding any of our quality or clinical initiatives, please contact Siana Wood, RN, senior quality management analyst, at (401) 459-5413 or siana.wood@bcbsri.org.

November was Diabetes Awareness Month

November was National Diabetes Awareness Month. With a prevalence of more than 10% in Rhode Island, diabetes remains a high priority for BCBSRI. Diabetes screening and management guidelines are provided below.

The Centers for Disease Control recommends that anyone aged 45 years or older be tested for diabetes, particularly if they are overweight. If their test results are normal, they should be retested in three years. Adults younger than 45 should also be tested if they are overweight and have one or more of these additional risk factors:

- Have a first-degree relative with diabetes
- Are African-American, American Indian, Asian-American, Pacific Islander, or Hispanic-American/Latino
- Are physically inactive
- Have blood pressure or lipid abnormalities
- Have a history of gestational diabetes

Diabetes is diagnosed using one of the following four methods (ADA, 2015).

FPG ≥126 mg/dL (7.0 mmol/L)*
Fasting is defined as no caloric intake for ≥8 hours

2-hr PG ≥200 mg/dL (11.1 mmol/L) during OGTT (75-g)*
Using a glucose load containing the equivalent of 75g anhydrous glucose dissolved in water

A1C ≥6.5% (48 mmol/mol)*
Performed in a lab using NGSP-certified method and standardized to DCCT assay

Random PG ≥200 mg/dL (11.1 mmol/L)
In individuals with symptoms of hyperglycemia or hyperglycemic crisis

- No clear clinical diagnosis? Immediately repeat the same test using a new blood sample.
- Same test with same or similar results? Diagnosis confirmed.
- Different tests above diagnostic threshold? Diagnosis confirmed.
- Discordant results from two separate tests? Repeat the test with a result above diagnostic cut-point.

**In absence of unequivocal hyperglycemia, result to be confirmed by repeat testing*

Management of diabetes

Management of diabetes depends on the type of diabetes and the patient. Diabetes management involves oral or injected medication, nutritional therapy, exercise, and lifestyle modifications as well as home blood glucose testing and regular periodic screenings. A1C should be maintained between or below 7% to 8%, depending on the patient. In addition, the regular screenings in the following section are both clinical standards of care and evaluated in the HEDIS Comprehensive Diabetes Care Measure.

Comprehensive diabetes care

The HEDIS Comprehensive Diabetes Care measure set includes screening rates for retinal eye exams, HbA1c, and blood pressure; medical care for kidney problems; and rates of A1c control in patients with type 1 and type 2 diabetes. Our HEDIS 2015 data demonstrates that a little over a quarter of our Commercial population (26.67%) have poorly controlled diabetes (HbA1c >9%). As you know, higher A1c values lead to higher rates of diabetes complications such as cardiovascular disease, amputation, blindness, kidney failure, and nerve damage (peripheral and autonomic). Below are practice tips for the HEDIS Comprehensive Diabetes Care measures.

Comprehensive Diabetes Care Measure	Measure population (Type 1 or 2 diabetes:)	Tips for Success
Hemoglobin A1c (HbA1c) Testing	An HbA1c test during the measurement year	Pre-visit planning may be useful. For members with upcoming appointments, medical assistants can mail a reminder letter and a lab slip to those due for HbA1c screening and other tests to help increase rates. Reinforce with members the importance of routine A1c testing as an indicator of diabetes control and to help guide treatment planning.
HbA1c poor control (>9.0%)	The most recent HbA1c test during the measurement year with a result greater than 9.0% OR a missing result	For this measure, lower rates (of poorly controlled members with diabetes) are desirable. Consider Diabetes Disease Management for patients with diabetes. Consider endocrinology referral for complex or refractory cases.
HbA1c control (<8.0%)	The most recent HbA1c test during the measurement year with a result less than 8.0%	Reinforce members' achievement of target A1c and its association with lower rates of complications
Eye exam (retinal) performed	A retinal eye exam by an optometrist or ophthalmologist in the measurement year OR a "negative for retinopathy" retinal exam by one of the above specialists in the year prior to the measurement year	The retinal eye exam may include (but does not require) dilation. Remind patients that diabetic eye disease can be asymptomatic, so routine exams are important for finding and treating problems early.

Comprehensive Diabetes Care Measure	Measure population (Type 1 or 2 diabetes:)	Tips for Success
Medical attention for nephropathy	A nephropathy screening test OR evidence of nephropathy	Dispensation of at least one ACE-I or ARB medication counts as evidence of nephropathy. Remind patients that, like eye disease, diabetic kidney disease may be asymptomatic. Regular tests can detect issues early, when treatment may help delay disease progression. Pre-visit planning may be useful when screening tests are due. For members with upcoming appointments, have medical assistants note (schedules or records) that a urine test for microalbumin is needed.
Blood pressure control (<140/90 mm Hg)	The most recent blood pressure reading taken during an outpatient visit or a nonacute inpatient encounter	Discuss the importance of blood pressure control, especially given the additional cardiovascular risks for people with diabetes.

BCBSRI offers a disease management program for Commercial members with diabetes. Interventions are based on risk stratification. All identified members (low risk) receive a mailing to introduce the program and provide educational material. A call-in line is also made available for additional information or questions. People with diabetes who have gaps in care (moderate risk) receive notifications recommending they contact their physician to schedule any necessary screening or testing. Members stratified as high risk are offered the opportunity to participate in telephonic Health Coaching with a BCBSRI registered nurse or registered dietitian. The notification to high-risk members who belong to a patient-centered medical home (PCMH) includes a recommendation that they contact the nurse case manager at their primary care physician's office for assistance with their diabetes management. If you have Commercial members who could benefit from the Diabetes Disease Management program, please call the BCBSRI Triage Line at (401) 459-2273.

Osteoporosis

According to the *National Osteoporosis Foundation's Clinician's Guide to Prevention and Treatment of Osteoporosis: 2014 Issue*, 9.9 million Americans have osteoporosis. Two million fractures are attributed to osteoporosis annually, resulting in 432,000 hospital admissions, 2.5 million medical office visits, and approximately 180,000 nursing home admissions nationally. Practice teams can help foster prevention of osteopenia and osteoporosis by discussing appropriate preventive measures with patients. The National Institutes for Health list the following risk factors for osteopenia and osteoporosis:

Nonmodifiable Risk Factors

- **Gender** – Women have higher risk due to lower peak bone mass, smaller bone structure than men, and the sharp decline in estrogen levels associated with menopause.
- **Age** – Advancing age increases risk.
- **Body size** – Slender, thin-boned women and taller women are both at increased risk.
- **Race** – Caucasian (white) and Asian women are at highest risk. African-American and Hispanic women have a lower but significant risk. Caucasian men are at higher risk than their non-Caucasian counterparts.
- **Family history**

Modifiable Risk Factors

- **Hormone deficiencies** – Premenopausal women with amenorrhea, menopausal women, and men with testosterone deficiency are at increased risk. Men taking certain medications for prostate cancer can also be at increased risk of osteoporosis.
- **Diet** – Diets low in calcium and vitamin D, excessive dieting, and inadequate caloric intake can increase risk.
- **Medications** – Long-term use of certain medications, including glucocorticoids and some anticonvulsants, leads to bone loss and increased risk of osteoporosis, as do some anticoagulants and immunosuppressants.
- **Inactive lifestyle or extended bed rest**
- **Excessive use of alcohol**
- **Smoking**

Patient education should include osteoporosis risk factors as well as the importance of adequate calcium and vitamin D intake, exercise, fall prevention, smoking cessation, and moderation of alcohol consumption. For additional fall prevention resources, please access the American Geriatric Society's Updated American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons and Recommendations.

The HEDIS measure for Osteoporosis Management in Women Who Had a Fracture (OMW) tracks the percentage of women ages 67 to 85 years old who 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 2015 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 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 that lists 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.

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 prevent patients from obtaining life insurance. RA is normally confirmed by a series of tests. Once the diagnosis of RA is confirmed, the codes described in the table on the next page should be used.

For both HEDIS and CMS Stars, the ART measure evaluates the use of DMARD therapy in members 18 years and older with rheumatoid arthritis. Periodically during the year, the BCBSRI Quality Management Department conducts ongoing provider assessments via fax to learn more about our RA patients and possibly impact the ART measure. On the next page 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 one ambulatory prescription dispensed for a DMARD (see table below) during the measurement year. *Exclusions:* members diagnosed with HIV or members who are pregnant during the current year. *Denominator:* members 18 years and older with two of the following events on different dates in the measurement year: • Outpatient visit with any diagnosis of rheumatoid arthritis • Nonacute inpatient discharge with any diagnosis of rheumatoid arthritis	• Only utilize codes for rheumatoid arthritis (RA) if diagnosis has been confirmed. • For members with confirmed RA, DMARD therapy is the current standard of care. • For rule-out, suspect, or possible RA, code the symptoms or appropriate condition. Below you will find useful diagnosis codes that may more accurately describe the services provided to your patients: - V13.4: Patient-Reported or Personal History of RA - V17.7: Family History of Arthritis - V82.1: Screening for RA - 714.9: Unspecified Inflammatory Polyarthropathy - 715.XX: Osteoarthritis - 716.5: Unspecified Polyarthritis or Polyarthropathy - 720.9: Unspecified Inflammatory Spondylopathy - 725.0: Polymyalgia Rheumatica

NCQA Table ART-C: Medications Counted as DMARD Therapy

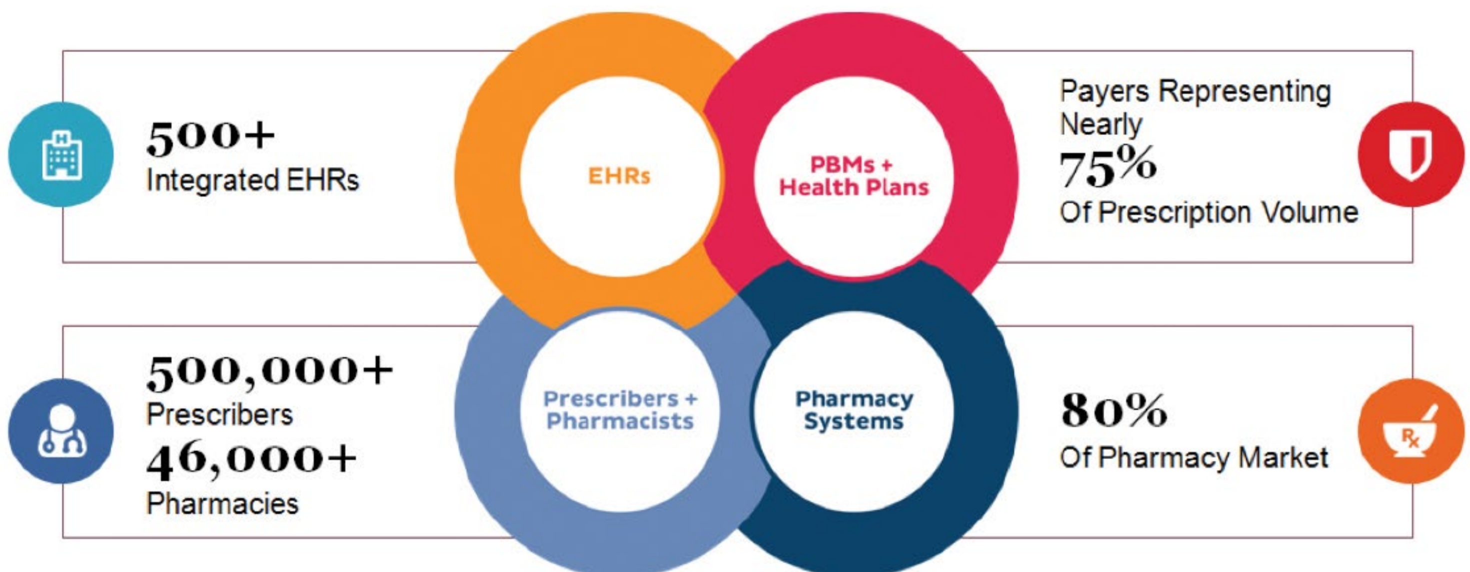
Description	Prescription	J Codes
5-Aminosalicylates	• sulfasalazine	
Alkylating agents	• cyclophosphamide	
Aminoquinolines	• hydroxychloroquine	
Anti-rheumatics	• auranofin • gold sodium thiomalate • leflunomide • methotrexate • penicillamine	J1600, J9250, J9260
Immunomodulators	• abatacept • adalimumab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

PBF Start saving time today with electronic prior authorizations

On January 1, 2017, BCBSRI will complete its transition to a new pharmacy benefit manager (PBM), Prime Therapeutics (Prime). The selection of Prime followed a comprehensive review process where BCBSRI focused on choosing a PBM partner that has a proven record of operational excellence and a commitment to serving the needs of providers and patients. In this month's update, we are focusing on electronic prior authorizations through CoverMyMeds®.

BCBSRI and Prime will offer electronic prior authorization (ePA) through CoverMyMeds to speed up the process to get your patients their medication. It's a helpful service for you and your patients.

Prior authorizations no longer have to be so cumbersome. Through CoverMyMeds, Prime gives you a free service to submit PAs electronically for any drug. ePAs are seamlessly integrated with your EHR system to provide you with ePA functionality right in your office.



ePA reduces administrative costs while minimizing your need for faxes and phone calls, although those methods will still be available. ePA through CoverMyMeds offers a number of benefits:

- Reduction of administrative waste
  - Eliminates phone calls and faxes
  - Tracks the status of your PA
- Faster determinations
  - Streamlines process for a quicker response
  - Provides determination recommendations to reviewing staff
- Validated and accurate PA requests
  - Directs prescribers to complete required fields

Here's how you can create an account for CoverMyMeds:

- Go to www.covermymeds.com
- Click on "Create a Free Account"
- Log in using your e-mail and password

CoverMyMeds is an independent company not affiliated with BCBSRI. It is your responsibility to review and decide whether to use CoverMyMeds' services. CoverMyMeds can be used for pharmacy prior authorization requests for Commercial BCBSRI patients who use Prime as their pharmacy benefits manager.

B Butler Hospital's Ambulatory Detoxification Program

This outpatient program meets the needs of members who do not meet the criteria for inpatient detox but are at high risk for relapse and higher utilization without structured supports. In addition to supports typically found in a detox program, Butler's program includes a Peer Recovery Coach who will follow the member after discharge. The Peer Recovery Coach will engage the member while at Butler and will conduct follow-up calls up to 30 days post discharge to ensure that the member is well supported through their recovery. The program requires prior authorization through Beacon Health Options. If you wish to refer someone to the program, please call Butler Hospital Intake at (401) 455-6214.

B Peer Recovery Coach Program

BCBSRI is piloting a program through Anchor Recovery/The Providence Center that will provide an opportunity for Commercial members with substance use disorders to work with a peer recovery coach. Peer recovery coaching is a SAMHSA-recognized tool that facilitates recovery and reduces healthcare costs. Peer recovery coaches are individuals in recovery themselves who have been through extensive training to provide support to their peers. Recovery coaches do not diagnose or treat addiction, but rather serve as a bridge to substance use services and community supports. At this time, services are offered via an alternative benefit and referrals are identified by Beacon Health Options and Anchor Recovery/The Providence Center.

Learn more about Anchor Recovery.

For additional information about the Peer Recovery Coach Program, please contact Sarah Fleury, LICSW, behavioral health performance specialist, at (401) 459-1384 or sarah.fleury@bcbsri.org

B CODAC Medication Assisted Treatment (MAT) Pilot Program

This outpatient buprenorphine/naloxone or buprenorphine program is offered by CODAC, a substance use disorder treatment facility. It 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, including medication assisted treatment such as Suboxone, nursing, counseling, and case management services that ultimately lead to recovery and the ability to maintain recovery in a less intensive treatment program. If you wish to refer someone to the program, please contact CODAC at (401) 871-6563.

B Follow Up After Hospitalization Quality Pilot Program

BCBSRI is committed to promoting better health outcomes and quality care for members with behavioral health needs. As part of this commitment, BCBSRI implemented a quality program for our behavioral health participating providers aimed at improving timely transitions from inpatient behavioral healthcare to outpatient behavioral health specialist services for members who experience an inpatient mental health admission.

The National Committee on Quality Assurance (NCQA) has an established Healthcare Effectiveness Data and Information Set (HEDIS) measure, Follow Up After Hospitalization for Mental Illness, which will be the basis for our determination of timely transitions. BCBSRI is focusing on the component of this measure that assesses the percentage of members 6 years of age and older who attend a follow-up behavioral health visit within seven calendar days of discharge from an inpatient admission for a primary mental health diagnosis.

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 providers who complete a visit with a member within the seven-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, director of behavioral health, at (401) 459-1467 or rena.sheehan@bcbsri.org, or Sarah Fleury, behavioral health performance specialist, at (401) 459-1384 or sarah.fleury@bcbsri.org.

PBF Updated in February 2017: Medicare opt-out

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

Medicare opt-out affidavits

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

Opt-out guidelines

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

Reimbursement guidelines for BCBSRI Commercial members with Medicare as primary coverage

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

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

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

Policies

PF Policies recently reviewed for annual update

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

- Acute Inpatient Rehabilitation Level of Care
- Belimumab
- BlueCHiP for Medicare Laboratory Network Hospital/Physician/Urgent Care Allowable Test Listing
- Cochlear Implants
- Endometrial Ablation
- Focal Treatments for Prostate Cancer
- Gait Analysis
- Hyperthermia for Cancer Therapy
- Intensity-Modulated Radiotherapy of the Breast and Lung
- Intensity-Modulated Radiotherapy: Central Nervous System Tumors
- Manipulation Under Anesthesia
- Measurement of Serum Antibodies to Infliximab and Adalimumab
- Omalizumab (Xolair)
- Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- PathFinderTG® Molecular Testing
- Patient-Controlled End Range Motion Stretching Devices
- Pegloticase
- Peripheral Artery Disease Rehabilitation
- Post-Payment Audits
- Progesterone Therapy as a Technique to Reduce Preterm Birth in High-Risk Pregnancies
- Skin Contact Monochromatic Infrared Energy as a Technique to Treat Cutaneous Ulcers, Diabetic Neuropathy, and Miscellaneous Musculoskeletal Conditions
- Temporary Prostatic Stents
- Transvaginal and Transurethral Radiofrequency Tissue Remodeling for Urinary Stress Incontinence
- Tumor Treating Fields for Glioblastoma
- Varicose Vein Treatment

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. Once on that page, click the drop-down box to sort policies by draft.

PF Artificial disc replacement, cervical

Effective February 1, 2017, insertion of an artificial cervical intervertebral disc will require prior authorization. The service and the corresponding CPT code will be found in the Preauthorization via Web-Based Tool for Procedures policy. Additionally, removal of an artificial cervical intervertebral disc will be a covered service and will no longer require prior authorization.

PF BlueCHiP for Medicare National and Local Coverage Determinations

BBCBSRI will be implementing updates to our claim editing rules and processes to help ensure that claims for members enrolled in our Medicare Advantage plans are processed according to standard Centers for Medicare & Medicaid Services (CMS) medical necessity guidelines.

The goal of these claim editing updates is to more closely align how we process Medicare Advantage claims with the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Noridian is our CMS LCD DME contractor and National Government Services (NGS) is our CMS Part B contractor. To ensure correct claims processing, we encourage our providers to review the CMS NCDs and LCDs that can be found here.

BCBSRI will continue to align with NCD and LCD updates and will make those updates on a quarterly basis. Please see the full text of this policy.

PF Breast Pumps – Change in benefit

Effective January 1, 2017, our Breast Pump Policy will be updated to cover commercial-grade breast bumps. Please see the full text of this policy.

PF Non-wearable automatic external defibrillator

Effective January 1, 2017, a new policy will be effective for Non-Wearable Automatic External Defibrillator. The device will require prior authorization for BlueCHiP for Medicare and will not be covered for Commercial products. The device has been added to the DME-Related Exclusions section for the Subscriber Agreement for commercial products. Please see the full text of this policy.

PF Circulating tumor DNA and circulating tumor cells for cancer management (liquid biopsy)

Effective December 1, 2016, the Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy) policy replaces the policy titled Detection of Circulating Tumor Cells in the Management of Patients with Cancer. The updated policy removes diagnosis code edits and finds that the use of circulating tumor DNA and circulating tumor cells is considered not medically necessary for all indications as there is insufficient peer-reviewed literature that demonstrates the service is effective. This applies to BlueCHiP for Medicare and Commercial products. Please see the full text of this policy.

PF Reminder: DME KX and KS modifier coding and payment guidelines

As a reminder, the use of modifier KX (requirements specified in the medical policy have been met) and the use of modifier KS (glucose monitor supply for diabetics beneficiary not treated with insulin) is required. Providers are required to append the KX and KS modifier to applicable HCPCS Level II durable medical equipment codes in accordance with Medicare guidelines. If claims are not submitted with the appropriate modifier, claims will deny. Please see the full text of this policy.

PF Dopamine transporter imaging with single-photon emission computed tomography (DAT-SPECT)

Effective January 1, 2017, the following code is not medically necessary as this radiopharmaceutical is used for DaTscan: A9584 – Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries. This is applicable to BlueCHiP for Medicare and Commercial products. Please see the full text of this policy.

PF Endobronchial valves

A new policy has been created for endobronchial valves. Effective November 1, 2016, the coverage determination for BlueCHiP for Medicare and Commercial products is not medically necessary for the following CPT codes: 31647, 31648, 31649, and 31651. Please see the full text of this policy.

PF Modifiers 59, X{EPSU}

During a recent claims review, it was noted that a high volume of claims were submitted with modifier 59, which defines a "Distinct Procedural Service." CPT instructions state that modifier 59 should not be used when a more descriptive modifier is available, so the use of modifier 59 should be very limited.

Effective January 1, 2015, The Centers for Medicare and Medicaid Services (CMS) established four new Healthcare Common Procedure Coding System (HCPCS) modifiers to define subsets of modifier 59, which are collectively referred to as X{EPSU} modifiers. CMS guidelines state that the X{EPSU} modifiers are more selective versions of modifier 59, so it would be incorrect to include both modifiers on the same line.

Here are the four modifiers:

- XE separate encounter, a service that is distinct because it occurred during a separate encounter
- XS separate structure, a service that is distinct because it was performed on a separate organ/structure
- XP separate practitioner, a service that is distinct because it was performed by a different practitioner
- XU unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

For additional information, please refer to the Coding and Payment Guidelines policy.

PF Non-Reimbursable Health Service Codes

Effective January 1, 2017, CPT code 83861 will be a not separately reimbursed service. This change is applicable to BlueCHiP for Medicare and Commercial products.

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