Blue Cross Blue Shield of Rhode Island

provider update

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

July 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.

Contents

BCBSRI Update

PFB ICD-10 Transition on October 1, 2015

As of October 1, 2015, all providers, hospitals, and facilities must be transitioned to ICD-10. This date was set by the Department of Health and Human Services. As of that date, behavioral health providers will be required to use ICD-10 codes only. BCBSRI recommends that behavioral health providers consider the purchase of DSM-V as it has direct mappings from the DSM-V codes to the ICD-10 codes.

The transition to ICD-10 codes impacts both the medical and behavioral health community, and BCBSRI will continue to share information to assist providers in preparing for the transition.

The Centers for Medicare and Medicaid Services (CMS) has created a comprehensive website, CMS ICD-10 Provider Resources, that contains materials to help providers with the transition, including:

- A checklist of tasks with estimated time frames for completion
- A guide outlining the tasks in each phase of the implementation and a timeline with suggested start/finish dates for tasks
- Individual documentation for small, medium, and large practices
- Links to physician professional organizations that may provide specialty-specific information

We are now in the process of scheduling ICD-10 compliance testing with our Trading Partners (billing agencies, clearinghouses, etc.). If your practice submits claims via a billing agency or clearinghouse, please advise your billing agency or clearinghouse to schedule testing by emailing BCBSRI directly at ICD-10PartnerTesting@bcbsri.org. Practices that directly submit electronic claims to us should also contact us to schedule testing.

When preparing for testing with BCBSRI, you may want to do the following:

- Review provider documentation practices and level of coding expertise of office personnel.
- Assess the amount of testing required for internal office systems.
- Talk with your EDI vendor/clearinghouse about their role in supporting ICD-10 Trader Partner testing.

Your billing agency or clearinghouse will need sample test claims from you to initiate the testing process with us. Once a test file is submitted by your billing agency or clearinghouse, we will determine if the file is compliant by returning any errors to you on the Provider Control Report.

If your clearinghouse is Emdeon, please contact them directly to let them know

you want to test, as they have set up a testing site that BCBSRI will use to complete our portion of the testing.

If you have any questions related to testing electronic claims, please email us at ICD-10PartnerTesting@bcbsri.org.

PFB How to Become an LGBTQ Safe Zone

BCBSRI encourages healthcare providers in our participating network to collaborate with us in support of the LGBTQ (lesbian, gay, bisexual, transgender, queer) community. Our goal is to identify environments in which LGBTQ members feel welcome and safe when seeking healthcare services locally. Healthcare settings that meet specific criteria will be referred to as LGBTQ Safe Zones and receive BCBSRI identification, such as an award, window cling, and designation in the Find a Doctor tool.

Who can apply for this designation and what are the expectations?

Any practice in the Rhode Island community can be a BCBSRI LGBTQ Safe Zone, as long as the entire practice (including providers, staff, and location) meets the following requirements:

- **Staff training**
  - > Each staff member should complete some cultural competence training for LGB and transgender care each year. Training may include classroom learning, e-learning, and/or relevant conferences.
- **Physical Space**
  - > At least one gender neutral bathroom is available for patient use.
  - > The posted patient non-discrimination policy (or patients' bill of rights) protections include the term "sexual orientation" and the terms "gender identity or expression."
- **Forms & Procedures**

Requirements

  - > There are procedures for using name and pronouns that are different from legal name and sex.
  - > There are procedures for sharing a patient's sexual orientation or gender (as appropriate) when referring a patient to another provider.
  - > Within the past year, a review of clinical assessments has taken place to ensure that forms and/or providers are not assuming a patient's gender, marital/partnered status, and/or sexual activity.
  - > Patients are called from the waiting room in a gender-nonspecific way that provides safety in cases where legal name and sex do not match preferred name and gender identity
- **Additional LGBTQ Support**
  - > Non-discrimination policy for employees is inclusive of protections relative to sexual orientation and gender identity and expression.
  - > At least one gender-neutral bathroom is available for staff use.
  - > The practice has materials on hand to refer LGBTQ patients to social supports and other community-based services.
  - > This practice has supported and/or has integrated into the LGBTQ community through one of the following ways: sponsorship of LGBTQ events, participation in RI PrideFest, outreach into the LGBTQ community, and/or offering specific services targeted to the LGBTQ community.

We hope that all BCBSRI participating practices will become LGBTQ Safe Zones. Participants are expected to display the BCBSRI Safe Zone symbol in

A survey of nearly 5,000 lesbian, gay, bisexual, and transgender individuals showed*:

- 70% of transgender or gender non-conforming and 56% of lesbian, gay, and bisexual (LGB) patients surveyed have experienced some type of discrimination in healthcare.
- 73% of transgender respondents and 29% of LGB respondents reported that they believed they would be treated differently by medical personnel because of their LGBT identity.
- 52% of transgender respondents and 9% of LGB respondents reported that they believed they would be refused medical services because of their LGBT identity.

*When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV. New York: Lambda Legal, 2010. Available at: http://www.lambdalegal.org/publications/when-health-care-isnt-caring.

a visible location to identify themselves as supporters of LGBTQ community and as committed to creating an environment free of homophobia, heterosexism, and bias. Participants should be comfortable when LGBTQ community members approach them to talk about LGBTQ-related issues and with helping these individuals take advantage of other LGBTQ-related resources.

What resources are available to BCBSRI LGBTQ Safe Zone participants?

The BCBSRI LGBTQ Safe Zone is administered by BCBSRI Network Management. BCBSRI Diversity & Inclusion Consultants are available to all participants for consultation and/or referral when they need help supporting or assisting LGBTQ individuals and other community members. Additionally, the following Health Peer Advocates are available as provider resources for support, information, and consultation.

- BCBSRI Diversity & Inclusion Consultants
  - > Visael "Bobby" Rodriguez
    BCBSRI VP & Chief Diversity Officer
  - > Stephanie Huckel, M.S.
    BCBSRI Senior Diversity & Inclusion Consultant
- Health Peer Advocates
  - > Ruben Hopwood, MDIV, Ph.D.
    Coordinator,
    Transgender Health Program
    Fenway Health
    (617) 927-6225
    rhopwood@fenwayhealth.org
  - > Tim Cavanaugh, M.D.
    Medical Director,
    Transgender Health Program
    Fenway Health
    tcavanaugh@fenwayhealth.org

If you have questions or would like additional information, please contact Susan Walker, Provider Relations Manager, at (401) 459-5381 or susan.walker@bcbsri.org.

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. Please review the Procedures and Durable Medical Equipment policies as well as the Preauthorization Quick Reference Guide for existing or new codes being added to services that already require preauthorization, or for changes to the method in which preauthorization is obtained (traditional BCBSRI vs. Clear Coverage). These changes will be effective on September 1, 2015.

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

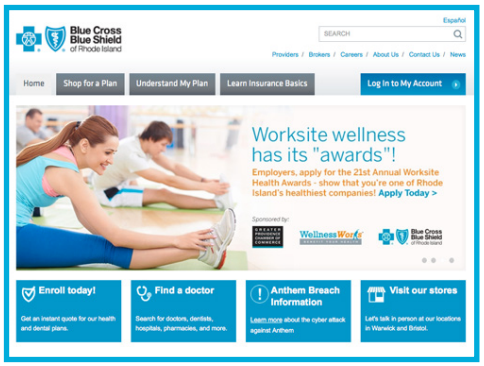
- Automated authorization: Real-time approval for services that meet clinical criteria
  - > Immediate proof of authorization while patient is in your office
  - > Printable confirmation with an authorization number
  - > Ability to submit requests 24/7
  - > Minimal need for phone calls, faxes, and 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).



Hints for HEDIS® (and More)

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

Thank You for Your Support

Please accept our thanks and gratitude for your hospitality toward and accommodation of our HEDIS medical record review staff in your practices during recent weeks. We recognize that it can be a challenge to find the additional space and time required for this initiative, and we appreciate your help. HEDIS data benefits all of us by identifying opportunities to improve outcomes, population health, and the delivery of cost-effective healthcare.

Adult Body Mass Index (BMI) Assessment

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 patients' 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 ages 18-74 who had an outpatient visit and who had their BMI documented during the measurement year or one year prior.

Reminder Cards

In an effort to encourage members to obtain important recommended screenings and tests, BCBSRI began mailing reminder cards in June to members for whom claims data indicates the need for a recommended service. The cards provide education about the importance of each service and remind members to call their provider to schedule the needed test or screening. Below is a list of the member populations targeted for each mailing.

Member Population	Type of Reminder Card Mailing
Women ages 50-74 who need a mammogram	Breast Cancer Screening
Women ages 21-64 who need cervical cancer screening	Cervical Cancer Screening
Members age 50-75 who need screening for colorectal cancer	Colorectal Cancer Screening
Children age 2 who need recommended vaccines	Childhood Immunizations
Adolescents age 13 who need recommended vaccines	Adolescent Immunizations
Adult members with diabetes who need any of the following: eye exam, nephropathy screening, A1c test	Diabetes Eye, Nephropathy, and/or A1c Test
Adult women ages 67-85 who suffered a fracture	Bone Mineral Density Test/Prescription for Treatment

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. In many EHRs, this is a function that needs to be turned on. For practices without EHRs, Provider Relations representatives will be distributing BMI wheels for use in your offices.

Improving Care Transitions

Care transitions are the movement of patients between healthcare locations, providers, or levels of care as patients' conditions and care needs change.* When these transitions are incomplete or disorganized, they can contribute to avoidable health problems, hospital readmissions, and increase the cost of healthcare. The goal of a successful care transition is for the patient, their caregiver(s), and their providers to understand the care plan and treatment changes. This requires clear communication, verifying patients' understanding of their plan of care, coordination of care between providers, and medication reconciliation at each level of care. The Center for Healthcare Research and Transformation offers these best practice recommendations for enhancing care transitions:

- **Clear Communication**
  Clinicians treating a patient at a certain level of care (hospital, skilled nursing, specialist office visit) communicate with the patient's primary care physician and other outpatient providers quickly, using a standard format. Such communication should include diagnoses, test and procedure results, pending tests, medication lists, rationale for medication changes, advance directives, caregiver status, contact information for the clinician, and recommended follow-up care. Time-sensitive tests or changes in medication warrant a same-day phone call to the primary care physician followed by written communication.
- **Verifying Patient/Caregiver Understanding**
  Studies indicate that patient "teach-back"—having patients restate instructions or concepts in their own words—is an effective way to confirm patient understanding. Patient education focuses on major diagnoses, medication changes, time of follow-up appointments, self-care, warning signs, and what to do if problems arise. Education can be supplemented by illustrations and written materials at appropriate reading levels.
- **Coordination of Care**
  Services, testing, referrals, and specialty care is arranged for patients, and provisions are made for its continuity or to be discontinued when appropriate. Summaries of the course of treatment, findings, or changes in the treatment plan are communicated with the primary care physician. Verification of the patient's understanding of treatment plan changes is confirmed. Complex patients will often require ongoing case management after a care transition to manage complicated conditions or multiple comorbidities.
- **Medication Reconciliation**
  Clinicians reconcile medications at each transition, such as inpatient, outpatient, or post-acute care. Clinicians check the accuracy of medication lists and dosages and look for contraindications. It can be helpful to have patients bring all medications (including over-the-counter, prescription, and herbal) into the office. Barriers to filling prescriptions are identified and addressed, such as financial, transportation, or psychosocial issues. Medication lists are shared with other providers to ensure medication safety and continuity.

*2008, National Transitions of Care Coalition, www.ntocc.org

PB Coverage of Transition-Related Hormones

BCBSRI is committed to appropriate coverage for all of our members, including our transgender member population. For those members who have pharmacy benefits through us, transition-related hormones are included in the benefits. Additionally, we have ensured that none of our drugs has gender-based restrictions. Traditionally, claims processing has denied payment for drugs based on gender criteria, primarily to help promote safety and prevent medication errors, fraud, and waste. Understanding the effect this could have on our transgender members, we have removed that qualifier. Now, if a person is receiving treatment for cervical cancer, for example, it does not matter whether they are listed as male or female in our records. The drugs they need will be considered for approval regardless of gender.

As medical professionals, pharmacists are tasked with helping to ensure that patients are getting the appropriate drug, in the right way, and limiting adverse reactions. When a pharmacist receives a prescription, it is their responsibility to review what is being prescribed, how much, and what other prescriptions the individual is taking. If the pharmacist sees that the prescription is for a significantly higher dose than the FDA recommends, they have the corresponding responsibility to seek clarification on the clinical appropriateness of the prescription before proceeding. This could happen with some transition-related medications, like estrogen. Open communication between the prescribing provider and the pharmacist to explain the reason for this dose could correct this issue and allow the prescription to be filled.

Pharmacy and medical claims systems ensure that the claims are processing to the correct policy by matching a variety of demographic information, primarily the ID number, name, date of birth, and gender. If any of these is different on the claim than it appears on the policy, the claim may be denied. This can be an issue with nicknames too. Regardless of whether a name on a policy is Alexander or Alexandra, even using Alex will result in a member being "not found." Providers should ensure that the information they use for claims filing matches what BCBSRI has on file, regardless of how the member identifies. Providers should also ensure patient information on a prescription matches the patient's insurance information.

Since the fall of 2013, testosterone has required preauthorization for everyone under age 40. If the information submitted meets the criteria established for safe and effective use of medications, the authorization can be approved. For example, while preauthorization is required for testosterone, gender dysphoria is a valid diagnosis for approval. Authorizations indicating that treatment is for gender dysphoria do not have to meet other criteria, such as being age 40 or over, having documented low testosterone, etc.

In 2013 and 2014, we began educating ourselves on the needs of the transgender community more than ever before. In 2015, we are expanding that education and will be providing LGB and transgender education to all of our customer and provider service representatives. It is our intention to provide every member with dignity and respect in ways that are important for each individual.

PFB Claims Adjustments

Beginning July 1, 2015, we will no longer accept claims adjustments over the phone or through Secure Messaging on BCBSRI.com to make a correction to a claim that was previously submitted with incorrect information. This change was communicated in the May and June issues of *Provider Update*.

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 clearinghouse if they submit claims adjustments on your behalf.

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

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

PFB Prospect Health Services

Effective July 1, 2015, BCBSRI and Prospect Health Services of Rhode Island, Inc. and CharterCARE Health Partners entered into a partnership that will benefit 6,500 Medicare Advantage members who have physicians affiliated with Prospect Provider Group of RI, LLC (PPGRI). PPGRI is a primary care and specialty provider independent practice association affiliated with the CharterCARE Health Partners, which includes Roger Williams Medical Center, Our Lady of Fatima Hospital, St. Joseph Health Center, and Elmhurst Extended Care.

PPGRI will utilize its Coordinated Regional Care model to provide additional resources for BCBSRI Medicare Advantage members, including:

- Nurse care managers who will coordinate all aspects of care
- Pharmacists to assist in medication management
- Case management services

The agreement includes new quality benchmarks and standards for patient safety, evidence-based care coordination, and satisfaction. Additionally, some aspects of care coordination that are traditionally performed by a health plan, such as case management and disease management with members, will be delegated to PPGRI. This will lead to better coordination of healthcare services for BCBSRI Medicare Advantage members choosing a PPGRI PCP.

Functions Delegated to PPGRI

As of July 1, 2015, BCBSRI has delegated the following case and disease management functions to PPGRI:

- Care coordination
- Clinical program management
- Case management activities

On September 1, 2015, BCBSRI will delegate the performance of the following medical/utilization management functions to PPGRI:

- Outpatient services and preauthorization review
- Referral management for out-of-network providers
- High-tech radiology and oncology services
- Inpatient admission and concurrent review
- SNF, inpatient rehabilitation, and long-term acute care hospitals
- Part B pharmacy services

This change will impact unaffiliated PPGRI providers as it relates to the medical management requirements for Medicare Advantage members.

Functions Not Changing

The following functions are remaining as is:

- **Behavioral Health Management**
  ValueOptions, our behavioral health management partner, will continue to be responsible for all preauthorizations and concurrent reviews for behavioral health services. Facility-based behavioral health services include:
  > Inpatient
  > Residential
  > Partial Hospitalization Program
  > Intensive Outpatient
- **Part D Pharmacy Services**
  Catamaran, our pharmacy benefit manager, and Walgreens, our specialty pharmacy benefit manager, will continue to be responsible for all Part D pharmacy services, including pharmaceutical preauthorizations.
- **Grievance and Appeals Requests, Claims Processing, and Credentialing**
  These functions will continue to be administered by BCBSRI.

In our August edition of *Provider Update*, we will provide you with more detailed information regarding this change.

PFB 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 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.
- Receive 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.

Policies

PF Policies Recently Reviewed for Annual Update

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

- Artificial Intervertebral Disc Insertion
- Clinical Trials Mandate
- Constraint-Induced Movement Therapy
- Fully Implantable and Semi-Implantable Middle Ear Hearing Aid – Insertion
- Intensive Behavioral Therapy (IBT) for Obesity
- Lyme Disease Diagnosis and Treatment Mandate
- Minimally Invasive Surgery for Snoring
- Newborn Metabolic, Endocrine, and Hemoglobinopathy, and the Newborn Hearing Loss Screening Programs Mandate
- Occipital Nerve Stimulation – Insertion
- Optical Coherence Tomography of the Anterior Eye Segment
- Orthognathic Surgery
- Payment Adjustments for Error and Hospital Acquired Conditions
- Physical and Occupation Therapy
- Postpartum Hospital Stays Mandate
- Post-Payment Audits Mandate and Adjustments
- Prolonged Physician Services
- Pulsed Radiofrequency for the Treatment of Chronic Pain
- Radium-223, Xofigo for Treatment of Metastatic, Castration-resistant Prostate Cancer
- Routine Foot Care and Nail Debridement
- Skilled Nursing Facilities, Concurrent Review For Continued Care Services
- Subcutaneous ICD (S-ICD®) Implantable Cardioverter Defibrillator

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 Termination of Pregnancy

The Termination of Pregnancy Policy has been updated to include the HCPCS modifier G7, which should be used to ensure correct claims processing in situations due to rape, incest, or a pregnancy certified by a physician as a life-threatening condition. Read the full text of this policy.

PF Removal of Not Medically Necessary Implanted Devices

A policy called Removal of Not Medically Necessary Implanted Devices has been created to document the prior authorization requirement for removal of these devices. This policy combines existing policies into one location. There is no change to coverage. Read the full text of this policy.

PFB Urine Toxicology Testing

Previously titled "Drug Testing Services and Urine Toxicology Screening," this policy has been updated with coding, criteria, and documentation requirements for Immunoassay Testing (i.e., Qualitative Testing, Screening) and Quantitative Testing (i.e., Confirmatory Testing) urine drug toxicology tests. Read the full text of this policy.

PF Policy Change: Advance Notice of Non-coverage

Effective September 1, 2015, an Advance Beneficiary Notice is no longer used for items or services provided under BlueCHiP for Medicare if the services are provided by a local BCBSRI-contracted provider. If a provider believes a service will not be covered by the plan, the contracted provider is expected to request a pre-service organization determination from the plan. This determination for BlueCHiP for Medicare members may be obtained by contacting BCBSRI or our vendor for the applicable services. A draft of this policy change was made available for comments.

The Advance Notice of Non-coverage (ANN), also known as an Advance Beneficiary Notice (ABN), is a written notice given by providers to a member to indicate that the service will not be covered by the member's insurance. The notice is applicable for commercial products and BlueCHiP for Medicare members only when they receive services from a non-contracted provider. Read the full text of this policy.

PFB July 2015 HCPCS Level II and CPT II and III Code Changes

We have completed our review of July 1, 2015 current procedural terminology (CPT*) and HCPCS code changes, including 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, 2015. The lists include codes that have special coverage or payment rules for standard products. (Some employers may customize their benefits.) We've included codes for services that are:

- "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 payment for the service.
- "Subject to medical review" – Preauthorization is recommended for commercial products and required for BlueCHiP for Medicare.
- "Subject to unlisted process" – Submit a claim form with all corresponding NDC numbers for review and reimbursement for the unlisted 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

*CPT is a registered trademark of the American Medical Association.

2015 CPT and HCPCS Codes Effective July 1, 2015

Code comments

0392T: Not medically necessary for BlueCHiP for Medicare and commercial plans

0393T: Subject to medical review for BlueCHiP for Medicare and commercial plans

Q9977: Not covered for commercial products; follow unlisted process for BlueCHiP for Medicare

Q9978: Not covered for BlueCHiP for Medicare and commercial products, pharmacy benefit only

PF DME Billing for Refills

Under the Coding and Payment Guidelines policy, specific DME and supply codes have been assigned a maximum number of units. This is based on the number of units that may be billed within a specified time frame for a member, regardless of the provider.

The Maximum Units of Service value used in our clinical editing is derived from several sources: National and Regional CMS (including DMEMAC), AMA guidelines, knowledge of anatomy, the standards of medical practice, FDA and other nationally recognized drug references, and claims data from provider billing patterns.

The time frames defined by BCBSRI are a month (28 days), 3 months (84 days), 6 months (168 days), and one year (365 days). Each DME and supply has been assigned a maximum number of units for only one of these time frames.

When a provider bills a certain number of units that exceed the assigned allowed for that procedure for a member, then the total number of units will be denied. Read the full text of this policy.

PF Artificial Pancreas Device System

Effective September 1, 2015, coverage for artificial pancreas device systems will change from not medically necessary to medically necessary when medical criteria are met. Prior authorization for the device should be obtained through the Clear Coverage web-based tool. Read the full text of this policy.

Blue Cross Blue Shield of Rhode Island

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