Blue Cross Blue Shield of Rhode Island

provider update

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

May 2015

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.

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BCBSRI Update

PFB REMINDER: Web-Based Preauthorization

As recently communicated, we transitioned most of our current BCBSRI web-based/fax prior authorization processes to McKesson's Clear Coverage™ decision support tool in December 2014. In April Provider Update we explained that select procedures rendered by multiple specialists will require preauthorization through the Clear Coverage system beginning June 1, 2015.

Clear Coverage's fully automated web-based system includes real-time decision support features. Here are some highlights:

- *Automated authorization:* Real-time approval for services that meet clinical criteria
  - > Immediate proof of authorization while patient is in your office
  - > Printable confirmation with an authorization number
  - > Ability to submit requests 24/7
  - > Minimal need for phone calls, faxes, and providing additional clinical information
- *Clinical decision support:* Automated interactive tool with InterQual® Criteria
  - > Confirms evidence basis for requested service or recommends alternatives
  - > Easily and clearly verifies if authorization is required for specific types of services by CPT or service type
  - > Printable clinical evidence summaries for use in your practice

Preauthorization for Services Through Clear Coverage

For a full list of the services that must be submitted for preauthorization through Clear Coverage, please review the following policies in the Provider section of **BCBSRI.com**:

- Preauthorization via Web-Based Tool for Procedures
- Preauthorization via Web-Based Tool for Durable Medical Equipment

Also, please review the Preauthorization Quick Reference Guide for a description of services by code(s).

Please note:

- Inpatient admissions, speech therapy, private duty nursing, and pulmonary rehab will continue to go through BCBSRI's traditional web-based/fax preauthorization process.
- High-tech radiology preauthorization requests will continue to go through MedSolutions, Inc., our radiology management vendor.
- Prescription drugs covered by the member's pharmacy benefit will continue to go through Catamaran, our pharmacy benefits manager.
- Prescription drugs covered by the member's specialty pharmacy benefit will continue to go through Walgreens Specialty Pharmacy.
- Behavioral health preauthorization requests will continue to go through ValueOptions, our behavioral health management vendor.

ValueOptions is responsible for all preauthorizations and concurrent reviews for behavioral health services. Facility-based behavioral health services include:

- Inpatient
- Residential
- Partial Hospitalization Program (PHP)
- Intensive Outpatient (IOP)

Outpatient behavioral health services include:

- Applied Behavior Analysis (ABA)
- Child & Family Intensive Treatment (CFIT)
- Transcranial Magnetic Stimulation (TMS)

Provider Education & Training

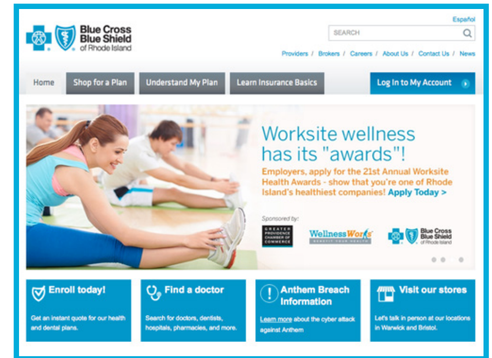
For your convenience, you will be able to receive training for Clear Coverage in the following ways:

- *Webinars* – Through May 28, we will be offering three webinars per week:
  - > Tuesdays at 7:30 a.m.
  - > Wednesdays at 12:00 p.m.
  - > Thursdays at 4:00 p.m.
- *On-site training in your office* Please contact the Physician & Provider Service Center to schedule.

Participants interested in attending any of these webinars should email their request to BCBSRIWebinar@bcbsri.org. Your enrollment will be confirmed via email, and instructions to access the webinar will be provided.

How to Access Clear Coverage on BCBSRI.com

You will need to log in to the secure Provider portal on BCBSRI.com to initiate the preauthorization process through Clear Coverage. Once logged on, click on Preauthorization, which is located in the left-hand navigation. If you can currently log in to **BCBSRI.com**, you will be able to access Clear Coverage immediately.



If you (or your practice) **do not** currently have a log-in to **BCBSRI.com**, please follow these steps:

1. Click *"Sign up for a log-in"* on the lower right-hand side of the Provider home page.
2. Follow the prompts to register as a participating provider and request a PIN. Please note that the information you provide online will be populated in a pdf that you will need to print, sign, and fax to BCBSRI.

For More Information

You can find more information in our Clear Coverage Frequently Asked Questions. If you have any questions regarding these changes, please 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.

Hints for HEDIS®

As part of our ongoing efforts to provide the highest quality care to our members, BCBSRI reviews Healthcare Effectiveness Data and Information Set (HEDIS) performance data as well internal data to identify opportunities to enhance clinical care for your patients, our members. "Hints for HEDIS" provides guidance and resources to help address these opportunities. If you have any questions, comments, or ideas regarding any of our quality or HEDIS initiatives, please contact Siana Wood, RN, Senior Quality Analyst, at (401) 459-5413 or siana.wood@bcbsri.org.

Body Mass Index (BMI)

According to the Centers for Disease Control (BRFSS, 2010), among Rhode Islanders age 18 and over:

- 62.9% of adults were overweight, with a BMI of 25 or greater
- 25.5% of adults were obese, with a BMI of 30 or greater

Calculating each patient's BMI and sharing the information with them can create a dialogue about healthy weight between you and your patients. The Adult BMI Assessment is a HEDIS measure for NCQA accreditation as well as a Medicare Stars measure. HEDIS defines this measure as the percentage of members 18-74 years of age who had an outpatient visit and who had their BMI docmented during the measurement year or one year prior.

Improve Your Rates: 4 Steps to Success

✓ Record the date of the outpatient visit

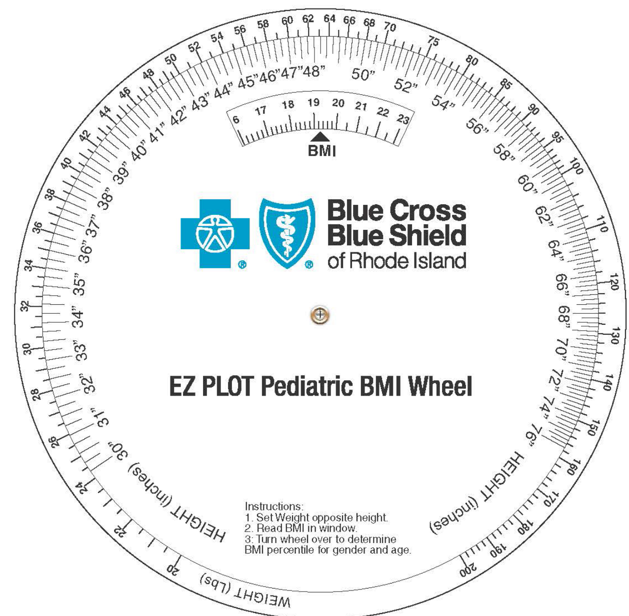
✓ Record the patient's height

✓ Record the patient's weight

✓ Calculate and record the patient's BMI

A review of HEDIS 2014 data showed the most opportunity for improvement in the Adult BMI Assessment measure among practices that do not have an electronic health record (EHR). If your practice has an EHR, please ensure it is calculating and recording the BMI after entering the patient's height and weight. For practices without EHRs, Provider Relations representatives will be distributing BMI wheels for use in your offices.

**HEDIS is a registered trademark of the National Committee for Quality Assurance.*



Cancer Screenings

Routine screenings remain one of the most effective ways to detect cancers (and precancerous changes) that might otherwise develop unnoticed. 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 following tests:

Test/Exam	Measure Population	Exclusions	Tips for Success
Breast Cancer Screening	Women ages 50-74 who have had a mammogram in the measurement year or one year prior	Women who have had bilateral mastectomy, two unilateral mastectomies, or a unilateral mastectomy with a bilateral modifier	• Ultrasounds and biopsies are not counted as evidence of breast cancer screening. • Talk with patients about what to expect when they have a mammogram. • Preventive tests are covered with no copay/cost-share.*
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	• Documentation in the medical record must include both a note indicating the date when the test was performed, and the result or finding. • Biopsies are not counted as evidence of screening. • Preventive tests are covered with no copay/cost-share.*
Colorectal Cancer Screening	Adults ages 50 to 75 who have had one of these three types of screenings: • Fecal occult blood test (FOBT) during the measurement year • Flexible sigmoidoscopy in the measurement year (or the four years prior to the measurement year) • Colonoscopy during the measurement year (or the nine years prior to the measurement year)	• Colorectal cancer • Total colectomy	• A digital rectal exam is not counted as evidence of a colorectal screening. • Talk with patients about what to expect from the recommended screening (e.g., procedure preparation, anesthesia, etc). This may allay fears about the test and help patients schedule tests more readily. • Preventive tests are covered with no copay/cost-share.*

**When suspicious tissue is encountered during a 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.*

Comprehensive Diabetes Care

The HEDIS Comprehensive Diabetes Care measure set includes screening rates for retinal eye exams, HbA1c, blood pressure, medical care for kidney problems, and rates of A1c control in patients with type 1 and type 2 diabetes. In 2013, 9.8% of Rhode Islanders were living with (diagnosed) diabetes, a prevalence rate that exceeded both Massachusetts' diabetes prevalence of 8.3% and the national rate of 9.7%. HEDIS 2014 data demonstrates that about a third of our Commercial population (32.85%) with diabetes have poor controlof the disease (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. Below are practice tips for the HEDIS Comprehensive Diabetes Care measures:

Comprehensive Diabetes Care Measure	Measure Population: Type 1 or 2 Diabetes Plus:	Tips for Success
Hemoglobin A1c 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.
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. Diabetics with 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.

PF Living Fit Benefit

Being active can help improve your patients' health and quality of life. That's why BlueCHiP for Medicare offers Living Fit! Members can get an unlimited-use health club membership at any one network facility for only $5 per month. Members pay the $5 membership fee month to month, and may cancel at any time. With their membership, BlueCHiP for Medicare members can take advantage of:

- Group fitness classes (Additional cost may apply.)
- State-of-the-art exercise equipment
- Knowledgeable, courteous staff
- Indoor swimming pool (available at some facilities)

We encourage you to speak with your patients about the importance of exercise to their overall health and well-being.

To learn more about member eligibility for low-cost fitness benefits, please call 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. You can read more about Living Fit here.

Monitoring Physical Activity is a Medicare Star Ratings program measure that is collected through the Health Outcome Survey (HOS). As a provider, you can advise BlueCHiP for Medicare members to start, increase, or maintain an exercise program where appropriate. This will help to address this specific measure for the Medicare Star Ratings program.

PFB Prescribers Must Take Action by June 1, 2015

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F *Medicare Program: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs* on May 23, 2014. This rule requires physicians and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be covered under Part D. Prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) by June 1, 2015, or earlier, to ensure that MACs have sufficient time to process the applications or opt out affidavits. The effective date for health plans to enforce this requirement via claim adjudication or denial is December 1, 2015.

PFB Coverage Determinations and Appeals

Coverage Determinations

A Coverage Determination, sometimes referred to as a Prior Authorization, is a decision made by the Prescription Drug Plan sponsor with respect to the following:

- Will the plan cover a prescription drug? *(Coverage Determination)*
- Will the plan make an exception to their established prescription tier? *(Tier Exception)*
- Will the plan make an exception to their established formulary? *(Formulary Exception)*
- Will the plan cover a supply greater than the quantity limit? *(Quantity Limit Override)*
- What will the cost share for a prescription drug be?
- Have the Prior Authorization or Utilization Management requirements been satisfied?

BCBSRI and our pharmacy benefits manager, Catamaran, have been striving to improve the timeliness of decisions for all Coverage Determination requests. The definition of *timely* depends on which plan the member has: Medicare Part D (BlueCHiP for Medicare) or a Commercial plan (VantageBlue, HealthMate Coast-to-Coast, BlueSolutions, or Classic Blue, to name a few.) To ensure members can fill the prescriptions they need when they need them, BCBSRI and Catamaran commit to an even faster turnaround time for requests marked Urgent.

Once Catamaran's Prior Authorization Department receives a request, the plan must notify the enrollee of the decision within a specific timeframe. For Commercial members, that must be within 360 hours (15 days) for Standard, and 72 hours (3 days) for Urgent. For Medicare Part D members, a Standard determination must be completed within 72 hours and within 24 hours for Urgent. **It is important to note that these timeframes are based on hours elapsed**, and the clock continues rolling overnight, through weekends, during holidays, and throughout inclement weather.

Prior Authorization Timeframes	Standard	Urgent
Commercial	360 hours (15 days)	72 hours (3 days)
Medicare	**72 hours (3 days)**	**24 hours (1 day)**

In order to meet these deadlines, it is imperative that the Prior Authorization form be filled out accurately and completely. If the form is missing any necessary medical information, the plan sponsor reaches out to the office to attempt to obtain the information within the specific timeframes after receiving the initial written statement. **If the missing information is not supplied within the timeframe, the request will be denied**.

This is of particular concern with Medicare Part D members, as the timeframes are so short. The Standard timeframe is 72 hours, and the Urgent timeframe is only 24 hours. That does not leave the Catamaran representatives much time to obtain missing information, particularly if the prescriber's office is closed. The determination must be made within the timeframe based on the information obtained at that point. **If the information provided is insufficient to support the request, and further information cannot be obtained within the timeframe, the request will be denied**.

Prior authorization guidelines and forms are available on the provider section of BCBSRI.com (no sign-in required), and are revised regularly. Using a general request or an outdated form could result in missing information critical for the authorization requirements. A helpful suggestion is to bookmark the location of the forms, and regularly pull the forms and criteria documents from the web rather than saving the forms themselves.

Prior Authorization Bookmarks	
Commercial	Commercial Formulary
Medicare	BlueCHiP for Medicare Formulary

Providers may also contact Catamaran's Prior Authorization Department directly to request forms, check status, or provide additional information.

Catamaran Contact Information	Telephone	Fax
Commercial	1 (866) 391-1164	1 (866) 391-7222
Medicare	**1 (866) 858-7907**	**1 (866) 391-2929**

If a form is received missing information that is necessary to determine if the coverage criteria are met, the Prior Authorization department at Catamaran makes up to three telephonic outreach attempts to the requesting office. **If additional information is not obtained within the determination timeframe, the request must be reviewed using only the information provided. If the criteria for authorization are not met according to the information that was supplied within the timeframe, the request must be denied.**

Appeals (Redeterminations)

An appeal is a review of an adverse coverage determination, the evidence and findings on which it was based, and any other evidence that has been submitted. As with coverage determinations, appeals have specific timeframes. BlueCHiP for Medicare appeals are handled by BCBSRI within 7 days for Standard requests, and 72 hours for Urgent. Commercial appeals are handled by Catamaran within 30 days for Standard requests, 72 hours for Urgent.

Appeals	Standard	Urgent	Handled by	Telephone	Fax
Commercial	30 days	72 hours	Catamaran	1 (866) 858-7907	1 (866) 391-2929
Medicare	**7 days**	**72 hours**	**BCBSRI**	**(401) 459-5784**	**(401) 459-5668**

Pharmacy

BCBSRI and Catamaran have worked diligently to ensure that determinations are being made in a timely manner. While this goal has been met, it has had a related consequence. More appeals are being submitted, and more decisions are being overturned with a particular set of avoidable circumstances in common. In large part, the reason for the initial denials has been **insufficient documentation on the initial request and an inability to obtain the additional information in a timely manner**.

This often happens when a request is submitted on a Friday afternoon and the office is subsequently closed on Saturday and Sunday (and with this winter's weather patterns, frequently on Monday as well.) **If insufficient clinical documentation was submitted and the representatives were unable to reach someone at the provider's office to obtain the information within the timeframe, these requests are denied**. This is happening even on cases when the appeals process reveals that they would have met the criteria and the authorization would have approved if only this information had been submitted within the timeframe.

This adds unnecessary steps to the process, generates more work for the provider's office, Catamaran, BCBSRI, and, sometimes even the member. Critically, it can also delay a member's ability to access a vital medication.

Please take the steps below to help avoid these circumstances, streamline the process, reduce labor, save money, and, most importantly, ensure patients access to their medications.

- Bookmark the links for the medical criteria and forms and use the most up-to-date authorization forms.
- Ensure use of the correct forms and phone or fax numbers for Medicare versus Commercial members. (Fast hint – BlueCHiP for Medicare policies start with ZBM).
- Review the criteria and ensure the patient's medical history supports use of this particular medication.
- **Complete ALL fields on the form; provide ALL documentation requested to support how the patient's medical history indicates they have met the criteria**.
- Use Urgent requests sparingly – only when it is truly imperative that the patient start on the drug immediately.
- Use Standard requests in most circumstances.
- **Be aware of the timeframes and follow up with outreach by a Prior Authorization Representative promptly to avoid timing-out.**
- Take office closures and staff availability into account when considering timeframes, and take special care to ensure all necessary documentation has been supplied to reduce the need for follow-up.

BCBSRI Prescription Drug Prior Authorization Quick Facts

Prior Authorization Timeframes	Standard	Urgent
Commercial	360 hours (15 days)	72 hours (3 days)
Medicare	**72 hours (3 days)**	**24 hours (1 day)**

Prior Authorization Bookmarks	
Commercial	Commercial Formulary
Medicare	BlueCHiP for Medicare Formulary

Catamaran Contact Information	Telephone	Fax
Commercial	1 (866) 391-1164	1 (866) 391-7222
Medicare	**1 (866) 858-7907**	**1 (866) 391-2929**

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PFB Claims Adjustments

Beginning July 1, 2015, we will no longer accept claims adjustments over the phone or through Secure Messaging on BCBSRI.com if the claim being changed was previously submitted with incorrect information.

How This Impacts You

Electronic Submitters

Providers who submit claims through the Electronic Data Interchange (EDI) have the capability to also request adjustments that way too. We encourage any participating providers who submit claims through the EDI to use this mechanism for all claims adjustments. We ask that you please convey this to your billing company or clearing house if they submit claims adjustments on your behalf.

If you have any questions on how to submit claims adjustments through the EDI, please click here to access the EDI Companion Guide, or 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.

Paper Submitters

Providers who submit claims through regular mail must complete the Adjustment Request Form and mail the information to us at:
Basic Claims Administration – Inquiry Unit – 00066
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699

F Claims Filing for Home Infusion Providers

Home infusion providers can submit claims for dates of service on or after July 1, 2015 on the CMS-1500 claim form and/or the 837P EDI transaction, which aligns with how you submit claims to other health plans. Dates of service rendered before July 1 should be filed on the CMS-1450 (UB-04) form and/or the 837I EDI transaction.

Adjustments requested after July 1 must be made on the claim form that was originally submitted.

PFB Provider Financial Responsibility for Pre-Service Review

Participating BlueCard inpatient service providers will be financially responsible for inpatient facility services that need pre-service review, which includes notification, precertification, preauthorization, and prior approval. Previously, the member was financially responsible for those services.

The Host (BCBSRI) and Home (the out-of-state Blues plan) plan providers must hold members harmless when a pre-service review is not received for inpatient facility services, unless responsibility for a pre-service review is otherwise specified in the member and/or group account contract.

Participating BlueCard providers may also be required to obtain a pre-service review for outpatient facility and professional services. Blues plans may have different rules on whether the provider or member is financially responsible if a pre-service review is not received for outpatient services.

PBF Credentialing Updates

The Council of Affordable Quality Healthcare (CAQH) has incorporated feedback from providers and health plan focus groups into the development of CAQH ProView™, a range of new features that will make it easier to update information, reducing the time and resources necessary to submit accurate, timely data to organizations.

Providers will be able to easily submit information through a more intuitive, profile-based design. CAQH ProView's time saving features include:

- Complete and attest to multiple state credentialing applications in one intelligent workflow design.
- Upload supporting documents directly into CAQH ProView to eliminate the need for manual submission and to improve the timeliness of completed applications.
- Review and approve Practice Manager information before data is imported.
- More focused prompts and real-time validation to protect against delays in data processing.
- Self-register with the system before a health plan initiates the application process.

PFB Policies Recently Reviewed for Annual Update

The following policies were recently reviewed for annual update. You can review the full text of these policies.

- Adrenal to Brain Transplantation
- Axial Lumbosacral Interbody Fusion
- Breast Prosthesis and Mastectomy Bras Mandate
- Colorectal Cancer Screening Mandate
- Contraceptive Drugs and Devices Mandate
- Cosmetic Services/Procedures
- Coverage of Complications Following a Non-covered Service
- Dermatologic applications of Photodynamic Therapy
- Lysis of Epidural Adhesions
- Mammograms and Pap Smears Mandate
- Manipulation Under Anesthesia
- Mechanical Wound Suction
- Microwave Tumor Ablation
- Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
- Signal Averaged Electrocardiography
- Speech Therapy
- Transtympanic Micropressure Applications as a Treatment for Meniere's Disease

As we continue to enhance our claims processing system, the following policies, as part of the annual review process, had diagnosis edits added to the updated policy. To ensure correct claims processing, please review the following policies.

- Automated Point of Care Nerve Conduction Studies
- Balloon Ostial Dilation for Treatment of Chronic Sinusitis
- Endovascular Procedures
- Interferential Current Stimulation
- Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate

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.

PF Subcutaneous ICD (S-ICD®) Implantable Cardioverter Defibrillato

Effective January 1, 2015, Subcutaneous ICD (S-ICD) Cardioverter Defibrillator insertions are covered for BlueCHiP for Medicare members and not medically necessary for Commercial products. Removal of a subcutaneous implantable defibrillator electrode (CPT code 33272) may be covered and prior authorization review is recommended for Commercial products.

Please note the following: Effective June 1, 2015, prior authorization will be required for BlueCHiP for Medicare and will be obtained via the online tool for participating providers. The applicable CPT codes relating to the Subcutaneous ICD (S-ICD) are 33270, 33271, 33272 and 33273.

This policy applies to the Subcutaneous Implantable Cardioverter Defibrillator only. As a reminder, Implantable Cardioverter Defibrillator (ICD) Insertions (not Subcutaneous) require prior authorization through the BCBSRI online prior authorization tool.

PFB April 2015 HCPCS® Level II Code Updates

We have completed our review of the HCPCS Level II code update. These updates will be added to our claims processing system and are effective on April 1, 2015.

The list includes codes that have special coverage or payment rules for standard products. (Some employers may customize their benefits.) We include codes for services that are:

- "Informational only" and measurement codes—Modifier or code is not used for claims processing
- "Not Separately Reimbursed"– Services that are not separately reimbursed are generally included in another service or are reported using another code and may not be billed to your patient.
- "Invalid" – Use alternate procedure code, CPT or HCPCS code
- "Not covered" – Includes services not covered in the main member certificate (e.g., covered as a prescription drug).
- Deleted code – Has been deleted and replaced with a HCPCS code

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

HCPCS Codes Effective April 1, 2015

EX: Modifier: Expatriate Beneficiary Informational only

JF: Modifier: Compounded Drug Informational only

C2623: Catheter, transluminal angioplasty, drug-coated, non-laser
Professional Providers: Invalid – Use alternate code
Institutional Providers: Not separately reimbursed

C9136: Injection, factor viii, fc fusion protein, (recombinant), per i.u. deleted code 3/31/15
It will be replaced with Q9975 which is effective April 1, 2015.

C9445: Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units
Professional Providers: Invalid – Use alternate code
Institutional Providers: Not separately reimbursed

C9448: Netupitant 300mg and palonosetron 0.5 mg, oral
Professional Providers: Pharmacy benefit only
Institutional Providers: Pharmacy benefit only

C9449: Injection, blinatumomab, 1 mcg
Professional providers: Use alternate code
Institutional providers: Not separately reimbursed

C9450: Injection, fluocinolone acetonide intravitreal implant, 0.01 mg
Professional providers: Use alternate code
Institutional providers: Not separately reimbursed

C9451: Injection, peramivir, 1 mg
Professional providers: Use alternate code
Institutional providers: Not separately reimbursed

C9452: Injection, ceftolozane 50 mg and tazobactam 25 mg
Professional providers: Use alternate code
Institutional providers: Not separately reimbursed

Blue Cross Blue Shield of Rhode Island
500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

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