Blue Cross Blue Shield of Rhode Island

provider update

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

August 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 Save the Date: October 3

Cultural Considerations and Applications to Healthcare

Presented by: Blue Cross & Blue Shield of Rhode Island with Brown University

Saturday, October 3, 2015
8:00 a.m. to 4:00 p.m.

This conference will build awareness of cultural identities in the healthcare setting and address cultural competence models of various populations, including gender, ethnic, racial, immigrant, and LGBTQ.

Keynote speaker:
Dr. Joseph R. Betancourt

P Population Health Registry

We have been working to develop a Population Health Registry for our provider network. This web-based solution will allow providers to manage populations of patients by aggregating disparate claims, electronic health record data, costs, lab results, and other clinical/financial data that will be updated in close to real time. The Population Health Registry will be made available to all Rhode Island primary care physicians and groups.

The overall goals of the Registry are to:

1. Provide timely, actionable data to providers in an electronic format.
2. Help providers optimally manage a population of patients.
3. Improve patient care outcomes.
4. Ultimately lower healthcare costs.
5. Provide support and tools for performance improvement initiatives, like Pay for Performance programs.

The registry will be made available in the early fall. You will be receiving more detailed information regarding this exciting tool next month, so stay tuned.

Please click here to RSVP for an onsite introduction and live demonstration of the Population Health Registry tool at the end of September. This event will be held at the Crowne Plaza in Warwick.

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. 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.

For Behavioral Health Providers

As of October 1, 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.

Resources for All Providers

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 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. As of October 1, 2015, existing or new codes are being added to services that already require preauthorization, and there are changes to the method in which preauthorization is obtained (traditional BCBSRI vs. Clear Coverage).

You can find more information—including a full list of the services that must be submitted for preauthorization through Clear Coverage—in the following policies on 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).

Highlights of Clear Coverage

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

P 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 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 months. 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.

Disease-Modifying Anti-Rheumatic Therapy for Rheumatoid Arthritis (ART)

The ART measure evaluates the use of disease-modifying anti-rheumatic drug (DMARD) therapy in members 18 years and older with rheumatoid arthritis for both HEDIS and CMS Stars. At right, you can find 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 on the next page) 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 use 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			

Adult and Pediatric BMI Wheels: Limited Additional Quantities Available

The Adult BMI Assessment and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents are HEDIS measures for NCQA accreditation. The Adult BMI Assessment is also a Medicare Stars measure. They require the assessment and documentation of encounter date, height, weight, and BMI value or percentile depending on age. A review of HEDIS 2014 data showed the most opportunity for improvement in these measures among practices that do not have an electronic health record (EHR). Provider Relations representatives recently visited with primary care practices without EHRs and brought them adult and pediatric BMI wheels to help calculate and document accurate body mass index measurements. **We have a limited quantity of extra BMI wheels available on a first-come, first-served basis.** If you would like to request BMI wheels, please contact Siana Wood, RN, Senior Quality Management Analyst at (401) 459-5413 or siana.wood@bcbsri.org.

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 in order to calculate BMI.

Use of Imaging Studies for Low Back Pain (LBP)

This HEDIS measure looks at the percentage of members (18-50 years old) with a primary diagnosis of new-onset low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis[1]. Clinical evidence indicates that in the absence of red flags (trauma, cancer, neurological impairment, IV drug use), diagnostic imaging (plain X-ray, MRI, CT scan) is not necessary for most cases of new-onset back pain[2].

BCBSRI utilizes the *Clinical Guidelines for the Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guidelines from the American College of Physicians and the American Pain Society*. The full guideline is available on the Annals of Internal Medicine and contains additional guidance for diagnosis and treatment. The table on the next page summarizes the HEDIS measure, population, and tips for improving performance.

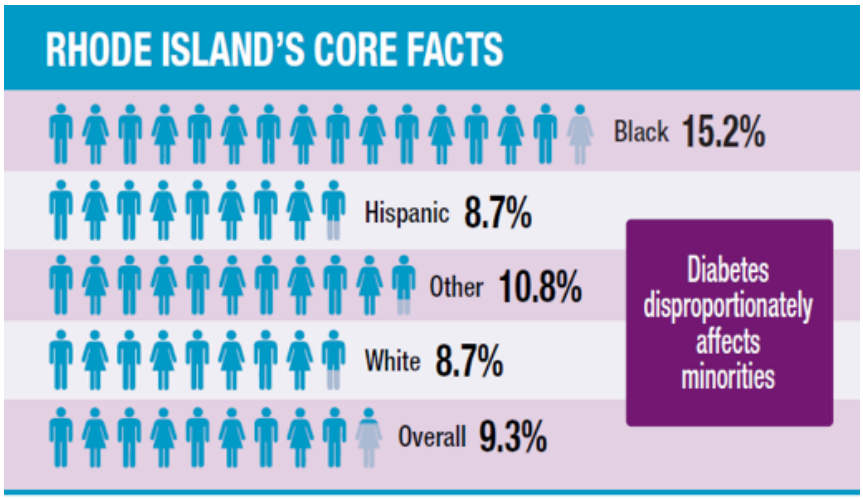
1. This measure is reported as an inverted rate. Members receiving imaging studies are subtracted from the denominator. A higher rate indicates better performance.
2. Citations located at http://www.qualitymeasures.ahrq.gov/content.aspx?id=48635&search=back+pain

Quality

Measure	Population: Numerator and Denominator	Tips for Success
Use of Imaging Studies for Low Back Pain (LBP)	**Numerator:** Members from the denominator who had an imaging study with a diagnosis of low back pain and no exclusions *Exclusions:* Cancer, trauma, neurologic impairment, or IV drug abuse	• Avoid ordering diagnostic studies in the first 6 weeks of new-onset back pain in the absence of red flags (e.g. cancer recent trauma, neurologic impairment, or IV drug abuse). • Encourage conservative treatment (pain management, activity modification, physical therapy) for new-onset low back pain without red flags. Remind patients that uncomplicated low back pain is typically a benign, self-limited condition, and that the majority of patients resume their usual activities in 30 days. • Use correct exclusion codes where necessary (e.g., code for cancer or other secondary diagnoses if these are why you are ordering the studies).
	Denominator: Members 18-50 years old with a principal diagnosis of low back pain at either an outpatient or an emergency room visit	

Available Now: FREE Diabetes Program for Medicare Advantage Members

A free program is available for Medicare Advantage members with diabetes (or prediabetes) from disparate groups, made possible by Healthcentric Advisors (the Quality Innovation Network-Quality Improvement Organization). Communities of color suffer from diabetes at much higher rates than their white counterparts, as shown in this infographic:



Quality

Eligibility Guidelines

This program is based on the evidence-based Stanford Model of Diabetes Self-Management Education. Health-centric Advisors seeks Medicare Advantage members with diabetes or prediabetes who also meet one or more of the following criteria:

- Identify as:
  - > African American
  - > Hispanic/Latino
  - > Asian/Pacific Islander
  - > Native American
- Live in a rural zip code

The program also welcomes Medicare Advantage members with diabetes and prediabetes who do not meet the above criteria. Please contact Brenda Jenkins (see end of article) for more information.

What the Program Offers

This free program includes:

- Groups of 10-20 participants facilitated by trained leaders
- Six weekly meetings, each two-and-a-half hours long, in community settings such as churches, community centers, libraries, and hospitals
- Meetings in English and Spanish
- Information about stress management, coping skills, exercise, medication, and healthy eating
- Participation by patients, including creating weekly action plans, sharing experiences, and helping each other solve problems they encounter with their self-management program

For more information or to refer patients, please contact Brenda Jenkins, RN, CDOE, D.Ay., CPEHR, PCMH CCE, by emailing bjenkins@healthcentricadvisors.org, calling (401) 528-3246, or securely faxing (401) 528-3237.

Pharmacy

PFB BCBSRI Wins Honorable Mention for Best of Blue Clinical Distinction Award

The Blue Cross and Blue Shield Association recently announced the winners of the 2015 Best of Blue Clinical Distinction Awards program for achievements in improving care delivery for the members they serve. BCBSRI was proud to receive an Honorable Mention for our Patient-Centered Pharmacy Program (PCPP)!

Beginning in July 2014, we pioneered a pilot program embedding full-time clinical pharmacists in patient-centered medical homes to focus on medication therapy management (MTM) and to engage high-risk members. There are currently six patient-centered medical homes involved in the program:

- Anchor Medical
- Coastal Medical
- Medical Associates of Rhode Island
- Rhode Island Primary Care Physicians Corporation
- South County Hospital Healthcare System
- University Medicine

Initially, the program has been open to Commercial patients over age 60 on fully insured plans, and BlueCHiP for Medicare members of any age. Other patients may be added upon referral from their providers or the pharmacist.

In just over five months during 2014, the MTM program logged over 4,000 interventions and is estimated to have avoided more than $2 million in healthcare costs. This works towards controlling healthcare cost trends as well as costs to the consumer, such as premiums and copayments.

Switching to More Cost-effective Medications

Over 500 of the interventions completed involved members switching to a more cost-effective medication, resulting in savings of over $700,000. This cost savings is shared with members when they can take advantage of lower tier copayments. For Medicare Advantage members, a reduction in drug costs lowers their Part D accumulators, helping avoid or mitigate the effects of the Coverage Gap.

Here's an example of how a member saved money by switching to a generic drug:

> The Medical Associates of Rhode Island pharmacist, Ronald Tutalo, had a patient on an expensive nasal spray. Ron asked if there was a reason the patient was not taking the generic. The patient had not even known there was a generic, so Ron contacted the prescriber, who agreed to the change. Thanks to his PCPP pharmacist, the patient was able to save on each fill!

Avoiding Medical Interventions

More than $1.1 million in costs were avoided by preventing over 200 ER visits or hospital admissions. Over $140,000 in costs were avoided from preventing over 1,500 additional prescription orders or physician visits. The example below shows how a pharmacist can help identity medication side effects and avoid medical interventions:

> Rhode Island Primary Care Physician Corporation pharmacist Bethany Spadaro completed a comprehensive medication review with a 65-year-old patient, and noticed that the patient was experiencing profuse sweating, a side effect likely due to the patient's antidepressant therapy. Upon further investigation, Bethany determined that the dose was too high for use in the elderly, and she recommended it be decreased or discontinued, both for safety and to avoid the side effect. The prescriber agreed with Bethany's recommendation to discontinue the medication, and the patient avoided an additional medical intervention.

Impacting Patients' Health and Safety

It is not just about the dollars saved. The MTM program brings the specialized knowledge and experience of a pharmacist into the patients' system of care. This can often have a direct impact on patient health and safety, as explained below:

> The Anchor Medical Associate pharmacist, Kenny Correia, had a patient who was using a high-risk over-the-counter sleep aid on a regular basis, which could increase the patient's risk of falls. Kenny counseled the patient on the risk, and recommended they switch to a safer over-the-counter sleep supplement. Upon follow-up with the patient, Kenny discovered that the patient did successfully make this switch.

Your Patients Can Receive MTM

Patients not receiving care in one of these PCPPs are still eligible for MTM. Most of the chain pharmacies here in Rhode Island participate with OutcomesMTM to provide MTM services, and those who fill their medications elsewhere can go to a participating pharmacy for services or may receive calls from telephonic pharmacists offering MTM services.

Regardless of whether they are in a PCPP, pharmacy, or on the telephone, the MTM pharmacists work with the prescribers to ensure patients are getting the right drug, at the right time, and in the right amount. Providers may receive letters, faxes, or phone calls from PCPP pharmacists as well as BCBSRI's own pharmacists regarding concerns with patients' prescriptions. It's this collaboration that has been found to improve patient outcomes.

BCBSRI is grateful to the providers who cooperate with these endeavors and proud of all the hard work the pharmacists are doing within their patient-centered medical home and with their patients. We look forward to building on this success to expand and improve the program in the future!

PFB Medicare Part D Prescriber Enrollment Requirement Update

On June 1, 2015, CMS released a Health Plan Management System (HPMS) memo titled "Medicare Part D Prescriber Enrollment Requirement Update." The memo announced the new enforcement date of the Medicare Part D prescriber enrollment requirement and set forth the following timeline of activities leading up to the new enforcement date of June 1, 2016:

January 1, 2016 – May 31, 2016

Part D Prescriber Outreach

- Develop and implement a prescriber outreach strategy to ensure enrollment of prescribers writing prescriptions for enrollees.
- CMS will provide sample communications by August 1, 2015.

April 1, 2016 – May 31, 2016

Enrollee Outreach

- There will be outreach to beneficiaries who will be impacted if their existing prescribers do not complete the Medicare Enrollment Application or Opt-Out Affidavit.
- CMS will provide further guidance on this effort by Q4 2015.

June 1, 2016

Enforcement of Part D Enrollment Requirements

- Point-of-sale edits will compare the submitted prescriber NPI on the claim to data on the Medicare enrollment file.
  - > Claims will be rejected if the prescriber is not enrolled on the claim "Fill Date" or on file with a valid opt-out affidavit.

Pharmacy

  - > A provisional fill of up to a three-month supply will be provided on the first reject for each member and drug. The beneficiary will also be provided with an individualized written notice.
- "Other Authorized Prescribers" (OAPs) will be exempt from the Medicare enrollment process.
  - > OAPs are defined as individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions.
  - > Claims for these OAPs should not be rejected at the point of sale.
  - > More detailed guidance for OAP exceptions are expected from CMS in future memos.

The HPMS memo also provided details of the Medicare Access and CHIP Reauthorization Act of 2015. This legislation was signed into law on April 16, 2015 and requires that for plan year 2016 and thereafter, claims for covered Part D drugs must include a valid prescriber NPI. Use of DEA numbers or any other type of prescriber ID other than a valid Type 1 NPI will result in rejected claims. Members will be notified at point of sale of the reason for the rejection.

BCBSRI will be working with our pharmacy benefits manager, Catamaran, to identify providers not already in compliance and develop outreach strategies and processes. We are confident that the vast majority of our providers are up-to-date with these requirements, and we appreciate the efforts of all to ensure compliance.

Claims

PFB Reminder: Claims Adjustments

As of July 1, 2015, we 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 May, June, and July *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

P Value-Based Payment Innovations

The healthcare industry is undergoing a shift from a fee-for-service model to a pay-for-value model. This approach emphasizes quality of care and positive health outcomes over quantity of care. Our value-based programs help to provide affordable, quality care to our members as well as savings to large employers.

To support this approach, the Blue Cross and Blue Shield Association has created a comprehensive national delivery framework to bring the value of other Blues plans' payment innovations to our national accounts. It will be aligned with the "triple aim" of federal healthcare reform: improving quality, reducing costs, and improving the health of the population.

Effective January 1, 2016, we will be aligning provider payment incentives and will be attributing all members with Blue Cross coverage to providers who are part of a value-based payment arrangement. Today, local providers in these types of arrangements are only receiving incentives for BCBSRI members. For example, if they treat a member with coverage from Blue Cross & Blue Shield of California, it does not count toward their value-based payment incentives. We're excited that all BlueCard members will be attributed to our providers in these arrangements in 2016, as this increases the opportunity to earn additional incentive payments.

If you are an independent or private practice physician and would like to learn more about how you can benefit from partnering with us through value-based payment arrangements, please contact our Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050 (out of state only).

PBF Prospect Health Services – Delegation of 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 use 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 case and disease management functions listed in the next column 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

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.

How This Change Impacts Unaffiliated PPGRI Providers

This change will impact unaffiliated PPGRI providers as it relates to the medical management requirements for Medicare Advantage members. Providers will need to identify if the BCBSRI member has a PPGRI PCP, by verifying benefits and eligibility. They can do this by calling the BCBSRI Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050. If the member has a PPGRI PCP you will be transferred to PPGRI's call center. Requests can also be faxed to PPGRI at (844) 762-9230.

If you request a preauthorization through BCBSRI or any of our other vendor partners not listed on the previous page, you will be redirected to PPGRI.

PF CareCore National and MedSolutions Merge

In December 2014, CareCore National, LLC ("CareCore") a specialty benefits management provider and MedSolutions, Inc. ("MedSolutions"), our radiology management vendor, merged to become CareCore/MedSolutions. Just recently they announced that the organization is now **eviCore healthcare**.

Please note there will be no changes to how prior authorizations are requested or the overall user experience as a result of this change. However, the logos that appear on the website, provider portal, and letters will be transitioned over the next few months. If you currently use the www.medsolutions.com site to initiate prior authorizations, you can do so until August 31, 2015. On or after this date you will need to use their new portal: myportal.medsolutions.com. Please click here to view a step-by-step guide on how to register on their updated portal.

If you have any questions pertaining to this change, please contact eviCore healthcare directly at online@medsolutions.com.

PBF Requirement to Refer Members to In-Network Providers for All BCBSRI Products

As BCBSRI-contracted providers/physicians, you have an obligation to coordinate members' care with contracted in-network physicians/providers. This includes all ancillary services such as clinical laboratory and pathology services, durable medical equipment, radiology, and behavioral health providers. Section 3.7 of the BCBSRI Physician/Provider Agreement Administrative Policies Manual outlines this obligation:

3.7 Contracted Providers. Physicians shall refer/coordinate Members' care to contracted providers at all times except when it is medically necessary to use a non-participating Blue Cross physician/provider. Physicians shall seek preauthorization for use of noncontracted providers by Members of coordinated care plans, except in cases of emergency care or inpatient hospital level of care, unless the Member has elected to use the noncontracted provider and assume all or some of the costs of the service. In all cases, physicians should provide necessary clinical information to coordinate the care of the Member, whether or not Blue Cross or the Member is responsible for some or all of the cost of care.

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

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.

- Autism Spectrum Disorder Mandate
- Electrogastrography (EGG)
- Enteral/Parenteral Nutrition Therapy
- Erythropoiesis-stimulating agents for End-Stage Renal Disease
- Evaluation of Hearing Impairment/ Loss
- Fluoroscopy Without Films
- Gender Reassignment Surgery
- High-Tech Radiology Imaging
- Infertility Treatment Services Mandate
- Medical Necessity
- Preventive Services for Commercial Members
- Thermography
- Wig Mandate

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 Policy Changes Due to Claims Processing Enhancements

Effective October 1, 2015, the services in the following policies will have updates due to continued enhancements in our claims processing system. Some of the policies below are new, as diagnosis edits related to the services were added. Please refer to the policies listed for specific information regarding coverage and the products impacted.

- Bone Turnover Markers for the Diagnosis and Management of Osteoporosis and Diseases Associated With High Bone Turnover
- Chelation Therapy for Off-Label Uses
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure
- Detection of Circulating Tumor Cells in the Management of Patients with Cancer
- Endometrial Ablation
- Enhanced External Counterpulsation (EECP) (former policy title: External Counterpulsation)
- Esophageal pH Monitoring
- Extracorporeal Shock Wave Therapy for Plantar Fasciitis and Other Musculoskeletal Conditions
- Homocysteine Testing in the Screening, Diagnosis, and Management of Cardiovascular Disease
- Image-Guided Minimally Invasive Lumbar Decompression IG-MLD for Spinal Stenosis
- Implantable Bone-Conduction and Bone-Anchored Hearing Aids
- Intravitreal Corticosteroid Implants
- Ocriplasmin for Symptomatic Vitreomacular Adhesion
- Ophthalmologic Techniques for Evaluating Glaucoma (former title: Computerized Ophthalmic Imaging for Glaucoma)
- Paraspinal Surface Electromyography (SEMG) to Evaluate and Monitor Back Pain
- Proteomics-Based Testing Related to Ovarian Cancer
- Semi-Implantable and Fully Implantable Middle Ear Hearing Aids
- Skin Contact Monochromatic Infrared Energy as a Technique to Treat Cutaneous Ulcers, Diabetic Neuropathy and Miscellaneous Musculoskeletal Conditions (former policy title: Monochromatic Infrared Energy (MIRE))
- Transesophageal Endoscopic Treatments for Gastroesophageal Reflux Disease
- Transcutaneous Electrical Nerve Stimulation
- Ultrasonographic Measurement of Carotid Intima-Medial Thickness as an Assessment of Subclinical Atherosclerosis Dynamic Posturography
- Wireless Pressure Sensors in Endovascular Aneurysm Repair

PF Services No Longer Medically Necessary

Effective October 1, 2015, the services in the following policies will change from covered to not medically necessary. Please refer to the policies listed below for specific information regarding coverage and the products impacted.

- Corneal Topography/Computer-Assisted Corneal Topography/ Photokeratoscopy (former policy title: Computerized Corneal Topography)
- Dynamic Posturography
- Electrical Bone Growth Stimulation of the Appendicular Skeleton- Implantable and Semi Invasive
- Electromagnetic Navigation Bronchoscopy
- Fecal Calprotectin Testing
- Immune Cell Function Assay
- Saturation Biopsy for Diagnosis and Staging of Prostate Cancer
- Urinary Tumor Markers for Bladder Cancer

Policies

PBF Skilled Nursing Facility Admissions

Effective September 1, 2015, prior authorization for admission to SNFs will be required. The provider ordering the SNF admission will be responsible for requesting prior authorization. In most cases, this will be the attending physician at the hospital from which the patient is being discharged.

To initiate prior authorization review from the hospital, please coordinate with the BCBSRI onsite nurse reviewer. Ordering providers initiating prior authorization review from an office or other subacute setting should contact our Utilization Management Department at (401) 272-5670. The request and supporting documentation can also be faxed to (401) 459-1623.

If the request for SNF admission does not meet the criteria, the ordering provider and member will receive a denial notice that follows the standard utilization review process. If authorization is not obtained prior to admission, the claim for SNF services will deny as provider liability. Please read the full text of this policy.

PF Transitional Care, Chronic Care and Complex Chronic Care Management

Effective September 14, 2015, the following codes are covered but not separately reimbursed for all providers: 99490, 99487, 99489, 99495, and 99496. Please read the full text of this policy.

PF Corneal Topography/ Computer-Assisted Corneal Topography/ Photokeratoscopy

Effective October 1, 2015, coverage for Computerized Corneal Topography, CPT code 92025, will change from a covered service to not medically necessary. There is insufficient scientific evidence that confirms improved health outcomes as result of the service. Please read the full text of this policy.

PF Preventive Services for Commercial Members

The Preventive Services for Commercial Members policy has recently been updated to include the following recommendations that apply for coverage without cost share under a member's preventive services health benefit:

- Preeclampsia Prevention: Aspirin
- Anesthesia for Preventive Colonoscopies – Please append modifier 33 (Preventive Services) for both the anesthesia and pathology testing for preventive colonoscopies.

Please note: System updates are presently being made and a mass readjudication of claims will be performed for services determined to be covered without cost share. Please read the full text of this policy.

PBF Additional July 2015 HCPCS® Level II Code Updates

We have completed our review of additional HCPCS Level II codes. These updates will be added to our claims processing system and are effective on July 1, 2015.

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

- "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.
- "Deleted code" – This 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

Additional HCPCS Codes Effective July 1, 2015

C2613 **Lung biopsy plug with delivery system**
Professional Providers: Invalid – Use alternate code
Institutional Providers: Not separately reimbursed

C9453 **Injection, nivolumab, 1 mg**
Professional Providers: Invalid – Use alternate code
Institutional Providers: Not separately reimbursed

C9454 **Injection, pasireotide long acting, 1 mg**
Professional Providers: Invalid – Use alternate code
Institutional Providers: Not separately reimbursed

C9455 **Injection, siltuximab, 10 mg**
Professional Providers: Invalid – Use alternate code
Institutional Providers: Not separately reimbursed

C9448 **Oral netupitant palonosetron**
Deleted code 6/30/2015. It has been replaced by Q9978, effective July 1, 2015.

C9737 **Laparoscopy, surgical, esophageal sphincter augmentation with device**
Deleted code 6/30/2015. It has been replaced by 0392T, effective July 1, 2015

Modifier JF **Compounded Drug**
Deleted modifier 6/30/2015. It has been replaced by Q9977, effective July 1, 2015.

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