Blue Cross Blue Shield of Rhode Island

provider update

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

November/December 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

P BCBSRI Study Shows Patient-Centered Medical Homes Improve Health, Lower Costs

Blue Cross & Blue Shield of Rhode Island (BCBSRI) recently released the results of a study that looked at patient-centered medical homes (PCMHs) over a five-year period, from 2009-2014. In the final year of the study, PCMH practices were 5 percent less costly and saved $30 million compared to standard primary care providers.

The analysis of BCBSRI's PCMH experience found that patients with complex medical conditions, like diabetes or cardiac health issues, are 16 percent less likely to be hospitalized or need to visit an emergency department, and readmissions to hospitals were 30 percent lower compared to someone seeing a standard primary care provider. In addition, patients at PCMH practices saw marked improvements in a range of quality measures, including diabetes care and colorectal screening.

The report tracked more than 89,000 commercial and 14,000 Medicare Advantage members within BCBSRI's PCMHs over the 2009-2014 time period. Today, BCBSRI has 137,000 patients seen in PCMH practices. Return on investment in the PCMH program was more than 250 percent. This highlights the value of focusing on enhanced access to team-based primary care and investing in programs that enable a coordinated care experience for those who need it most.

PBF New Products for 2016

BCBSRI is excited to introduce two new products: BlueCHiP for Medicare Advance and BlueCHiP Advance Commercial. Both plans are effective on January 1, 2016. **These plans require referrals for care provided by specialists or other providers outside the scope of primary care.**

Below is detailed information about each new product.

BlueCHiP for Medicare Advance

This limited network plan replaces BlueCHiP for Medicare Select and offers a number of new features, including a wider provider network. The doctors and hospitals in this exclusive network were chosen for their ability to improve coordination and

communication across all aspects of patient care. In addition, BlueCHiP for Medicare Advance features:

- $0 premium option for members
- $5 copays for primary care visits
- $2 copays for preferred generic drugs
- $100 yearly allowance for eyeglasses and contacts

Members who choose this plan must receive care within the BlueCHiP for Medicare Advance network of providers and facilities. In addition, referrals will be required when being treated by specialists or any other providers outside of the scope of primary care.

BlueCHiP Advance Commercial

In this tiered network product, premiums are low, but benefits are rich. Members who work with their PCPs to select the most appropriate services, providers, and facilities will experience significantly lower out-of-pocket expenses. Members will also receive:

- Annual foot and eye exam for diabetics at no cost
- $2 maintenance medications for asthma, diabetes, and COPD

Members who choose this plan have the option of receiving care from any of the providers and facilities within the BCBSRI network of providers, but their out-of-pocket copay, coinsurance, and deductible will vary based on the rendering provider's tier. Referrals will be required when being treated by specialists or any other providers outside of the scope of primary care.

Referral Process

For both of these new products, members will choose a PCP. As with current BlueCHiP Commercial products, the primary care physician is responsible for coordinating care and issuing referrals to specialists for BCBSRI members. To make the referral process easier, BCBSRI will launch a web-based tool on bcbsri.com in January.

Please note that once the referral tool is live, web-based referrals will be required for all BlueCHiP Commercial products and BlueCHiP for Medicare Advance. Until then, please follow the existing referral process. Also, please continue to follow the existing referral process for New England Health Plan members.

If a referral is ***not*** *obtained before a specialist provides care, the claim will deny.*

Webinars Available

To provide more information about these new products and the referral process, we will present educational webinars beginning at the end of January. More details to follow in the January *Provider Update*.

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

P Disease Management Programs

BCBSRI conducts Asthma and Diabetes Disease Management programs for our Commercial and Federal Employee Product (FEP) members. Members who are eligible for these programs are contacted by mail or telephone based on risk stratification.

- A mailing is sent to all identified members (low risk) to introduce the program and provide educational material. A call-in line is also made available for additional information or questions.
- Diabetics with gaps in care (moderate risk) receive notifications suggesting 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. High-risk members who are part of a patient-centered medical home (PCMH) also receive the high-risk mailing suggesting they contact the nurse case manager at their primary care physician's office. Interventions are conducted on an ongoing monthly basis.

If you have members who could benefit from either the Asthma or Diabetes Disease Management program, please call the BCBSRI Triage Line at (401) 459-2273.

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.

November Is Diabetes Awareness Month

With a prevalence of nearly 10 percent in Rhode Island, diabetes remains a high priority for BCBSRI. Diabetes screening and management guidelines are provided below.

The Centers for Disease Control and Prevention (CDC) recommends that anyone aged 45 years or older should be tested for diabetes, particularly if they are overweight. Adults who are younger than 45 should be tested if they are overweight or obese and have one or more additional risk factors—a first-degree relative with diabetes; being African-American, American Indian, Asian-American, Pacific Islander, or Hispanic-American/Latino; physical inactivity; blood pressure or lipid abnormalities; or a history of gestational diabetes. Diabetes is diagnosed using one of the following four methods (ADA, 2015):

A1c ≥6.5%* – Perform in lab using NGSP-certified method and standardized to DCCT assay
Fasting Plasma Glucose (FPG) ≥126 mg/dL (7.0 mmol/L)* – Fasting defined as no caloric intake for ≥8 hrs
2-hr Plasma Glucose (PG) ≥200 mg/dL (11.1 mmol/L) during Oral Glucose Tolerance Test (OGTT)* – Performed as described by the WHO, using glucose load containing the equivalent of 75g anhydrous glucose dissolved in water
Random PG ≥200 mg/dL (11.1 mmol/L) in persons with symptoms of hyperglycemia or hyperglycemic crisis
*In the absence of unequivocal hyperglycemia, results should be confirmed using repeat testing.
If clinical diagnosis is unclear, repeat same test using a new blood sample for confirmation. If two discordant results, the result above cut point should be repeated.

Quality

Management of Diabetes

Management of diabetes depends on the type of diabetes and the patient. Diabetes management involves oral or injected medication, nutritional therapy, exercise, and lifestyle modifications as well as home blood glucose testing and regular periodic screenings. A1c should be maintained between or below 7 to 8 percent, depending on the patient. In addition, the following regular screenings are both clinical standards of care and evaluated in the HEDIS Comprehensive Diabetes Care Measure:

Comprehensive Diabetes Care Measure	Measure Population: (Type 1 or 2 diabetes plus)	Tips for Success
Hemoglobin A1c testing	A HbA1c test during the measurement year	• Pre-visit planning may be useful. For patients 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 patients the importance of routine A1c testing as an indicator of diabetes control and to help guide treatment planning.
HbA1c poor control (>9.0%)	The most recent HbA1c test during the measurement year with a result greater than 9.0% **OR** a missing result	• For this measure, lower rates (of poorly controlled members with diabetes) are desirable. • Consider diabetes disease management for patients with diabetes. • Consider endocrinology referral for complex or refractory cases.
HbA1c control (<8.0%)	The most recent HbA1c test during the measurement year with a result less than 8.0%	• Reinforce members' achievement of target A1c and its association with lower rates of complications.
Eye exam (retinal) performed	A retinal eye exam by an optometrist or ophthalmologist in the measurement year **OR** a "negative for retinopathy" retinal exam by one of the above specialists in the year prior to the measurement year	• The retinal eye exam may include (but does not require) dilation. • Remind patients that diabetic eye disease can be asymptomatic, so routine exams are important for finding and treating problems early.
Medical attention for nephropathy	A nephropathy screening test **OR** evidence of nephropathy	• Dispensation of at least one ACE-I or ARB medication counts as evidence of nephropathy. • Remind patients that, like eye disease, diabetic kidney disease may be asymptomatic. Regular tests can detect issues early, when treatment may help delay disease progression. • Pre-visit planning may be useful when screening tests are due. For patients 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 non-acute inpatient encounter	• Discuss the importance of blood pressure control, especially given the additional cardiovascular risks for people with diabetes.

Quality

Members with diabetes may benefit from supplemental support from diabetes educators, classes, and structured self-management programs. Below is a list of the resources we offer for members with diabetes:

- **Diabetes Disease Management Program (for Commercial members).** Interventions are based on risk stratification and may include educational materials, reminders about needed screenings and tests, and health coaching. If you have Commercial members who could benefit from the Diabetes Disease Management program, please call the BCBSRI Triage Line at (401) 459-2273.
- **Case Management Program (for Commercial and Medicare Advantage members).** Our case managers can help members with diabetes improve their self-management skills, connect them with resources such as certified diabetes outpatient educators (CDOEs), and provide support. Case managers can also assist when members have difficulty paying for medications, supplies, or care. To refer a member to Case Management, please call (401) 459-5683 or 1-888-725-8500 and leave a message.
- **Classes in Our Retail Stores (for Commercial and Medicare Advantage members).** Our retail stores periodically offer classes that members with diabetes may find helpful, including diabetes and free exercise classes. Members can learn more about the offerings in our retail stores by calling (401) 459-2200 or visiting https://www.bcbsri.com/yourbluestore.
- **Living Fit Benefit (for some BlueCHiP for Medicare members depending on their plan).** This benefit provides an unlimited-use health club membership at any one network facility for only $5 per month. Members pay the $5 membership fee month to month, and may cancel at any time. With their membership, BlueCHiP for Medicare members can take advantage of group fitness classes (additional cost may apply); state-of-the-art exercise equipment; knowledgeable, courteous staff; and at some facilities, indoor swimming pools. We encourage you to speak with your patients about the importance of exercise for their overall health and well-being. To learn more about BlueCHiP Medicare member eligibility for low-cost fitness benefits, please call our Physician & Provider Service Center at (401) 274-4848 or 1-800-230-9050 (out of state only), Monday through Friday, 8:00 a.m. to 4:30 p.m.
- **Healthcentric Advisors Diabetes Program for Medicare Advantage members.** See page 8 for more about this program.

Osteoporosis Management in Women Who Had a Fracture

The HEDIS measure for Osteoporosis Management in Women Who Had a Fracture tracks the percentage of women aged 67 to 85 years old who have received a bone mineral density (BMD) scan or filled a prescription to prevent or treat osteoporosis within six months of a recorded fracture during the measurement year. HEDIS 2015 results indicate that only 17.65 percent of eligible female BlueCHiP for Medicare members met these criteria. This score ranks in the 25th national percentile, indicating opportunity for improvement.

We continue to partner with MedXM, a company specializing in heel ultrasounds, a diagnostic test that fulfills this measure. MedXM schedules in-home visits for female BlueCHiP for Medicare members who have had a fracture and no BMD scan recorded within six months of the incident. Members who meet these criteria will receive a letter from BCBSRI about MedXM, and a phone call from MedXM to schedule a visit from a technician who will complete a heel ultrasound. A fax notification will be sent to all PCPs listing their patients who will receive outreach from MedXM. PCPs will also receive a copy of the results to review and file in the patients' records.

There is no charge for this in-home visit, and it will not affect your patients' healthcare coverage in any way. These visits are not meant to replace the care your patients receive through their PCP. MedXM is not involved in the care or treatment of the patient, nor will they prescribe medications. Patients will be encouraged to remain up-to-date with their preventive care and routine office visits with their PCP.

Controlling Blood Pressure

Hypertension is frequently asymptomatic, yet can damage the heart, brain, kidneys, and vascular system. Controlling Blood Pressure (CBP) is a measure for both HEDIS and CMS Stars. The following table outlines the current measure as well as tips for success.

Measure	Measure Population (Hypertension Adequately Controlled)	Tips for Success
Controlling 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 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. • Encourage physical activity in patients without contraindications. Some BlueCHiP for Medicare members have a fitness benefit as part of their plan. • Consider refresher training to help standardize CBP measurement techniques among your staff. See below 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 (JNC 7), published and developed by the National High Blood Pressure Education Program in coordination with the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health.

The full guideline is available on the NHLBI website. You can also view the BCBSRI clinical practice guideline for high blood pressure on our secure provider portal.

New Onset, Non-Acute Low Back Pain

With winter (and inclement weather) approaching, new diagnoses of back pain may result from injuries secondary to shoveling snow or slipping on wet/frozen surfaces. 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[1]. BCBSRI utilizes the Clinical Guidelines for the Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. The full guideline contains additional guidance for diagnosis and treatment. We track performance in this area using the HEDIS measure "Use of Imaging Studies in Low Back Pain (LBP)," which examines 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[2]. The table below summarizes the HEDIS measure, population, and tips for improving performance.

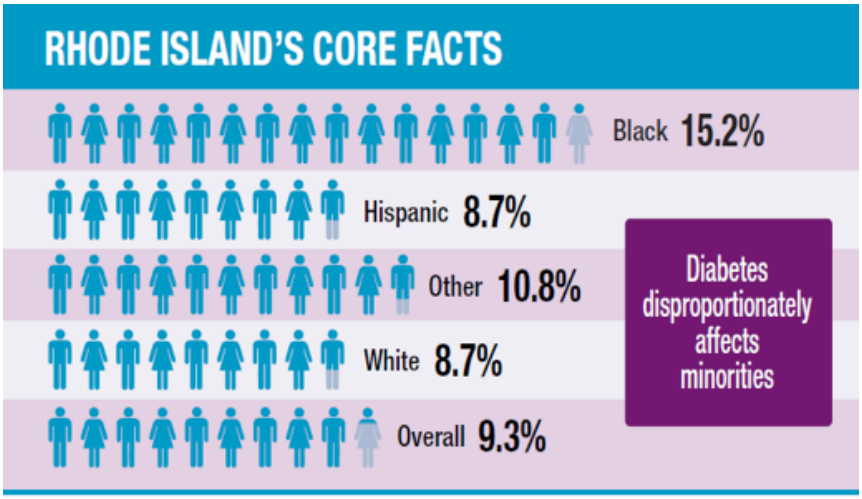
Measure	Population: Numerator and Denominator	Tips for Success
Use of Imaging Studies for Low Back Pain (LBP)	***Numerator:*** Members from the denominator who had an imaging study with a diagnosis of low back pain and no exclusions ***Exclusions***: Cancer, trauma, neurologic impairment, or IV drug 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).

[1] Citations located at http://www.qualitymeasures.ahrq.gov/content.aspx?id=48635&search=back+pain

[2] This measure is reported as an inverted rate. Members receiving imaging studies are subtracted from the denominator. A higher rate indicates better performance.

PBF Available Now: FREE Diabetes Program for Medicare FFS and Medicare Advantage Members

BCBSRI is pleased to announce a program for Medicare Advantage members with diabetes (or pre-diabetes) 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:



Eligibility Guidelines

This program is based on the evidence-based Stanford Model of Diabetes Self-Management Education. Healthcentric Advisors seeks Medicare Advantage members with diabetes or pre-diabetes 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 below) for more information.

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.

P Quality Interactions

We are pleased to offer primary care physicians, mid-level practitioners, and nurses an educational opportunity to enhance your communication with patients from different cultures. Through Quality Interactions, an interactive training, you can take part in "real-life" patient encounters created to deepen your understanding of how the diverse patient population in Rhode Island views and values their health.

You have the option of doing this training online at your own pace.

Incentives for Completing the Training

Complete each of the three Quality Interactions modules with a score of 70 percent or greater and receive three FREE CME/CEU credits!

How to Use Quality Interactions

1. Visit Quality Interactions

2. Select "New User"

3. Enter Organization ID 92700

4. Create a unique username and password, then complete and submit the registration form

5. Select the appropriate course title and complete it

6. Complete the evaluation (required)

Primary care physicians, mid-level practitioners, and nurses should take the *Test Your Skills for Clinicians* modules. Pediatric physicians, mid-level practitioners, and nurses should take the *Test Your Skills for Pediatricians* modules.

Please note: You do not need to take all three courses in one sitting; however, if you exit in the middle of a section, you'll have to retake that section the next time you log in. To prevent this, please log out between sections.

Questions?

Please contact PCMH@BCBSRI.org or call Sarah Enright at (401) 459-5295.

PBF Save the Date: Rhode Island Trans* Health Conference for Providers: January 30, 2016

BCBSRI, along with The Warren Alpert Medical School of Brown University and Rhode Island College, is proud to help support the state's second Trans* Medicine Conference for medical, behavioral health, and allied healthcare providers as well as self-identified members of the transgender and gender-nonconforming community. This one-day conference is scheduled for January 30, 2016 at Rhode Island College. The purpose of the conference is to:

- Provide education on important concepts related to caring for transgender patients
- Enhance clinical expertise
- Expand the community's access to care

Experts from the region will present on best practices and lessons from their own work. Continuing education units will be available for physicians, nurses, and behavioral health providers. Attendance at the conference helps fulfill staff training requirements for practices applying to become LGBT Safe Zones. If you have any questions about the conference, please contact the Brown University Office of Continuing Medical Education by phone at (401) 863-2871 or by email at cme@brown.edu.

PBF BCBSRI Welcomes Two New Participating Providers

BCBSRI is pleased to announce two new participating programs that are available to your patients with mental health and substance use disorders: HealthPath and Butler Hospital's Ambulatory Detoxification Program.

HealthPath

This innovative pilot program—offered through a partnership between BCBSRI, Continuum, and Care New England—is designed to provide BCBSRI members with comprehensive behavioral health services. The program highlights the benefits of team-based care through care delivery provided by a multidisciplinary team of psychiatrists, nurses, independently licensed clinicians, peer support specialists, and substance abuse specialists. This team provides individualized office, home, or community-based services depending on the patient's identified needs. HealthPath offers clients access to psychiatric care, counseling, case management, health and wellness care, life skills support (including vocational and educational training), medication management, transportation to and from medical appointments as needed, and flexible appointment dates and times as well as weekend and holiday emergency care. The services are intended to assist members struggling with behavioral health conditions in reaching their highest level of functioning through a coordinated and individualized treatment approach.

If you have a patient who you believe would benefit from HealthPath, please contact Continuum Behavioral Health at (401) 415-8868 to schedule an intake appointment. Patients who present at intake and do not meet eligibility criteria will be referred to appropriate providers.

Butler Hospital's Ambulatory Detoxification Program

This outpatient program meets the needs of members who do not meet criteria for inpatient detox but are at high risk for relapse and higher utilization because they lack structured supports. In addition to supports typically found in a detox program, Butler's program includes a Peer Recovery Coach who will follow the member after discharge. The Peer Recovery Coach will engage the member while at Butler and will conduct follow-up calls up to 30 days post discharge to ensure that the member is well-supported through their recovery. The program requires prior authorization through ValueOptions. If you wish to refer someone to the program, please contact Butler Hospital Intake at (401) 455-6214.

B Introducing... Beacon Lens

Beacon Lens is the blog from Beacon Health Options, BCBSRI's behavioral health partner and the nation's preeminent behavioral health company. The blog's focus is on rapid response to the most pressing and controversial issues in behavioral healthcare today.

In addition to blog posts, Beacon Lens also features a selection of white papers that Beacon Health Options has written regarding current issues in behavioral health.

Click here to read and subscribe to The Beacon Lens.

PBF National Employer Group Accounts

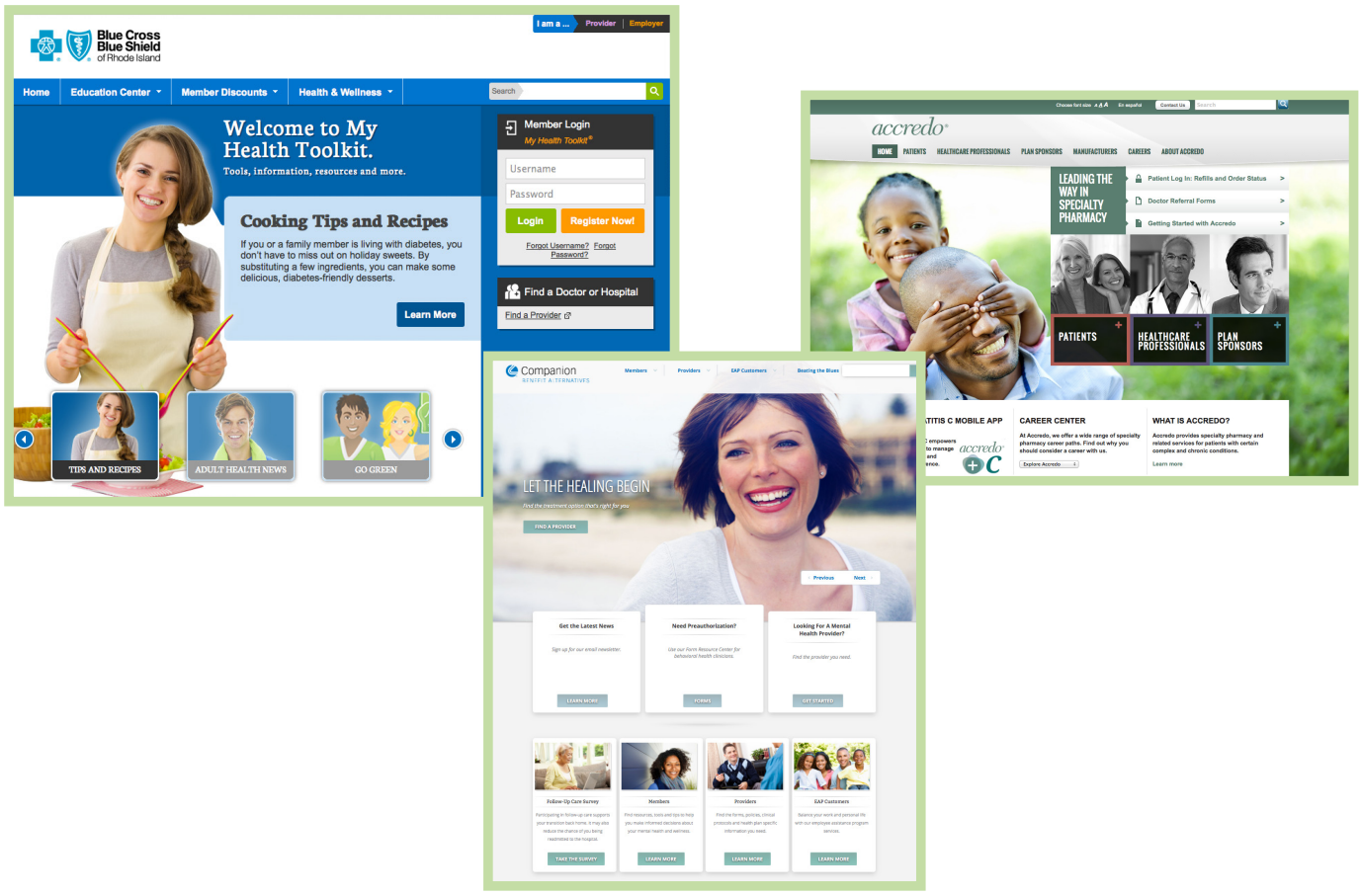
BCBSRI continues to offer a national solution to service the unique needs of select multi-state clients. While the members associated with these accounts will continue to be enrolled through BCBSRI and present BCBSRI membership ID cards, they will be serviced via National Alliance, which is a different platform than our local membership. In 2016, member IDs associated with this platform will have a prefix of **BOU, GTY, and MGE**.

There are some features that are unique to this national platform. When a member's ID has one of the prefixes listed above, please do the following:

- Verify benefits, eligibility, and member liability by visiting www.myhealthtoolkitri.com.
- Look on the back of the member's ID card for phone numbers for preauthorizations. Employer groups who are managed through National Alliance will use their vendors, such as:
  - > NIA for radiology management
  - > Accredo for specialty pharmacy
  - > Companion for behavioral health

If you have any questions, 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.

Please note, there could be differences in prior authorization requirements. Please ensure you validate the prior authorization requirements by visiting www.myhealthtoolkitri.com before rendering services.



PBF IMPORTANT: Enroll in Medicare as a Provider

If you are a provider who currently prescribes drugs for Medicare patients but who is not enrolled in (or validly opted out of) Medicare, it is crucial for your patients' health that you enroll in Medicare (or validly opt out, if appropriate) because of a new Medicare requirement. Please follow the steps below as soon as possible. A delay on your part could result in your Medicare patients not being able to obtain drugs you prescribe for them.

What Has Changed and When?

The Centers for Medicare and Medicaid Services (CMS) have published rules that will soon require nearly all providers, including Medicare Advantage providers, who prescribe drugs for Part D patients to enroll in Medicare (or validly opt out, if appropriate). This includes providers such as dentists, physicians, psychiatrists, residents, nurse practitioners, and physician assistants. Beginning June 1, 2016, CMS will enforce a requirement that Medicare Part D prescription drug benefit plans *may not cover drugs* prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances.

Why Is This Important to My Patients and Me?

Unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you are not able to prescribe covered Part D drugs. Please also note that if you opt out, you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services; see 42 CFR 405.440 for details).

What Steps Do I Need to Take?

To help your Medicare patients, please **enroll in Medicare** either fully to bill or for the limited purpose of prescribing Part D drugs. There are **no fees** to complete the process. You can do so electronically *or* on paper:

1. **Electronic process:** Use the PECOS system at go.cms.gov/pecos. For limited enrollment, we recommend using the step-by-step instructions at go.cms.gov/PECOSsteps and a video tutorial at go.cms.gov/PECOSVideo; or
2. **Paper process:** Complete the paper application for limited enrollment at go.cms.gov/cms855o and submit it to the Medicare Administrative Contractors (MAC) in your geographic area. To locate your MAC, please refer to the MAC list at: go.cms.gov/partdmaclist.

If you need assistance with the process of enrolling in (or validly opting out of) Medicare, please contact the MAC within your geographic area.

Thank you for your prompt and careful attention to this important matter, and for serving Medicare beneficiaries. These new CMS rules will enable federal officials to better combat fraud and abuse in the Part D program through verification of providers' credentials via the Medicare enrollment/opt-out process.

Questions? Need Assistance?

Please contact CMS at providerenrollment@cms.hhs.gov if you have questions about this notice, or if you:

- Are unsure whether you are already enrolled in (or validly opted out of) Medicare
- Have questions about a pending application
- Are concerned that you are not eligible to enroll in Medicare

If you need assistance with the process of enrolling in (or validly opting out of) Medicare, please contact the MAC within your geographic area. To locate your MAC, please refer to the MAC list on the CMS website at go.cms.gov/partdmaclist.

Please visit the CMS Part D Prescriber Enrollment website at go.cms.gov/PrescriberEnrollment for helpful information about the new requirement, such as resources to check your application status, or to sign up for the listserv to receive updates.

Background Information

The Medicare program is administered by CMS within the U.S. Department of Health and Human Services. The Medicare program is divided into four parts:

1. Part A generally covers inpatient hospital services
2. Part B generally covers physician services
3. Part C (Medicare Advantage) refers to Medicare-approved private health insurance plans for individuals enrolled in Parts A and B
4. Part D covers the cost of most prescription medications

The Part D prescriber enrollment rules referred to in this notice are CMS-4159-F *Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs* (79 FR 29843; May 23, 2014); and CMS-6107-IFC *Medicare Program; Changes to the Requirements for Part D Prescribers* (80 FR 25958; May 6, 2015).

PBF Biologics, Biosimilars, and Interchangeables

The FDA has approved Zarxio (filgrastim-sndz), the first biosimilar product, and there are more to come. An oversimplified view is that biosimilars are to biologics as generics are to brands, but there is more to understand about the differences. Biologics, biosimilars, and interchangeables are part of a complex issue, and as more enter the market and BCBSRI's coverage policies evolve, we will be addressing the topic of biosimilars over a series of updates.

What Are Biologics?

These are medications made from living organisms, including humans, animals, and microorganisms such as bacteria or yeast and are manufactured through biotechnology, derived from natural sources, or produced synthetically. Many of the medications used to treat anemia, inflammatory bowel disease, neutropenia, psoriasis, rheumatoid arthritis, and various types of cancer are biologics.

What Are Biosimilars?

A biologic that has already been FDA approved is referred to as the **reference product,** and a new biological product that is highly similar to the reference product is known as a **biosimilar**. In terms of safety and effectiveness, biosimilar products have no clinically meaningful differences from the reference product they were compared to. They must have the same mechanism of action, meaning that it works in the same way as the reference product. The FDA only approves biosimilars with the same mechanism of action, route of administration, dosage form, and strength as the reference product.

Prescribing Biologics vs. Biosimilars

When a provider prescribes a biologic, a biosimilar may not be automatically substituted for the reference product by a pharmacist without the prescriber writing for the biosimilar by name or the pharmacist asking the prescriber to change the prescription to the biosimilar.

What Are Interchangeables?

Biosimilars that are expected to produce the same clinical result as the reference product may be considered to be interchangeable. Alternating or switching between the reference product and an interchangeable biosimilar is no greater risk than the risk of using the reference product alone.

Prescribing Biologics vs. Interchangeables

When a provider prescribes a biologic, an interchangeable **may** be substituted for the reference product by a pharmacist without a new prescription. This means that a patient may receive the interchangeable instead of the reference product, even if the prescription was written for the name of the reference product.

Are Biosimilars Just Generics?

Generic drugs are copies of brand name drugs. They have the same active ingredient, and are the same as the brand name drug in dosage, form, safety, strength, route of administration, quality, performance characteristics, and intended use. Brand name and generic drugs are bioequivalents. Biosimilars are very similar to the reference product, but they are allowed certain differences because they are made from living organisms. Biosimilars have no clinically significant differences in terms of safety, purity, and potency from the reference product.

Are Biosimilars or Interchangeables Safe?

When a manufacturer seeks approval for a biosimilar or interchangeable product, they include data to show that the proposed product is expected to produce the same clinical results as the reference product in any given patient. They must include data from analytical studies, animal studies, and clinical studies showing assessment of immunogenicity and pharmacokinetics or pharmacodynamics.

For a biosimilar to be approved as an interchangeable product, it must be demonstrated that the safety risk is not increased and effectiveness does not decrease if a patient switches between using the interchangeable and the reference products.

For more information, please click the links below:

http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm290967.htm

http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/default.htm

http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm436399.htm

F Claims Filing Update for Institutional Providers

Consistent with industry standards, BCBSRI made an update to claims filing for institutional providers on October 11, 2015. As of this date, we require all inpatient institutional claims, as well as specific outpatient claims, to be filed with the admission date, time, and diagnosis code through the 837I EDI transaction. This applies to those institutional providers who file Type of Bills: 12X, 22X, 32X, 34X, 81X and 82X.

If you have any questions regarding these claim filing changes, please contact our Facility Call Center at (401) 274-3103 or 1-800-637-3718, ext. 6067 (out of state only).

PF Claims Filing for Home Infusion Providers

Home infusion providers can submit claims for dates of service on or after January 1, 2016 on the CMS-1500 claim form and/or the 837P EDI transaction, which aligns with how you submit claims to other health plans. Dates of service rendered before January 1, 2016 should be filed on the CMS-1450 (UB-04) form and/or the 837I EDI transaction. Adjustments requested after July 1 must be made on the claim form that was originally submitted.

PF Change in Participating Provider Status for DaVita Healthcare Partners

BCBSRI has been working to continue a participating provider relationship with ISD Renal, Inc., which is owned by DaVita Healthcare Partners ("DaVita"). However, despite BCBSRI's efforts, DaVita has elected to terminate its contract with BCBSRI, with the contract expiring on December 8, 2015. As of that date, DaVita, which provides renal services at 1635 Mineral Spring Avenue, North Providence, RI, is considered a non-participating provider with BCBSRI.

We are asking that all BCBSRI participating providers not make any new referrals to DaVita for BCBSRI Commercial or Medicare Advantage members, Federal Employee members, and members of Blue Plans nationwide (BlueCard patients), collectively referred to as "members," to ensure compliance with your BCBSRI Participating Physician Agreement

BCBSRI also is requesting that all participating providers transition any members currently receiving services at DaVita to a participating renal dialysis facility. A listing of participating renal dialysis facilities can be found through the BCBSRI Find a Doctor tool.

The outline below highlights how patients will be affected if services are rendered at DaVita's facility.

- BCBSRI PPO and BlueCHiP Commercial Members After the Transition Period

  BCBSRI Commercial PPO members may still receive renal services at DaVita if their BCBSRI plan covers out-of-network services, and they choose to do so. However, members will have to pay more for those services. BCBSRI will reimburse the member directly up to our allowed amount for all covered services. Services will be subject to the member's applicable out-of-network benefit level, which may include copayment, coinsurance, and/or deductible. The member may also be responsible for paying DaVita the difference between the allowed payment and DaVita's charge.

  BlueCHiP Commercial Non Flex members may be responsible up to DaVita's charge. Services will be considered out-of-network and non-covered for BlueCHiP Commercial Non Flex members.

- BlueCHiP for Medicare

  BlueCHiP for Medicare members are required to obtain prior authorization for out-of-network benefits. Most BlueCHiP for Medicare members do not have coverage for out-of-network services. Please contact the BCBSRI Physician & Provider Service Center at

  (401) 274-4848 or 1-800-230-9050 (out of state only) for more information regarding BlueCHiP for Medicare out-of-network benefits and requirements.

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

PBF Provider Fee Schedule Updates

BCBSRI is committed to improving the health of our members and all Rhode Islanders by providing access to high-quality, cost-effective healthcare. To ensure reimbursement rates remain updated and consistent with this commitment, BCBSRI reviews its fee schedules on a yearly basis.

Update to Standard Fee Schedules

BCBSRI will be updating its standard fee schedules for Commercial and Medicare Advantage reimbursement for dates of service on or after January 1, 2016. BCBSRI continues to use the Rhode Island Medicare Fee Schedule as the basis for the standard fee schedule reimbursement as it contains resource-based relative value, or RBRVS, pricing. For limited services that are not priced by Medicare, BCBSRI will retain its developed fees from 2014.

How to View the Updated Fee Schedules

For your convenience, the updated fee schedules are available in Excel format in the secure Provider section of bcbsri.com. The previous fee schedules are included for your reference. You will need to log in to bcbsri.com to view the fee schedules.

If you don't currently have log-in access to bcbsri.com, please follow these steps:

1. "Sign up for a log-in"
2. Follow the prompts to register as a participating provider and request a PIN. Please note that the information you provide online will be populated in a PDF that you will need to print, sign, and fax to BCBSRI.

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).

PBF Reminder: Update Your Practice Information!

It is important that you update your practice information regularly by completing a Practitioner Change Form. All providers voluntarily terminating their network participation are required to provide a 60-day advance notice, which is a contractual obligation. It is especially important to do this, as it can impact our members' ability to be transitioned to another PCP in a timely fashion or choose a PCP when enrolling for coverage. Please click here to access the form.

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.

- Acute Inpatient Rehabilitation Level of Care
- Ambulance: Air and Water Transport
- Anastomosis of Extracranial-Intracranial Arteries
- Aqueous Shunts and Stents for Glaucoma
- Belimumab
- Bone Mineral Density Studies
- Botulinum Toxin Injection
- Breast Pumps
- Breast Reconstruction and Applicable Mandate
- Carotid Angioplasty/Stenting Without Embolic Protection
- Cellular Immunotherapy for Prostate Cancer
- Coding and Payment Guideline
- Continuous Glucose Monitoring
- Cooling Devices used in the Home and Outpatient Setting
- Denosumab (Prolia and Xgeva)
- Electrical Stimulation and Electromagnetic Therapy for Wound Treatment
- First-Trimester Detection of Down Syndrome Using Fetal Ultrasound Markers Combined with Maternal Serum Assessment
- Focal Treatment for Prostate Cancer
- Hospital Readmissions
- Home Spirometry
- Human Leukocyte Antigen (HLA) Testing Mandate
- Hyperbaric Oxygen Therapy
- Hyperthermia for Cancer Therapy
- Injectable Bulking Agent for Fecal Incontinence
- Injectable Fillers
- Inpatient Admission
- Intra-Articular Hyaluronan Injections for Osteoarthritis
- Intraoperative Neurophysiologic Monitoring
- Laser Treatment for Port Wine Stains
- Lung Volume Reduction Surgery
- Mental Illness and Substance Abuse Mandate
- Neural Therapy
- Off-Label Use of Prescription Drugs for Cancer Mandate
- Omalizumab (Xolair)
- Outpatient Observation Services
- Pediatric Dental Services – Essential Health Benefit
- Pediatric Feeding Disorders
- Pegloticase
- Percutaneous Tibial Nerve Stimulation
- Pelvic Floor Stimulation as a Treatment for Urinary and Fecal Incontinence
- Preauthorization via Web-Based Tool for Durable Medical Equipment (DME)
- Preauthorization via Web-Based Tool for Genetic Testing
- Preauthorization via Web-Based Tool for Procedures
- Preventive Services for BlueCHiP for Medicare Members 2016
- Phototherapy for Seasonal Affective Disorder
- Prostate Cancer Genomic Assays – NEW
- Respiratory Syncytial Virus Immunoglobulin
- Rhinomanometry and Acoustic/Optical Rhinometry
- Salivary Estriol as Risk Predictor for Preterm Labor and Management of Menopause and/or Aging
- Smoking Cessation Mandate
- Therapeutic Shoes for Diabetics Mandate
- Total Artificial Hearts as Permanent Replacement Therapy
- Transpupillary Thermotherapy for Treatment of Choroidal Neovascularization
- Unlisted Procedures
- Vectra DA Blood Test for Rheumatoid Arthritis – NEW
- Vertebral Fracture Assessment
- Viscocanalostomy and Canaloplasty

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 Hospital Readmissions

Effective February 2, 2016, the payment guidelines for readmissions to an acute general short-term hospital will change from 10 calendar days to 14 calendar days from the date of discharge when the care is provided in the same hospital with the same, similar, or a related diagnosis. Please note our standard timeframe for administrative appeals is 60 days.

PF Intra-Articular Hyaluronan Injections for Osteoarthritis

Effective January 1, 2016, BCBSRI will be modifying the Intra-Articular Hyaluronan Injections for Osteoarthritis medical policy. Coverage for this policy will be changed from covered to not medically necessary for BlueCHiP for Medicare and BCBSRI Commercial members.

The following HCPCS codes will be **not medically necessary** effective **January 1, 2016**:

- J7321
- J7323
- J7324
- J7325
- J7326

Additionally, CPT 20610 is **not medically necessary** when billed with one of the HCPCS codes listed above.

As a reminder, members are to be held harmless for any charges unless they have signed an Advance Beneficiary Notice prior to the procedure. Please read the full text of this policy.

PBF Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease

Due to an update to this new policy, the effective date has been changed from December 1, 2015 to January 1, 2016. As reported in October 2015, the measurement of novel lipid and nonlipid risk factors is considered **not medically necessary** as there is insufficient peer-reviewed scientific literature to demonstrate that the service is effective. We have revised the coverage determination for B type natriuretic peptide testing (CPT code 83880). B type natriuretic peptide testing is covered but not separately reimbursed when used in conjunction with standard diagnostic tests, medical history, and clinical findings during an evaluation of heart failure in an acute care setting or other setting (i.e., emergency department) where test results are immediately determined. Please read the full text of this policy.

PF Intensity-Modulated Radiotherapy of the Breast and Lung, Cancer of the Head and Neck or Thyroid, Central Nervous System Tumors, and Prostate

Due to updates in our claims editing system, effective January 1, 2016, diagnosis code edits have been added to the intensity-modulated radiotherapy (IMRT) policies for treatment of breast and lung, cancer of the head and neck or thyroid, central nervous system tumors, and prostate. The CPT and HCPCS codes in each policy are considered medically necessary when billed with one of the diagnosis listed.

PF Coding Reminder

Per the American Congress of Obstetricians and Gynecologists Coding Manual, CPT code 76831 – Saline infusion sonohysterography (SIS), including color flow Doppler, includes imaging of uterus, tubes, ovaries, and pelvic structures. Therefore, CPT code 76856 – Ultrasound, pelvic (nonobstetric), real time with image documentation; complete should not be filed in conjunction with CPT code 76831.

PF Clinical Practice Guidelines Update

The 2015 Clinical Practice Guideline for Low Back Pain was presented for review and approved at the July 15, 2015 Professional Advisory Committee meeting. The next review will be conducted in July 2017.

The 2015 Clinical Practice Guideline for Coordination of Care was presented for review and approved at the May 13, 2015 Professional Advisory Committee meeting. The next review will be conducted in May 2017.

The 2015 Clinical Practice Guideline for the Diagnosis & Management of Chronic Heart Failure was presented for review and approved at the September 16, 2015 Professional Advisory Committee meeting. The next review will be conducted in September 2017.

P EKG During a Preventive Visit

According to the U.S. Preventive Services Task Force (USPSTF), an electrocardiogram should not be performed routinely on asymptomatic adults who are at low risk for coronary heart disease. The USPSTF has determined that the incremental information provided by the resting electrocardiogram (beyond that obtained with conventional risk factor assessment) is not likely to alter risk stratification or improve clinical outcomes. USPSTF recommends against using electrocardiogram to screen for coronary disease in asymptomatic adults who are at low risk for coronary disease.

Effective January 26, 2016, BCBSRI will deny claims for 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) when billed in the office setting for patients 18 years of age and older without an appropriate diagnosis.

Policies

PF Gender Reassignment Surgery

The Gender Reassignment Policy has been updated to reflect that this policy is also effective for BlueCHiP for Medicare members. To request preauthorization, please contact the Health Services Management Department at (401) 272-5670, extension 3012, or fax your request to (401) 272-8885. Please read the full text of this policy.

PF Drugs and Biologicals Payment Policy

BCBSRI has payment policies for various drugs and biologicals that are covered under the member's medical coverage. This will ensure that claims are paid in accordance with industry standard coding practices, under generally accepted clinical guidelines, and in a consistent manner across the network. These edits do not take the place of prior authorization when that is required. They are applied to claims to screen for coding errors and dosage that exceeds generally accepted limits. Claims denials are subject to utilization review processes if the denial reason is one of medical necessity (e.g., diagnosis or unusual dosage). If there is no specific policy for an agent, BCBSRI will rely upon the following sources:

- Manufacturer's prescribing information (FDA-approved label)
- Elsevier Gold Standard's Clinical Pharmacology
- Thomson MICROMEDEX® (DRUGDEX®, DrugPoints®)
- American Hospital Formulary System (AHFS) DI
- National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium
- Local Coverage Determinations (LCDs)

These policies will address diagnostic indications, the appropriate dose, and the appropriate frequency of administration as well as other industry standard guidelines. Please read the full text of this policy.

PF Prostate Cancer Genomic Assays

A new policy was created to document that the Genetic Test Prolaris™ is not medically necessary for Commercial Products and requires prior authorization through the online authorization tool for BlueCHiP for Medicare. Please read the full text of this policy.

PBF 2016 CPT® Code Changes

We have completed our review of the 2016 Current Procedural Terminology (CPT) 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 January 1, 2016. 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.
- "Not Separately Reimbursed" – Services that are not separately reimbursed are generally included in payment for another service or are reported using another code and may not be billed to your patient.
- "Subject to Medical Review" – Preauthorization is recommended for commercial products and required for BlueCHiP for Medicare.
- "Medicare Lab Network Exempt" – This indicates that these codes are not subject to the exclusive lab networks agreement for BlueCHiP for Medicare plans. These lab tests can be performed by hospitals, physicians, and urgent care centers. As a reminder, all laboratory services that are not listed as exempt from the exclusive lab network for BlueCHiP for Medicare members must be performed at East Side Clinical Laboratories, Quest Diagnostics, Coastal Medical, and Lifespan Laboratories in order to be covered. We list exceptions to this general rule.

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

2016 CPT Updates

Code comments

37252 Not separately reimbursed for institutional providers for BlueCHiP for Medicare and commercial products

37253 Not separately reimbursed for institutional providers for BlueCHiP for Medicare and commercial products

43210 Not medically necessary for commercial products

65785 Subject to medical review for BlueCHiP for Medicare and commercial products

74712 Subject to medical review for BlueCHiP for Medicare and commercial products

74713 Subject to medical review for BlueCHiP for Medicare and commercial products

80081 Medicare lab network exempt

81162 Subject to medical review for BlueCHiP for Medicare and commercial products, Medicare lab network exempt

81170 Subject to medical review for BlueCHiP for Medicare and commercial products

81218 Subject to medical review for BlueCHiP for Medicare and commercial products

81219 Subject to medical review for BlueCHiP for Medicare and commercial products

81272 Subject to medical review for BlueCHiP for Medicare and commercial products

81273 Subject to medical review for BlueCHiP for Medicare and commercial products

81276 Subject to medical review for BlueCHiP for Medicare and commercial products

81311 Subject to medical review for BlueCHiP for Medicare and commercial products

81314 Subject to medical review for BlueCHiP for Medicare and commercial products

81412 Not medically necessary for BlueCHiP for Medicare and commercial products

81432 Not medically necessary for BlueCHiP for Medicare and commercial products

81433 Not medically necessary for BlueCHiP for Medicare and commercial products

81434 Not medically necessary for BlueCHiP for Medicare and commercial products

81437 Not medically necessary for BlueCHiP for Medicare and commercial products

81438 Not medically necessary for BlueCHiP for Medicare and commercial products

81442 Not medically necessary for BlueCHiP for Medicare and commercial products

81490 Not medically necessary for commercial products

81493 Not medically necessary for commercial products

81525 Not medically necessary for commercial products

81535 Not medically necessary for BlueCHiP for Medicare and commercial products

81536 Not medically necessary for BlueCHiP for Medicare and commercial products

81538 Not medically necessary for commercial products

81540 Not medically necessary for commercial products

81545 Subject to medical review for BlueCHiP for Medicare, not medically necessary for commercial products

81595 Not medically necessary for commercial products

88350 Medicare lab network exempt

93050	Not medically necessary for BlueCHiP for Medicare and commercial products
96931	Not medically necessary for BlueCHiP for Medicare and commercial products
96932	Not medically necessary for BlueCHiP for Medicare and commercial products
96933	Not medically necessary for BlueCHiP for Medicare and commercial products
96934	Not medically necessary for BlueCHiP for Medicare and commercial products
96935	Not medically necessary for BlueCHiP for Medicare and commercial products
96936	Not medically necessary for BlueCHiP for Medicare and commercial products
99177	Not covered for BlueCHiP for Medicare, not medically necessary for commercial products
99415	Not separately reimbursed for BlueCHiP for Medicare and commercial products
99416	Not separately reimbursed for BlueCHiP for Medicare and commercial products
0396T	Not medically necessary for BlueCHiP for Medicare and commercial products
0397T	Not medically necessary for BlueCHiP for Medicare and commercial products
0398T	Not medically necessary for BlueCHiP for Medicare and commercial products
0400T	Not medically necessary for BlueCHiP for Medicare and commercial products
0401T	Not medically necessary for BlueCHiP for Medicare and commercial products
0402T	Not medically necessary for BlueCHiP for Medicare and commercial products
0403T	Not covered for BlueCHiP for Medicare and commercial products
0404T	Not covered for BlueCHiP for Medicare and commercial products
0405T	Not covered for BlueCHiP for Medicare and commercial products
0406T	Not medically necessary for BlueCHiP for Medicare and commercial products
0407T	Not medically necessary for BlueCHiP for Medicare and commercial products
0408T	Not covered for BlueCHiP for Medicare and commercial products
0409T	Not covered for BlueCHiP for Medicare and commercial products
0410T	Not covered for BlueCHiP for Medicare and commercial products
0411T	Not covered for BlueCHiP for Medicare and commercial products
0412T	Subject to medical review for BlueCHiP for Medicare, not medically necessary for commercial products
0413T	Subject to medical review for BlueCHiP for Medicare, not medically necessary for commercial products
0414T	Not covered for BlueCHiP for Medicare and commercial products
0415T	Not covered for BlueCHiP for Medicare and commercial products
0416T	Not covered for BlueCHiP for Medicare and commercial products
0417T	Not covered for BlueCHiP for Medicare and commercial products
0418T	Not covered for BlueCHiP for Medicare and commercial products
0421T	Not covered for BlueCHiP for Medicare and commercial products
0422T	Not medically necessary for BlueCHiP for Medicare and commercial products
0423T	Not medically necessary for BlueCHiP for Medicare and commercial products

Policies

0424T Not covered for BlueCHiP for Medicare and commercial products

0425T Not covered for BlueCHiP for Medicare and commercial products

0426T Not covered for BlueCHiP for Medicare and commercial products

0427T Not covered for BlueCHiP for Medicare and commercial products

0428T Subject to medical review for BlueCHiP for Medicare, not medically necessary for commercial products

0429T Subject to medical review for BlueCHiP for Medicare, not medically necessary for commercial products

0430T Subject to medical review for BlueCHiP for Medicare, not medically necessary for commercial products

0431T Not covered for BlueCHiP for Medicare and commercial products

0432T Not covered for BlueCHiP for Medicare and commercial products

0433T Not covered for BlueCHiP for Medicare and commercial products

0434T Not covered for BlueCHiP for Medicare and commercial products

0435T Not covered for BlueCHiP for Medicare and commercial products

0436T Not covered for BlueCHiP for Medicare and commercial products

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

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.

12/15 PRR-17466