Blue Cross Blue Shield of Rhode Island

provider update

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

August 2016

Dr. Gus Manocchia
Senior Vice President and Chief Medical Officer

Greetings,

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

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

Contents

BCBSRI Update

P Weekly Training Webinars Available for Blue Insights Population Health Management Tool

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

Blue Insights will allow you to view:

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

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

P Web-Based Referral Management Tool Is Now Available

BCBSRI has introduced the new web-based referral management tool, which is now live and can be accessed through the "Referral" link on our secure provider site.

When registering your practice on the referral tool, please be aware that you must have a valid:

- User name for bcbsri.com, which you currently use to log on to bcbsri.com
- Email address for bcbsri.com, which is the email you provided when first registering on bcbsri.com
- Tax ID credentialed with BCBSRI
- Organization or provider name credentialed with BCBSRI

(continued on next page)

BCBSRI Update

We are asking all primary care physicians (PCPs) and specialists to use this tool to launch a referral and check the status of referrals from PCPs to specialists for specific BCBSRI products, including:

- BlueCHiP Commercial
- BlueCHiP for Medicare Advance
- New England Health Plan (NEHP)

Please note that NEHP cross border referrals to providers not in the BCBSRI network will continue to follow the traditional fax-based process. However, services rendered within the BCBSRI network will need to be submitted through the web-based tool. Please also note that referrals initiated after July 1 need to be entered into the tool no later than September 1, regardless of whether or not a paper referral was already done.

PCPs will be responsible for generating referrals to specialists for members enrolled in these products. Specialists will be responsible for ensuring a referral is in place prior to rendering services. If services are rendered without a referral being entered in the referral management tool, the claim may deny. Additionally, specialist-to-specialist referrals are not allowed. If a patient is referred by a specialist to another specialist, the PCP must initiate a new referral.

If you were unable to attend one of our seminars in June to learn how to use the referral tool, please enroll in one of our educational webinars. Webinars are available now and the schedule is as follows:

Tuesdays, 7:30 to 8:30 a.m.

Wednesdays, noon to 1:00 p.m.

Thursdays, 4:00 to 5:00 p.m.

To enroll in a webinar, please email BCBSRIWebinar@bcbsri.org. If you have any questions about this process, please contact your provider relations representative or send an email to ProviderRelations@bcbsri.org.

PBF REMINDER: Update Your Practice Information!

It's important that you update your practice information regularly by completing a Practitioner Change Form. This ensures that your patients and our members have access to accurate data as well as fulfills the CMS requirement—and the contractual obligation—that providers give BCBSRI a 60-day notification of any provider or practice changes.

Please submit all practice demographic changes as soon as possible to avoid any delays in claims payment.

The Practitioner Change Form should be submitted when there is a change to any of the following:

- Street address and/or suite number
- Phone number
- TIN
- Office hours
- Panel changes (open/close)
- Adding or removing a location
- Other changes that affect your accessibility and availability to patients

If you have any questions regarding these requirements, please email ProviderRelations@bcbsri.org.

PBF BCBSRI Offers LGBTQ Safe Zone Certification

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.

More information about our program and the requirements can be found on our secure provider site or by clicking here. If you have questions, please contact Susan Walker, provider relations manager, at (401) 459-5381 or susan.walker@bcbsri.org.

BCBSRI Update

PBF Information Security and Protecting PHI

There have been many recent hacking attacks on electronic health records. We want to let you know about one in particular and give you some best practices for keeping patient data secure.

Recently, a hacker calling himself "The Dark Overlord" illegally acquired over nine million electronic health records (EHRs) from various healthcare provider databases. The Dark Overlord, whose real identity remains unknown, has put the stolen information up for sale on the Dark Net. The Dark Net is a computer network with restricted access, used primarily for illegal peer-to-peer file sharing. The targeted databases were likely breached by using credentials stolen from a third-party vendor. The Dark Overlord was able to obtain these credentials by exploiting a zero-day vulnerability in the Remote Desktop Protocol and Software, thus exposing the protected health information (PHI) of current and former patients. Patient names, addresses, dates of birth, Social Security numbers, and telephone numbers were among the breached PHI as well as diagnoses and partial medical history in some instances.

There is no evidence to suggest that any healthcare provider in Rhode Island has been compromised, but we want to remind providers to be vigilant about securing PHI. These tips can help:

- Use complex passwords that are hard to crack but easy to remember. Here are some examples and tips. Please do NOT use the sample passwords in the article.
- Do not share passwords to the bcbsri.com portal. If you'd like additional users in your office to be granted access to the portal, please call the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050.
- Lock your computer when you're not actively using it. Press Ctrl, Alt, Delete and hit Enter or simply press the Windows Key and the letter "L".
- Ensure websites you visit start with "https" and not just "http".
- Do not allow unknown individuals to access your computer locally or remotely. For example, some scammers call and pretend to be "Microsoft" technicians, saying your computer is infected.
- Ensure that any software or application used to store or access PHI and EHRs (such as Remote Desktop software) are updated with the latest security patches to reduce vulnerabilities.

PF Hints for HEDIS® (and More)

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

August Is National Immunization Awareness Month

Ensuring that children and teens receive timely immunizations is one of the most important ways to safeguard public health. By reducing the spread of communicable disease, immunizations keep serious contagious (and potentially fatal) illnesses such as measles, mumps, rubella, chicken pox, hepatitis, and many others from becoming widespread. In addition to protecting the health of individuals and the community, immunization also helps protect our community's vulnerable individuals—those who cannot be vaccinated, and those with compromised health (such as the elderly, infants, and those with compromised immune systems). Two HEDIS measures evaluate youth immunization status: childhood immunization status and immunizations for adolescents. Summaries of each measure are listed below.

Measure	Measure Summary
Childhood Immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
Immunizations for Adolescents	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

On the Rhode Island Department of Health website, current vaccine guidelines are available for infants, children, teens, and adults.

Clinicians can find materials on the Centers for Disease Control website to assist in discussing vaccines with parents and answering questions about vaccine safety.

- Materials to Help Providers Discuss Immunizations with Parents
- Vaccine Fact Sheets to Give to Parents

Quality

Chlamydia Screening in Women

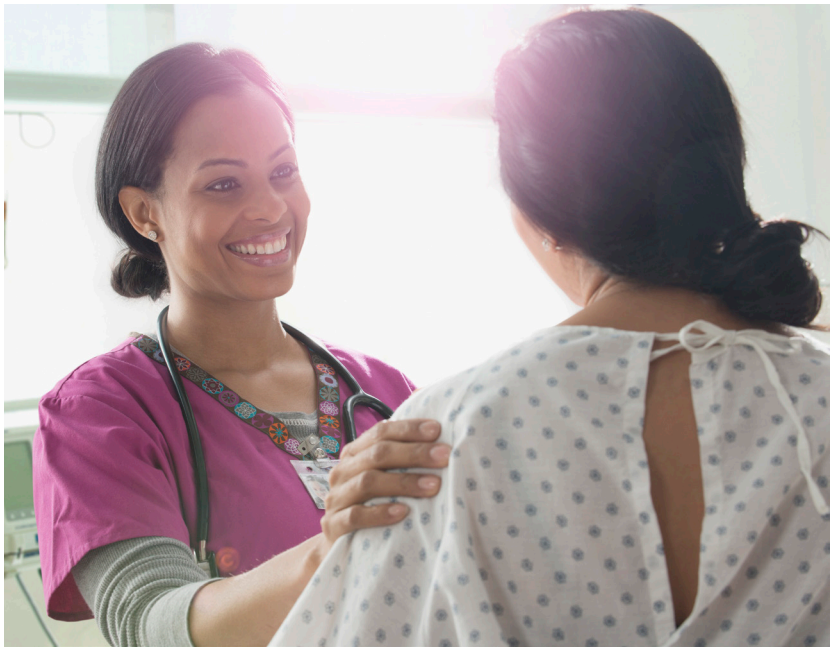
The HEDIS measure Chlamydia Screening in Women measures the proportion of sexually active females between the ages of 16 and 24 who had at least one test for chlamydia during the measurement year. Chlamydia screening continues to be a HEDIS measure because testing is a Grade B U.S. Preventive Services Task Force service for women under 25 years of age. It's cost-effective, and it can prevent pelvic inflammatory disease that leads to infertility.

Many young people engage in sexual risk behaviors that can result in unintended health outcomes. In 2013, among high school students in Rhode Island, 59.1% did not use a condom during their last sexual intercourse (among students who were currently sexually active). According to a 2015 State Health Profile from the CDC, Rhode Island:

- Ranked 29th among 50 states in chlamydial infections (410.6 per 100,000 persons) and ranked 43rd among 50 states in gonorrheal infections (43.2 per 100,000 persons).
- Reported rates of chlamydia among women (561.6 cases per 100,000) that were 2.3 times greater than those among men (249.5 cases per 100,000).

Source: http://www.cdc.gov/nchhstp/stateprofiles/pdf/rhode_island_profile.pdf

BCBSRI HEDIS plan performance in the Chlamydia Screening in Women measure demonstrates opportunity for improvement. Our Commercial population had a rate of 57.02% in 2015—far from our goal of 70.09%. We encourage our providers to have an active dialogue around sexual activity with their young female patients and recommend testing for sexually transmitted infections, as appropriate.



Quality

Comprehensive Diabetes Care

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

Comprehensive Diabetes Care Measure	Measure Population Type 1 or 2 Diabetes and:	Tips for Success
Hemoglobin A1c (HbA1c) testing	An HbA1c test during the measurement year	• Pre-visit planning may be useful. For members with upcoming appointments, medical assistants can mail a reminder letter and a lab slip to those due for HbA1c screening and other tests to help increase rates. • Reinforce with members the importance of routine HbA1c 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.

Quality

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

Controlling Blood Pressure

Nationally, 1 in 3 Americans have hypertension, but only half are well controlled. In 2013, according to BRFSS (the Centers for Disease Control's Behavioral Risk Factor Surveillance System), 33.8% of Rhode Island adults had been told by a physician that they have hypertension. Frequently asymptomatic, hypertension can damage the heart, brain, kidneys, and vascular system and increase risk for stroke, heart attack, and vascular dementia. Controlling Blood Pressure is both a HEDIS and CMS Stars measure. The table below summarizes the 2016 HEDIS specifications.

Measure	Measure Population (Hypertension Adequately Controlled)	Tips for Success
Controlling High Blood Pressure: The percentage of members aged 18-85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled	Members aged 18-59 whose BP was <140/90 mm Hg Members aged 60-85 w/diagnosis of diabetes whose BP was <140/90 mm Hg Members aged 60-85 without diagnosis of diabetes whose BP was <150/90 mm Hg	• HEDIS uses the most recent BP reading recorded (in the measurement year) after a diagnosis of hypertension. If there are multiple values in one visit, the lowest systolic and lowest diastolic can be used for HEDIS. • **Be sure to document the number as recorded; the BP should not be rounded up.** • Be sure to use correct diagnosis codes. Notations of "rule out HTN," "consistent w/HTN," and "possible HTN" are not adequate confirmation of a hypertension diagnosis. • Have sphygmomanometers checked and calibrated annually. • Consider referral to a registered dietician for patients who require nutritional guidance. • Consider refresher training to help standardize BP measurement techniques among your staff. See the next page for more information.

Measuring Blood Pressure: Technique Matters

The American Heart Association provides guidelines for blood pressure measurement that include the following instructions about proper technique:

- Patient should be seated comfortably, with back supported and legs uncrossed.
- If possible, measure blood pressure after patient has been sitting for five minutes.
- The cuff should be applied to bare skin, not over clothing.
- Patient's arm should be supported at heart level.
- The cuff bladder should encircle ≥ 80% of the patient's arm circumference.
- Mercury column should be deflated at 2 to 3 mm per second.
- Neither the patient nor the person taking the measurement should talk during the procedure.

BCBSRI adopts the recommendations of the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, published and developed by the National High Blood Pressure Education Program in coordination with the National Heart, Lung, and Blood Institute of the National Institutes of Health.

The full guideline is available on the National Heart, Lung, and Blood Institute website. You can also view the BCBSRI clinical practice guideline for high blood pressure on bcbsri.com.

Tools for Your Patients

The Million Hearts® campaign is a national initiative with a goal of preventing one million heart attacks and strokes by 2017. The Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services co-lead the initiative on behalf of the U.S. Department of Health and Human Services. The initiative's website contains data, research, provider tools, and patient materials designed to inform clinical practices and promote prevention and management of chronic cardiovascular diseases such as hypertension. You can find an array of information and tools on the Million Hearts website.

Persistence of Beta Blocker Treatment

The HEDIS measure for Persistence of Beta Blocker Treatment applies to patients who were discharged after an inpatient hospitalization for acute myocardial infarction. Research has demonstrated that the use of beta blockers can help prevent a second, potentially fatal myocardial infarction. The measure looks for treatment of patients (in whom there are no known contraindications) with beta blockers for six months after discharge. Listed below are recommendations for improving patient adherence with beta blockers:

- Emphasize the importance of taking recommended medication(s) after a cardiac event, and that beta blockers in particular can be lifesaving.
- Continue to suggest and support lifestyle changes such as quitting smoking, weight reduction, beginning an exercise program, and improving nutrition.
- Encourage patients to meet with embedded pharmacists or nurse care managers (in practices that have them) for counseling regarding medications and addressing any barriers.
- Refer a member to BCBSRI case management staff if the member has challenges adhering to prescribed medications or difficulty filling their prescriptions. To refer a member, please call the BCBSRI Triage Line at (401) 459-2273.

Medication Reconciliation Post-Discharge

Consistent medication reconciliation, particularly during and after transitions of care, helps minimize medication errors and maintain patient safety. The National Committee for Quality Assurance added a Medication Reconciliation Post-Discharge measure to the Medicare product line effective with HEDIS 2016. This measure looks at the percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age or older for whom medications were reconciled within 30 days of discharge. During HEDIS medical record review, abstractors will examine specific documentation within the outpatient medical record (though an outpatient visit is not required). Note that the medication reconciliation can be performed by a prescribing practitioner, clinical pharmacist, or registered nurse and need not be through a face-to-face encounter (can be telephonic). Listed below are medical record elements that help fulfill HEDIS criteria for this measure:

- Documentation that the provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)

- Documentation of the member's current medications with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service
- Notation that no medications were prescribed or ordered upon discharge

Fall Risk Reduction Among Medicare Members

Reducing the Risk of Falls is a CMS Stars measure that calculates the percentage of Medicare members 65 years of age or older who had a fall or had problems with balance or walking in the past 12 months (denominator) and who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner (numerator). The Medicare Health Outcomes Survey (HOS) baseline and follow-up surveys provide the data for this measurement. The specific HOS survey questions are as follows:

- **HOS Survey Question 50:** A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?
- **HOS Survey Question 51:** Did you fall in the past 12 months?
- **HOS Survey Question 52:** In the past 12 months, have you had a problem with balance or walking?
- **HOS Survey Question 53:** Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:
  - » Suggest that you use a cane or walker.
  - » Check your blood pressure lying or standing.
  - » Suggest that you do an exercise or physical therapy program.
  - » Suggest a vision or hearing testing.

The Centers for Disease Control's Stopping Elderly Accidents, Deaths, and Injuries (STEADI) program recommends the three-step "Ask, Review, Recommend" approach, which providers can complete in one visit with older patients.

1. ***Ask*** patients if they've fallen in the past year, feel unsteady, or worry about falling. A "yes" to any of these indicates increased fall risk and that further assessment is needed.
2. ***Review*** medications and stop, switch, or reduce the dosage of drugs that increase fall risk.
3. ***Recommend*** vitamin D supplements of at least 800 IU/day with calcium, unless contraindicated.

Factors that Increase Fall Risk	Interventions to Reduce Fall Risk
• History of fall(s) in the last 12 months • Fear of falling • Problems with heart rate and/or rhythm • Cognitive impairment • Incontinence • Depression • Foot problems • CNS or psychoactive medications • Medications that can cause sedation or confusion • Medications that can cause hypotension • Postural hypotension	• Educate patient. • Recommend vitamin D +/- calcium. • Refer to PT to enhance functional mobility and improve strength and balance. • Refer to community fall prevention programs. • Manage and monitor hypotension. • Modify medications. • Address foot problems. • Optimize vision. • Optimize home safety. (Home PT or visiting nurse programs can also conduct home safety evaluations and recommend adaptive equipment such as grab bars, improved lighting, and eliminating throw rugs.)

The STEADI web page contains additional free resources for clinicians, including guidance on assessing patients' functional ability, videos, algorithms for intervention, and patient education handouts. We encourage you to routinely screen older patients for fall risk and to foster conversations about fall prevention.

Screening for Colorectal Cancer

Routine colonoscopy remains the most effective way to detect colon cancer and precancerous changes that might otherwise develop unnoticed. Preventive care such as a colonoscopy is covered at no cost to the member (according to the Affordable Care Act). As of June 2016, the U.S. Preventive Services Task Force updated their screening guidelines. It is recommended that adults ages 50-75 undergo regular screening. Methods and screening intervals vary and may depend upon patient risk profile, health status, and other factors.

The HEDIS measure for Colorectal Cancer Screening evaluates the percentage of eligible members who have had fecal occult blood test, flexible sigmoidoscopy, or colonoscopy during certain time frames. The measure is summarized below, along with tips for success.

Test/Exam	Measure Population	Exclusions	Tips for Success
Colorectal Cancer Screening	Adults ages 50 to 75 who have had one of these three types of screenings: • Fecal occult blood test 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). 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 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.*

Pharmacy

BCBSRI Prepares for January 1, 2017 PBM transition to Prime Therapeutics

On January 1, 2017, BCBSRI will complete our transition to a new pharmacy benefit manager, Prime Therapeutics. In preparation for this transition, we plan to regularly include articles related to Prime in upcoming issues of Provider Update. This Q&A with Beth Hebert-Silvia, managing director of Pharmacy, is the first in a series of articles.

Q. *Why did BCBSRI choose Prime Therapeutics as the pharmacy benefit manager?*

A. We selected Prime following a comprehensive review process. They have a proven record of operational excellence and a commitment to serving the needs of providers and members. Fourteen Blues Plans own Prime, which is the fourth largest PBM in the country. Prime has a 25-year track record of integrating pharmacy and medical data to identify opportunities for improved health outcomes and reduced pharmacy costs for members.

Q. *Will patients be able to get the drugs providers prescribe for them?*

A. Providers can check the formulary status of drugs they prescribe through the electronic medical record via ePrescribe or through their existing workflow. If the drug prescribed has a utilization review program attached to it, providers will need to initiate a new prior authorization request. Forms will be available at myprime.com. Providers can also process utilization review requests electronically through CoverMyMeds®, Prime's electronic prior authorization tool.

Q. *What is electronic prior authorization?*

A. Electronic prior authorization is an online method for doctors and pharmacists to submit utilization management requests in a streamlined, structured manner to Prime. It eliminates traditional paper forms, faxes, and follow-up calls. This service is free for providers to use and is integrated with participating retail pharmacies. The service is used by more than 80 percent of U.S. pharmacies. Electronic prior authorization reduces prescription abandonment by catching rejections at the pharmacy.

Q. *Will patients still be able to get their prescriptions by mail?*

A. BCBSRI and Prime will make PrimeMail® available for our members who use long-term medicines. Patients who use 90-day prescription services like PrimeMail have higher adherence rates than those who use 30-day retail pharmacies. In addition, 90-day supplies save your patients money. Depending on the benefit plan, out-of-pocket cost share is usually lower. Prime will conduct personalized outreach to current mail-service pharmacy members. Certain prescriptions are not allowed to be transferred to Prime and will require new Rx orders, including controlled substances, compound prescriptions, prescriptions with no remaining refills, or expired prescriptions. Also, payment information will not be transferred, and members will need to establish their payment method with Prime directly.

Q. *How will providers know if the move to Prime will affect their patients?*

A. BCBSRI will work closely with Prime with the goal of a seamless transition with respect to loading active prior authorizations and accurate formulary set-up for claims processing. If significant member disruption is identified, member notifications will be provided along with an update to providers who may be materially impacted. There are no planned formulary changes associated with the transition to Prime. A significant testing and validation plan is in place to verify benefit plan set-up.

Prime is committed to helping members get the medicine they need to feel better and live well.

Please watch future issues of Provider Update for additional information about the transition to Prime. In addition, BCBSRI will launch a comprehensive educational program for the new electronic prior authorization tool. That training will kick off in November.

B Follow-Up After Hospitalization Quality Pilot Program

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

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

To help improve the number and therefore the percentage of members who attend a follow-up behavioral health visit as well as improve transitions of care, BCBSRI will provide a $40 incentive payment to participating providers who complete a visit with a member within the seven-day timeframe. Discharges to intermediate levels of care as well as some types of member coverage are not included in this pilot program.

A detailed communication fully outlining the quality program was mailed to all participating behavioral health outpatient professional providers on July 1, 2016. The additional reimbursement will be effective for inpatient mental health discharges from July 1, 2016 through June 30, 2017. If you have any questions, please contact Rena Sheehan, BCBSRI director of behavioral health, at (401) 459-1467 or rena.sheehan@bcbsri.org, or Sarah Fleury, BCBSRI behavioral health performance specialist, at (401) 459-1384 or sarah.fleury@bcbsri.org.

B Clinical Practice Guidelines for Behavioral Health

On June 8, 2016, BCBSRI reviewed and adopted Beacon Health Options' Clinical Practice Guidelines for the treatment of Attention-Deficit/Hyperactivity Disorder and Major Depression. These guidelines were originally created and published by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association, respectively. These guidelines are reviewed and approved by Beacon Health Options biannually and then forwarded to BCBSRI for final approval and adoption.

If you have any questions regarding the Clinical Practice Guidelines, please contact Sarah Fleury, behavioral health performance specialist, at (401) 459-1384.

PF BlueCHiP for Medicare Advance

The following Skilled Nursing Facilities have been recently added to the BlueCHiP for Medicare Advance network:

- Greenville Skilled Nursing and Rehabilitation
- Harris Health Center, LLC
- Harris Health Care Center – North
- Trinity Health and Rehabilitation

PBF Marketing of Medicare-Related Products

The Centers for Medicare & Medicaid Services (CMS) has rules related to provider marketing activities as it relates to Medicare Advantage (MA) and Part D plans. CMS places limitations on a provider's ability to market MA and Part D plans since providers may not know all plan benefits and costs and to reduce beneficiary confusion related to whether or not the provider is acting as an agent of the health plan versus acting as the beneficiary's provider. We are reminding you of the do's and don'ts of provider marketing activities below:

Providers may:

- Provide the names of Plans/Part D Sponsors with which they contract and/or participate (see below for additional information on provider affiliation).
- Provide information and assistance in applying for the Low-Income Subsidy.
- Make available and/or distribute plan marketing materials.
- Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their state Medicaid Office, local Social Security Office, CMS' website at http://www.medicare.gov/ or 1-800-MEDICARE (1-800-633-4227).
- Share information with patients from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" (from http://www.medicare.gov/), or other documents that were written by or previously approved by CMS.
- Announce a new affiliation once within the first 30 days of a new contract agreement. This may be done through direct mail, email, by telephone, or advertisement. The provider does not need to notify beneficiaries that the provider may contract with other Plans/Part D Sponsors.
- Distribute continuing affiliation announcements, which may be made through direct mail, email, phone or advertisement. Continuing affiliation announcements must clearly state that the provider may also contract with other Plans/Part D Sponsors.
- Announce new or continuing affiliations between providers and specific Plans/Part D Sponsors through general advertising (e.g., radio, television, websites).

Providers may engage in discussions about plan options with beneficiaries should a beneficiary seek advice. However, providers must remain neutral when assisting with enrollment decisions and not:

- Offer scope of appointment forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Health Plans or Part D Sponsors.
- Offer anything of value to induce plan enrollees to select them as their provider.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distribute materials/applications within an exam room setting.

If you have any questions regarding this, please don't hesitate to 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.

Claims

PF Laboratory Claims Filing Reminder: QW Modifier

In accordance with the Centers for Medicare & Medicaid Services (CMS), BCBSRI requires that providers are appropriately certified based on the Clinical Laboratory Improvement Amendments (CLIA) of 1988 requirements for each lab test performed in their office.

Certain lab tests are waived under CLIA in facilities that hold a CLIA certificate of waiver. Per CMS guidelines, BCBSRI requires that those labs/tests be filed with the "QW" modifier to ensure accurate claims processing.

Please refer to the CMS website for more information about CLIA-waived tests.

Contracting & Credentialing

PBF Quest Diagnostics No Longer in BCBSRI Laboratory Network Effective July 1, 2016

If you refer your patients to Quest Diagnostics or if you have BCBSRI patients who use Quest Diagnostics labs, we ask that you transition them to a participating laboratory as soon as possible. This facilitates a smooth transition for your patients and helps them avoid any out-of-pocket expenses they would incur if using Quest Diagnostics, which is now non-participating.

Please note that BCBSRI participating providers are required to refer members to BCBSRI participating providers, including ancillary providers, such as laboratories and durable medical equipment providers.

As of April 1, 2016, BCBSRI added the following laboratories and all of their locations to our BlueCHiP for Medicare network:

- CharterCARE Laboratory Services – Roger Williams Medical Center and Our Lady of Fatima Hospital
- CNE Laboratories
- South County Health Laboratories

We are pleased that we are able to add these system of care laboratories to our laboratory network to provide additional access for our BlueCHiP for Medicare members.

These laboratories join our existing laboratory service providers, including:

- East Side Clinical Lab
- Lifespan Laboratories
- Coastal Medical Laboratory
- Many specialty laboratories – Full listing of participating laboratories available at bcbsri.com through the Find a Doctor tool

A complete list of all BCBSRI participating laboratories is available on our Find a Doctor tool.

If you have any questions about these changes, please call our Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050 (out of state only).

Policies

PF Policies Recently Reviewed for Annual Update

The following policies were recently reviewed for annual update. The full text is available on our Policies page.

- Advanced Directive Planning
- Bioimpedance Devices for Detection and Management of Lymphedema
- Cochlear Implants
- Cooling Devices Used in the Home and Outpatient Setting
- Enhanced External Counterpulsation (EECP)
- First-Trimester Detection of Down Syndrome Using Fetal Ultrasound Markers Combined with Maternal Serum Assessment
- Hospital Readmission
- Inpatient Admission
- In Vitro Chemoresistance and Chemosensitivity Assays
- Lung Volume Reduction Surgery
- Monitored Anesthesia Care (MAC)
- Outpatient Pulmonary Rehabilitation

For your review, we also post monthly drafts of medical policies being created or reassessed. As a reminder, you can provide comments on draft policies for up to 30 days. Draft policies are located on our Policies page. Once on that page, click the drop-down box to sort policies by draft.

PF Modifier 25

Following an analysis of claims, BCBSRI has re-evaluated payment for claims submitted with modifier 25.

Effective October 15, 2016, the amount allowed for an evaluation and management (E&M) service when submitted with a modifier 25 will be reduced by 50 percent. This change will apply when a modifier 25 is appended to a problem-oriented E&M service (99201-99215) or a general ophthalmological code (92002-92014) and is submitted on the same date of service by the same provider with a procedure having a 0-, 10- or 90-day post-operative period.

All other applicable reductions, including mid-level practitioner reduction, will remain in place. E&M services that are reimbursed under a per diem or all-inclusive payment arrangement will not be impacted by this reduction.

When billing an E&M service along with a procedure, the documentation in the member's medical record must clearly demonstrate that:

- The purpose of the E&M service was to evaluate a specific complaint.
- The complaint or problem addressed can stand alone as a billable service.
- Extra work was performed that went above and beyond the typical work associated with the procedure code.
- The key components of the appropriately selected E&M service were actually performed and address the presenting complaint.
- The purpose of the visit was other than evaluating and/or obtaining information needed to perform the procedure/service.
- Both the medically necessary E&M service and the procedure are appropriately and sufficiently documented by the physician in the patient's medical record to support the claim for these services.

In all cases where modifier 25 is appropriately appended, the provider must ensure that documentation is present in the patient's medical record to fully substantiate both the E&M visit and the procedure. To that end, BCBSRI will periodically conduct random audits of claims submitted with modifier 25 to determine appropriate usage and ensure records contain appropriate documentation.

Please review the Coding and Payment Guidelines Policy in its entirety.

If you have additional questions, please contact Brian Wolf, MD, senior medical director, at (401) 459-5432 or brian.wolf@bcbsri.org.

Policies

PF Preventive Services for Commercial Members

The Preventive Services for Commercial Members Policy has recently been updated to include the recommendation below, which applies for coverage without cost share under a member's preventive services health benefit.

Colorectal Cancer Screening

Effective July 1, 2016, a new HCPCS code S0285 has been added for the preventive service that includes a pre-operative examination/consultation prior to a preventive colonoscopy.

Please refer to the complete guidelines that are found in the coding and coverage grid found in this policy for correct claims processing. See the full text of this policy.

PBF Clinical Practice Guidelines Updates

The 2016 Clinical Practice Guideline for the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure was presented for review and approved via a fax vote from the members of the July 20, 2016 Professional Advisory & Credentials Committee. The next review will take place in July 2018.

The 2015 Clinical Practice Guideline for the Well-Child was presented for review and approved by the Professional Advisory & Credentials Committee on May 13, 2015. The next review will take place in May 2017.

The 2016 Clinical Practice Guideline for Chronic Obstructive Pulmonary Disease (COPD) was presented for review and approved by the Professional Advisory & Credentials Committee on March 16, 2016. The next review will take place in March 2018.

Blue Cross Blue Shield of Rhode Island
www.bcbsri.com
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.
08/16 PRR-81973